Introduction to Advanced Medical Homes

AMH Tier 3: High-Need Care Management

December 3, 2018

Contents

Part I:
Care Management Through the AMH Program

What is Care Management?

Care management is a team-based, person-centered approach to effectively managing patients' medical, social, and behavioral conditions

Key Care Management Activities

- Development of **comprehensive assessments, care plans**, and the deployment of prevention and **population health programs**
- Management (e.g., coordination of services) of enrollee needs **during transitions of care** as well as those with **rare diseases or high-cost procedures**
- Care management for **special populations**, including individuals **at high-risk** and or **those that require chronic care**

AMHs are designed to serve as the primary vehicle for robust, local care management in the State's managed care transition

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

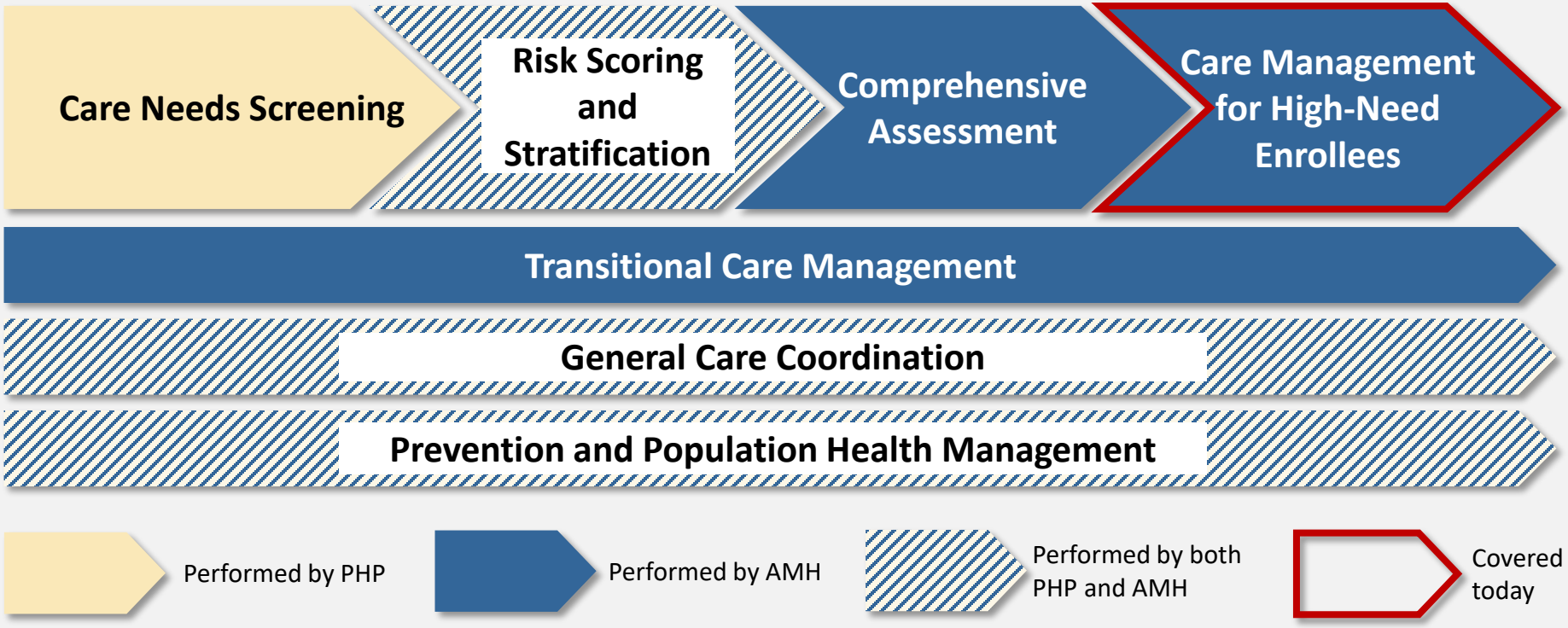
- PHPs must have an **established system of local care management** through AMHs, Local Health Departments (LHDs) as well as care management provided by the PHP that delivers high quality care
- PHPs will be required to submit a **"local Care Management plan"**
- PHPs can **delegate care management responsibility** to AMH Tier 3 practices but are ultimately responsible for ensuring that members receive needed services
- If Medicaid enrollees receive care management from more than one entity, the PHP must ensure that Care Plans document the **roles and responsibilities of all local care managers** (e.g., AMHs and LHDs)

The State will ensure a robust system of local care management by requiring standard contract terms in PHP contracts with AMHs*

** The State will produce standard contract language and clauses, but will not review individual contracts – see Appendix B for standard AMH contract terms.*

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.*

Types of Care Management to be Performed by Tier 3 AMHs

Care Management for High-Need Enrollees

- Only for patients identified as high-need by the PHP's Care Needs Screening/risk score or the AMH risk stratification*
- **Longitudinal**, ongoing care management
- Guided by the Care Plan

Transitional Care Management

- Available to all empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer, and who are at high-risk of readmissions or other poor outcomes
- **Short-term** care management along with medication management

= **Detailed Today**

** Care Needs Screening, Risk Stratification, and Comprehensive Assessment detailed in previous webinar available on AMH Training website.*

Part II:
Staffing Requirements for High-Need Care Management

Care Manager Training and Qualifications

For each high-need patient, AMHs must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment

Care Manager Requirements

- Each high-need patient must be assigned a care manager with **minimum credentials of RN or LCSW**
- 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**
- **Care managers do not need to be physically embedded** at the practice location (i.e., care manager does not need a full time "desk" in the practice) but must offer for face-to-face interaction

Multi-Disciplinary Care Teams

Multi-disciplinary care teams enable practices to comprehensively address both the medical and non-medical drivers of health

Care Team Members

- The patient
- Caretaker(s)/legal guardians
- Care manager/care coordinator
- Primary care provider
- Behavioral health providers
- Specialists
- Nutritionists
- Pharmacists and pharmacy techs

Patients may have a wide range of health-related needs that cannot be treated effectively by a single professional

Part III: Delivering High-Need Care Management

Care Plan

Following the Comprehensive Assessment, Tier 3 practices must develop an individualized and person-centered Care Plan for each high-need member

Required Elements

- **Measurable** patient (or patient and caregiver) goals
- Medical needs, **including any behavioral health needs**
- Interventions, including **medication management and adherence**
- Intended **outcomes**
- **Social, educational, and other services** needed by the patient

The Care Plan must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification, and Comprehensive Assessment along with knowledge about the patient

Care Plan, Continued

Care Plan Requirements, Continued

- Tier 3 practices **must complete each Care Plan within 30-day of completion of the Comprehensive Assessment** and must be updated:
  - At a minimum of every 12 months
  - When a patient's circumstances or needs change significantly
  - At the patient's request, and/or when a new Comprehensive Assessment occurs

- Practices must periodically evaluate the care management services provided to high-risk, high-need patients and ensure services are meeting patients' needs, and **refine the care management services as necessary**

- The Care Plan must be **documented, stored, and made available** to the patient and care team members

- Care Plan development **cannot delay service delivery** to a patient

- Practices must develop policies and procedures to close out the Care Plan process, should the care team determine that the patient no longer requires an ongoing Care Plan**; patients must be notified of this process**

Responding to Admission, Discharge, and Transfer (ADT) Data Feeds

Tier 3 practices must track empaneled patients' utilization in local EDs and hospitals in their catchment area through active access to an ADT feed

Accessing ADT Data

- Health Information Exchanges (HIEs) enable the safe and secure transition of protected patient health information between health care providers and allow Tier 3 practices to implement a systematic, clinically appropriate care management process for responding to high-risk ADT alerts
- AMHs are encouraged to connect with NC HealthConnex or other ADT sources including the North Carolina Hospital Association

Responding to ADT Alerts in Real-Time or Near Real-Time

- **Real time (minutes/hours)** response to outreach from EDs relating to patient care or admission/discharge decisions
- **Same-day or next-day outreach** for designated high-risk subsets of the population to inform clinical care
- **Follow up with the patient within a several-day period** to address outpatient needs or prevent future problems for patients at high-risk for poor outcomes who have been discharged from a hospital or ED

Working with a CIN/Other Partner to Provide High-Need Care Management

CINs/other partners can support Tier 3 AMHs as they provide care management to high-need patients in a number of ways

Potential Roles

- Provide **local, on-the-ground staff**
- Assist in the development of the **Care Plan**
  - Develop **clinical workflows** to help the practice **develop and update** Care Plans on an ongoing basis
  - **Identify and aggregate actionable data** that can be used to inform Care Plan development
- Facilitate connections to an **ADT data feed** and provide **solutions/protocols** for responding to ADT events

Overlapping Care Management Entities

Local Health Departments (LHDs) play a critical role in the provision of care management services for high-risk pregnant women and at-risk children; if LHDs meet AMH criteria, they are also permitted to participate as AMHs

Care Management for High-Risk Pregnant Women & At-Risk Children

- PHPs will **contract with LHDs** to administer care management services for these populations
- PHPs will be responsible for ensuring that the **care management roles and responsibilities are not overlapping** for high-risk pregnant women and at-risk children
- PHPs must ensure **documentation of Care Plans and roles and responsibilities** with all parties (e.g., LHD, Tier 3 AMH, etc.)

For more information, visit the Program Guide for Management of High-Risk Pregnancies and At-Risk Children in Managed Care.

Part IV:
Real Life Example

Example Scenario

Mother and eight year old son are enrolled in a Standard Plan PHP and the primary care provider (PCP) the mother selects is participating as a Tier 3 AMH

Child

- Poorly controlled asthma
- Multiple ED visits in the past year
- Missed 15 days of school due to asthma-related illness

Mother

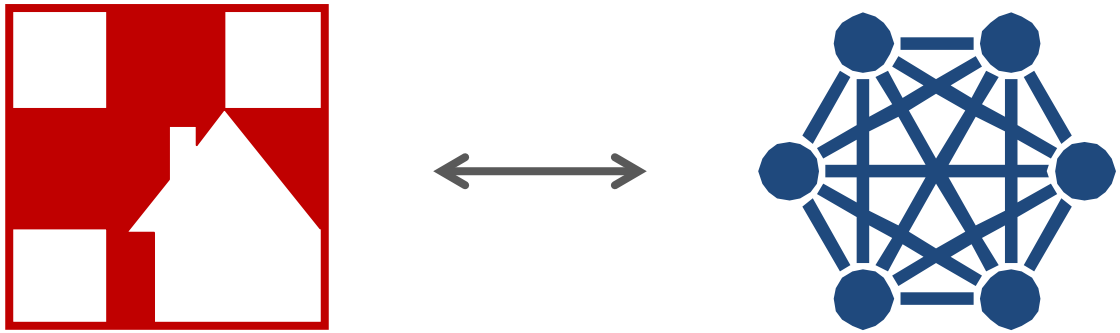
- Having difficulty fully engaging in child's treatment plan
- Unable to find stable housing

Temporary Home

- Family staying with friends
- Temporary housing contains multiple smokers (i.e., asthma trigger)

Example Scenario (cont'd)

The family's Tier 3 AMH has partnered with a CIN to support the delivery of local care management



AMH

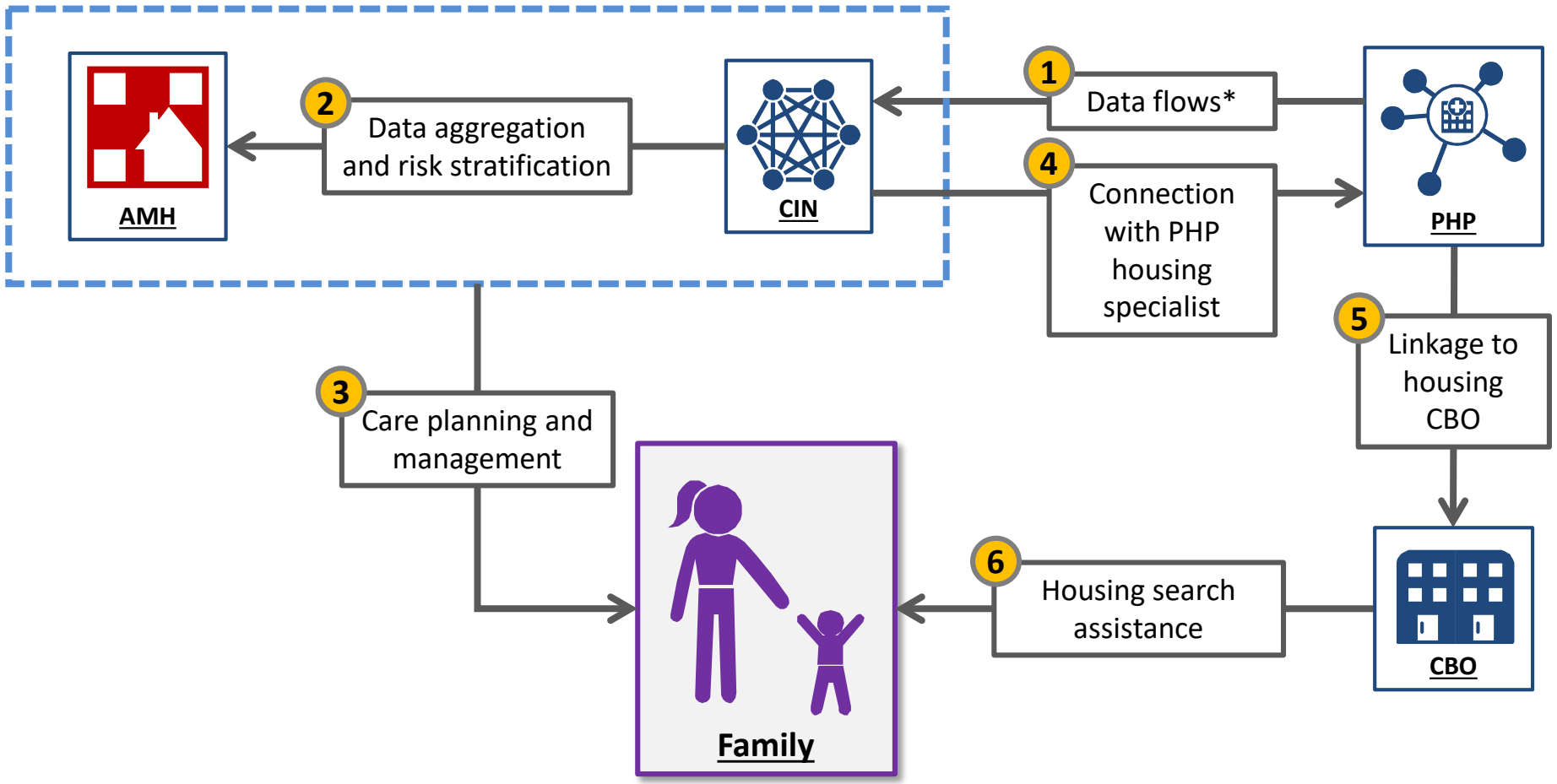
- Conducts care planning and multi-disciplinary local care management with the help of CIN

CIN

- Aggregates data from PHP and conducts risk stratification
- Monitors and responds to high-risk ADT alerts
- Conducts care planning with AMH and provides or supports multi-disciplinary local care management

Example Scenario (cont'd): Situation #1

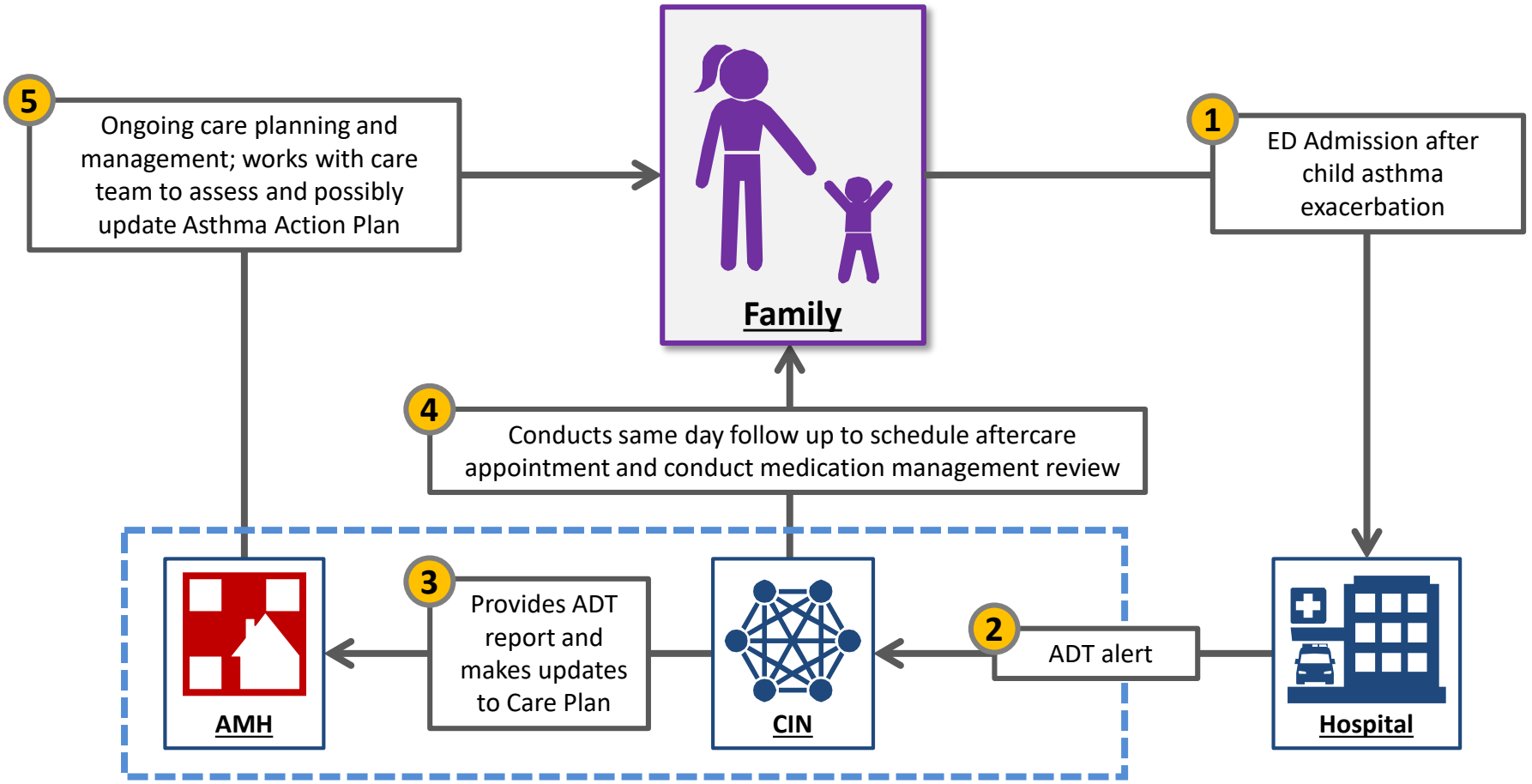
Situation: **The family's AMH Tier 3 practice identifies key issues and acts as a hub for referrals to services**



*Includes beneficiary assignment information, PHP risk score, Care Needs Screening results, quality measure performance information, encounter data, and other clinical data

Example Scenario (cont'd): Situation #2

Situation: **Boy has an asthma exacerbation over the weekend and is taken to the ED**



Part V:
Q & A

Part VI:
Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars

- **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.

Appendix B: Standard Terms for PHP Contracts and 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: Additional Definitions

Additional Definitions

Item	Definition
Care Coordination	Process of organizing patient care activities and sharing information among all participants concerned with an enrollee's care to achieve safer and more effective care
Case Management	Services that assist individuals in community settings, or those transitioning to community settings, to gain access to medical, social, and other services