AMH Accountability: Certification, Contracting, and Oversight
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(Slide 1) Good afternoon, everyone. My name is Jaimica Wilkins and I'm a Senior Program Analyst with the North Carolina Medicaid program. Thank you for joining today's webinar entitled Introduction to Advanced Medical Homes Accountability: Certification, Contracting, and Oversight. This is the third in our series of training, focused on Advanced Medical Homes, or AMH programs, which will launch when North Carolina transitions its Medicaid program from a fee for service structure to managed care, beginning in November of 2019. This webinar will provide an overview of North Carolina's Medicaid transformation, and the AMH programs, as well as describe how the state will hold prepaid health plans, or PHPs, AMHs and clinically integrated networks, or CINs, and other partners accountable. And ensure the AMH program achieves is goals.

Today's presentation will be led by Jonah Frohlich and Adam Striar from Manatt Health, the state's technical assistance provider for the Medicaid transformation. For additional background on the AMH program, we encourage you to visit the AMH webpage, which includes slide decks and recordings from previous webinars, the AMH provider manual, Frequently Asked Questions, or FAQs, information on future trainings, and other resources.

The AMH webpage link is in the back of this presentation, and can also be located by Googling NCDHHS Advanced Medical Homes. We thank you for your continued engagement in this important topic, and we hope to see you at future webinars.

I will now turn you over Johan and Adam, so they may walk you through the remainder of this presentation. Thank you.

Adam Striar

Thanks Jaimica, and hi everyone. I'm Adam Striar and I'm a manager here at Manatt Health, and like Jaimica said, I am joined here by my colleague Jonah Frohlich, who's a managing director here. So thank you again to all the attendees for taking time out of your busy days to be here today. This is just a really important effort as part of the state's Medicaid transformation, so we really do appreciate your continued engagement on this.

Today we'll plan to take an in depth look at the accountability structures built into the AMH program. So we'll think about how the state is going to ensure that the program is meeting needs of its beneficiaries, while achieving the state's policy goals. Then we'll spend a little time providing more of a practical guide for practices in understanding their roles and responsibilities under the AMH program.

(Slide 2) So we'll start off with just some brief context on North Carolina's Medicaid transformation and he AMH program. For folks who have attended previous trainings, some of

this material will be familiar, but we do think it's important to set the context here. But for the bulk of the presentation, we're really going to focus on key program accountability structures. So these fall into three main categories. The first is AMH Certification. So this is the process DHHS will use to permit specific AMH's to participate in the program. The second is PHP Contracting. So here we'll think about how contracts will define responsibilities, payment amounts and other terms and conditions between the state PHPs, AMHs, and clinically integrated networks. And then finally, we'll think about ongoing oversight of AMHs. In this section, we'll detail some of the processes that the state PHPs and AMHs can use to oversee the ongoing functions of entities that share in the delivery of care management under this model.

And finally, time permitting, we'll conclude with some Q&A. So we strongly encourage you, if you have any questions, please just enter them into the Q&A panel on the bottom right hand corner of the screen. We'll try to get through as many of those as we can at the end of this presentation.

And then finally, we'll just sign off with some next steps and direct you just to test some other training resources.

(Slide 3) So let's take a quick step back in this section and juts take a high level look at North Carolina's Medicaid transformation and just to provide a context for today's discussion. As I said earlier, some of this material will be familiar to folks who have come to our previous webinars, but we think this will be important to the rest of the presentation.

(Slide 4) So in September of 2015, the North Carolina general assembly passed registration the transition of Medicaid from a fee for service model to a managed care model. The transition to managed care aimed to achieve a few goals. So, advancing high value care, improving population health, engaging in supporting providers and the also establishing a sustainable program with predictable cost for the state.

Under managed care, approximately 8 out of every 10 Medicaid and NC Health Choice beneficiaries will receive their health coverage through PHP. And just to flag, going forward, any time that we mention Medicaid beneficiaries in the context of the AMH program, we are, included in that definition are NC Health Choice beneficiaries. So these are kids enrolled in the state CHIP program.

So, under the AMA model, North Carolina Medicaid providers will need to contract with the PHPs, and will be reimbursed for medical services directly by PHPs, rather than the state. There will two types of PHPs. So there'll be commercial plans. There will be three of these, and these will be operated by commercial insurance carriers on a statewide basis. There will also be what we are referring to as provider led entities. And these are basically state licensed entities that either have a primary business purpose of owning or operating Medicaid practices. Or have a majority of the entities' governing bodies composed of a list of physicians or other providers.

PHPs will offer two kinds of products. So the first is the standard plan. And this is for most beneficiaries, and these will launch beginning in late 2019.

But the state will also be developing, as early as 2021 what we are referring to as tailored plans. These are for high need populations, such as enrollees with serious mental illness, those suffering from substance use disorder, individuals with intellectual and developmental disabilities, those enrolled in the states traumatic brain injury waiver, and those enrolled in the state's Medicaid Innovations Waiver.

One item to flag here is that certain populations will continue to receive deeper service coverage on an ongoing basis, even after managed care launches. So this includes populations that are exempt or excluded from managed care altogether. But it also includes populations that will roll into managed care on a delayed timeline.

(Slide 5) So now I'm just quickly going to walk through some of the key features of the Advanced Medical Homes program, or AMH program. So AMH seeks to build on the Carolina ACCESS Program, which is the state's currently operating primary care management program, and preserves broad access to primary care services for Medicaid enrollees and strengthen the role of primary care management, care coordination and quality improvement as the state transitions to managed care.

So a key thing to understand about AMH is the practices will have a number of different options for participation. So if practices wish, if they're currently enrolled in Carolina ACCESS, the can continue on into AMH with very few changes. And this will actually occur throughout a grandfathering process where practices that are enrolled in Carolina ACCESS will automatically become certified through AMH.

The practices that are ready to take on more advanced care management functions can also choose to do so in exchange for an additional care management payment. Practices are also free to rely on either in-house care management capacity, or work with organizations known as clinically integrated networks or other partners that can help support some of these more advanced functions. And then unlike in Carolina ACCESS, practices will not be required to contract with Community Care North Carolina. As it stands today, practices that wish to fully participate in Carolina ACCESS and get that full per member per month payment have to sign a contract with their local CCNC network. And we just want to be clear that's no longer going to be the base in the AMH program.

That's not to say that if your practice is happy with its CCNC that I cannot continue to work with them, and practices are more than free to do that it they're satisfied with their current arrangement with their CCN.

(Slide 6) So, the AMH program will have multiple tiers of care management responsibility, which are each associated with escalating per member per month payment. And practices will enter these tiers either by applying through NC tracks, or as I mentioned earlier, being grandfathered in based on their current Carolina ACCESS participation.

So I'll just spend a moment here talking through some of these images between these tiers. So tiers one and two will primarily be for practices that are satisfied with Carolina ACCESS and don't wish to take on an additional care management responsibility. And under these two tiers, the PHP, the prepaid health plan will retain primary responsibility for care management. And the requirements on practices, so the things the practices need to do to be qualified to participate in these tiers are the same as they are in Carolina ACCESS. So this, these are certain requirements around after hours care, availability, the availability of interpretation services, minimal hours of operation, and offering certain preventative and ancillary services.

So, in exchange for providing these services, practices will receive medical home fees. And these are going to set at levels that are at least as high as the current PM PM payments that practices receive as part of Carolina ACCESS. The only difference here is that these will come from the PHP rather than directly from the state.

One key issue for consideration with respect to tiers one and two – practices are likely going to need to coordinate across multiple plans. So PHPs are likely to employ different approaches to care management and practices in tiers one and two are going to have to work with each plans' care managers, which may add some administrative burden to participation. So Tier 3 is completely new under managed care and involves practices taking on new care management responsibilities. Under the arrangement PHPs will delegate primary responsibility for care management down to the practice level. In order to do this, to do Tier 3, practices must meet the Tier 1 and Tier 2 requirements, but must also attest to meeting a set of additional capabilities. Similar to tiers one and two, Tier 3 practices will also receive these medical home fees, but they'll also have an opportunity to negotiate care management fees and performance incentive payments will be additional to those medical home fees in our attempt to compensate practices for taking on those additional care management responsibilities.

And so one of the key advantages of Tier 3 is that practices will be able to employ a single care management platform across all their PHP contracts. So whether that's in house or it's through a clinically integrated network can deliver the same care management services regardless of what plan their patient is enrolled with.

Tier four we'll launch in subsequent years. We're not going to talk about this today. But this tier will provide an opportunity for practices to enter into more advanced alternative payment arrangements down the road.

(Slide 7) This diagram here just provides a high level look at the accountability structures the state has built into the AMH program. Just to ensure that beneficiaries are receiving those required care management services. So the key takeaway from this slide here is that DHHS will not be directly overseeing AMHs or Clinically Integrated Networks, but that there will be layers of oversight built into the program, you know, both for contracting, and then through the state's certification of AMHs. So, what does DHHS actually do in model? So, DHHS will be responsible for incorporating care management requirements into all PHP contracts. So this

essentially requires that PHPs ensure that all of their members receive certain care management services, regardless of if they're enrolled with an AMH or not. DHHS will oversee and monitor the PHPs, they'll establish required terms and conditions that must be in all contracts between PHPs and AMHs, and then, as I mentioned earlier, they'll also be responsible for certifying that AMH practices are allowed to go out and contract as AMHs.

And PHPs, just moving on down through this figure here, PHPs will be responsible for overseeing AMHs and CINs that may be working with them. PHPs will establish certain care management provisions in their contracts with AMHs, and they'll also have the ability to exercise ongoing oversight of AMHs to ensure that practices are meeting all of their obligations.

Moving on down to AMHs, these – the AMHs, of course, will be responsible for actually delivering the care management services if they're in Tier 3, but they'll also be responsible for overseeing any clinically integrated networks or partners that they decide to work with.

And finally, these clinically integrated networks that are at the bottom level of this diagram here, these clinically integrated networks, we, the state envisions, will be able to support AMHs in a number of different ways. So, through providing things like care management staffing, helping with data and analytics, and also assisting with contract with PHPs. It's important to note here that CINs will not be certified or approved in any way by the state. So, it is up to the PHPs and the AMHs to ensure that any organization that they decide to work with is fulfilling all of their obligations. And just one note here, for those who are interested in learning more about CINs, we'll actually be hosting the fourth in our series of webinars on Thursday, November 1st, and this will focus exclusively on CINs and how AMHs can most effectively work with them.

(Slide 8) So, in this section, we're just going to spend a couple of minutes going through the first key mechanism of accountability in the AMH program, and that is DHHS's certification of individual AMH practices.

(Slide 9) So, what does certification mean in the context of AMH? Certification requires practices to attest that they are capable of supporting care management, a certain set of care management requirements, either alone or as part of a CIN or other partner. And what do practices need to do to become certified? So, this can actually happen in a few different ways. So, one is by logging in to NC Tracks and attesting. So, any practice that wishes to change their tier will need to go ahead and do this. And this includes all practices that wish to participate in Tier 3. There won't be any practices that will be grandfathered into this tier. So, anyone that wishes to join that will actually need to go and log in and complete an attestation.

However, as we've mentioned a few times, if you're in Carolina ACCESS, and you're happy with your current setup, you can become certified through the grandfathering process. And this process has actually already occurred. So, if you were enrolled in Carolina ACCESS as of September 9th, you are already certified for AMH Tiers 1 or 2, depending on your status within Carolina ACCESS. And we definitely encourage practices that – to go ahead and log in to NC

Tracks and check their status and make any changes. NC Tracks is open for attestation at this time. So, you can actually go in and make any changes right now.

And just a couple of other points on certification: Certification must be completed for each NPI location combination. So, organizational NPIs will actually need to be certified for each location under that NPI. And we also just want to make clear that there currently is no batch attestation process. So, there's currently no way for practices to log in and attest for multiple locations within one single form. Unfortunately at this time it does have to be done separately for each location.

And finally, we just want to be clear about what certification and attestation actually obligate a practice to do. So, neither attestation nor certification obligates a practice to participate in the AMH program in any capacity. So, if a practice attests to Tier 3 and they decide, for example, that the care management fees that they're being offered are not sufficient, they're totally free to decide just to participate in Tier 2 or to not participate at all. So, the attestation is not bind. Practices will still have flexibility after they go through that process.

And finally, practices are permitted to attest to Tier 3, even if they don't necessarily have these capabilities in place right now. We recognize that many practices are likely ramping up their capabilities at this time but have plans to have these ready to go by the time managed care launches, and those practices are completely free to attest to a higher tier.

(Slide 10) One other important concept to understand with respect to certification is how it's going to be tracked and how it differs from contracted status with a PHP. So, what is an AMH certification status? So, this represents the highest tier at which an AMH can contract with a PHP. Each AMH will only have one such designation. And this is separate from contracting and does not actually trigger PHP payments. Payments will only begin once the practice has contracted with a PHP. And this process is managed by the state, so, the state holds the certification status, and PHPs can't go in and change a certification status, you know, so that it would affect the practice's relationship with other PHPs.

And so how is this different from the AMH contracted status? So, practices are free to choose to contract at different tier levels with each PHP, though they are not permitted to exceed their maximum tier certification status. There are going to be multiple PHPs in each region. And AMHs are strongly encouraged to contract with as many of them as they wish. And they don't necessarily have to be at the same level of AMH under each contract, and are permitted to go up to their highest certification level with each. And just to be clear, so the state will track contracted tier levels within each practice across each individual PHP contract.

So, just to help clarify this, we have a small example over on the right-hand side here. So, this is a hypothetical practice that's certified for Tier 3, and in this example, there are four PHPs in this AMH's region. So in two of them, it agrees to contract at a Tier 3 level, but with one of them, maybe it's not able to reach an agreement on care management fees, so it decides just to remain at a Tier 2 level. And then finally, for this last PHP, the practice just decides that it

doesn't want to be in this PHP's network. And this is all fine and totally permissible. So, the key point here is, the practices have flexibility to do different kinds of contracts with different PHPs.

(Slide 11) And just quickly, before we move on to the next section, we wanted to flag a couple of key upcoming dates. So, starting from the left, as we mentioned earlier, practices participating in Carolina ACCESS were actually grandfathered into AMH certification on September 9th.

So, now we have moved into this attestation period. So, this is when practices will have the opportunity to attest the Tier 3 for the first year of managed care. And this will run through February 1, 2019. After this point, PHPs will not be contractually obligated to honor Tier 3 certification, so, if you're a practice that is considering Tier 3, we strongly encourage you to go in before this date and complete your attestation. And the significance of the February 1st date is this is when the state plans to announce which PHPs will be able to participate in North Carolina's Medicaid program as managed care plans. At this point, certified AMHs will actually be able to go out into the market and contract as AMHs.

And then, finally, once the contracting period concludes, managed care will go live beginning in November of 2019. And this is when AMHs would actually begin to receive those PMPM payments.

So, that is certification. I'm now going to turn it over to Jonah Frohlich, also from Manatt, who's going to walk us through some of the other key elements of AMH accountability.

Jonah Frohlich

(Slide 12) Thank you very much, Adam. So, as a first step under Managed Care – advance the slide here – under Managed Care, under contracts entered between the state and PHPs, PHPs will be paid a per-person capitation rate by the state. Now those capitation rates are set using actuarial principles, and they are based on a number of factors, including historical utilization and others. And they are meant to provide a reimbursement structure that will match payment to the expected financial risk assumed by each of the PHPs. Now those financial capitation rates for the first year of the contract will be set prior to program launch, prior to November. And they'll reflect more recent program data, provided reimbursement levels, legislative and other PHP requirements.

(Slide 13) There are six key rate-setting elements that are depicted below, and they include basic adjustment base data, prospective trend factors. This could be anything including inflation, medical inflation and other factors, or, other programmatic change adjustments. If there are programmatic changes, additional requirements, those may impact the premium pre-member per month. Per the managed care adjustments, they may include other requirements that are added. They're also administrative tacks and profit underwriting gain and final base capitation rates are factors into. The ultimate PMP paid by the state to the PHPs.

(Slide 14) Now, PHPs must contract with all willing providers that agree to accept fee-for-service payment levels and are in good standing with the North Carolina Medicaid program, and Adam described that in some detail. Those AMH contracting requirements include the following: First, PHPs must accept all Tier 1 and Tier 2 certifications as is. They may not reclassify practices during the initial contracting period. Now Adam also mentioned that PHPs are required to contract with 80% of all AMH Tier 3 practices. And those are located within each region. Now, PHPs won't be required to contract with Tier 3 certified practices at the Tier 3 level, if they're unable to reach mutually agreeable contract terms. Although this would count against their 80% contracting requirement. However, for any practices where they cannot meet that contract term, they must accept those Tier 3 certified practices into their provider network at a minimum Tier 2 level. They can't make again agreement on those Tier 3 contracting terms.

(Slide 15) PHP contracts with Advance Medical Homes must contain standard contract terms. The state will produce standard contract language and clauses, but it's not going to be reviewing contracts between AMHs and PHPs. Now the appendix to this document that is listed on the AMH website has a list of those standard AMH contract terms. So, payment terms include the following: First they must provide sufficient detail regarding medical home fees, care management fees, and applicable performance incentive payments. Those were those for Tier 3, AMHs, for example. They must also adhere to payment floors as established by the state. These must include reimbursement and those floors must be in those contracts. There are a number of other requirements, as well. Terms must be mutually agreeable to both the PHP and the AMH. They must specify responsibilities of activities performed by an AMH, versus those that are retained by the PHP. It must describe responsibility for all required AMH tiers. It must also specify reporting standards and performance monitoring in alignment with the state's standards. Must specify consequences for underperformance, including appeals rights, and it must include data sharing and provisions for privacy and security in alignment with the state's data sharing policies.

(Slide 16) Medical fees are intended to serve as payment floors. These are enhanced payment floors. And PHPs are required to pay no less than published medical home fees. Now those published medical home fees are depicted in the table to the right. And they are as follows: For Tier 1 AMHs, they will receive $1 per member per month medical home fees for all enrollees in Tier 2 AMHs will receive $2.50 per member per month for most enrollees and $5 per member per month for members for the aged, blind and disabled eligibility group. Your three AMHs will have the same PMPM medical home fee arrangements as Tier 2 providers. Now practices in any AMH tier may negotiate higher medical home fees with PHPs. So, for example, a PHP may agree to pay a practice $4 PMPM for non-ABD beneficiaries, and $8 PMPM for ABD beneficiaries.

Now, medical home fees though may not be tied to the achievement of value-based benchmarks. So, for example, a PHP may not withhold or require that a practice score above the 50th percentile on MH quality measures to receive the full medical home fees.

(Slide 17) Tier 3 AMHs should consider assigned care-management responsibilities, regional cost variation, and other factors when negotiating care management fees. So, what should they consider? Things like additional costs associated with supporting Tier 3 care-management responsibilities and are intended to be covered by the care-management fees. The state has not set a minimum payment amount for care-management fees paid by Tier 3 practices to Tier 3 practices by PHPs, and these will be negotiated separately between PHPs and AMHs.

Now negotiation consideration should include at least the following: First, PHPs are required to contract, as we mentioned previously, with 80% of AMH Tier 3 practices located in each region, which PHP operates, providing an incentive to offer fair rates. Practices may wish to base negotiation of care-management fees off the care-management component for the PHP capitation rate. That's the amount that the PHPs are being paid to perform care management by the state.

Now, further information on PHP rates, you'd see Section 9 of the Medicaid Managed Care draft rate book. That's available on the AMH website. AMHs may work with CINs or other partners to assist with the contracting. Now, we're going to offer a lot more detail in subsequent webinars and to describe some of the support that CINs may provide to support contracting.

(Slide 18) Tier 3 practices will be eligible for additional incentive payments based on their performance on state-approved AMH quality measures. The sample measures, a group of them, are depicted in the figure to the right, and will primarily be claims based and survey based. They include measures such as how people rate their personal doctors, childhood immunization status, cervical cancer screening, comprehensive diabetes care, medical assistance with tobacco cessation, and others. Now these measures are currently tentative, and a final measure list will be provided prior to go live.

For the first two years of the programs, these incentives – the incentives between the PHPs and the AMHs – will be on what's called an up-side only basis. And that means that practices will not be at risk for losing money, i.e., be penalized or be exposed to downside risk, if they do not meet specific performance targets. Now, PHPs will not be permitted to require practices to pay back PMPM medical home fees, care management fees, or any other payments for medical services during this time. That's the basis of this up-side only payment arrangement. Practices are permitted to negotiate arrangements that include down-side risks, but PHPs may not mandate them. And payment arrangements must be guided by the Healthcare Payment Learning and Action Network Framework, it's called the HCP LAN Framework, and specifically categories 2 through 4 in that framework. Those categories reflect varying levels of value-based payment. And more information on the HCP LAN Framework and those categories can be found in Appendix C of this document that is available on the AMH website.

(Slide 19) Now PHPs may assess the capabilities of Tier 3 certified practices as part of the initial contracting process and prior to managed care go live. So, the activities that are permissible under the PHP assessment activities include onsite reviews, telephone consultations, documentation review, and other virtual or offsite reviews. The role of CINs that other partners

can play include the following: the CINs or other partners may assist with PHP contract negotiation on behalf of AMHs, as we've mentioned. PHPs may perform evaluations of the CIN or their other partners instead of or in addition to the AMH, if the AMH contracts with the CIN or third party to provide any of the Tier 3 care management required services. And even if contracting through a CIN or other partners, AMHs are still ultimately accountable to the PHP for fulfilling contractual obligations and achieving quality outcome. So, if a PHP – excuse me, if an AMH delegates some of the care management functions to a CIN, the AMH is still fully accountable to meeting and fulfilling those requirements.

(Slide 20) Preparing for PHP contracting, AMHs should begin preliminary conversations with PHPs as soon as possible to understand payment terms and other considerations. A set of AMH-specific contracting elements is depicted in the figure on the right, and includes: care management roles and responsibilities, medical home fee amounts, care management fees, if they're applicable, in particular for Tier 3 AMHs, performance incentive payments, including measures and performance benchmarks, reporting requirements, payment terms, and data sharing. Contracting considerations include the following: How the PHP envisions working with providers to help improve quality of care, reimbursement rates and opportunities for alternative payment arrangements, pay for performance, value-based payments, up-side shared savings, and other types of arrangements, reporting requirements, dispute resolution processes, data tools and other resources that will be available to contracted providers, prior authorization processes and timely filing requirements, and contract renewal and termination clauses and timeframes. These are all considerations that AMHs should factor in when preparing for and beginning negotiating contracts with their PHPs.

(Slide 21) Finally, we'll turn to AMH oversight.

(Slide 22) PHPs will be primarily responsible for ongoing oversight of AMHs in their network. A PHP oversight includes: that PHPs will have broad discretion in ongoing oversight and monitoring of AMH practices' performance against tier-specific AMH requirements. And in future years, the state may consider collaborative approaches to streamlining monitoring with the help of PHPs. PHPs that delegate functions to AMH Tier 3 practices will have additional requirements as part of the National Committee for Quality Assurance or NCQA accreditation process, beginning in Year 3 of managed care. Those include elements such as: reviewing parts of the program where delegation occurs between PHP and AMH, conducting an annual file audit, performing an annual evaluation, and performing an evaluation of population health management reports. If an AMH is unable to perform activities associated with its assigned tier, PHPs may reclassify the practice and cease AMH payments.

(Slide 23) So, in this case, PHPs can reclassify Tier 3 practices as Tier 2 or Tier 2 practices as non-AMH, they may also cease payments of medical home fees, care management fees, and other performance incentive payments if practices are not meeting contractual obligations. PHPs can't, however, lower the tier level of other AMH practice locations associated with the same organizational NPI or CIN without performing an assessment on those other locations. They may also not lower the tier level of an AMH practice location based on a different PHP's

findings and reclassification. They can't change an AMH's certification status with respect to other PHPs, and they may not reclassify practices to Tier 1 status. If a PHP does cease medical home payments after performing the assessments, they must send notices of cancellation of medical home fees to both the state and the AMH.

(Slide 24) Now there's an appeal process, and AMH practices have the right to appeal reclassifications for underperformance through each PHP's appeal process. Practices do have appeal rights to the state for the state-designated practice certification process, but not for PHP reclassification of their tier. The state, however, will monitor PHPs' reclassification decisions as part of its overall monitoring of PHP activities. And the state may consider PHP's pattern of AMH reclassification in its ongoing compliance activities and contracting decisions. In the event that a PHP reclassifies a Tier 3 certified AMH to a Tier 2 level, to a non-AMH level, this contract will not be counted in the numerator or denominator of the PHP's 80% Tier 3 contracting requirements.

(Slide 25) And finally, AMHs may choose to delegate certain AMH practice operations to CINs or other partners. And we'll go into great detail on these types of requirements and delegation in further – in subsequent webinars.

Now for AMHs, considerations include: AMH practices, first of all, are ultimately accountable to PHPs for fulfilling contractual obligations and for quality outcomes regardless of if they choose to work with a CIN or other partner. Practices must ensure proper care management oversight of contracted CINs or other partners, and the state and PHP do not have official oversight of CINs. So the state will not maintain lists of the CINs or other partners. They won't validate their authenticity and they won't do any audits. It is ultimately up to the AMH to understand the capabilities of its CIN or other partners. With respect to considerations for CINs or other partners, the state envisions that many Tier 3 AMHs will work with CINs and other partners to support practice operations and deliver the required care management services. And practices will have broad flexibility to use CINs and other partners, and may wish to utilize them to help negotiate AMH contracts with PHPs. And as we stated, subsequent webinars will provide greater detail about these kinds of arrangements.

That concludes at least the presentation portion of the webinar today, and we'd not like to open this up to questions and answers. And I know there've been a number of those that have been entered into the Q&A. I think we'll go for a process of beginning to review those and answer those questions right now.

(Slide 26) Adam, I'll start with the first one. And I can pose this to you, if you like. The first question I saw here was that, is, will the care management requirements for Tier 3 be adjusted for pediatrics, since many of the requirements are mostly geared to adult medicine?

Adam Striar

Thanks, Jonah. So, the answer to that is, no. So there are, there are, the Tier 3 requirements are the Tier 3 requirements. But we totally understand that pediatric populations may have

different needs and recognize that many of the Tier 3 requirements are not going to apply to children. That said, there are other care management programs that, in the state, that focus on maternity health and at-risk use, so these are the existing OBCM programs and CC4C programs that operate through the local health departments. And these will also be transitioned to similar models under managed care. So, we'll be rolling out more trainings on those programs at a later date, and we definitely encourage you to check those out.

Jonah Frohlich

Great. Thank you. There's another question here: Will all the PHPs use the same care management platform, or will each PHP have its own care management platform if a practice decides to participate in all six regions? With all six in a region?

Adam Striar

So, we really view that as one of the advantages of Tier 3. So, in Tiers 1 and 2, PHPs are likely to use their own care management platforms. They're going to have their own care managers. They're going to have their own ways to do risk stratification. So, it may be challenging for practices to manage all of, working across all of these PHPs. So, Tier 3 really offers practices the opportunity to consolidate their care management and apply it in a unified way across their entire population – across their entire patient panel regardless of what plan the patient is enrolled with. And that can be done, you know, in-house, if a practice has more advance capabilities and has care managers, you know, imbedded within their practice, that they can do all of that themselves. Or they can work with a single fee – if they can work with a CIN that will work to aggregate data that they receive from their PHPs, can help with staffing. So there are various ways that Tier 3 practices can work to ease the administrative burden of working across multiple PHPs.

Jonah Frohlich

Great. There's a next question that some of the PHPs say they do their own care management, and they provide an example of Centene, and they don't have AMHs in other states where they operate. And why do we have this additional layering being added by the department? So, while in some states, or many other states, they might not have an AMH-type program for managed care, the state has laid out a series of guiding principles for care management, and some of those include that care management, for example, should be local. And as part of the program, there's a real desire to try to create a care-management infrastructure that's as close to the practice as possible. Now, under the current Carolina ACCESS program, there is a sort of medical home or care management program, and that's really all done through CCNC. And so what this transition is is really a shift from a CCNC care management program to care management program that is delivered both by PHPs and and, in the case of practices that have the infrastructure capability or the partners down to the practice level. And so it really gives providers an option to be able to deploy resources, care management resources at a local level, have them in-house, or deployed across the network of the practices in which they're part of, and deliver that care directly as part of the care team. And so it's really an option. It provides

some flexibility. If a practice does not feel they have the care-management infrastructure or isn't prepared to have a contract with a CIN or other partner, then they can delegate or at least assign or have those care management responsibilities retained within the PHP like Centene or any other, and then those PHPs can use their care-management infrastructure themselves to deliver the case-management requirement.

Adam Striar

Great. And there's a couple of other questions that I saw here that I thought were really good. So, one is, will the PCP have to contract with all AMH Level 3 practices certified by February 1st? Or only a certain percent? And then a related question is, what happens to the other 20%, all things being equal, and is there an appeals process? So, PHPs will be required to contract with 80% of all Tier 3 certified practices in the regions in which they operate. And this will be assessed as of February 1st. So, we mentioned earlier that practices – PHPs will not be required to honor Tier 3 certifications that take place after this date, and that's because this 80% figure is being calculated off of the list generated on February 1st.

And so the follow-up question to that, what happens to the other 20%? So we'd like to stress that the state is considering mechanisms to provide incentives for PHPs to contract with more than 80% of Tier 3 practices. So the state is actually not permitted by legislation from implementing a PHP withhold, which, until 18 months out. But basically what that would do is the state would withhold a certain percentage of PHP capitation payments contingent on contracting with a certain percentage of Tier 3 AMHs. And after 18 months, the Department plans to implement that, and actually implement it in a graduated way that rewards PHPs for going above and beyond that 80%, so, you know, even though that the contractual requirement is to contract with at least 80%, there still will be incentives for PHPs to contract with more than that minimum 80%.

Jonah Frohlich

It's really important for everyone to recognize that, you know, in terms of the question, will PHPs have to contract with all AMH Level 3 practices? Adam said, the will have to contract with all of them, but not necessarily at that Level 3 – at Level 3. 80% of them, they will have to contract at that level. For the other 20%, as Adam just said, they would have to contract with them at at least a level, at a Tier 2 level. So, it's just really important to know. If you go through the steps of attesting, putting the entire infrastructure in place, or working with another CIN or other partner, the AMH cannot leave you out of the network. They will try to. They will try to contract via the Tier 3 level, and for 80% of the proximate region, they'll have to.

One clarification here, there's a question – there's an error, I think in one of our notations, we'll have to update. We said the end date is the attestation. Should be January 31, 2019. I think we put in the slide it's, as January 31, 2018. The past. That's not the case. So, just to be clear, for Tier 3 attestation, in order for you to land on the list of the PHPs and to qualify sort of in that 80% level, you would need to attest by January 31, 2019.

Adam Striar

And on that point, one thing that I also just want to be clear about is that, that drop-dead date only applies to Tier 3. So, practices are free to go in and sign up for Tier 2 at any time. That's on an ongoing rolling basis. You know, and as soon as a practice signs up for that, and then contracts with a PHP, that certification status will be transmitted to the PHP, and the practice would begin receiving the medical home fees. So that date only applies to Tier 3.

Jonah Frohlich

There's another question here. Are Tier 1 and 2 practices eligible for additional incentive payments? They're eligible, they're not required. PHPs are encouraged to begin offering performance incentives, based on AMH measures. There are no additional care-management fees, but there will be encouragements to add incentive payments for Tiers 1 and 2, and practices should feel free to try to negotiate those with their PHP partners.

Adam Striar

And so, I think we have time for maybe one or two more questions here. So, one that I see here in the chatbox, so under the current arrangement with CCNC and CC4C, this practice has case managers and the per-member per-month payment is shared to cover that cost. Under the new arrangement, the state expects us to continue that same kind of service, but now we have to pay for it ourselves. So, so the answer to that, to that question is, practices, you know, will need to meet those Tier 2 requirements in order to, in order to be able to participate in AMH, and those are things like, you know, providing certain office hours, providing certain preventive and ancillary services, you know, providing oral interpretation services. So, just complying with those set of five or six requirements, that's something that the practice would need to, or would be responsible for on its own. That said, for the additional Tier 3 requirements, that's, those additional capabilities are really what the care management fee and the performance incentive payments are intended to cover. So, we really encourage practices when they're going into that negotiation to think about what additional infrastructure they're going to need to put in place, and what they're costs are going to look like, and make sure they're comfortable with the level of care-management payment that they are receiving before they enter into those arrangements.

Jonah Frohlich

Great. And there are a couple more questions associated with Tier 3 certification. What happens if a practice wants to be Tier 3 after January 31st? The may absolutely attest after the 31st. What it means is, you're just not guaranteed to be within sort of that 80% that the PHP negotiates with. So you still can do it. But in the first year, you won't fall under that list of required 80% of Tier 3 practices. You will still, of course, be part of the Tier 2 network at a minimum.

A couple other related questions, one is: Will rural health clinics be eligible to receive additional care management reimbursement if they're performing work at a Tier 3 status? If they attest to Tier 3 and provide all of the primary care, they are a qualified primary-care practitioner, and meet all of the Tier 3 requirements, then absolutely. Rural health clinics can qualify and receive those additional payments. And, I think – are there any other questions, Adam we want to try to address before we close?

Adam Striar

Yeah, so there's one more here that I think I can answer pretty quickly. So, it's, if a practice is recognized at a PCMH level, will this go hand-in-hand with care management in Tier 3? And so the answer to that specific question is, yes, there will be a lot of overlap between PCMH and MH. Just to be clear, that PCMH certification does not have any bearing on AMH certification status. So, a practice that is PCMH certified, if they want to go in and do Tier 3, that they would need to apply for that separately.

Jonah Frohlich

Yeah, if you have managed to get Level 3 PCMH recognition, you'll be able to meet the Tier 3 requirements under the MH program. All right. Great.

(Slide 27) Well, thank you all very much for your time. We really appreciate all of your engagement and involvement here. In terms of next steps.

(Slide 28) Want to make sure that you are aware on November 1st, we will have the next webinar, which is on roles and responsibilities of CINs and other provider partners. Four more webinars are being scheduled, most of them for this year. We anticipate having three on Tier 3 requirements, and in early January, we will have a webinar on IT needs and data-sharing capabilities.

(Slide 29) More of that information can be found on the website, https://medicaid.ncdhhs.gov/advanced-medical-home. And for any additional information, you can find it by emailing us at Medicaid.Transformation@dhhs.nc.gov . Or at the U.S. mailbox address listed on Slide 29. As we've mentioned, there's also an AMH website, where this information, a number of resources, FAQ's, are all posted, and where you'll fine white papers, manuals, and other documentation. Thank you very much for your time today. And we will see you again in a future webinar.