

AMH 102 and Transitioning Carolina ACCESS

Kelly Crosbie

(Slide 1) Good afternoon, and my name is Kelly Crosbie and I'm a senior program manager with the North Carolina Medicaid program. Thank you for joining today's webinar entitled Introduction to the Advanced Medical Home Program: AMH 102 and Transitioning Carolina ACCESS. This is the second in our series of training focused on the Advanced Medical Home or the AMH program, which will launch when North Carolina transitions its Medicaid program from a fee for service structure to managed care, beginning in November 2019. In this webinar we will provide a more detailed overview of how providers in the current Carolina ACCESS program will transition into AMH, and what that means for provider payments. Jonah is going to get more into the Carolina ACCESS program, but this is a reminder, Carolina ACCESS is our current primary care program. So, it is for primary care physicians and it includes the care management that beneficiaries also receive through CCNC. Jonah will detail that more in the presentation. For additional background on the AMH program, we encourage you to visit the AMH webpage, which contains the AMH 101 slide deck from the previous webinar as well as a detailed manual for Advanced Medical Home providers. The web page also contains registration information for our upcoming AMH regional training. We will be coming to you across the state. These will take place in 6 locations across the state, beginning this week with Wilmington on August 30th. We'll also include Greensboro, Greenville, Asheville, Huntersville and Raleigh, and they'll run through September and early October. A note for those of you that are planning to attend these, the regional trainings will feature very similar material to the AMH 101 and 102 webinars. However, we believe that this is a great time for additional Q&A, it's an opportunity to speak directly with us at the state, and it's a great opportunity for you to speak to your peers in the provider community. So, we hope that these will be valuable for you guys. We know that they'll be valuable for us to talk with you directly about the Advanced Medical Home program. We thank you for your continued engagement in this important effort, and we hope to see you at the in person trainings and in future webinars. I'm now going to turn this over to Jonah Frohlich. He's going to walk through the remainder of the presentation. Jonah is a managing director with the state's technical assistance provider, Manatt Health. Thank you.

Jonah Frohlich

Thank you Kelly and good afternoon everyone. Thank you for joining us for today's webinar and making time out of your busy schedules. As Kelly mentioned, this is the second in a series of education sessions and modules that the department is supporting over the next several months. We'll post dates and times of future webinars and education sessions, and copies of these materials along with recordings of the webinars will be posted on the AMH training website.

(Slide 2) So, for today's session, as Kelly mentioned, we're going to provide an overview of the Advanced Medical Home program, and as part of that we want to also provide an overview of Carolina ACCESS, and the transition from Carolina ACCESS to the AMH program. We want

make some comparisons and then highlight some key distinctions between Carolina ACCESS and the AMH program, and provide a few use cases which will help illustrate at a high level the financial impact that the transition will have for hypothetical practice. We'll then provide some summary statements, and then in this material that will be posted on the website there's an appendix that has some supplemental information. The audio recordings have not yet been posted. We are in the process of doing so and they will be available soon.

(Slide 3) So, let's turn to part 1, which is an overview of Advanced Medical Homes, and for those who attended last week's 101, please bear with us. Some of this introductory material is similar. It will be the same. It's important though to repeat here to provide context for some of the later material which includes the cases that we discussed, that I just mentioned.

(Slide 4) So, just for everyone's information, the vision for Advanced Medical Homes was developed by the department as the program was being initiated, and the vision here is to build on Carolina ACCESS to preserve broad access to primary care services for Medicaid enrollees, and to strengthen the role of primary care in care management, care coordination and quality improvement as the state transitions to managed care. The practices will have options as Advanced Medical Homes. Current Carolina ACCESS practices may continue as AMHs in the new program with very few changes. The practices ready to take on more advanced care management functions may also be eligible for supplemental payment. Practices that rely on in-house care management capacity or contract the Clinically Integrated Network or other provider partner or vendor, can do so at their choice. Unlike in Carolina ACCESS, practices will not be required to contract with CCNC, though they may choose to do so.

(Slide 5) AMHs are designed in this program to enhance access to local primary care-based care management Medicaid enrollees. The AMH program includes per member per month medical home payments for primary care providers to delivery primary care case management or PCCM services. A minimum practice requirement in the AMH program will be the same as those in Carolina ACCESS. The AMH program allows and encourages PHPs to delegate more advanced care management responsibility down to the practice level. Now their studies have shown that local care management is a cost effective way to improve individual and population health in the AMH program is designed to provide local care management. AMHs can manage care as a practice or by contracting with the CIN or with other third-party care management partners or vendors. Practices that take on more advanced care management functions will receive additional per member per month reimbursement from PHPs.

(Slide 6) There are at initiation of the program will be 3 tiers in the AMH program with the 4th tier to be launched at a further date, at a later date. For Tier 1 and 2 practices that qualify for AMHs, the prepaid health plans will retain primary responsibility for care management and practice requirements care management will be the same as for Carolina ACCESS. In tiers 1 and 2 providers will be needing to coordinate across multiple plans. They'll need to interface with multiple PHPs who will retain primary care management responsibility, and those PHPs may deploy different approaches to care management. They may have different care management platforms or services. AMH payments or these medical home fees for AMHs in Tiers 1 and 2

will be the same as in Carolina ACCESS and are non-negotiable. In Tier 3, prepaid health plans may delegate full primary responsibility for delivering care management to the practice level. Practices in Tier 3 meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities. Tier 3 allows for a single consistent care management platform, and practices will have the option to provide all of that in house or to contract with a single CIN or other care management partner or vendor across all their Tier 3 prepaid health plan contract. PMPM medical home fee payments for Tier 3 providers will be the same as in Carolina ACCESS and are non-negotiable. However, additional care management fees can be negotiated between PHPs and the practices.

(Slide 7) Next we want to provide an overview of Carolina ACCESS today.

(Slide 8) For those of you who participate in Carolina ACCESS, you know that it's been North Carolina's primary care case management program since the 1990s. It's North Carolina's regionally based program that provides primary care case management services to North Carolina Medicaid beneficiaries. In this program, North Carolina Department of Health and Human Services contract with Community Care of North Carolina or CCNC to provide enhanced care management services. Carolina ACCESS practice requirements include: after hours medical advice, their maximum enrollment limit, provide availability of oral interpretation services; require a minimum set of hours of operation and preventative and ancillary services. A list of those services are available in the appendix in this material on the website.

(Slide 9) Carolina ACCESS also has 2 levels. In CAI or Carolina Access 1 practices must meet all necessary requirements as determined by North Carolina DHHS and also those are listed in the materials in the appendix. Now payments to practice include \$1 per member per month or PMPM, for beneficiaries enrolled with the practice in addition to fee for service payment that are issued by the department. Carolina ACCESS II commonly referred to as CCNC, CAII practices must meet all CAI practice requirements and sign a separate contract with their local CNCC network. In addition to fee for service payments, practices receive \$2.50 per member per month for most Medicaid and North Carolina health choice beneficiaries contributed to that practice, and \$5.00 per month for age, blind and disable beneficiaries.

(Slide 10) In terms of the transition from Carolina ACCESS to Advanced Medical Home program, AMH builds on the existing infrastructure of Carolina ACCESS. AMH tiers 1 and 2 incorporate Carolina ACCESS requirements and payment models into manage care. The providers in AMH, tiers 1 and 2, will continue to have the same practice requirements and receive the same member per month payments. Primary care practices participating in or eligible to participate in Carolina ACCESS are also eligible to participate as AMHs. For providers that are currently participating in Carolina ACCESS they'll be automatically grandfathered in to the new program as AMHS. Medicaid providers that are not participating in Carolina ACCESS must enroll in Carolina ACCESS through NC Tracks before they will be eligible for AMH certification. Practices not currently enrolled in Medicaid will first need to enroll in Medicaid and complete the Carolina ACCESS supplemental application.

(Slide 12) Now the role of Carolina ACCESS and fee for service in North Carolina Medicaid going forward, there's some distinctions here; from the fee for service program Carolina Access will continue to operate concurrently with AMHs for populations remaining in fee for service coverage. Approximately 20% of beneficiaries are expected to remain in that coverage. Now these include exempt and excluded beneficiaries and those that haven't yet enrolled in managed care. Practices may continue participating in CAII for FFS populations that they serve. Carolina ACCESS I will sunset for practices not currently in Carolina Access. In managed care AMH program replaces Carolina Access. Practices must go through a Carolina Access application process in order to participate in AMH. It is not necessary to be a CAII practice or to sign a contract with CCNC. Carolina Access status will streamline a practice's path, becoming an AMH, but for example CAI practices will be grandfathered into AMH Tier 1 and CAII practices will automatically be grandfathered into AMH Tier 2. Practices not currently participating in Carolina Access can still enroll in an AMH, but will first need to enroll in Carolina Access.

(Slide 13) So, the following slide provides a guide path for the transition from Carolina Access to AMH or for providers not currently enrolled in Medicaid. So for those who are not enrolled in Medicaid, you have the opportunity to participate in AMH as a Tier 2 certified provider, by enrolling in Medicaid and Carolina Access. You may also successfully enroll in Medicaid Carolina Access and attest to Tier 3, to become a Tier 3 certified AMH provider. You will not be permitted to enter into the AMH program as a Tier 1 certified provider. For all other currently Medicaid enrolled providers there are three pathways. So for those who are enrolled, but are not participating in Carolina Access, you may participate as an AMH Tier 2 certified provider, by enrolling in Carolina Access. You may also participate as a Tier 3 certified AMH by enrolling in Carolina Access and attesting to Tier 3. If you do nothing the default is that you will not be an AMH eligible practice. For current providers who are CAI, in the CAI category, if you do nothing you will default into the AMH Tier 1 certified category. You may however elect to participate in Tier 2 by NCTracks or attest to Tier 3 and become an AMH Tier 3 certified provider. You may also elect to opt out all together by NCTracks and you will not be an AMH eligible provider. You may continue of course to serve the Carolina Access beneficiaries. For those Medicaid enrolled providers who are CAIIs or CCNC practices, then you may opt for the AMH program through NCTracks. To do so you may continue serve beneficiaries in the FFS program. If you do not opt and do not attest to Tier 3, you will automatically default into the Tier 2 category. You may also attest to Tier 3 and become a Tier 3 AMH.

(Slide 14) So in terms of this roadmap, the following provides an illustration of how practices not currently enrolled in Medicaid may participate in the AMH program. So for options 1 and 2, our practices new to NC Medicaid may enroll in NC Medicaid through NCTracks and complete the Carolina ACCESS application. In option 1 you become a Tier 2 certified provider. You may then contract the prepaid health plan and receive medical home payments. You may also enter into option 2, complete Tier 3 attestation, become an AMH Tier 3 certified provider, and contract with a prepaid health plan to receive medical home payments and can negotiate additional care management payments with each of your PHP partners. Then there's the third option, which is to not participate as an AMH and no option is required for that option. Practices new to a Medicaid program may not participate in AMH as a Tier 1 provider.

(Slide 15) For providers who are non-Carolina ACCESS Medicaid practices, but they're Medicaid enrolled there are three options. In options 1 and 2, you may submit a managed change request through NCTracks to apply for Carolina ACCESS. If you do, you would automatically be entered in the AMH Tier 2 certified category and you can begin contracting with PHPs and receive medical home payments. You may also in option 2 complete a Tier 3 attestation in NCTracks, become Tier 3 certified and contract with prepaid health plans to receive medical home payments and supplemental care management payments. And option 3 you may elect to not participate as an AMH and no action is required; no further action is required, excuse me.

(Slide 16) Now for CA practices, excuse me for CAI current practices and that represents approximately 534 practices serving over 38,000 beneficiaries, there are four options. In the first option, if you take no action, you will automatically be grandfathered in the AMH Tier 1 category. In option 2 you may elect to participate in Tier 2 through NCTracks to become a Tier 2 certified provider and you may contract with PHPs to begin receiving medical home payments. In option 3 you may complete a Tier 3 attestation in NCTracks to become Tier 3 certified and then contract with PHPs to receive medical home and additional care management fees. In option 4 you may opt out and not participate as an AMH.

(Slide 17) And then finally for current CAII or CCNC practices that represents over 1700 practices serving approximately 1.6 million beneficiaries, there are really three options. On the left, as you can see, an option is not to participate; you may not participate as an AMH Tier 1 provider. So the three options that you do have, first if you take no action you will automatically default into the Tier 2 category in the AMH program and you can begin contracting with PHPs and receive medical home payments. You may also in option 3 complete a Tier 3 attestation in NCTracks, become Tier 3 certified and receive medical home and care management payments. Option 4 is to opt out, in which case you would not be participating as an AMH.

(Slide 19) So next we want to turn to comparing Carolina ACCESS and AMH programs. So first we want to point out a couple of key similarities between the two programs. So first the types of programs eligible for Carolina ACCESS in the AMH program are the same. Second AMH Tier 2 requirements are the same as CAI and CAII requirements. Third practices may continue to work with CCNC if they choose. And fourth payment structures for AMH Tier 1 and 2 mirror those in CAI and CAII.

(Slide 20) Now there are also a number of key distinctions between Carolina ACCESS and AMH that we would like to point out. Carolina ACCESS payments commence as soon as practices are certified as CAI or CAII. However, in the AMH program, AMH payments to practices will not commence until contracts with PHPs are signed. The attestation through NCTracks are grandfathering from Carolina ACCESS only provide the certification status. Practices must then contract with PHPs to receive payments for fee for service and medical home. Now in Carolina ACCESS the second distinction is that CCNC is the sole vendor of care management services. In the AMH program CCNC is no longer the sole care management vendor and practices are free to contract with any CIN partner. Third distinction is that in Carolina ACCESS practices must

contract with CCNC to receive \$2.50 or \$5.00 PMPM payments, depending on the beneficiary category. In the AMH program practices need not contract to the CIN or other partner to receive those payments, they can perform those care management services in house, to receive those medical home fees. And fourth in Carolina ACCESS, Carolina Access only has two levels and practices only receive six PMPM medical home payments. In the AMH program practices can participate in AMH at the Tier 3 level and be eligible for additional care management fees. Note as well, Tier 3 requirements go above and beyond those in Carolina ACCESS I or II and performance incentive payments may be issued by prepaid health plans.

(Slide 22) So finally we want to show some practice use cases which illustrate the impact at a very high level the financial impact to a theoretical practice. So, on this slide we're showing a couple of things, first to note, most North Carolina Medicaid practices that are going to be eligible to participate in the AMH program will have beneficiaries that remain in fee for service. Most beneficiaries will be transitioned into manage care in November 2019 but beneficiaries in some regions will transition to Managed Care on a delayed timeline some specified timing beneficiaries will remain in fee for service. CA I and II will continue to receive Carolina ACCESS payments, fee for service and medical home payments for those beneficiaries. As in Carolina ACCESS medical home practices will receive higher medical home fees for aged, blind and disabled beneficiaries. So let me start with this hypothetical patient panel, I want to walk through this because in the next in the series of next slides we're going to show what the impact is to each practice for serving these beneficiaries depending on what tier or category that practice participates in both in CA in the Carolina ACCESS and the advanced medical home program. So in this theoretical practice, there are 300 beneficiaries who will be transitioning to the manage care program in 2019 CA 1 practices or AMH Tier 1 payments would be \$1.00 per member per month and for those practices that are CA 2 or AMH Tier 2 or 3 they'll receive \$2.50 per member per month payment. There's a second category here of population of patients in this case 50 are nonage blind and disabled beneficiaries that are not yet enrolled in Managed Care these might be individuals with a serious mental illness if it's not in the ABD category or it may be a beneficiary that's in a region that has not yet rolled out Managed Care and these beneficiaries will remain in fee for service. In that case the practice will receive a \$1.00 per member per month if they're CA 1 or AMH Tier 2 provider and \$2.50 per member per month if they're CA 2 or AMH Tier 2 or 3 medical provider. For the third population the 50 patients that are both age blind and disabled and be transitioning into Managed Care if you're CA 1 or AMH provider you'll receive a \$1 per member per month if you're a CA 2, CCNC provider or an AMH Tier 2 or 3 or medical home provider you'll receive \$5.00 per member per month for those beneficiaries; and finally for the fourth category of beneficiaries 100 age blind, disabled beneficiaries are attributed to this practice and if you're a CA 1 or AMH provider you'll receive \$1.00 per member per month for each of those beneficiaries or \$5.00 per member per month for CA 2 or AMH Tier 2 or 3 medical home. The point here is that even with the same panel composition practices may receive different per member per month payments based on their AMH or Carolina ACCESS designation.

(Slide 23) So we're going to take a look now at a few different scenarios to see how this translates in real dollars so let's start with a sample practice. In this case sample practice 1

they're non Carolina ACCESS provider, non-Carolina ACCESS provider's don't receive currently any Care Management fees through the Carolina ACCESS program. So in option 1 this Carolina ACCESS practice will decide to become an AMH Tier 2 provider, in the future in the first year they'll receive total payments of \$12,000 for the year that's \$12,000 in advance medical home payments, but no Carolina ACCESS payments for beneficiaries remaining in fee for service because if we notice they're not a CA practice and they're not currently enrolled in Carolina ACCESS. In option 2 in this case the provider becomes a Tier 3 AMH provider they will also receive \$12,000 for the entire year or that in panel patient population Care Management of medical home fees plus they may negotiate additional Care Management fees with a PHP, both payments of \$12,000 are AMH payments for managed care beneficiaries plus they may receive additional negotiated Care Management fees and performance incentives and no Carolina ACCESS payments for beneficiaries remaining in fee for service unless they contract with CCNC for fee for service.

(Slide 24) So how does this translate we want to make sure you're clear on how those dollars translate and what it really looks like. So in the top left corner of this slide we have a fee schedule the payments schedule that we reviewed in the previous slide and here you can see that three tiers of providers and the different payments amount for Managed Care beneficiaries who either all in non ABD and ABD and you can see the payment amounts for each one of those categories, and again for the fee for service beneficiaries each different type of provider practice receives payments, different payments for the different types of beneficiaries. So in this first illustration for a non-CA provider 300 beneficiaries are enrolling in Managed Care and are non ABD for those 300 beneficiaries the practice receives \$2.50 per member per month and over 12 months results in \$9,000 in medical home payments to the practice. The practice also has 50 Managed Care age blind and disabled beneficiaries attributed to them will receive \$5.00 per member per month and over 12 months will result in \$3,000 in medical home payments to the practice. Unless the practice participates with and has a contract with CCNC in this case in this illustration they don't they will not receive any PMPM payments. As a result the total medical home fees for this provider practice are \$12,000 in the first year.

(Slide 25) Let's go to a second sample. Here we have sample two and this is a current CA1 practice and again for this same impaneled population that we reviewed, current state Carolina ACCESS payments will be \$6,000. Now this practice has 3 options, they may default into the AMH Tier 1 category and if they do so they'll continue to receive \$6,000 per year in medical home payments, that's \$4,200 for Managed Care beneficiaries and \$1,800 for Carolina ACCESS payments for those beneficiaries remaining in the fee for service program. A CA1 practice as we mentioned may also elect to participate in the AMH program for Tier 2 provider, in that case their future payments will increase to \$13,800 AMH payments medical home payments for Managed Care beneficiaries will be \$12,000 and Carolina ACCESS payments for the services provided to remaining beneficiaries and fee for service will be \$1,800 per year and the third option the CA1 practice may elect to become a Tier 3 AMH. In that case they also receive \$13,800 in medical home payments plus any additional negotiated fees negotiated between PHP's and that practice. As in the Tier 2 provider AMH medical home fees for Managed Care beneficiaries are \$12,000 and any additional negotiated care management and performance

incentive payments will be made by the PHP to the practice and Carolina ACCESS payments for the beneficiaries remaining in fee for service will be \$1,800.

(Slide 26) So again how does this translate, recall the fee schedule the top left corner of the slide and if the practice elects to default do nothing meaning to not become a Tier 2 or 3 provider so if they default into the Tier 1 category then for each one of those beneficiaries served they receive \$1.00 PMPM and so in this case there are 300 beneficiaries that are non ABD category and Managed Care and those 300 beneficiaries receive \$1.00 PMPM and over 12 months that translates into \$3,600; they'll receive \$600 for Managed Care aged, blind and disabled beneficiaries \$600 for those beneficiaries remaining in fee for service who are in Carolina ACCESS and \$1,200 for those beneficiaries who remain in fee for service and are aimed in the age, blind and disabled category for a total of \$6,000 per year in medical home payments. Now for practices entering AMH Tier 2 and this also holds for Tier 3 so in the latter case for Tier 3 does not factor in any supplemental incentive payments of care management fees but for practices entering into AMH Tier 2 or 3 for the 300 beneficiaries in Managed Care and non-aged, blind and disabled category they'll receive \$2.50 per member per month for 12 months resulting in \$9,000 in medical home payments. They'll receive for the 50 beneficiaries in Managed Care who are age blind and disabled, \$5.00 per member per month over 12 months resulting in \$3,000 in medical home payments. For the remainder of their panel patients who are in fee for service there are 50 beneficiaries in the fee for service non aged, blind and disabled category they'll receive \$1.00 per member per month for 12 months resulting in \$600 in medical home fees; and for the 100 beneficiaries in fee for service who are aged, blind and disabled in the Carolina ACCESS program receive \$1.00 per member per month for 12 months resulting in \$12,000 in medical home fees result is \$13,800 in medical home fees per year.

(Slide 27) In our final illustration these are CA2 practices and here for the same in panel population current state Carolina ACCESS payments would be \$19,500 per year. Now if that practice elects to do nothing meaning that they do not attest to Tier 3 they would default into the Tier 2 program and will continue to receive \$19,500 in medical home payments. \$12,000 of those payments are for medical home fees for Managed Care enrollees and \$7,500 for enrollees remaining in fee for service. For those who elect to become Tier 3 providers they would receive the same amount of payments for their Managed Care enrollees and for their fee for service enrollees however they can negotiate additional Care Management fees and receive additional performance payment incentives from the PHP's they contract with.

(Slide 28) And to illustrate this once more note the fee schedule in the top left corner of this slide for the 300 beneficiaries who are in Managed Care and not aged, blind, disabled the practice will receive \$2.50 per member per month payments over 12 months resulting in \$9,000 medical home fees. For the 50 beneficiaries who are in the aged, blind, disabled category and are in Managed Care, they'll receive a \$5.00 per member per month payment for each beneficiary and over 12 months results in \$3,000 in medical home fees. The remaining beneficiaries that they serve in fee for service in this case for the 50 beneficiaries that are in fee for service were in the non-aged, blind, disabled category they'll receive \$2.50 per member per month over 12 months resulting in \$1,500 in payment medical home payment, and for the 100

beneficiaries remaining in fee for service and are in the age, blind, disabled category practices will receive \$5.00 per member per month over 12 months resulting in \$6,000 in medical home payments for a total medical home fees of \$19,500. And again for tier providers you also have the ability to negotiate additional Care Management fees and receive additional incentive payments.

(Slide 30) So Kelly mentioned there are a number of additional learning opportunities here and we want to point a few of these out to you. So first of all, in terms of upcoming webinars in early October we will be hosting a webinar on AMH oversight delegation and contracting. We will also later that month have a webinar on roles and responsibilities of CIN's and other provider partners. We will have a series on detailed Tier 3 AMH requirements and one webinar on IT needs and data sharing. Now please also note as Kelly mentioned we have these upcoming regional AMH trainings. Now at the beginning of the webinar she pointed out that these regional trainings will feature very similar material and content that we presented last week in the 101 and this week in the 102, but we feel again there's a great opportunity to interface with the folks at the state who are helping to oversee this program and with your peers so that you have an interactive Q & A session. For more information about registering for the these events and upcoming webinars you can please refer to the AMH website at <https://medicaid.ncdhhs.gov/advanced/medical/home>

(Slide 31) And if you have any questions you may send them to : Medicaid.Transformation@dhhs.nc.gov you can send mail to the Department of Health and Human Services, division of health benefits that's 1950 Mail Service Center Raleigh North Carolina 27699. The AMH website we will be continuing to post these materials and other information including white papers about the AMH program. That concludes the presentation portion of this webinar we'd be happy to answer questions I believe a number may have come through the Q & A and I'd ask Adam if he can begin to present those to us. Thank you.

Questions and Answers

Adam Striar

Sure and if folks have questions we ask that you please just type those into your Q & A panel and we can go through those and start to respond to them. And Jonah just to kick us off here so we've gotten a number of questions just asking to clarify the difference between the medical home fee and the Care Management fee can you just speak a little bit to what types of practices will receive those, how they are impacted by AMH tier status so if you could just speak to some of the key distinctions between those two fees, that would be great.

Jonah Frohlich

Sure so medical fees are nonnegotiable and they are set based on the tier either as a CA practice or an AMH practice so the higher the tier in AMH for example you can be eligible for different fee structures. So CA1 practice or an AMH 1 practice is eligible for a will receive a \$1.00 per member per month payment for enrolled beneficiaries. AMH Tier 2 and 3 can receive

higher payments of \$2.50 and \$5.00 per member per month based on the category of the beneficiary's they serve. Those are nonnegotiable payments. And they are received based on the category the beneficiary that's served. Care management fees are different. And these are only eligible to practices that qualify at a higher level or that AMH Tier 3. And those are negotiated between the practice or those representing the practice so it could be a CIN. And all the PHPs that that practice is contracting with. So during the negotiation process practices or CINs on their behalf have the ability to negotiate care management fees. And those care management fees are supplemental to the medical home fees. They do not replace them. They are additive and it's really up to the PHP and the AMH to decide what is fair and just based on those care management fee payments. Does that answer the question or is there anything you'd like to add Adam?

Adam Striar

No that was great and can you just clarify how if at all these payments will impact providers' regular medical services payments?

Jonah Frohlich

They should have no impact on regular payments. So those providers who are serving beneficiaries that remain in fee for service will continue to receive fee for service payments on the current Medicaid C schedule from the state. For those practices that are in the AMH program and contracting with PHPs they will also continue to receive fee for service payments based on a negotiated amount with each PHP with floors set based on the Medicaid fee schedule which may be higher. So you will have no direct impact on those fee for service payments. They are supplemental to fee for service payments.

Adam Striar

Great, and can you just clarify the role that CINs or other care management partners are going to play in this process and what if any role there will be for CCNC going forward?

Jonah Frohlich

Sure. So CINs and let's just define them for a moment. Now these are clinical integration networks and the way that the program envisions use these practices being working with CINs is as follows. Now CINs are in this case, they're care management organizations or they're entities that provide care management services. You know the one that's most commonly known in the state is CCNC and it's served very well the Carolina Access program for many years. In the AMH program CINs may be a host of different types of organizations. CCNC is one but it may be a health system, or a hospital. It may be a vendor partner that the practice will contract with and provide the care management services. Some or all of those care management services on behalf of the practices. So the way that this is envisioned is that a practice that's in the AMH program if it wants to assume these additional care management responsibilities like they become an AMH Tier 3 provider, they may choose to contract with a

CIN. It could be CCNC; it could be another provider, another health system, another hospital, or another vendor. And they would negotiate the kinds of services that that organization provides to meet the AMH care management requirements. So that includes things like risk stratifying a population, or receiving and integrating data from hospital, admit, discharge, and transfer data feeds into the practices information system. So some practices may decide to do all those things in house and in which case they wouldn't need to contract with a CIN. Or they may delegate some of those responsibilities to a CIN. For example they may delegate the risk stratification piece to a CIN and request or require that the CIN use information both practice management, billing information, or clinical information received from a variety of sources to help risk stratify their population and provide that to the practice to help them manage those beneficiaries in a way that's most appropriate. So I think that begins to describe how CINs in this context are expected to participate in this program and partner with practices to meet the care management requirements of the AMH program.

Adam Striar

Great. And so just switching gears a little bit here, it looks like we've received some questions about who exactly are the beneficiaries that are going to roll into managed care and who is going to stay in fee for service. Is that something you can speak to Jonah?

Jonah Frohlich

Yes absolutely, I may ask for you to provide a little bit more of detail here but so the AMH program and the managed care program is rolling out in a couple of stages but in this first wave there will be a population of beneficiaries that are currently in the fee for service program that will migrate into managed care. And there'll be beneficiaries in regions that first have prepaid health plan contract and that are in non-sort of high risk or non-age blind disabled categories. And so those beneficiaries will migrate into the managed care program and then providers will contract with PHPs to serve those beneficiaries. There are some categories of age blind disabled beneficiaries in those regions that will also migrate into managed care. And again those practices will then negotiate with the PHP to serve those beneficiaries. There are some regions that will transition to managed care later and in those cases in those regions fee for service beneficiaries all fee for service beneficiaries will remain in fee for service. Not just the age blind and disabled or high risk beneficiaries but all of those. So there will be waves and those and exactly how that rolls out will be will soon be announced and discussed and shared with the community. Does that answer your question? Or are there additional details you might want to provide?

Adam Striar

Yeah so I'll just quickly walk through the list of populations that are exempt and excluded. So as Jonah said most beneficiaries will roll into managed care in the next year or so. Most rolling in beginning in November of 2019 with some regions rolling in later. There are populations that are exempt or excluded entirely. So exempt beneficiaries have the option to enroll but are not required to do so. So these are beneficiaries that are dually eligible for Medicare and Medicaid,

beneficiaries that are enrolled in the pace program, those that are medically needy, beneficiaries that are only eligible for emergency services, those that are presumptively eligible, and that's during the period of presumptive eligibility only but they remain fee for service, and those that are enrolled in the health insurance premium payment program. Additionally, there's the beneficiaries that are excluded entirely and that group is composed of members of federally recognized tribes.

Jonah Frohlich

Great.

Adam Striar

Again just switching gears again here. Can you just talk a little bit about how providers will go about enrolling in AMH, what they'll actually need to do, where they'll need to login, things like that, and when they may expect to hear more information on this topic?

Jonah Frohlich

Sure, so if you're currently a CA, a Carolina Access practice and you don't do anything you'll default into the AMH program. And you'll automatically be essentially registered by the state as an AMH practice and in November and later this year when the prepaid health plans are selected they will then access that list and begin reaching out to the practices to begin the contracting process. So nothing needs to be done if you are a current CA practice but you may also if you're a CAI practice for example or a CAII you may elect to participate in an AMH 2 or 3 in attest to an AMH Tier 3 in which case you would need to go into NC Tracks. So you go to the department's website. Go to the NC Tracks website and then either elect to participate or attest to Tier 3. Once that process is done you then become attested and certified as an AMH 2 or 3 practice. And if all of that is done before February 1st of 2019 then you will appear on the list for every PHP in that region and there are certain requirements about what percentage of practices those PHPs must contract with. So we're really encouraging all providers to go to NC Tracks to make sure you're aware of your status and for those interested in attesting to Tier 3 to do so through NC Tracks. If you're not currently enrolled in Medicaid as a provider then you'll need to go into NC Tracks to enroll first in Carolina Access and then become an AMH provider if you're further interested in enrolling in the AMH program and contracting with PHPs. Is there anything you'd like to add to that Adam?

Adam Striar

No that was great thanks.

Jonah Frohlich

I think one other question that came up, Adam, that I've seen both in the 101 and today is regarding different practice locations and if you were tapped as a provider once does that mean for any location you become an AMH Tier 3 for example. And the answer I believe is no. When

you're enrolling in the AMH program it's at the unit of analysis or sort of the unit of attestation is at the NPI location level. So that means like each location within a group NPI will need to join the AMH if they wish to do so. Group NPIs do not need to participate across all their locations and they may participate in different tiers across each. So you may if you participate in different if you're in different practices and with some practices you may be a Tier 3 AMH and in some practices as a provider you may be at Tier 2.

Adam Striar

Great, and on a related note can you just speak a little bit to how enrollment in the AMH program will impact enrollment in fee for service in Carolina Access and vice versa. I'm hoping you can speak a little to the extent that those two are related and if say a practice were to go and opt out of AMH does that impact their Carolina Access status or their ability to see Medicaid patients?

Jonah Frohlich

Right, so you need to be enrolled in Medicaid program at all to see a beneficiary and be reimbursed by the state. But you may hear Carolina Access provider you may elect not to participate in managed care. Not become an AMH and continue to serve beneficiaries in the fee for service population. As a Carolina Access I or Carolina Access II or CCNC practice. So that will not impact your ability to serve those beneficiaries. It's fully up to every practice to decide if they want to opt out of the AMH program. We of course hope that's not the case and that you continue to serve those populations in managed care context. So it's just important to note. It doesn't- by electing not to be in one program like AMH does not prohibit you from participating in Carolina Access and serving fee for service beneficiaries.

Adam Striar

Right and just one caveat to note there for practices that are not already in Carolina Access is those practices will actually need to go through that Carolina Access enrollment process on NC Tracks before they'll be permitted to enroll in AMH and doing that will actually automatically qualify those new practices to be AMH Tier 2 for whatever reason the practice at that point decided that they did not want to be in Tier 2 they could then go in and opt out of AMH but in order to get there in the first place they would need to go in through NC Tracks and complete the Carolina Access application.

Jonah Frohlich

Right and if they opt out of AMH they still can serve those beneficiaries both in fee for service and managed care but they would not be eligible for any medical home payments.

Adam Striar

Great, so it looks like we've gotten a couple of extra questions. This time about local health departments and their core programs. So, OBCN and CC4C. Can you just speak briefly to how AMH will fit with those programs and how they might be affected?

Jonah Frohlich

Sure and Adam if you have anything to add please do so. So and we covered this a little bit in the AMH 101 Webinar. OBCN and CC4C will continue to exist in the Carolina Access program. They'll shift in name primarily in the AMH program and local health departments will continue to serve those beneficiaries who qualify for those care management programs. So it's important to note that the role of local health departments will continue to serve beneficiaries who qualify for OBCN and CCC either in the Carolina Access current program or in the managed care context. Local health departments by the way may also participate as AMHs and if they provide those qualified primary care services may do so. So for those beneficiaries that do qualify for those two care management programs if you're a participating provider in the AMH program you'll be working with local health departments to provide those services to those beneficiaries. Adam is there-there may be some additional detail that you want to add here too.

Adam Striar

Nope that's great. I will note that the department will have more information about these new care management programs for at risk children and pregnant women. That will be forthcoming later in the fall so stay tuned for more information there.

Jonah Frohlich

Great.

Adam Striar

Jonah I know we're almost at time but we've gotten a couple of questions about Tier 3 requirements. I know we don't have time to go through those in detail but if you could just briefly speak to what may be coming down the pike on Tier 3 that folks may be interested in.

Jonah Frohlich

Sure, we'll be presenting as we mentioned through the webinars on Tier 3 requirements those go above and beyond what's currently required in Carolina Access 2. And there are categories of requirements and we'll provide details about them subsequently. And I mentioned some of them. There are requirements around risk stratification. There are requirements around empanelment of patients. There are requirements around medication reconciliation, medication management. So there's a number around information technology and receiving and incorporating information from hospital ADT or admission, discharge and transfer feeds

from hospitals. It's quite comprehensive and what we want to make sure all the participant providers are aware of sort of the nature of those requirements and in subsequent webinars we also want to have some discussion about what we would expect a CIN might do to fulfill those requirements. So what's happening at the CIN level and which of those requirements we expect most practices will retain and do in house. So things like empanelment of patients are the kinds of care management Tier 3 requirements that we expect most practices will retain in house. They'll do the empanelment at the practice at the site. But things like risk stratification may happen at a CIN level because they're aggregating data from multiple sources. So those are an example of the kinds of things that we'll discuss in the future, in future webinars.

Adam Striar

Great and just a note for those that are interested in learning more right now the full list of Tier 3 requirements is available in the Appendix of the AMH 101 webinar which is posted on the AMH webpage.

Jonah Frohlich

Perfect. Well thank you very much for joining us today. We really again appreciate your time and we look forward to either seeing you in one of our sessions in North Carolina or in future webinars. Have a terrific day.