AMH Introduction to Advanced Medical Homes – IT and Data Sharing
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Kelly Crosbie

(Slide 1) Good afternoon! My name is Kelly Crosbie and I'm the Deputy Director for Quality and Population Health with the North Carolina Medicaid program. Thank you for joining today's webinar entitled Introduction to Advanced Medical Homes IT and Data Sharing. This is the eighth in our series of training focused on the advanced medical health or AMH program which will launch when North Caroline transitions its Medicaid program from a fee for service structure to managed care beginning in November 2019. As we have discussed in previous webinars, the AMH program will serve as the primary vehicle for delivering care management to Medicaid beneficiaries once the state transitions to managed care and will involve prepaid health plans or PHPs delegating care management responsibility to practices that are certified AMHs. To perform these delegated responsibilities, AMHs will need to have timely access to complete, accurate, individual level and population level data. And there will be specific requirements on the PHPs relating to how they will provide practices with data. In today's webinar, we will provide an overview of key of requirements and expectations for AMHs and PHPs related to IT infrastructure and data sharing. Today's presentation will be supported by Manatt Health, the state's technical assistance provider for the Medicaid transformation. Adam Striar, a manager with Manatt will present a brief introductory session and Lammot du Pont, the senior advisor with Manatt, will speak to the details of the IT and data sharing requirements. For additional background on the AMH background on the AMH program, we encourage you to visit the AMH webpage which contains slide decks and recordings for previous webinars, the AMH provider manual, FAQs, policy guidance and other resources. The AMH webpage is linked in the back of this presentation and can also be located by just Googling NC DHHS Advanced Medical Home. As a final reminder, we strongly encourage any practices interested in participating in AMH Tier 3 to complete the required attestation through NC Tracks no later than January 31. We remind you that both doing so, practices are attesting that AMH capabilities will be in place by the launch of managed care later this year. AMH capabilities do not necessarily need to be in place right now, in order for a practice to complete the Tier 3 attestation. I will now turn it over to Adam Striar who will walk us through the first part of the presentation.

Adam Striar

(Slide 2) Great! Thanks Kelly. So I'll just quickly walk us through our agenda here for the day. So I'll start off by providing just a recap of the AMH program requirements and also the care management model that the state has established. I'll then turn it over to Lammot who talk us through the IT and data sharing specific elements of the program. So this will include a brief discussion of the department's overall data strategy including its overarching philosophy with respect to the use of data and AMH. And then also what IT and system's AMHs will need to have in place in order to participate in the program. We'll then talk through each specific data flow including how each flow will be used by practices. What are the AMH program

requirements related to each flow and then how clinically integrated networks and other partners can support the use of each data element. We'll then spend a few minutes talking through a few data use cases which are essentially just practice examples of how AMHs might use data to support the goals of the program and then we'll conclude with some brief Q&A, time permitting, and direct you to some additional resources on the AMH program. We encourage you if you have questions at any point during this presentation to please type those in to the Q&A box in the bottom right hand corner of your WebEx screen. Again, we'll consolidate those at the end of the presentation and respond to as many of them as we have time for.

(Slide 4) So here I'm just going to spend a brief moment providing a recap of just the key points and high notes on the AMH program that we've covered in previous webinars, just to set the context for today's discussion. So for those of you that have attended previous webinars, you may have seen this slide before. It basically just provides a condensed overview of the AMH care management model. Essentially the way the AMH program is going to work is that prepaid health plans or PHPs will delegate certain care management functions down to the practice level. AMH Tier 1 and 2 practices will take on care management functions that are similar to what exists in Carolina Access today while Tier 3 practices will take on additional care management responsibility in exchange for higher reimbursement. And so what you see here is essentially the universe of care management functions that the state envisions under managed care. And you'll see on the slide that the responsibility for each of these functions is split between PHPs and AMHs. And, again, the division of labor here is specific to each tier and what you see on the slide is the division of responsibilities in Tier 3. And I'm not going to walk through each of these steps in detail, but—and for folks that are interested in learning more about the model, we encourage you to visit our previous webinars which are on the AMH homepage—but there are essentially two key tranches of care management here and across the top row you have all of the processes that are part of what we are calling high needs care management which is for those beneficiaries with the highest and most complex needs. And then we have transitional care management which is for individuals that are discharged from the hospital. And then finally we have just general ongoing responsibilities related to care coordination and then also prevention and population health management. One final note here is that practices will expected to access and use data in different ways to support different elements of this care management model and that that's what we hope to shed a little light on throughout today's presentation.

(Slide 5) Okay. So as I mentioned, AMHs practices will use multiple types of data from PHPs and other sources to carry out care management functions and assume responsibility for population health under the AMH program. So two key things to note here, requirements as to the use of data are going vary by tier. So Tier 3 practices are going to have additional responsibilities related to accessing and using certain data flows. Also much of this data is going to be accessed through each AMHs PHP. PHPs will each track and maintain their own population health data and be responsible for sharing that data with AMH practices but in addition to that practices are going to need to access certain data flows through other sources. So in terms of data that all AMHs, so including those in Tiers 1 and 2 along AMH Tier 3 practices, these practices are

going to need to access beneficiary assignment information from PHPs. They'll also have access to initial care needs screening information for all of their assigned members. They'll receive risk scores for each of their assigned members from the PHPs and they'll also receive information on quality performance across the set of AMH measures from each of their PHPs. Now specific to Tier 3 there are some additional data sources that practices will have access to and will need to be able to use. So these Tier 3 practices will receive encounter data files from PHPs. So encounter data being claims that are received and adjudicated by a PHP. And they'll also eventually have access to NCCARE360 which the state has previously referred to as its resource platform. It's currently under development but will eventually provide practices with access to information about local human services in their communities. And we just note that PHPs and AMHs will be responsible for each of these data flows for complying with all federal and state privacy and security requirements regarding the collection, storage, transmission, use and destruction of data.

(Slide 6) Okay, and then just before we turn to the data requirements in detail, I just want to quickly recap what we mean when we talk about clinically integrated networks or CINs and other partners which the state really believes are going to play a very important role in supporting AMHs, particularly in Tier 3. So CINs and other partners can support AMHs in a number of different ways, including by managing data, supporting analytics and delivering advanced care coordination and care management. We want to be really clear here that we are referring to a wide range of organizations and are not strictly referring to the federal definition of clinical integration which as many of you know has important implications for anti-trust law. So we are deliberately adding the clause, other partners, here because the state really wants practices to have flexibility to work with different types of organizations that meet their specific needs. So this could include working with a large hospital or a health system or other organization where they may actually be some element of meaningful clinical integration in a legal sense of the term. But we also want practices that would prefer to work with a care management organization or a technology vendor to be able to do so, even if there is not necessarily meaningful clinical integration in that relationship. So just to be clear, both of these types of arrangements would be permissible from the perspective of the department and we do not expect and we're not requiring the practices contract with organizations that meet a definition of clinical integration, according to the federal standards. Okay, I'm going to pause there and just turn it over to Lammot whose going to walk us through the data strategy and the data flows in some more detail.

Lammot du Pont

(Slide 8) Thanks Adam. Now we're going to dive into the details of the AMH data strategy and I think its important context to note that the strategy that we're talking about today and the material we are presenting is based on a policy paper that the department released last July. It is available on the website that Kelly noted and also at the back of this presentation. And if you haven't had a chance to do so, we encourage you to review it because it encapsulates a lot of what we are discussing and provides additional details. So the strategy itself is anchored by four principles. The first is to ensure that all AMHs have timely access to the relevant and individual

level of information that they need to perform their care management responsibilities. That principle is buttressed by equipping the AMH Tier 3's and eventually the Tier 4 practices with the tools and resources they need to seamlessly manage the care across their PHP populations. Third, the principle of minimizing administrative and cost burdens on all stakeholders, where they be AMHs, PHPs or other practice, wherever possible. And finally, the data strategy is focused on and engages beneficiaries by increasing their access to information to help them engage better in management of their care.

(Slide 9) The data landscape is going to consist of different types of technologies and tools and on this slide we want to walk through some of the basic types of technologies that were are going to discuss and that you all are going to encounter. The first is electronic health record technology. And all practices are encouraged to, but are not required to use, a certified electronic health record technology for the AMH program. Using certified EHR technology has benefits but as noted it is not a required element of the program. The second type of system that many practices will use is often characterized as care management systems. And as explained in the AMH provider manual and requirements for AMH Tier 3 certification is that AMH Tier 3 practices must have a process to document and to store care plans in a clinical system of records. So typically that will be done through a care management system. Secondarily, AMH tier practices may, but are not required to, have additional types of tools and capabilities to perform care management, including risk stratification, population health platforms or other business analytics tools. The third type of information tool is systems that help move information and exchange data with others. Otherwise known as health information exchanges. Many of you are familiar in North Carolina that there is a state law that requires hospitals and practitioners who provide Medicaid services and who also have an electronic health record system to connect to and provide data with the statewide health information exchange, North Carolina HealthConnex. North Carolina HealthConnex is overseen by the North Carolina Health Information Exchange Authority (HIE). AMHs are free to access data from HealthConnex and other information, including admissions, discharge and transfer based alerts from not only North Carolina HealthConnex, but any other HIE that may meet their needs. That can include a hospital system or other type of organizational or enterprise health information exchange.

(Slide 10) So on this slide we lay the ground work for the data flows that we're going to discuss today. And there are two important points on this visualization. The first is that you'll see multiple prepaid plans represented. And this reflects the new landscape where practices are likely to have relationships and therefore data exchanges with more than one PHP. The department recognizes that these new types of data exchanges with multiple entities will create new complexities. One way to mitigate the complexity, as Adam mentioned, is for AMHs to work with clinically integrated networks or other partners who can provide the tools and technologies to help manage the flow of different types of data.

(Slide 11) In addition to working with a CIN and other partners, the state is also taking specific steps to help reduce the complexity and the cost to practices. This is a multi-pronged strategy that first involves alignment with national standards, where possible, and reuse of those

standards as widely has possible. Secondly, it involves the department providing technical reference guides and implementation specifications for PHPs and AMHs. In addition, the department is going to help facilitate and ensure that end-to-end testing and training for the exchange of key data elements, like beneficiary assignment and counter data, are available and can be put in place prior to the launch of the transition to managed care. And finally, the department will work with the AMH Technical Advisory Group to identify opportunities for consistent approaches to be deployed for data content, the format of data and transmission methods. So all these strategies again are going to be deployed to help reduce the level of complexity that you will face in the new landscape.

(Slide 12) So now we move into the specific data flows. In this section we are going to focus on the anticipated flows of specific types of data between AMHs and PHPs. For each data type, we will first describe how the AMHs can use the data, then we will highlight any relevant contractual certification requirements for AMHs and PHPs and then finally we'll offer some suggestions on ways that clinically integrated networks and other partners can help assist AMHs in exchanging the data and meeting the requirements.

(Slide 14) The first set of data flows that we're going to dive into are those between the AMH and the PHPs. And the first data type is beneficiary assignment information. PHPs will be required to send to the AMHs the list of beneficiaries assigned to them. This is going to be important information that informs the practices those individuals for whom they have care management responsibilities. The data will also be important to help determine AMH payments. AMHs will only receive, per member, per month, payments for patients that are assigned to them. And finally, the provision of this data will help AMHs support and meet one of their requirements. AMH Tier 3's must ensure that the assignment list that they have and received from the PHP, are reconciled with their own internal lists and are up-to-date in a clinical system of record. The second box illuminates the requirements for the PHPs in terms of the timing of the transmission of the data. Point-in-time assignment lists will be transmitted at least monthly. Projected assignment lists by the following month. Information on newly-enrolled and assigned beneficiaries within seven days. And ad hoc assignment changes in seven days. In helping to manage beneficiary assignment information, CINs and other partners can collect and organize beneficiary assignment information on behalf of the AMHs to help them reconcile the patient list and they can also assign in generating and transmitting the list of beneficiaries to external partners who can then use it to draw down data related to those beneficiaries.

(Slide 15) The next type of data is risk scores. And the details of risk stratification requirements were shared in a previous AMH webinar that was held on November 14, 2018. And I'll walk through some of the highlights here, again focusing on how the data are to be used; some of the requirements and then ways in which CINs and other partners can help support the exchange of risk scores. PHPs will be required to conduct risk stratification and to share the results, the risk scores, of assigned beneficiaries with AMHs. The data can be used from the scores to help inform the delivery of care management and the development of care plans. In addition, Tier 3 AMHs have specific requirements that indicate and require that they combine

risk scoring information received from PHPs with clinical information to score and stratify the patient panel. What are the requirements for PHPs? PHPs have a triggering requirement for them to send information is that they must notify AMHs when beneficiaries fall into one of the priority population categories. The content of that risk score must include the risk scoring result with AMH practices for the assigned beneficiaries. PHPs will also be encouraged to share an explanation of the risk score methodologies but it is important to note that each PHP is permitted to use their own proprietary risk scoring algorithm in calculating the final risk score that is shared with AMHs. In helping address some of the complexity and potential variability between risk scores, clinically integrated network and other partners can normalize risk status for the assigned beneficiaries based on the data from multiple PHPs. They can also help incorporate the risk stratification calculation relevant information and combine it with gaps in care data, other clinical data, and information related to social determinants of health. And finally, in terms of business analytics, they can provide services to develop detailed risk assessment and customized care management approaches for the AMH. When a beneficiary enters managed care, the PHPs must conduct an initial care needs screening and they must share the results with the AMHs.

(Slide 16) The AMHs can use the screening results to inform comprehensive assessments and they can use them to build the care plans. In terms of requirements, the PHPs must share the care needs screening results with the AMH within seven calendar days of conducting and completing the screening. In terms of requirements regarding the content, the PHP's care needs screening tool must identify six categories of information that are illustrated on this page. That content being shared with the AMHs there are a number of things that a CIN or other partner can do. The CIN and other partner can help compile or parse specific elements of the screening to inform care management functions and processes. On the other hand they can also aggregate beneficiaries' care needs screening results to identify patterns and inform AMHs performance.

(Slide 17) The fourth data element that's shared between PHPs and AMHs are quality measure performance information. The department has released a provisional set of nine measures that will be finalized before care management goes live and these measures were reviewed in the AMH 103 webinar held on October 12. PHPs will be required to provide regular performance feedback to AMHs on these nine measures. The data will be used to provide reoccurring feedback to help AMHs calibrate and optimize their care management processes. In addition the information will provide insights into the incentive payments. It's important to note that all Tier 3 practices, and some Tier 1 and Tier 2 practices will be eligible for performance incentive payments based on their performance against these AMH quality measures. In terms of requirements PHPs must provide feedback on quality scoring results to each AMH practice. The timing is such that the feedback must be provided on both an annual and an interim basis for selected measures. Additional details with respect to the format and other information will be provided based on feedback and input from the technical advisory group after the PHP procurement. In terms of the roles that CIN and other partners may provide, highlighting some of the potential roles is the ability to aggregate performance data at the practice level to

provide dashboards on quality measures. This can inform the processes that AMHs deploy to help assist in care management.

(Slide 18) The fifth element to consider is encounter data. PHPs will be required to share all encounter data for attributed beneficiaries on a timely basis with Tier 3 AMHs. This information will be used by the Tier 3 AMHs to provide information for each beneficiary to inform critical care management functions including risk stratification and care plan development. Encounter data will also provide valuable insights into the total cost of care for a beneficiary. PHPs will compile their adjudicated claims from providers and transmit attributed beneficiary encounter data to the Tier 3 AMHs or their designated CINs and other partners. The department will set timing requirements based on feedback again from the AMH technical advisory group and stakeholder input. The department will provide detailed specification and companion guides with technical details that will align with national standards and help inform the expected format for the encountered data to be provided from the PHPs to the AMHs. Again, one of the important roles that CINs and other partners can provide is the ability to collect and organize encounter data from multiple PHP sources and make it actionable by the AMHs.

(Slide 19) The next set of data flows focuses on the AMHs ability to access particular types of clinical data.

(Slide 20) The first is access to admission, discharge and transfer data that will enable the tracking of empaneled patient's utilization of local emergency department and hospitals. AMHs can use ADT feeds to create alerts that trigger intensive care management and help identify individuals who will need transitional care management. Tier 3 AMHs are required as part of their certification to have active access to an ADT source that correctly identifies specific empaneled patients' discharge or transfers to or from an emergency department or in-patient setting in real time or near real time. North Carolina laws, we mentioned earlier, requires that hospitals and practitioners who provide Medicaid services must connect to the North Carolina health connects. This connection can include connection to ADT feeds. Again it's important to note that the access to ADT feeds and alerts can come from North Carolina health connects and other sources of ADT feeds and alerts. With respect to a sample of the types of services that a CIN and other partner could provide on the right-hand side that highlight that it's the fourth, sorry, the third bullet. They can provide used daily batched ADT information to facilitate patient prioritization.

(Slide 21) AMHs will also need to collect other data in a timely manner. And these types of data can include patient's test results, selected lab values, and other immunization data and gaps in immunizations to help inform and oversee and manage beneficiary care. In terms of requirements it's important to note while there are no contractual requirements to access or use clinical data for care management, the department strongly encourages providers to access clinical data. Providers have multiple options for accessing clinical data. If a provider is affiliated with a health system, they may access clinical data or other providers' affiliated information with the same system that their health system's EHR software provides. For access to clinical information from non-affiliated practices including immunization data and information on

prescriptions for controlled substances, AMHs are encouraged to work with North Carolina Health Connects and other data sources to assess data sharing opportunities and establish data sharing agreements in time to have them in place and operational by the transition to managed care. In terms of roles that a CIN and other partner may provide is they can collect, parse and organize clinical data from multiple sources and they can help integrate that clinical data into the AMHs system of record.

(Slide 22 and 23) The next category speaks to the information that is needed to address the unmet resource needs. Sometimes referred to as the Social Determinants of Health. With respect to the Social Determinants of Health data, Tier 3 AMHs will receive information on beneficiaries' unmet resource needs and address these needs by connecting beneficiaries to available community resources. AMHs can use data on Social Determinants of Health to connect the beneficiaries not only to the resources for assisting them; they can also track referrals to such resources to address housing, food, transportation and interpersonal safety. Many of you on the webinar today may have heard about a new statewide effort. This fall the North Carolina Foundation for Health Leadership and Innovation announced the selection of a team that is creating a statewide tool to make it easier for providers, care managers and community-based organizations, to work together to connect people with community resources. The tool is called NCCARE360 and will be available for free and help caregivers identify available community resources and make and track referrals to those resources. In the future, ones certified by the department as fully functional, PHPs and Tier 3 AMHs will be encouraged to use NCCARE360. CINs and other partners can help AMHs by reviewing information on beneficiaries' unmet resource needs and providing actionable information directly to care managers based on those identified needs.

(Slide 24) The last data flow speaks to the ways in which AMHs and PHPs can use information to directly engage beneficiaries. AMHs are strongly encouraged to engage patients in their own health by making secure information sharing with patients easier and more widespread. And AMHs have multiple options to engage patients. That can include the use of patient portals that are offered by providers' EHRs.

(Slide 25) In addition the department also encourages AMHs and PHPs to explore innovative strategies that allow beneficiaries to control how their information is utilized and the format in which it is able to be shared and exchanged with them and their caregivers. With respect to some support that CINs and other partners can provide, they can develop a means for that secure data transfer to occur and reports to beneficiaries as needed. For example, CINs and other partners can develop workflows that respond to certain events, and share specific information with patients.

(Slide 26) So now we move to Part V. And in this part, we bring together the multiple data flows to showcase typical use cases and workflows that you will potentially encounter.

(Slide 27) In the first Use Case, we address Risk Stratification. So, in this Use Case, the scenario is that a Tier 3 practice partners with a CIN or other partner to compile risk stratification scores from multiple PHPs, combines it with encounter data information on social determinants of

health and other clinical data to inform the care management process. On the left hand side, you can see that data will be flowing in risk scores from multiple PHPs, as we mentioned that the risk scores and methodologies could vary between the PHPs. The CIN or other partner, illustrated in the middle of the screen, can ingest the information on the risk stratification scores and combine it with data, clinical data, from a health information exchange like the North Carolina HealthConnex, compile it, and help provide actionable, normalized risk stratification scores that can be used by care managers and population health managers at the AMH.

(Slide 28) The second Use Case illustrates flow of information regarding admission discharge and transfer alerts. In this scenario, a patient is enrolled in an AMH Tier 3, and is admitted to a local hospital and requires transitional care management and access to community based services. On the left hand side, an alert is created once that patient is admitted to the local hospital. That alert is ingested by the CIN or other partner's technical system, where it's compiled with other information to create an alert. The alert is transmitted to the AMH Tier 3 care manager and allows two things. First it allows rapid follow up for the care manager for that patient. And secondly, it offers the opportunity for the care manager to access and refer the patient to community-based resources via NCCARE360.

(Slide 29) So that is the compilation of workflows and at this time, we'll entertain questions. So we'll just take a brief pause here, and if folks do have any questions, we again encourage you to enter those into the Q&A box in the bottom right hand corner of your WebEx screen.

Q&A

Okay, so it looks like we have one question here on the AMH add to station deadline. So, someone commented, "Do practices have to attest to Tier 3 AMH by 1/31/2019 to be included in the 80 percent of Tier 3 AMHs that the PHPs must contract with?" I'll start off by saying that there will be subsequent opportunities for practices to enter the AMH program past January 31st. That said, we do strongly encourage practices to go in and attest by this date. And that's for a couple of reasons – one, we really feel as though it will allow for the optimal experience of testing and getting up to speed for practices and ensuring that all systems and capabilities are in place prior to the launch of Managed Care, and also we remind you that attestation is nonbinding. So, Tier 3 practices that attest to Tier 3 are not locked in to necessarily performing Tier 3 functions if, for whatever reason, they're not able to either get a Care Management fee that they deem to be appropriate or secure desired contracts with all PHPs.

We would like to direct you also to policy guidance that the state has recently released on this topic. This is, again, can be found on the AMH homepage. And this basically explains the department's expectations with regards to Tier 3 AMH contracting. So if you have further questions on that topic, we encourage you to look at that memo.

So on the technical side, there's a question that asks whether the Care Management documentation system have to be the same as an electronic health record system. And the answer is no. Oftentimes in the marketplace, you'll find an electronic health record vendor that

offers a care management documentation system. Or they could be separate functions and tools. So there is no requirement that Care Management documentation system be an electronic health record system, or be a population health tool. It is simply a matter that the functionality of documenting the clinical information and the relevant care information has to be in a system of record.

And we have a question here, "So, once you stratify a patient, do you need to re-stratify a patient after a certain period of time?" And first off, if you have specific questions about re-stratification, we definitely encourage you to view our previous webinars on this topic, where we talk about it in greater detail. But our general rule of thumb with regards to doing re-stratification of patients is that practices aren't necessarily required to re-stratify over any set period of time, but practices do need to have a process or a defined methodology in place to determine when it's necessary, when it's most appropriate to re-stratify each of their attributed patients.

Okay, and then we have another question here. "If a patient is found to be attributed to a practice, but is not seen by the practice, will there a recommended workflow to remove the patient from the PHPs list for the AMH, or will this be something established between the PHPs and the AMH. So, really the answer to this is the latter, so the state is generally not going to be involved in adjudicating patient attribution. So this is something that, in general, we recommend AMHs to work with their PHPs on.

Okay, and we have another question here. "Will we have a choice of quality measures to pick from, or will they be picked for us?" So again, we talk about quality measures and performance incentive payments in more detail in an earlier webinar, but we'll say that there will be a specific list of AMH measures that AMHs and PHPs will be able to choose from when executing their contracts. That said, the quality measure list has not been finalized to date. I would expect more information about the quality measures in the coming months. But we have posted a tentative list of AMH measures in one of our previous presentations on the topic.

Okay, and we have another question here. "Once a patient is attributed to a certain practice, AMH 2 or AMH 3, and they go to a different practice because they're on vacation, can they be seen, and will the practice get paid for their services?" And the answer to that question is, yes. Attribution does not have anything to do with whether or not a practice will get paid for, get paid their regular fee for service rate for a visit. Attribution matters with respect to the AMH payment specifically. So those are per member, per month payments. The Care Management fees for Tier 3 and the medical home fees for Tiers 1 and 2. Those will be distributed on a per member, per month basis. Based on patient assignment. But if a practice sees a patient that is not assigned to them, and is maybe assigned to another Medicaid provider, that practice would still be able to get paid their regular fee for service rate from the PHP for that visit.

We received a question, "Can a practitioner participate in Medicaid if it doesn't have an EHR and can't connect to HealthConnex?" I think it's important in the context of the AMH Tier 3 Care Management, although there's not an explicit requirement to have a certified electronic health record, the requirements for Care Management and the requirements to have a

documented clinical system would imply that there is a system of record that would be needed to be deployed by the AMH Tier 3, that is accepting additional responsibility for the Care Management of beneficiaries assigned to them.

We also received a question of, "When would the specifications for the claims and encounter file be available?" That information will be forthcoming after the PHP and awards announcement, there will be technical guides and information that is provided to the PHPs, so that the transmission of encounter data from PHPs to the state is in a consistent and common file format.

And we have a question here. "If a practice sees a patient that is not one of theirs, and they don't participate with the PHP that the patient is involved with, will they still get paid for seeing that sick patient?" So that's subject to agreement between the particular PHP and the AMH, but we would like to note that practices, North Carolina's Medicaid Managed Care will take the form of any willing provider. So any provider that is willing to accept fee for service rates cannot be turned down for a contract with a PHP. So there should be no reason why a practice would not be able to secure a contact with a specific PHP if they're willing to accept fee for service rates, so because of that, we don't foresee this being a huge issue. But again, if a practice were to see a patient that is in a PHP with which, in which the practice is not in the network, that's again up to the AMH and the PHP to work out that payment arrangement.

Okay, and we've gotten a few questions on where to find the state's guidance with respect to Tier 3 contracting and the AMH Tier 3 contracting requirements. So, I'll just direct folks to this guidance here. So, if you're able to navigate to the AMH homepage, which again, you can do that by googling "NC DHS Advance Medical Home." Right on that homepage there, there should be a resources subheading, and beneath that, there is a link entitled "Programmatic Guidance on PHP Contracting Requirement for Tier 3 AMH Practices." And that should be the guidance that you're looking for.

We also received a question, the following: "Will providers have the ability to determine the level of detailed information to share with North Carolina HealthConnex? For example, psychologists may see clients do not want basic information such as diagnosis in the record to distribute among other providers." With respect to the AMH program, the AMH certification and participations do not govern the type of information exchanged, or what information are provided. That information is guided by both federal and state laws, and also would be determined by the participation use agreements with North Carolina HealthConnex.

We also have a question regarding, "How hard would it be for a practice to meet the data sharing requirements on their own, without a partner, with the CIN or other entity?" And the answer to that is that there is an acknowledgement that the level of technical exchange and information collection could be complicated and could be complex, and more than would be capable for small to medium-sized practices. In which case, it would make sense for them to explore opportunities and options to partner with and work with a clinically integrated network, or another partner.

Okay, and so we have a question here, "Will all Tier 3 practices have to provide primary care services?" And the answer to that question is yes. The AMH program is a primary care medical home model at its heart. The types of providers that are allowed to participate in AMH is actually the same as there currently is in Carolina Access. So this includes a number of different subspecialties, regardless of specialty, the practice does need to be providing primary care services in order to participate in AMH

(Slide 31) Okay, so we're not seeing any additional questions here. So, I'd just like to direct you on this last slide to some additional information if you're looking to learn more about the AMH program. We've listed a number of web resources here, so, including the AMH homepage, where the guidance that I mentioned earlier is located. We also have links to all of our previous trainings. We've also placed in this presentation, links to a number of different policy white papers and other guidance that may be of interest. We also encourage you, if you have further questions, to please write into the department at the email address listed at the top of this slide, so that's Medicaid.Transformation@dhhs.nc.gov. Or you can send in by physical mail to the address listed on the slide.

We thank all the participants again for taking time out of your busy day. Hope you have a really great rest of your afternoon.

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