Introduction to the Advanced Medical Home Program

AMH 101

August 23, 2018

Contents

Part I:
North Carolina's Medicaid Transformation

Overview of Managed Care Transition

Under managed care, approximately 8 out of 10 Medicaid/NC Health Choice* beneficiaries will receive health coverage through Prepaid Health Plans (PHPs)

- **North Carolina Medicaid providers will need to contract with PHPs and will be reimbursed by PHPs, rather than by the state directly**

- There will be **two types of PHPs**:
  1. Commercial plans
  2. Provider-led entities

- PHPs will offer **two types of products**:
  1. Standard plans for most beneficiaries
     - *Scheduled to launch in late 2019*
  2. Tailored plans for high-need populations
     - *Will include enrollees diagnosed with a serious mental illness (SMI), substance use disorder (SUD), or intellectual/developmental disability (I/DD) and those enrolled in the state's traumatic brain injury (TBI) waiver*
     - *Tentatively scheduled to launch in July 2021*

Note: Certain populations will **continue to receive fee-for-service (FFS) coverage** on an ongoing basis

** Note: References to "Medicaid" hereafter are intended to encompass both Medicaid and NC Health Choice.*

Care Management Approach

Guiding principles of care management approach under NC Medicaid managed care

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ 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**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

AMHs are designed to serve as **a vehicle for executing on this approach in a managed care context**

Evolution of Existing Programs Under Managed Care

The state will build on existing care management infrastructure under managed care

Pre-Transformation: FFS	*Post-Transformation:* Managed Care	
Carolina ACCESS	AMH	*Focus of Presentation*
Care Coordination for Children (CC4C)	Care Management for At-Risk Children	
Obstetric Care Management (OBCM)	Care Management for High-Risk Pregnancy	

*Note: These programs will **remain in place** **post-transformation** for populations that remain in FFS coverage*

Note: Local Health Department providers can participate in Care Management for High-Risk Pregnancy/Care Management for At-Risk Children and in AMH simultaneously

Part II:
Overview of AMH

Introduction to AMH

Vision for AMH in Managed Care

Build on the Carolina ACCESS program to ***preserve broad access to primary care services*** *for Medicaid enrollees and* ***strengthen the role of primary care in care management, care coordination, and quality improvement*** *as the state transitions to managed care*

Practices will have <u>options</u> under AMH:

- Current Carolina ACCESS practices may **continue into AMH with few changes**; practices ready to take on more advanced care management functions **may be eligible for additional payments**
- Practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**
- Unlike in Carolina ACCESS, **practices <u>WILL NOT</u> be required to contract with Community Care of North Carolina (CCNC) to participate in AMH**

AMH Tiers

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments
(paid by PHP to practice)

- **Per member per month (PMPM) Medical Home Payments**
  - Same as Carolina ACCESS
  - Non-negotiable

Tier 3

- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- **Single, consistent care management platform:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 PHP contracts

AMH Payments
(paid by PHP to practice)

- **PMPM Medical Home Payments**
  - Same as Carolina ACCESS
  - Non-negotiable
- **Additional Care Management Payments**
  - Negotiated between PHP and practice

Tier 4: To launch at a later date

AMH Payment Structure

AMH practices will continue to receive medical home payments for assigned members and may earn additional care management fees

Tier	Practice Requirements	Primary Responsibility for Care Management	Clinical Services Payments	PMPM Medical Home Payment	Care Management Fee	PHP Performance Incentive to Practices
1	Same as for Carolina ACCESS	PHP	Will continue—PHPs must comply w/ minimum rate floors set at Medicaid FFS levels	$1.00	None	None required, but PHPs encouraged to begin offering performance payments based on AMH measures
2	Same as for Carolina ACCESS	PHP		$2.50 (most enrollees) or $5.00 (members of the aged, blind and disabled [ABD] eligibility group)	None	
3	Tier 1 and 2 requirements, and additional Tier 3 care management responsibilities	Practices responsible; AMH practices may arrange for care management functions to be performed by a CIN/other partner at their discretion		$2.50 (most enrollees) or $5.00 (members of the ABD eligibility group)	Negotiated between practices, or CINS on behalf of practices, and PHPs	PHP must pay performance incentive payments to practices if practices meet performance thresholds on standard AMH measures, which may include total cost of care
4	*Will launch after year 2—though PHPs and providers can go above and beyond Tier 3 requirements at any time*					

AMH Practice Eligibility Requirements

AMH practice eligibility requirements will be the same as those for Carolina ACCESS

- AMH-eligible practices must **provide primary care services** and **be enrolled in the North Carolina Medicaid program**
  - For a full list of required primary care services, see Appendix A
- Examples of eligible practices are single- and multi-specialty groups led by allopathic and osteopathic physicians in the following specialties:
  - General Practice
  - Family Medicine
  - Internal Medicine
  - OB/GYN
  - Pediatrics
  - Psychiatry and Neurology
- For a full list of permitted subspecialties, refer to NCTracks

Practice Requirements: Tiers 1 and 2

Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS practices

Requirements for AMH Tiers 1 and 2*

1. Perform **primary care services** that include certain preventive & ancillary services**
2. Create and maintain a **patient-clinician relationship**
3. Provide direct patient care a **minimum of 30 office hours per week**
4. Provide access to medical advice and services **24 hours per day, seven days per week**
5. **Refer to other providers** when service cannot be provided by primary care provider (PCP)
6. Provide **oral interpretation for all non-English proficient beneficiaries and sign language** at no cost

** See Appendix B for standard terms and conditions for PHP contracts with AMH practices.*
*** See Appendix A for required services.*

Practice Requirements: Tier 3 Requirements

- **Practice requirements for Tier 3 include all Tier 2 requirements plus additional care management responsibilities**
- **AMHs must attest that they or their contracted CINs/other partners are capable of fulfilling these requirements**

Additional Requirements for AMH Tier 3*

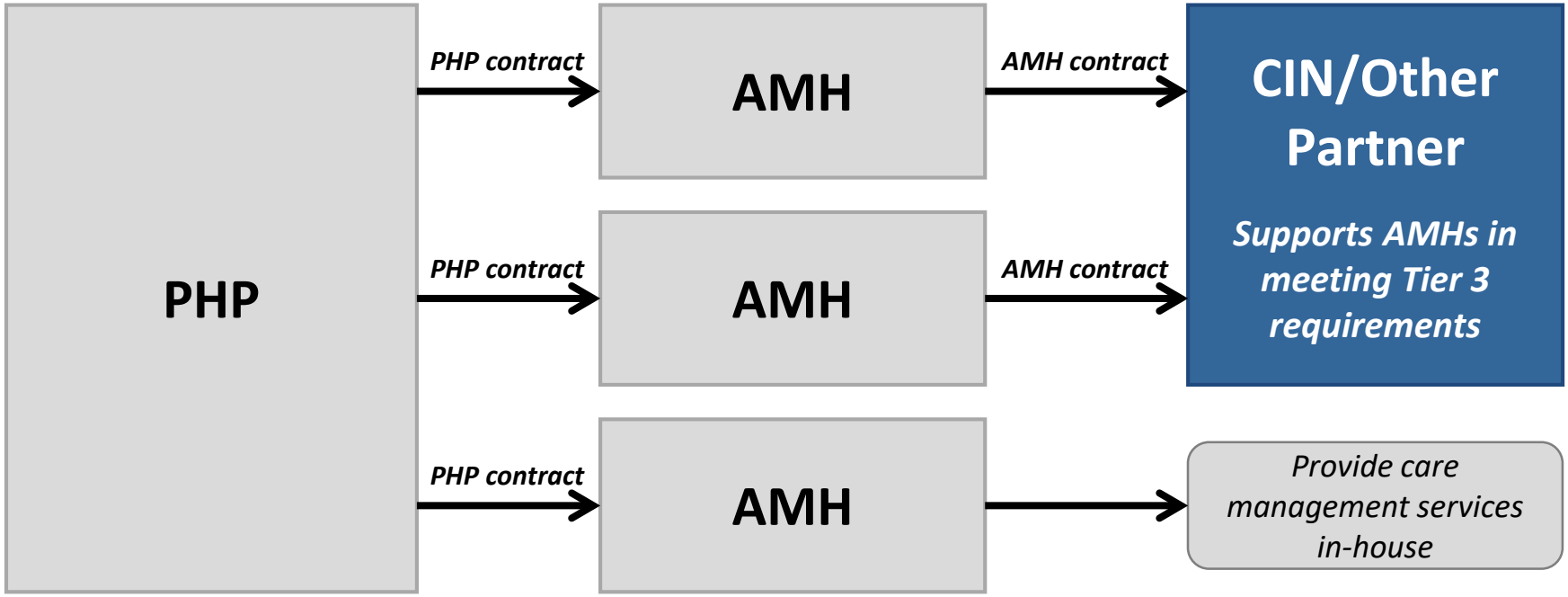
- **Risk stratify** all empaneled patients
- Provide **care management to high-need patients**
- Develop a **Care Plan** for all patients receiving care management
- Provide **short-term, transitional care management** along with **medication management** to all empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are high-risk of readmissions and other poor outcomes
- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use**

** See Appendix C for full Tier 3 requirements.*

*** More details on data requirements to follow in webinar on IT Needs and Data Sharing Capabilities.*

Practice Requirements: Tier 3 Care Management Partners

Many Tier 3 practices will choose to rely on a CIN/other partner to fulfill Tier 3 care management responsibilities



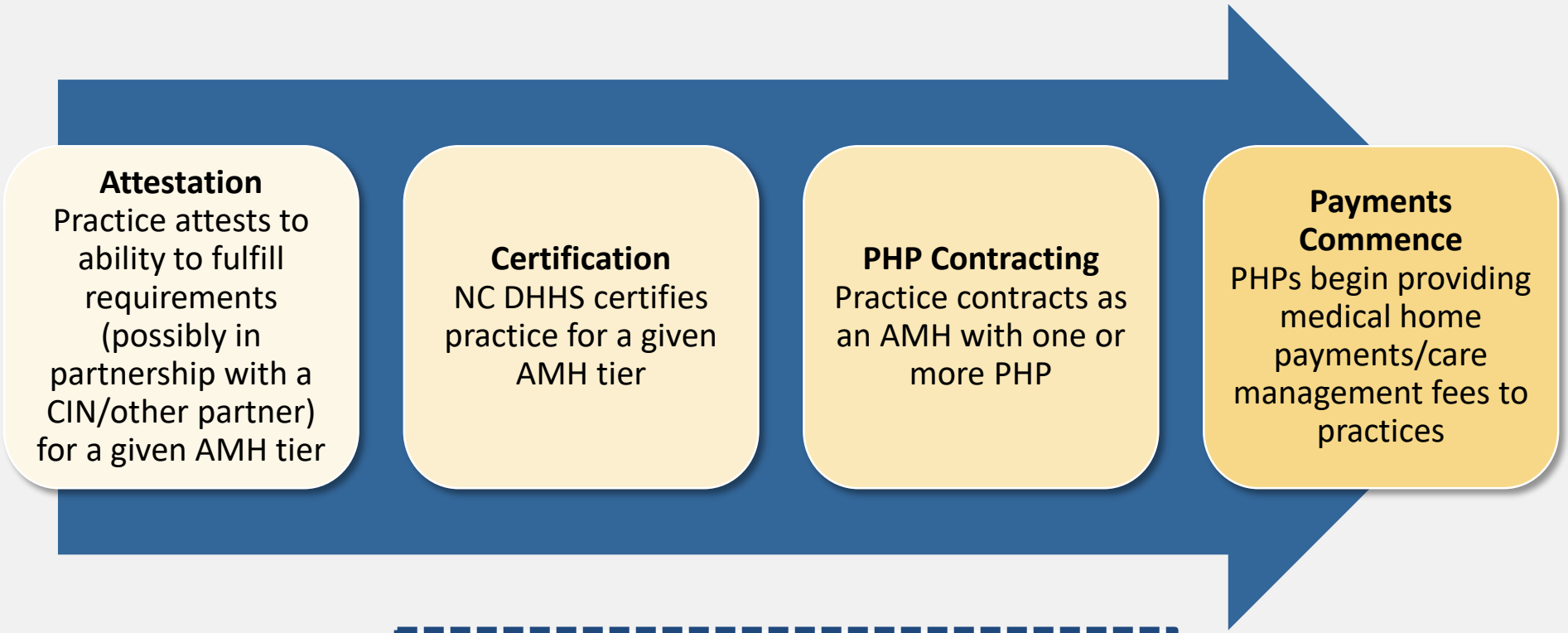
Practices are free to use a CIN/other partner of their choice (or none at all) and are no longer required to contract with CCNC*

*Practices will still be required to contract with their local CCNC network in order to participate in CAII/CCNC for FFS.

Part III: Transitioning from Carolina ACCESS to AMH

AMH Certification Process

- **NC DHHS is responsible for certifying that practices may participate in a given AMH Tier**
- **Medical home payments/care management fees to practices commence only once the practice has contracted with a PHP as an AMH**



Certification itself does not trigger payments

Attestation and Certification

The State is responsible for **certifying that practices are eligible** to participate in AMH*:

- **Practices not currently enrolled** with NC Medicaid will need to complete enrollment application via NCTracks in advance of attestation
- **Medicaid-enrolled practices not currently enrolled in Carolina ACCESS** will be required to enroll through NCTracks; this will automatically certify practices for Tier 2
- Practices already participating in Carolina ACCESS are automatically grandfathered into AMH
  - Practices currently enrolled in CAI will need enroll in Tier 2 via NCTracks
  - Practices currently enrolled in CAII/CCNC will automatically be placed in Tier 2
- All practices will need to submit an attestation trough NCTracks to participate in Tier 3 – there is no "grandfathering" for this Tier

AMH-certified practices can contract **up to their highest certification level** with one or more PHPs

** More information on attestation processes to follow in next week's "AMH 102" webinar.*

Contracting with PHPs

Generally, PHPs must honor AMH certifications given by the state

PHPs **must accept Tier 1 and Tier 2 certifications "as is"** and may not choose to reclassify practices during the initial contracting period

PHPs are **required to contract with 80% of Tier 3-certified practices** in their service areas*

- NC DHHS will maintain a "master list" of AMHs by tier certification status

PHPs, however, are **responsible for oversight**

- In limited instances, PHPs **can reclassify practices** that fail to satisfy requirements of their tier

** Note: PHPs will not be required to contract with Tier 3-certified practices at a Tier 3 level if they are unable to reach mutually agreeable contract terms (although this would count against the PHP's 80% contracting requirement). PHPs must accept Tier 3 certified practices into their provider networks at a minimum Tier 2 level if they cannot reach agreement on Tier 3 contracting terms.*

Carolina ACCESS to AMH Transition Roadmap

A practice's current Carolina ACCESS status will determine its eligibility for and pathway to each of the AMH tiers

		Eligibility for AMH Program			
		Not AMH Eligible	**AMH Tier 1 Certified**	**AMH Tier 2 Certified**	**AMH Tier 3 Certified**
Provider not enrolled in Medicaid		Default placement	[Not permitted]	✓ If successfully enroll in Medicaid and Carolina ACCESS	✓ If successfully enroll in Medicaid/Carolina ACCESS and attest to Tier 3 requirements
Medicaid-enrolled providers	**Not participating in Carolina ACCESS**	Default placement	[Not permitted]	✓ If successfully enroll in Carolina ACCESS	✓ If successfully enroll in Carolina ACCESS and attest to Tier 3 requirements
	CA-I	Opt out of program via NCTracks	Default placement	✓ If elect to participate in Tier 2 via NCTracks	✓ If successfully attest to Tier 3 requirements
	CA-II (CCNC)	Opt out of program via NCTracks	[Not permitted]	Default placement	✓ If successfully attest to Tier 3 requirements

Timeline of AMH Program Launch*

PHPs will be required to contract with AMHs that are certified before Feb. 1, 2019

2/1/19:
- NC DHHS announces **PHP selection**
- State **finalizes list** of certified AMHs

10/1/18 – 1/31/19	Feb. ’19 – Nov. ‘19	Nov. ’19 +
Attestation (interested practices attest to meeting AMH capabilities)	**PHP Contracting** (PHPs form their provider networks; AMH-certified practices contract with PHPs as AMH practices)	**Managed Care and AMH Program Go Live** (Practices begin receiving payments from PHPs)

- Practices will still be able to attest after Feb. 1, 2019, but PHPs will not be contractually obligated to honor their certification
- The state will certify a list of AMH Tier 3 practices at the start of each contracting period in subsequent plan years

*Dates are approximate and subject to change

Part IV: Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars:

- **August 28, 12:30-1:30pm:** AMH 102 and Transitioning Carolina ACCESS
- **TBD:** AMH Oversight, Delegation, and Contracting
- **TBD:** Roles and Responsibilities of CINs and Other Provider Partners
- **TBD:** AMH Tier 3: Patient Identification, Assignment, and Tracking
- **TBD:** AMH Tier 3: Care Management
- **TBD:** AMH Tier 3: Care Planning
- **TBD:** IT Needs and Data Sharing Capabilities

Upcoming AMH Regional Trainings:

- **August 30:** Wilmington, 10am–12pm
- **September 17:** Greensboro, 10am–12pm **and** 2pm–4pm
- **September 19:** Greenville, 10am–12pm
- **September 24:** Asheville, 11am–1pm
- **September 25:** Huntersville, 10am–12pm
- **October 4:** Raleigh, 10am–12pm

AMH Training Website and FAQs: https://medicaid.ncdhhs.gov/amh-training

Additional Information

Questions?

- **AMH Training Website and FAQs:** https://medicaid.ncdhhs.gov/amh-training
- **Email:** Medicaid.Transformation@dhhs.nc.gov
- **U.S. Mail:** Dept. of Health and Human Services, Division of Health Benefits
  1950 Mail Service Center
  Raleigh NC 27699-1950

Policy Papers

- NC DHHS, "North Carolina's Proposed Program Design for Medicaid Managed Care," August 2017
- NC DHHS, "North Carolina's Care Management Strategy under Managed Care," March 9, 2018
- NC DHHS, "Data Strategy to Support the Advanced Medical Home Program in North Carolina," July 20, 2018

Appendix A:
AMH Required Preventive & Ancillary Services

AMH Required Preventive & Ancillary Services

Required Preventive and Ancillary Services												
NCTracks assigned #	Carolina ACCESS/CCNC Preventative Health Requirements	Required for providers who serve the following age ranges										
		0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	All Ages	3 to 17	7+	11 to 18	11+	18+	21+
1	Adult Preventative & Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8 & 9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					

AMH Required Preventive & Ancillary Services (cont'd)

Required Preventive and Ancillary Services (cont'd)												
NCTracks assigned #	Carolina ACCESS/CCNC Preventative Health Requirements	Required for providers who serve the following age ranges										
		0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	All Ages	3 to 17	7+	11 to 18	11+	18+	21+
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Developmental Screen	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing for high-risk patients (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Appendix B:
Standard Terms for PHP Contracts with AMHs

Standard Terms for PHP Contracts with AMHs

Standard Terms and Conditions for PHP Contracts with Advanced Medical Home Practices	
PHPs will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices' agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements.	
1	Accept enrollees and be listed as a primary care practice in the PHP's enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.
2	Provide Primary Care and Patient Care Coordination services to each enrollee.
3	Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
4	Provide direct patient care a minimum of 30 office hours per week.
5	Provide preventive services.
6	Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees.
7	Maintain a unified patient medical record for each enrollee following the PHP's medical record documentation guidelines.
8	Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
9	Transfer the enrollee's medical record to the receiving practice upon the change of primary care practice at the request of the new primary care practice or PHP (if applicable) and as authorized by the enrollee within 30 days of the date of the request , free of charge.

Standard Terms for PHP Contracts with AMHs (cont'd)

Standard Terms and Conditions for PHP Contracts with Advanced Medical Home Practices (cont'd)	
PHPs will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices' agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements.	
10	Authorize care for the enrollee or provide care for the enrollee based on the standards of appointment availability as defined by the PHP's network adequacy standards.
11	Refer for a second opinion as requested by the patient, based on Department guidelines and PHP standards.
12	Review and use enrollee utilization and cost reports provided by the PHP for the purpose of AMH level utilization management and advise the PHP of errors, omissions, or discrepancies if they are discovered.
13	Review and use the monthly enrollment report provided by the PHP for the purpose of participating in PHP or practice-based population health or care management activities.

Appendix C:
AMH Tier 3 Attestation Requirements

AMH Tier 3 Attestation Requirements

Section I requirements (information required to link practices to existing IT records)		
#	**Requirement**	**Rationale/Description**
N/A	Organization Name	The organization's legal name should be entered exactly as it appears in NCTracks, to facilitate matching.
N/A	Name and Title of Office Administrator Completing the Form	The form should be completed by the individual who has the electronic PIN required to submit data to NCTracks on behalf of the practice.
N/A	Contact Information of Office Administrator Completing the Form (e-mail and phone number)	
N/A	Organization NPI (or Individual NPI, for practitioners who do not bill through an organizational NPI)	
N/A	Phone Number	This should be the general number and address used to reach the practice, as opposed to the specific contact information requested for the office administrator (above)
N/A	E-mail Address	
N/A	If you are seeking to attest for multiple clinical service locations, please provide information for additional locations	The attesting administrator should have the authority to attest for all locations listed

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations		
#	**Requirement**	**Rationale/Description**
Tier 3 AMH practices must be able to risk stratify all empaneled patients. To meet this requirement, the practice must attest to doing the following:		
1	Can your practice ensure that assignment lists transmitted to the practice by each PHP are reconciled with the practice's panel list and up to date in the clinical system of record?	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate. The clinical system of record is an electronic health record or equivalent.
2	Does your practice use a consistent method to assign and adjust risk status for each assigned patient?	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/partner or system would meet this requirement or application of clinical judgment to risk scores received from the PHP or another source will suffice.
3	Can your practice use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel? (See supplemental question 5 to provide more information.)	
4	To the greatest extent possible, can your practice ensure that the method is consistent with the Department's program Policy of identifying "priority populations" for care management?	Not all care team members need to be able to perform risk stratification (for example, risk stratification will most likely be done at the CIN/partner level, or may be performed exclusively by physicians if done independently at the practice level), but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
5	Can your practice ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently?	
6	Can your practice define the process and frequency of risk score review and validation?	Practices should be prepared to describe these elements for PHPs.
Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following:		
7	Using the practice's risk stratification method, can your practice identify patients who may benefit from care management?	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management designations need not precisely mirror risk stratification levels.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following: (cont'd)		
8	Can your practice perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs? The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum (see supplemental question 5 to provide further information): o Patient's immediate care needs and current services; o Other State or local services currently used; o Physical health conditions; o Current and past behavioral and mental health and substance use status and/or disorders; o Physical, intellectual developmental disabilities; o Medications; o Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety); o Available informal, caregiver, or social supports, including peer supports.	In preparation for the assessment, care team members may consolidate information from a variety of sources, and must review the Initial Care Needs Screening performed by the PHP (if available). The clinician performing the assessment should confirm the information with the enrollee. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the enrollee's claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. This section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The enrollee may be referred for formal diagnostic evaluation. The practice or CIN/partners administering the Comprehensive Assessment should develop a protocol for situations when an enrollee discloses information during the Assessment indicating an immediate risk to self or others. The review of medications should include a medication reconciliation on the first Comprehensive Assessment, as well as on subsequent Assessments if the enrollee has not had a recent medication reconciliation related to a care transition or for another reason. The medication reconciliation should be performed by an individual with appropriate clinical training.
9	Does your practice have North Carolina licensed, trained staff organized at the practice level (or at the CIN/partner level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients?	Care managers must be assigned to the practice, but need not be physically embedded at the practice location.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following: (cont'd)		
10	For each high-need patient, can your practice assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW? (See supplemental question 6 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and their clinician during routine visits.
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan.		
11	Can your practice develop the Care Plan within 30 days of Comprehensive Assessment or sooner if feasible while ensuring that needed treatment is not delayed by the development of the Care Plan?	30 days is the maximum interval for developing a Care Plan. If there are clinical benefits to developing a Care Plan more quickly, practices should do so whenever feasible.
12	Can your practice develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible?	Practice may identify their own definitions of 'individualized', 'person-centered' and 'collaborative', but should be able to describe how their care planning process demonstrates these attributes.
13	Can your practice incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan? o Can your practice include, at a minimum, the following elements in the Care Plan o Measurable patient (or patient and caregiver) goals o Medical needs including any behavioral health needs; o Interventions; o Intended outcomes; and o Social, educational, and other services needed by the patient.	Intended outcomes can be understood as clinical steps identified by the care team that will lead to the enrollee/caregiver-defined goal. For example, the enrollee may set a goal of no longer needing frequent fingersticks and injected insulin. The care team may develop an intended clinical outcome that represents the level of glycemic control at which the enrollee could attempt a trial of oral hypoglycemics, and a second intended clinical outcome that represents the level of control on oral hypoglycemics that would allow the enrollee to continue with the regimen.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan. (cont'd)		
14	Does your practice have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment? (See supplemental question 7 to provide more information.)	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate.
15	Does your practice have a process to document and store each Care Plan in the clinical system of record?	The clinical system of record may include an electronic health record.
16	Can your practice periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary?	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate.
17	Can your practice track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time?	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s) .

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan. (cont'd)		
18	Can your practice or CIN implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)? o Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission. o Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital; o Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)	Practices (directly or via CIN/partners) are not required to respond to all ADT alerts in these categories, but they are required to have a process in place to determine which notifications merit a response and to ensure that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough with regard to the designation of ADT alerts as requiring or not requiring follow-up; the interval within which follow-up should occur; and the documentation that follow-up took place that an external observer could easily determine whether the process is being followed.
Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.		
19	Does your practice have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following: o Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits o Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; o NICU discharges; o Clinical complexity, severity of condition, medications, risk score	

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes. (cont'd)		
20	For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, can your practice assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW? (Please see supplemental question 8 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN should still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and their clinician during the transition period.
21	Does your practice include the following elements in transitional care management? o Ensuring that a care manager is assigned to manage the transition o Facilitating clinical handoffs; o Obtaining a copy of the discharge plan/summary; o Conducting medication reconciliation; o Following-up by the assigned care manager rapidly following discharge; o Ensuring that a follow-up outpatient, home visit or face to face encounter occurs o Developing a protocol for determining the appropriate timing and format of such outreach	The AMH practice is not required to ensure that follow-up visits occur within a specific time window because enrollees' needs may vary. However, the practice must have a process for determining a clinically-appropriate follow-up interval for each enrollee that is specific enough with regard to the interval within which follow-up should occur and the documentation that follow-up took place that an external observer could easily determine whether the process is being followed.
Tier 3 AMH practices must use electronic data to promote care management		
22	Can your practice receive claims data feeds (directly or via a CIN/partner) and meet Department-designated security standards for their storage and use?	

AMH Tier 3 Attestation Requirements (cont'd)

Supplemental Questions		
#	**Requirement**	**Rationale/Description**
S1	Will your practice work with a CIN or other partners?	This element must be completed, but responses will not affect certification.
S2	If yes, please list the names and regions of the CIN(s) you are working with.	This element must be completed, but responses will not affect certification. This list should include the full legal name of each CIN.
S3	Who will provide care management services for your AMH? (e.g., CIN or other CM vendor) ❑ Employed practice staff ❑ Staff of the CIN ❑ Staff of a care management or population health vendor that is not part of a CIN ❑ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.
S4	If you are working with more than one CIN/partner, please describe how CINs/partners will share accountability for your assigned population.	This element must be completed, but responses will not affect certification. When practices elect to work with multiple CINs/partners, they can divide their population among CINs/partners based on regional or other categorizations, but should ensure that they can readily identify which CINs/partners have primary accountability for which patients.
S5	Practices/CINs/partners will have the option to assess adverse childhood experiences (ACEs). Can your practice/CIN/partner assess adults for ACEs?	This element must be completed, but responses will not affect certification.
S6	What are the credentials of the staff that will participate in the complex care management team within practice/CIN/partner? (Please indicate all that apply.) ❑ MD ❑ RN ❑ LCSW ❑ Medical Assistant/LPN ❑ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.

AMH Tier 3 Attestation Requirements (cont'd)

Supplemental Questions (cont'd)		
#	**Requirement**	**Rationale/Description**
S7	For patients who need LTSS, can your practice coordinate with the PHP to develop the Care Plan?	This element must be completed, but responses will not affect certification. Practices and CINs/partners are not required to have same capabilities as PHPs for screening and management of LTSS populations.
S8	What are the credentials of the staff that will participate in the transitional care management team within practice/CIN/partner? (Please indicate all that apply.) ❑ MD ❑ RN ❑ LCSW ❑ Medical Assistant/LPN ❑ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.