AMH Tier 3: Patient Identification and Assessment
November 14, 2018

Dr. Nancy Henley

(Slide 1) Good afternoon. I'm Dr. Nancy Henley, Chief Medical Officer for North Carolina Medicaid. Thank you for joining today's webinar, "AMH Tier 3: Patient Identification and Assessment." This is the fifth in our series of trainings focused on Advanced Medical Home or AMH. AMH will launch when North Carolina transitions its Medicaid program from fee-for-service to managed care beginning in November of 2019. Today's webinar is the first of three webinars focused specifically on AMH Tier 3. Tier 3 provides for an opportunity for primary care practices participating in North Carolina Medicaid to establish a uniform local care management platform by taking on additional care management responsibility at the practice level. In return, Tier 3 practices may receive additional payments from prepaid health plans referred to as PHPs. Today we will focus on patient identification and assessment and discuss how patients will be assigned to PHP from practices, how PHPs and practices will risk score and stratify patients and AMH responsibilities around the comprehensive assessment, which ultimately feeds into the delivery of care management. Today's presentations will be delivered by Dr. Emily Carrier and Adam Striar from Manatt Health, the State's technical assistance provider for Medicaid transformation, and myself. For additional background on the AMH program, we encourage you to visit the AMH webpage. It contains slide decks and recordings from previous webinars, the AMH provider manual, FAQs, information on future trainings and other resources. The AMH page is linked at the back of this presentation, or you can just Google it: NC DHS Advanced Medical Homes. We thank you for your continued engagement in this very important effort, and we hope to see you at future webinars. I'm going to turn this over now to Adam who will walk through our agenda for today.

Adam Striar

Thanks Dr. Henley, and thanks again to all the attendees for making time in your day to join us. We really do appreciate all of your continued engagement on this really important effort. So just to introduce myself, my name is Adam Striar. I'm a manager here with Manatt Health. And I'm joined today by my colleague, Dr. Emily Carrier, who's the Senior Manager here at Manatt. Dr. Carrier is a physician with over 15 years of experience, including in direct patient care, but also doing policy research and in developing new payment and delivery models during her time at the Centers for Medicare and Medicaid Services. So she'll be speaking to us a bit later in some more depth about the requirements for Tier 3 of the AMH program.

(Slide 2) So just to quickly walk through our agenda for today's webinar, Dr. Henley is going to start off by providing some context with just a brief high-level overview of North Carolina's Medicaid transformation and the AMH program generally. And then we'll talk a little bit about why the department designed the program in this way – sort of its goals for the program going forward. We'll then spend a little bit of time outlining the processes in managed care by which patients will be able to choose plans and providers. This is something we recognize we've received a lot of different questions about. So we just want to make sure we're being really

clear about how this process is going to work under managed care. But today's session is mostly going to focus on AMH Tier 3, which again is the most advanced level of the AMH program. So today we're going to focus on two key components of Tier 3. And these include risk stratification, which, again, is the process by which AMHs will identify high need patients that are need of care management, and then the comprehensive assessment, which is basically a more in-depth examination of a patient's medical needs which will be us to help guide care management under AMH model. Also, along the way we'll provide a handful of use cases, which basically will illustrate how an AMH might execute on these different care management functions with the help of a prepaid health plan, and also working alongside a clinically integrated network or CIN. Time permitting, we'll follow this up with some Q & A, so we encourage you to enter any questions that you have at any time during the presentation in the Q & A box, in the bottom right-hand corner of your screen. And then finally we'll conclude with some key next steps and direct you to some other training resources that may be of some interest.

I'm now going to turn it back to Dr. Henley who's going to say just a few words about AMH and the Medicaid transformation more broadly.

Dr. Nancy Henley

(Slide 3) Thank you. Let's take a high-level look at the role of care management in North Carolina's transformation to provide context for today's discussion.

(Slide 4) Moving to Slide 4, robust care management is a cornerstone of the State's managed care transition. In establishing a framework for delivering appropriate care management in North Carolina or North Carolina's beneficiaries, the State started from a core set of principles. These include: Medicaid enrollees will have access to appropriate care management; two, Care management should involve multidisciplinary teams; three, local care management is the preferred approach; and four, care managers will have access to timely and complete enrollee-level information; enrollees will have access to programs and services that address unmet health-related resource needs such as housing, transportation, food; care management will align with statewide priorities for achieving quality outcomes and value.

To remind you how AMH fits into all of this, AMHs are designed to serve as a vehicle for executing on this approach, the managed care context. The State recognizes that many of these features already exist at Carolina Access, the State's current primary care case management program. AMH exists to build on this program's success with an eye towards following each of these principles and providing an even greater proportion of care management locally.

(Slide 5) Looking now at Slide 5. Some mention of the previous slide, local care management is a key principle of the State's managed care transition. In keeping with this, under managed care, PHP is required to ensure a robust system of local care management that is performed at the site of care, in the home, or in the community with face-to-face interaction wherever possible. The reason for this is that there's a significant body of evidence that patients prefer

care management delivered locally using caregivers that they know and trust, and these types of programs lead to better health outcomes.

So what are PHP requirements around local care management? PHPs must have an established system of local care management through AMHs or local health departments (LHDs) as well as care management provided by the PHP itself for certain services which may be beyond the local site capacity. PHPs are responsible also for oversight of local care management, but can they delegate primary responsibility to AMH Tier 3 practices. PHP's task is to ensure that the majority of their patients are receiving local care management. To reiterate, AMH is the vehicle for achieving all this. PHPs will be able to use their AMHs to pass a significant amount of care management functions down to their network practices.

And finally, if Medicaid enrollees receive care management from more than one entity, the PHP must ensure care plans detail the roles and responsibilities of local care managers. So, if the patient has been flagged as needing care management through both an AMH and through one of the State's local health department programs, it's the responsibility of the PHP to ensure that roles and responsibilities between the two are clear in order to avoid duplication.

A key note in this topic is that the AMH program is intended as a minimum initial framework for which PHPs and practices can innovate around payment and delivery models to support local care management. The State encourages PHPs and practices to develop innovative ways to deliver better care management to patients that need it and to support care delivery to new payment models as long as those comply within the State requirements.

(Slide 6) Moving on to Slide 6. For those of you who've attended previous webinars, this slide may be looking really familiar. But it provides the foundation for us here, so we'll go over it again. It's an overview of the universe of care management functions that a state envisions under managed care. It shows how the State will ensure that high-need individuals, and those transitioning out of the hospital or other in-patient settings, will receive appropriate local care management. I'll walk briefly through this to provide a context for the rest of today's discussion. The care management process that you see in this diagram is divided into three separate categories. The yellow arrows are functions that will generally be performed by the PHP. The blue boxes will generally be performed by Tier 3 AMH. And the crosshatch boxes will be shared responsibility between the two.

The top row of the diagram displays the process of flagging high-need individuals and rounding them into appropriate care management. We will focus our attention today on the first three elements. The first yellow box on the top left is the care needs screening. This is actually required by federal regulation and will generally be done by the PHP. These screenings involve a set of standardized screening questions for each patient. They must be completed within 90 days and must be shared with the AMH. Care need screenings are required to screen for chronic or acute conditions, behavioral health needs, medications and unmet health-related resource needs, plus other items.

The second component in the striped arrow is risk scoring and stratification. This will generally involve each PHP using proprietary methods to assign a risk score to each member. This data must then be transmitted to Tier 3 AMHs. The Tier 3 AMHs will be required to take in this information and use it to stratify their own patient panel.

The third is the comprehensive assessment in blue. This will only be performed on individuals that are identified by the practice base risk stratification as a high need. This is more in-depth person centered assessment of a beneficiary health and behavioral health needs, functional needs and accessibility needs. It's intended to help the care team make decisions about the type of care management that the patient needs and to help inform the personal care plan.

All this finally leads to the actual delivery of care management for patients who identify as high need. We will not focus on this step today, but it is the ultimate result of the care need screening, risk scoring and stratification, and comprehensive assessment as described here.

Now running parallel to the top row are a set of ongoing care management and related pathways for individuals who are not identified as high need by the practice based risk stratification. We will not focus on these today, but I want so summarize them for you to complete the picture: transitional care management for individuals that are discharged from an in-patient stay or the emergency room; next is the general care coordination function that's available to all patients; and last, the various preventive and population health management efforts.

Thank you, and I'm going to turn it over now to – Adam Striar and Dr. Carrier are from Manatt who will walk us through key processes related to patient assignment and primary care provider selection.

Adam Striar

(Slide 7) Thanks Dr. Henley. So, as I mentioned earlier, this something that we've received a number of questions about from providers. So we just wanted to provide some background on the processes for patients to both choose their health plan and also how they're going to choose their primary care provider or PCP. In this section we'll also spend just a little bit of time talking about how patients will be assigned to AMHs and then what assignment actually means in terms of a provider's ability to see Medicaid patients and also receive payment for those services.

(Slide 8) So under managed care enrollees will have the opportunity to choose their PHP or they will be auto-assigned. So, while there is some nuance, depending on the type of enrollee, most individuals prior to the launch of managed care will go through – there will initially be an open enrollment period where these enrollees will receive notice from the State that they will either be able to select a health plan directly using a form or they will have the option to work with an enrollment broker who can help them make a decision about what health plan to enroll with.

Now if enrollees do not select a PHP by the end of the open enrollment period, they will actually be auto-assigned to a plan. So this basically means that the State will choose a plan for the enrollee, and for mandatory managed care populations, those enrollees will be automatically be enrolled in that plan. So, in order to facilitate this, the State is developing an auto-assignment process that really prioritizes keeping families in the same PHP and also preserving existing enrollee-provider relationships. So, this auto-assignment algorithm is going to consider these factors in addition to what PHPs are available in an enrollee's region, what eligibility category that the enrollee is in. So, if a particular plan is better suited to serve special populations that that would factor in here. Previous PHP enrollment – so if a patient has previously been enrolled with one of the carriers that's offering a plan in this market. And then also considering equitable distribution of members amongst all the PHPs in the State.

Following enrollment, all enrollees will have a 90-day "choice period" – during both initial application and annual renewals – to change their PHP without cause. After this 90-day choice period, enrollees can still switch plans, but they would need to demonstrate cause to do so.

So the bottom line here is really that it's easiest for patients to select their plan during open enrollment or during the first 90 days following enrollment.

(Slide 9) So, as I mentioned on the previous slide, the State will rely on an enrollment broker to facilitate enrollment in PHPs and has contracted with MAXIMUS to fulfill this roll. So, their responsibilities will generally include providing enrollment assistance and educating enrollees on the different types of plans available. And they'll do things like develop and share welcome packets with enrollees. They'll help individuals select PHPs and PCPs that are most appropriate to meet their needs. Again, really focusing on maintaining existing physician-patient relationships. They'll also be able to enroll individuals in different settings. So, over the phone, online or face-to-face in certain communities. And they'll also be responsible for continued outreach to members to communicate the transition of medical services as the State rolls into managed care. And MAXIMUS will begin providing these services beginning in June 2019.

(Slide 10) So under managed care, enrollees will also have the opportunity to choose their primary care provider or they will go through an auto-assignment process. So, individuals will first have an opportunity to choose their PCP when they are enrolling with their plan. But if they do not do this for whatever reason, they will be assigned to a PCP by the PHP in which they enroll. The State is regulating this process and requires that PHPs consider a number of different factors in assigning members to particular PCPs. These include in descending order of importance: enrollee claims history – so this will establish if there is a relationship between a patient and a provider – which, again, the State wishes to maintain if at all possible. It will then consider if there are relationships between a provider and a member of the patient's family. So if there's no direct relationship between the patient and provider, PHPs will then be required to consider these family member provider relationships. They'll then have to consider geography – so, how close the provider is to the patient's home address. And then they'll also be required to consider things like special medical needs and language and cultural preference as they are assigning members to PCPs.

But just to confirm, the vast majority of practices that regularly see a patient will be assigned that patient through the auto-assignment process based on their claims history together. It really is the goal of the Department here not to disrupt these existing patient-provider relationships.

After assignment, enrollees will have a 30-day "grace period" to change their PCP for any reason. Enrollees can also change their PCP without cause after their initial PCP visit, and up to one additional time every 12 months. So, there will be ample opportunity here for enrollees to change PCPs if they would like to do so. But after this period, enrollees will need to show cause in order to change PCPs. So this would include situations where the provider has failed to provide accessible appropriate care, the enrollee disagrees with the treatment plan and additional related factors like that. But the bottom line here, again, is that members will be able to choose PCPs with few restrictions initially, but may to demonstrate cause outside of the grace period.

On other thing to note here is that members will only be able to select PCPs that are contracted with their PHP. So, if a PCP declines to contract with a particular health plan that may be a situation that would limit enrollee access to that particular provider.

(Slide 11) So AMHs need to ensure that they have a clear understanding of which patients are assigned to them. This is really important for AMHs, particularly Tier 3s, to be able to do their jobs effectively.

Prior to managed care launch, practices will receive patient attribution files from PHPs that will let them know who their assigned patients are. And so as part of being a Tier 3 AMH, practices will be required to ensure that these assignment lists are reconciled with their patient panelist. So, basically, checking the assignment lists against the practices panel to see if any assigned patients are not on their panel, and vice versa. So if any patients are on their panel that haven't been assigned to them.

They'll also need to make sure that the practice's patient panel list is up-to-date in the practice's clinical system of record. So, like in EHR or equivalent system. And they need to have processes in place to ensure that this is done whenever clinically appropriate. And this is mainly because accurate patient empanelment is critical for a whole wide range of AMH functions. So, risk stratification, which Emily is going to talk about shortly. Practices will need to have an accurate list from the PHPs that matchers their patient panel in order to be able to do this really, but also that in order to evaluate care management services and see how effectively they're working, to know who to track at local EDs and hospitals, and also for informing transitional care management, medication reconciliation, and a whole host of other activities that are part of the AMH model.

(Slide 12) So just a couple of other brief notes on patient assignment. So, if a provider is contracted with a PHP and has an existing relationship with a patient that contains routine visits and claims, that patient will likely be assigned to that provider even if the enrollee does not make a selection. And as I've explained earlier, the auto-assigning process really is designed to

keep patients and providers together that have a relationship that is documented through claims. Also, providers will only be assigned patients for PHPs with which they have a contract. So, even if a PCP has a relationship with a patient, the PCP has to have a contract with that patient's plan in order to have that member assigned to them.

And a couple of key notes about payment here. AMHs can still treat and will receive payment for services rendered, regardless of patient assignment. So if a PCP sees a patient for a regular office visit, even if that patient is not assigned to them, the PCP will still get paid for the visit by the PHP, assuming that the practice has contracted with the plan. Where assignment really comes into play is for these per member per month AMH payments. So these are your medical home fees, your care management fees, and performance incentive payments. These are distributed based on patient assignment. And so, if a member is not assigned to a practice, the practice would not receive those per member per month payments.

So, what can AMHs do to manage their list of assigned patients? So, enrollees can request assistance from PCPs to switch their PCP assignment. Enrollees however must request the change from the PHP themselves. And providers cannot contact a PHP directly to request that a patient be assigned to them without the consent of the patient. PCPs, however, can request that patients be removed from their panel. This would just require the PCP to contract the plan and make this request.

And then one final note. PCPs should work with PHPs to clarify requirements around accepting new patients, opening and closing panels and panel size. We know that some providers have expressed concerns about not being able to manage their panels if they enroll in managed care. And this is a concern that the Department takes very seriously. And it does not wish to force providers that are already full to take on new patients. But this is something that should be worked out between the PHP and the AMH during the contracting cycle.

So now I'm going to turn it over to Dr. Emily Carrier who's going to turn our focus for the remainder of the presentation to the Tier 3 requirements.

Dr. Emily Carrier

(Slide 13) Thanks Adam. This is Emily. And, let's see if I can advance the slide. So what I'm going to talk to you about primarily is risk stratification overall. So I'm going to talk about actually. Let me just go back to the previous slide. So I'm going to talk about risk stratification primarily and it's one of the most important tasks for Tier 3 AMHs and we can think about risk stratification as the process of assigning a relative risk score for all the patients that are practices, but it's really a lot more than that. It's not just making sure that everyone has a, you know, a number next to their name on a spreadsheet because the state or health practice do that with the claim database. It's about making sure that the Medicaid program can take advantage of the tremendous value of clinicians. We know clinicians have a just a tremendous amount of the knowledge, their own ideas, and goals when they come into the process. We know that patients that aren't just marching through schedules and clinical encounters like in an assembly line so the goal in this is has been to incorporate as much flexibility as possible -- really to

create process that complies with all relevant federal and state, law and regulations. And, ensures practices are aware of all the information, all the resources that are out there and covers some key elements, but there are also checks to leave practices flexibility that they need working on their own or with partners to do this work in a way that makes the most sense for them. So, for the next couple of slides I am going to talk about what PHP input is in the risk stratification process and then turn to what the AMA tier and other information they have. So, let talk about the care need screening first. Essentially, the care needs screen -- this is something that's a federal requirement. This is something that generally going to be done by the PHP although they may delegate that time. It's a one-time assessment. It's kind of a preliminary assessment of each enrollees' needs. And, the idea is that it would form the PHP risk score methodology although those steps make happen in parallel in certain cases, so PHPs are required to make their best efforts to conduct a care need screening for all enrollees. The aim is to get better clarity on the enrollee health related needs. Sometimes enrollees are difficult to reach, so the PHP may not be successful in reaching every enrollee but they are required, I believe, two efforts to reach them. And, the idea is that it needs to be done -- or the efforts need to be made within 90 days of enrollment and then once the care needs screen is completed, they are expected to share with the AMH within 7 days of completion or as soon as the patient is assigned. And, again we understand sometimes things are going to happen in slightly different order, depending on how the patient is moving through the system and then once they completed the care needs screening on intake, they are expected to repeat it at least annually for individuals that aren't engaged in active care management. So, what's going to be in the care needs screening, it's going to be the patient acute and chronic condition, a particular focus on chronic pain, understanding their behavior health needs to include substance abuse disorders, their medication lists, both what the system things they are taking and what they are actually taking and then other factors that the PHP might need to be aware of they can ask about and then also un-met health related resource needs. We've included housing, food, transportation, and interpersonal violence. So this is the kind of information that the PHP is going to collect. Again, we expect this one from their PHP risk core approach but the two efforts may happen in parallel. So now, let's talk about the PHP as risk core, so they are going to take this clinical screening information. They are going to take claims of patients and shared with them by the state or as time evolves after manage care launch they will have their own encounter databases they can work with and they may have other data that they use. They will assign a risk score to each enrollee. These different PHPs may take a different approaches so you may not see an exactly consistent approach across PHPs and one thing that will be important for AMHs and their partners to keep in mind is that they when the AMHs is thinking about this at the level of their practice panel, they will need to find a way to kind of harmonize the risk cores, not necessarily at the level of individual numbers but at some general level to make sure that they have an understanding of who is high risk across their different health plan enroll membership. And, we are expecting that the PHPs will need share the information that will support AMHs in this task. We also expect that this is the kind of thing that an AMH can reach out to their partners for support. The state is going to monitor the PHPs scoring methodology to make sure whatever methodology they choose, they adequately identify the priority populations. And then, as I said the PHPs will share the risk score and the AMHs practices are expected to use the risk score to inform their own efforts about stratifying their

patient panels in determining which patient would benefit from care management. So, this is kind of the minimum requirements for the PHP risk scoring. We talked about the various types of data they would bring in so the care needs screening which we spoke about, the claim history, but these are some other types of data they'll have access to as well. They will have pharmacy, lab data, ADT feed information, background information about the members, where the members lives and other demographic information and then information from social service and other referrals. And, what they are meant to do is feed all of these various data flows into generating a risk score and in turn, use that methodology to identify which members are in priority population. This is actually another legal requirement. They are required to identify adult and children with special healthcare needs and then what you see on the second bullet is this right-hand box. There are number of other populations that the state has decided to focus on as well, so you can see some additional populations here. Folks without PHP needs, folks whose risks may be remarkable not because it's particular high at the moment, but because it's rising very rapidly. Unmet resource needs related to social determinants. This is an area where you can expect to see a lot of activity and then there is room to identify other priority groups as needed. AMH practices are expected to help with identifying these populations to the greatest extent possible, understanding again that they have sort of a special perspective and information that they can bring to that.

Let's talk about risk stratification and how the two or three practices will be stratified. So, we just talked about how the PHP will generate their risk score and now we are going to talk about practices doing their risk stratification. Again, risk stratification is taking the information that the AMH practices has been given and using it to assign a relative risk category and Tier 3 AMH practices are expected to risk stratify their empaneled patients as part of identifying who would benefit most from care management. And again, the goal has to really been to try to create a process that ensures that the practice is aware of the information and hitting certain key elements but allowing as much flexibility as possible. So the AMH practice is expected to use a consistent method to assign an adjust risk status but the requirements are not descriptive about which method they use. They just need to use it in a consistent way and they can integrate the PHP risk scoring also with their own, so they need to take into account the PHP risk score, but they are certainly not expected to purchase their own risk stratification software and plug the same information back into it and generate a new number. They are free to do that if that's the approach that makes the most sense for them, but they are absolutely not required to do so. This could be a simple as reviewing the information available and kind of applying their own clinical judgement to the information to say yes. Another PHP thinks this person is high risk and based on review, we think so too or the PHP has flagged this person as high risk, but we know them well and we know that they actually have a lot of support that the PHP isn't aware of. You know, they have really great family member who is with them every step of the way to make sure they don't get into trouble. So this is the kind of thing the risk score as long as it's done consistently the PHP risk stratification method could be as simple as that. And again, the goal of this to identify priority population and to use this information to inform decisions about who gets care management and what kind of care management resources they get.

So some other things to know about the risk stratification methodology in addition to being consistent and applied to all empaneled patients, the entire care team is to understand the basis of the methodology even if only one or a few members of the care team are actually doing it, everyone should have general understanding of what it means to be high risk versus low risk and the practice should be able to define how they go about risk core review and validation. Again, not prescribing a specific method but the practice should have it and should have it and be able to define it in a way that an outside person can easily understand. The practice can do this on their own, but they are also welcome to work with CIN other partners. We expect that CINs could provide a lot of assistance that CIN and other partners may be able to provide on risk scoring and stratification and this is not a task that a practice wants to take on by itself. So again, the aim is to have flexibility here. These are potential ways that CINs and other partners could support practices. There certainly not the only ways and practices that want to do this themselves are more than welcome to do so. CIN and other partners could compile service scoring results from multiple PHPs. And as we talked about earlier, harmonize them so that the practice is only looking at a single harmonized set of numbers. They could do the work of incorporating the risk scoring and stratification findings into the care plan, which is sort of the next step in this process -- or one of the next steps in this process. And, they can also supplement the risk scoring and stratification with analytics that they may bring with them to allow for different kinds of risk assessments, more focused on specific clinical areas, other kind of customized care management approaches and again, these are all just illustrative examples. There all kinds of creative ways that we expect practices could do this on their own and with partners. A lot is going to depend on a specific population of an AMH practice and those specific resources that they bring to the people.

So, here we have one -- again this is again just an example of a use case of how risk stratification might work as a partnership so in this scenario, we have -- let's say our AMH practice is a large, unaffiliated group practice. It has some of the care management functionality in-house but doesn't have all of it. So, in this case we start with as we talked about earlier the PHP performs service scoring and it shares the information with the AMH practice and in this case, the AMH practice has chosen to work with a partner organization and so the PHP shares with both of them and the primary care practice has the local care manager that does a lot of the work related to developing the comprehensive assessment, the care plan and making sure that the care management actually happens after leading the care team and working with high risk patients on an on-going basis and their partner does a lot of the data analytics stuff behind the scenes and the scenario such as aggregating the risk scores across all the different PHPs, making sure that they are kept up-to-date, translating them into the appropriate stratification, pulling ADT flows and identifying episodes or visits that may trigger the need for additional care management, aggregating all this information from other data flows like lab data, for example. So this is just one example just to get you thinking about different way practices and CINs might work together to accomplish the goals of risk stratification. So again, the goal has been to design as much flexibility into the process as possible and let people really think creatively about how to meet these needs.

So, the next step I want to talk about is the comprehensive assessment and this is what comes out of the risk stratification process. So the idea is that for all the patients that the risk stratification identifies as high need, the PHP would conduct this comprehensive assessment on them. A comprehensive assessment compared to the care needs of the screening that we talked about earlier that's conducted by the PHPs, the AMHs practices would conduct those. This is just a more thorough assessment that's really going to get into the detail of what a patient's needs that have been identified as high priority needs and concerns are and help to guide the care management activities that are going to help addressed those needs.

So, this is a list of some of the required elements. Really, it should be patient centered so some of these elements may be much more important than others for any particular patient, but the idea is that the assessment should cover at some level all of these. And, this is again, their immediate needs, what they are doing right now, the physical and dental health conditions and this is a good example of an opportunity to do things like mediation reconciliation, cleaning up the problem list if that's a possibility, a special focus on their mental and behavior health needs, any physical and intellectual developmental disabilities. So talking about what kind of support they might have including peer support and then talking about -- these are just some other areas where the plan would explore. We talked about the four priority health related resource domains and again, these will keep coming up across these presentations, housing, food, transportation and personal safety -- just anything ongoing that the practice needs to know about and then PHP have the option to ask about exposure to adverse childhood experiences or trauma -- the PHP or the AMH. And again, the goal of all of this is not just to gather information that lives on a file somewhere but for the Tier 3 AMH practice to sort think critically about whether what kind of care management is going to best suit this patient and how the care plan can help adjust their needs.

So, the comprehensive assessment needs to be done, it needs to be reviewed by care team members and we need to develop a care plan based on the findings of that assessment within 30 days of the assessment. There are some sections of the assessment -- again trying to build in flexibility. If the practice wants to incorporate some standardized screening tools then we give some examples here of PHQ-2 or GAD-7, but there are many, many others in the behavior and mental health area. Their certainly allowed, but it's definitely not required. And, this is something that I think a lot of practices may have questions about. The lead clinicians, the physical or nurse practitioner that may be the licensed, independent provider at that clinic site is not required to be the one doing the comprehensive assessment. It can be done in a team, as long as the team has someone with an RN or LCSW. We understand that the team may be working as a team and that individual may not be the one leading every section of the assessment. Taking into the account the different clinic sites have different workflows and wanting to be respectful of that, but especially when they are working as a team. There should be just the practice or the partner that is administering the assessment should have some protocol for what to do when a patient discloses information during the assessment they can't sit for 30 days but indicate some sort of an immediate risk that needs to be addressed. And again, not dictating what that protocol is but just saying that an AMH Tier 3 practice should have one. And then, at each assessment the review should include medication management, so

when the Tier 3 is done its assessment, they incorporate the findings, all these information that have been gathered so far so we have the information from the PHP care needs screening, the risk scoring and the comprehensive assessment and then any other clinical knowledge that they bring to the table and they put that into the care plan. So this just an opportunity to bring all this together and emphasize to inform what the plan is going to be going forward. So, again this is a significant task and we expect that a lot of practices are going to expect to work with partners on the comprehensive assessment. Partners and CINs are definitely support Tier 3 AMHs that used to work with them in the comprehensive assessment and care plan development task for patients who they identify as high needs. And, again these are just examples. We hope that practices, CINs and partners will develop many creative ways to work together, but these are some examples developing protocol for the comprehensive assessments, creating tools that can make assessment faster and easier to do and other resources for delivering them. Assisting the CINs could contract with local care managers and I want to emphasize the word "local" here. It's really important that care delivery be done locally rather than remotely and then there are other tools that they can help develop, not just administering. If these staff could administer the comprehensive assessments, they could also work on developing the care plan that follows from the finding of that assessment. And, then when there's all this data instead of being share by PHP and others, they can be responsible for bringing it together. So, this is an opportunity for, you know, practices that might contract with multiple PHPs to have some support in digesting all the different data that may be coming out from different sources and maintaining it on an on-going basis.

And, again this is just another illustrative use case of the comprehensive assessment and again in our scenario, our AMH Tier 3 practice is a large practice. It has some of the care management functionality but not all of it and it's not affiliated with the health system but it has chosen to work with the CIN or with another partner. So, in this case again that PHP is sharing is performing its risk scoring and its preliminary care needs assessments and sharing that information both with the AMH practice and with its designated partner. The PHP has decided that they are going to employ the local care managers and those care managers are going to do the assessment, fill out the care plan based on the assessment and make sure that the care management and care coordination happens on an on-going basis. The CIN would pull together a lot of the data analytics that's coming to them in terms of PHP risk scoring and stratification. They're kind of ingesting it and processing it and let's say in this scenario they might provide a technology tool that provides a digital form for clinicians to fill out as they're administering the assessment. And that tool might see that information as a clinical system of record to eliminate the need for data entry. They could create workflows for updating the care plan on an ongoing basis. Again, they could do things like monitoring ADT feeds since practices may not have the staffing to devote to that directly. And again, they might pull together other data flows to create sort of an easy to work with list of actionable information. And the AMH would work with them on an ongoing basis to make sure that this is a process that everybody understands.

(Slide 14) So that brings us to our last slide. We have a Q&A going on now. I think we have a number of questions. I'm actually going to turn it back over to Adam for a minute.

Adam Striar

Thanks Emily. So, just a reminder, if you have any questions, please go ahead and enter those into your Q & A box in the bottom right hand corner of your screen. We have about eight minutes here, so we'll try to get through as many of these as we can. But, if we're not able to get to them today, we will be sure to respond to you offline or make sure these get incorporated into FAQs as appropriate. So, we've gotten a number of questions here. So, one that I want to respond to, someone asked about whether a specific software tool is something that they can use to deliver the comprehensive assessment. And we -- the question is actually with respect to the risk scoring and stratification.

So, we just want to reiterate that practices are not required to use any particular kind of tool when they are doing their risk scoring. The requirements only specify that practices have to use a consistent method that they're applying across their patient panel. In addition to that, they need to apply some kind of clinical judgment on top of the risk scores that they receive from the PHP. So, just ensuring that all patients on the panel are receiving a risk score is really the only requirement here and practices are certainly not expected to go out and purchase risk scoring or stratification software to achieve that.

And it looks like we have another question here asking if practices are required to perform a comprehensive assessment on all patients. And the answer to that question is no. So, comprehensive assessments are intended only to be done on patients that are identified as high risk or as being in one of these states priorities population by that PHP risk score that will come to the practice. We certainly recognize that comprehensive assessments can be time consuming and we certainly wouldn't expect that practices perform them on all patients. So, again, this is really something that is intended to be only for those patients identified as high risk.

I just want to pause there. Emily, are there any questions that you wanted to have a chance to respond to?

Dr. Emily Carrier

I believe there was a question about the credentials of the clinicians performing a comprehensive assessment. The provider, the AMH provider manual, which is a good resource, talks about the comprehensive assessment and with the requirements around it. And no. 8 talks about the specific requirement. So, basically, the requirement can happen during a regular clinician visit, but we understand that that may not always be what works best for the clinician and the patient. So, it can also be done separately by a team. And the team needs to be led by a clinician that has a minimum credential of RN or LCSW. That does not mean that every team member has to have that credential by any means. That does not mean that the RNs or LCSW has to be present for all components of the assessment, even if they're not involved. But they need to be leading the team. Our expectation would be that they would probably want to weigh in on some of the more clinical aspects of it, like the medication reconciliation aspects of it. And again, as I mentioned, there should be some kind of protocol or plan in place so that

other team members, if they identify any kind of concerning information that they don't think can wait to go through the regular process can escalate that information to make sure that the patient gets the support they need immediately.

Adam Striar

Thanks Emily. Looks like we have another question here about what a practice should do if they're interested in closing off their panel or limiting the number of Medicaid patients that they take. So, this is something that would need to be worked out between the practice and each PHP with which that practice contracts. The state is not requiring that PCP's take on a certain number of patients and certainly recognizes that practices may already have panels that are full. So, this is something that should be worked out during the contracting process between each practice and each PHP.

And it looks like we have a couple of questions about clinically integrated networks. So, we have one about if the state is going to certify clinically integrated networks. So, the answer to that question is no. So, the state is not exercising any direct oversight of clinically integrated networks, nor will it be putting out any kind of a list of CINs that practices are permitted to work with. This is really the responsibility of the practice to determine what capabilities it needs the CIN to fulfill and figuring out who it wants to work with in a way that best meets its needs within a contracting arrangement that is favorable to the practice.

So practices really need to be working with these organizations and figuring out what they can offer. If a practice is happy with the service that CCNC is providing as a CIN, they are more than welcome to stay with CCNC, but we reiterate that this is not a requirement of the AMH program and practices are free to work with other vendors that may be able to provide technology to support their care management. May be able to provide staffing support. They're also more than welcome to take on these responsibilities in house that they have those capabilities.

And Emily, I think you had another question that you wanted to respond to?

Dr. Emily Carrier

Yeah there was a question about what's an ADT event. So, ADT is admissions, discharges and transfers and this refers to databases that track admissions, discharges and transfers for patients, basically hospitalizations and ED visits. And so that would be, for example, and Tier 3 AMHs are expected to have some way of being aware of what's going on with those databases either directly or via a CIN or another partner. And so that might be -- you get a ping that your patient is at the emergency department for asthma and you know you can intervene because you know their asthma plan really well and you jump in.

Adam Striar

(Slide 15) Thanks Emily. So, just recognizing the time we just want to quickly run through next steps before we sign off here for the day. (Slide 16) So, we just wanted to remind you that we do have three more webinars in our series of AMH training webinars. So, on December 3, we have an additional webinar on Tier 3 which will focus on high need care management. Then again on December 18, we'll focus on the transitional care management requirements within Tier 3 and then we'll conclude this series on January 10 with a webinar on IT needs and data sharing within the AMH program.

We encourage you to visit the AMH web page with the URL listed here. Here, you'll be able to find all of our previous training materials, as well as registration information for the upcoming webinars. (Slide 17) If you have any questions that were not answered today, we encourage you to write to the email address listed here, so medicaid.transformation@dhhs.nc.gov. You're also free to send in any questions to the department's physical mailing address listed here. And again, we have all sorts of resources and registration links available on the AMH webpage.

(Slide 18) So, thank you again to all of the participants and we hope you have a great rest of your day.