Introduction to Advanced Medical Homes

AMH Tier 3: Patient Identification and Assessment

November 14, 2018

Contents

Part I

Overview: North Carolina's Medicaid Transformation and AMH

Care Management Principles

Robust care management is a cornerstone of the State's managed care transition

Care Management Guiding Principles

- ❑ 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**

Local Care Management

PHPs must 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

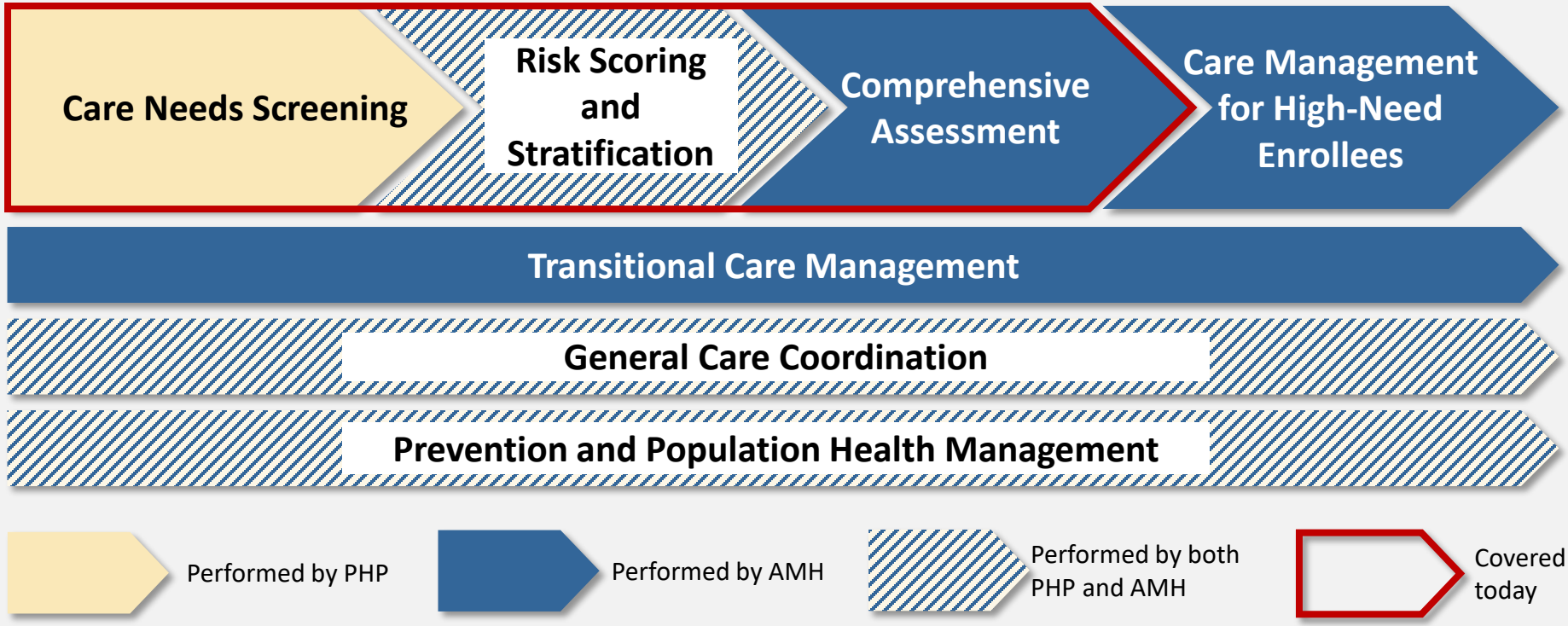
Requirements for Local Care Management

- PHPs must have an **established system of local care management** through AMHs, Local Health Departments (LHDs) as well as care management provided by the PHP that delivers high quality care
- PHPs are responsible for **oversight of local care management**, but can delegate primary responsibility to AMH Tier 3 practices
- 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** (e.g., AMHs and LHDs)

The AMH program is intended as a minimum initial framework for which PHPs and practices innovate around payment and delivery models to support local care management

Care Management Approach: Tier 3

Tier 3 AMH practices are responsible for a range of local care management functions; CINs/other partners can assist practices in fulfilling some of these responsibilities*



Note: AMH Tier 3 practices will have broad flexibility in determining how CINs/other partners can help meet Tier 3 needs

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

Part II

Patient Assignment and Primary Care Provider Selection

Overview of Patient Prepaid Health Plan (PHP) Selection

Under managed care, enrollees will have the opportunity to choose their PHP or they will be auto-assigned

PHP Selection

- If enrollees do not select a PHP by the **end of the open enrollment period**, they will be auto-assigned to a plan
- DHHS is developing auto-assignment algorithms that **prioritize keeping families in the same PHP and preserving enrollee-provider relationships**. Auto-assignment algorithm will also consider:
  - PHPs available in a enrollee's region
  - Eligibility category (e.g., special populations)
  - Previous PHP enrollment
  - Equitable distribution among PHPs
- All enrollees will have a **90-day "choice period"** – during both initial application and annual renewals – to change PHPs without cause

North Carolina's Medicaid Managed Care Enrollment Broker

MAXIMUS will provide enrollment assistance and education to individuals as they select from a variety of PHPs

Key Functions

- Develop and share **welcome packets** for enrollees
- Help individuals **select PHPs and PCPs** that are most appropriate to meet their needs
- **Maintain** existing physician-patient relationships
- Enroll individuals over **the phone, online, and face-to-face** in some communities
- Continued outreach to members to **communicate transition and services**

MAXIMUS will provide support to Medicaid enrollees starting in June 2019

Overview of Patient PCP Selection

Under managed care, enrollees will have the opportunity to choose their primary Care Provider (PCP) or they will be auto-assigned

PCP Selection

- Enrollees that do not select a PCP **during the plan selection period** will be assigned a PCP by the PHP in which they enroll
- PCP auto-assignment will consider:
  - Enrollee claims history
  - Family member provider
  - Geography
  - Special medical needs
  - Language/cultural preference
- All enrollees will have a **30-day "grace period"** after notification of their PCP assignment to change their PCP without cause
- Enrollees can also change their PCP **without cause** after their initial PCP visit, and up to one additional time every 12 months; enrollees may change their **PCP with cause** at any time

Patient Assignment and Empanelment

AMHs must ensure that they have a clear understanding of which patients are assigned to them

Assignment and Empanelment Requirements

- AMHs must ensure that PHP patient assignment lists are **reconciled with the practice's patient panel list**
- Patient panel lists must be **up to date** in the clinical system of record (e.g., an EHR or equivalent)
  - There is no set minimum interval for this review, practices should develop processes to ensure it is done when clinically appropriate

Accurate patient empanelment is critical for a wide range of AMH functions:*

- Risk stratification
- Evaluation of care management services
- Tracking ED and hospital utilization
- Transitional care management
- Medication reconciliation

* Any population health management task will likely involve review of the panel list

Patient Assignment and Empanelment Considerations

Key Considerations for Providers Include:

- If a provider is contracted with a PHP and has an existing relationship with a patient that contains routine visits/claims, **that patient will likely be assigned to that provider** even if the enrollee does not make a selection
- Providers will only be assigned patients for **PHPs with which they have a contract**
- AMHs **can still treat and will receive payment for services rendered**, regardless of patient assignment; PHPs cannot require pre-authorization for payment for primary care services
- However, **AMHs will NOT receive PMPM AMH payments*** for patients that are not assigned to them

What can AMHs do to manage their list of assigned patients?

- Enrollees **can request assistance from PCPs to switch** AMH/PCP assignment. Enrollees however must request the change from the PHP
- Providers cannot contact a PHP to request that a patient be assigned to them **without patient consent**
- PCPs **can request that patients be removed** from their panel
- PCPs should **work with PHPs to clarify requirements** around accepting new patients, opening and closing panels and panel size

*Includes Medical Home Fees, Care Management Fees, and Performance Incentive Payments

Part III

AMH Tier 3 Responsibilities: Risk Stratification

Care Needs Screening

The Care Needs Screening is a one-time assessment of each enrollee's needs and informs the PHP's risk scoring methodology

Care Needs Screening Considerations and Requirements

- PHPs must make "best efforts" to conduct a Care Needs Screening for all enrollees **to identify a range of health-related needs**
- The Care Needs Screening helps identify enrollees in need of a **Comprehensive Assessment** for care management
- Federally-mandated Care Needs Screening **must be completed within 90 days of enrollment**
- PHPs will share Care Needs Screening result with the member's assigned AMH **within seven days of screening or assignment** (whichever is earlier)
- PHPs must attempt to perform a Care Needs Screening **at least annually** for individuals not engaged in care management

Minimum Care Needs Screening Requirements

- Chronic or acute conditions
- Chronic pain (i.e., pain that lasts greater than three months or normal tissue healing)
- Behavioral health needs, including opioid usage and other substance use disorders
- Medications – prescribed and being taken
- Other factors or conditions which the PHP would need to be aware to inform interventions
- Unmet health-related resource needs, including housing, food, transportation, and interpersonal safety

PHP Risk Scoring

PHPs will use a combination of claims, clinical screening information and other data to assign each enrollee a risk score

PHP Risk Scoring Requirements

- PHPs will be responsible for using their plan-specific risk scoring methodologies to **identify members of "priority populations" and assign risk scores to all PHP members**
- The State will monitor scoring methodologies to ensure that the PHP methodologies **adequately identify priority populations**
- PHPs will share risk scoring results and information on priority populations with all AMHs
- AMH Tier 3 practices must use the risk score to stratify their patient panels and inform decisions about which patients would benefit from care management

PHP Risk Scoring, Cont'd

PHPs will use a combination of claims, clinical screening information and other data to assign each enrollee a risk score

PHP Risk Scoring Methodology Minimum Requirements

- Incorporate Care Needs Screening results
- Claims history and analysis
- Pharmacy data
- Immunizations
- Lab results
- ADT feed information
- Provider, social service, member and self-referrals
- Member's zip code
- Member's race and ethnicity

Priority Populations for Care Management

- Enrollees with Long-Term Services and Supports (LTSS) needs
- Adults and children with "special health care needs," a category that includes enrollees with HIV/AIDS
- Enrollees at rising risk
- Enrollees with high unmet resource needs related to social determinants of health
- Any other priority groups identified by the PHP

Risk Stratification Requirements for Tier 3 Practices

Tier 3 AMH practices must risk stratify empaneled patients to identify those who may benefit from care management

AMH Risk Scoring Requirements

- Use a consistent method to **assign and adjust** risk status
  - AMHs may integrate the PHP's risk scoring results with their own
- Use a consistent method to **combine risk scoring information** received from PHPs with clinical information to score and stratify their patient panel
- Identify **priority populations**
- Ensure entire care team **understands the basis of the risk scoring** methodology
- Define the process of **risk score review and validation**

The State expects PHPs and AMHs will work together through the AMH Technical Advisory Group to determine the appropriate format and frequency for sharing risk information

Working with CIN/Other Partners on Risk Stratification

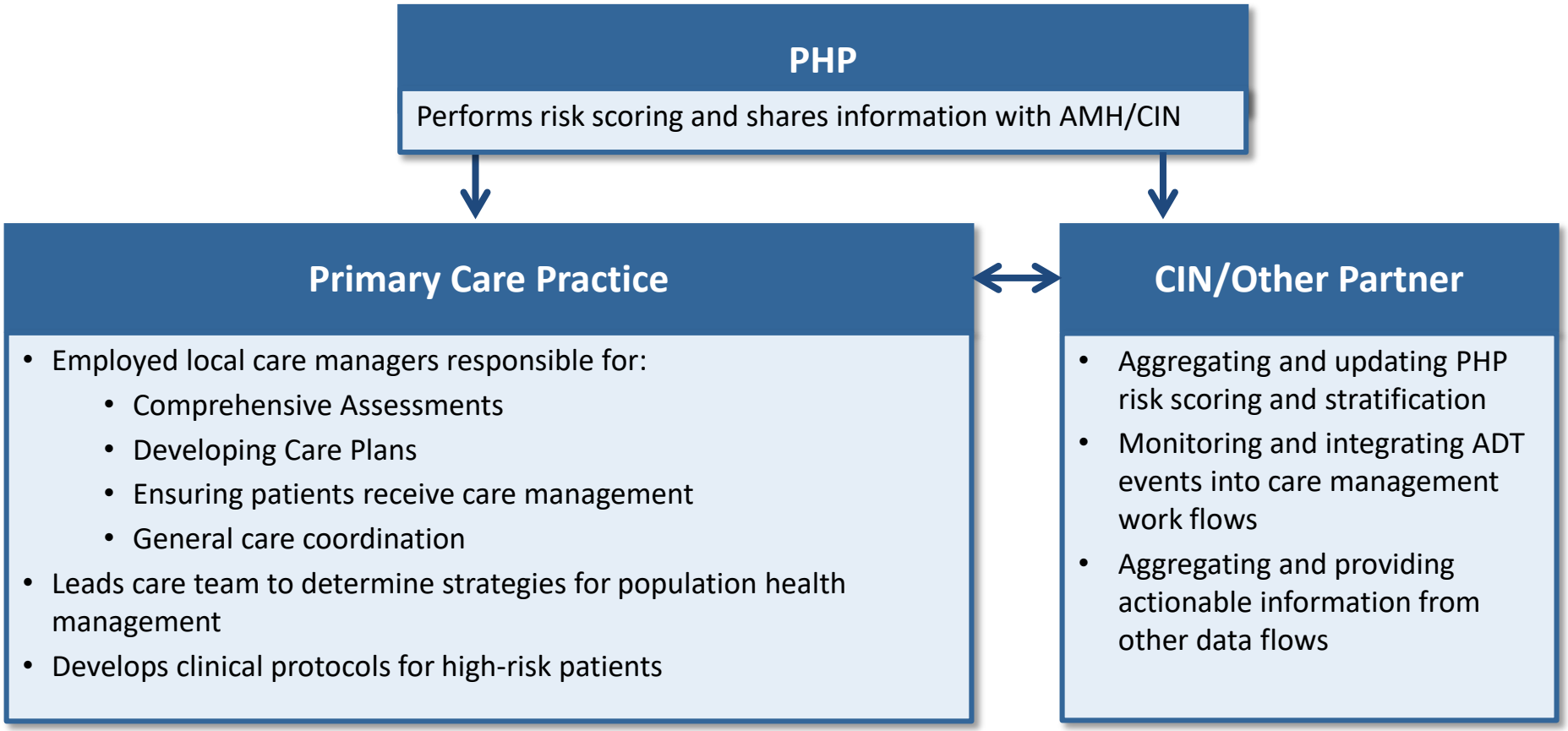
CINs/other partners can aggregate and update PHP risk stratification and scoring for Tier 3 AMHs

Potential CIN/Other Partner Tasks

- **Compile risk scoring results from multiple PHPs** and combine them into a single, actionable risk stratification score
- Incorporate risk scoring/stratification findings **into the Care Plan**, once a risk level has been assigned to an enrollee
- Use analytics to develop more **detailed risk assessments and customized care management** approaches

CIN/Other Partner Use Case: Risk Stratification

***Scenario*: Large-sized, unaffiliated group practice has some but not all of the necessary care management functionality in-house**



Part IV
AMH Tier 3 Responsibilities: Comprehensive Assessment

What is a Comprehensive Assessment?

A Comprehensive Assessment is a patient-centric assessment of their health care, functional, and accessibility needs

Required elements:

- Patient's immediate care needs, current services and other State or local services currently used;
- Physical and dental health conditions;
- Current and past mental health and substance use status and/or disorders;
- Physical, intellectual, or developmental disabilities;
- Medications prescribed and taken;
- Available informal, caregiver or social supports, including peer support
- Four priority health-related resource domains*;
- Any other ongoing conditions that require a course of treatment or regular care monitoring; and,
- At the PHP's option and for adults only, exposure to adverse childhood experiences (ACEs) or other trauma.

In conjunction with patient goals, the Comprehensive Assessment should inform whether the patient should receive care management and feed into the Care Plan

* Four priority health-related resource domains include: housing, food, transportation, and interpersonal safety.

AMH Tier 3 Requirements – Comprehensive Assessment

Tier 3 AMHs are responsible for completion of the Comprehensive Assessment

Requirements

- The Comprehensive Assessment should be reviewed by care team members and a Care Plan must be developed **within 30 days of the Assessment**
- The 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 practice or CIN/other partner administering the Comprehensive Assessment should **develop a protocol** for situations when a **patient discloses information during the Assessment** indicating an immediate risk to self or others
- The review should include **medication management** at each Assessment
- AMHs must incorporate findings from the **PHP Care Needs Screening and risk scoring, practice-based risk stratification and Comprehensive Assessment** with **clinical knowledge** of the patient into the Care Plan

Working with CIN/Other Partner on Comprehensive Assessment

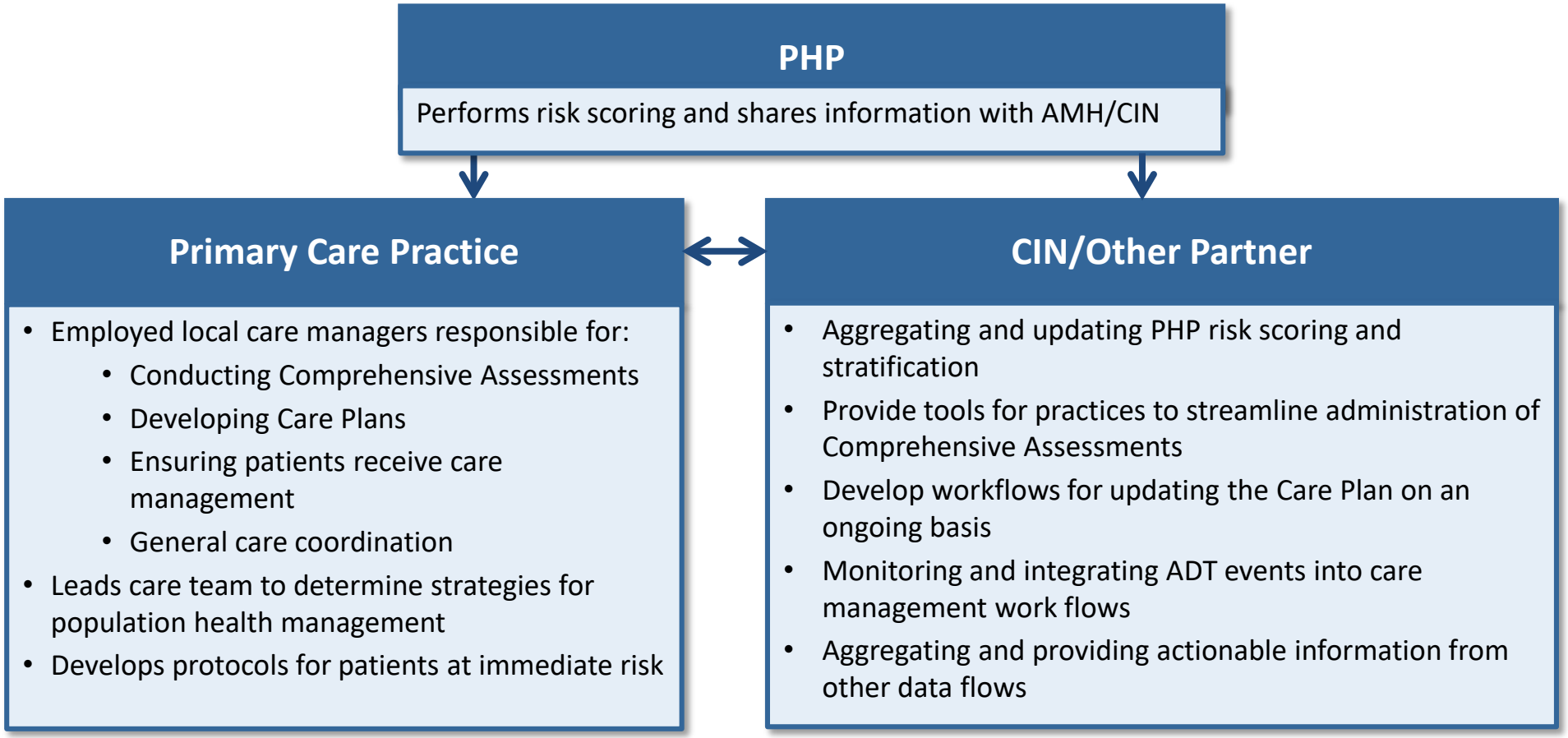
CINs/other partners can support Tier 3 AMHs as they conduct a Comprehensive Assessment and develop a Care Plan for patients identified as high-need

Potential CIN/Other Partner Tasks

- Perform or assist in **protocol development** for the Comprehensive Assessment
- **Provide tools** for practices **to streamline administration** of assessments
- Assist in completing the Comprehensive Assessment using CIN-contracted local care managers
- Assist the development of Care Plan using **CIN-contracted local care managers**
- Identify and **aggregate actionable data** that can be used to inform care plan development
- Develop workflows for updating the Care Plan on an **ongoing basis**

CIN/Other Partner Use Case: Comprehensive Assessment

***Scenario*: Large-sized group practice has some but not all of the necessary care management functionality in-house and is not affiliated with a large health system**



Part V
Q & A

Part VI
Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars

- **December 3, 2018:** AMH Tier 3: High Need Care Management
- **December 18, 2018:** AMH Tier 3: Transitional Care Management
- **January 10, 2019:** IT Needs and Data Sharing Capabilities

For more information and to register for these webinars, visit the AMH webpage: https://medicaid.ncdhhs.gov/advanced-medical-home

Additional Information

Questions?

- **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

AMH Webpage

- https://medicaid.ncdhhs.gov/advanced-medical-home

White Papers, Manuals, and FAQs

- *UPDATED*: NC DHHS, North Carolina Advanced Medical Home (AMH) Program Frequently Asked Questions, October 18, 2018
- North Carolina Advanced Medical Home (AMH) Program Data Strategy in Support of Care Management, October 4, 2018
- NC DHHS, Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers, August 28, 2018
- NC DHHS, "Data Strategy to Support the Advanced Medical Home Program in North Carolina," July 20, 2018
- NC DHHS, "North Carolina's Care Management Strategy under Managed Care," March 9, 2018
- NC DHHS, "North Carolina's Proposed Program Design for Medicaid Managed Care," August 2017

Part VII
Appendices

Appendix A
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): ○ Patient's immediate care needs and current services; ○ Other State or local services currently used; ○ Physical health conditions; ○ Current and past behavioral and mental health and substance use status and/or disorders; ○ Physical, intellectual developmental disabilities; ○ Medications; ○ Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety); ○ 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? ○ Can your practice include, at a minimum, the following elements in the Care Plan ○ Measurable patient (or patient and caregiver) goals ○ Medical needs including any behavioral health needs; ○ Interventions; ○ Intended outcomes; and ○ 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)? ○ 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. ○ 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; ○ 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: ○ Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits ○ Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; ○ NICU discharges; ○ 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? ○ Ensuring that a care manager is assigned to manage the transition ○ Facilitating clinical handoffs; ○ Obtaining a copy of the discharge plan/summary; ○ Conducting medication reconciliation; ○ Following-up by the assigned care manager rapidly following discharge; ○ Ensuring that a follow-up outpatient, home visit or face to face encounter occurs ○ 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.