Introduction to Advanced Medical Homes

AMH Tier 3: Transitional Care Management;

AMH Frequently Asked Questions

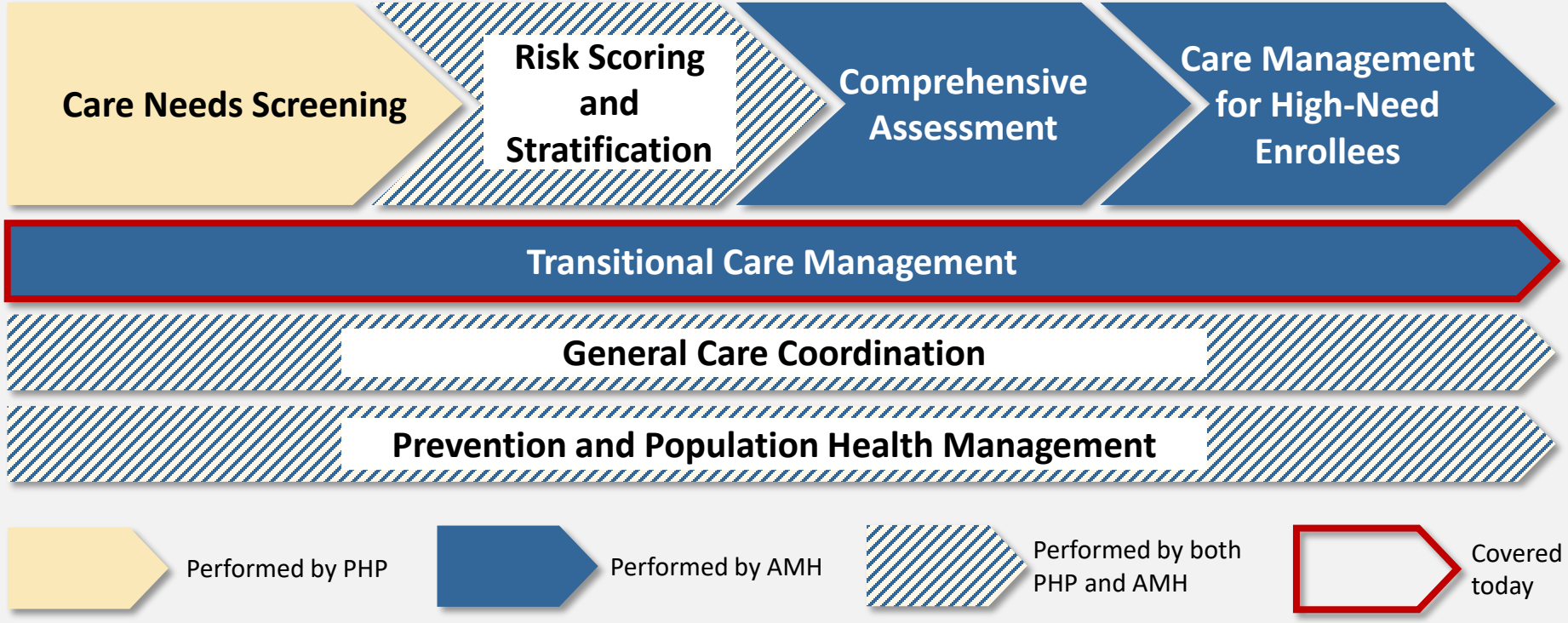
December 18, 2018

Contents

Part I:
Care Management Through the AMH Program

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 reconciliation

 **= Detailed Today**

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

Part II: Delivering Transitional Care Management

Overview of Transitional Care Management

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

- Follow-up care can help **reduce the likelihood that patients are readmitted to the hospital/ED** or experience **avoidable adverse outcomes**
- PHPs will be required to ensure that all patients moving from ED or inpatient settings, **who are at high-risk of readmissions or other poor outcomes,** receive transitional care management
- PHPs will delegate this function to Tier 3 AMHs
- Transitions subject to requirement:
  1. *ED visit*
  2. *Inpatient admission (short or long-term)*
  3. *Institutional admission (short or long-term)*

Identification of Patients in Transition

AMHs must develop a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes

Methodology Must Take into Account the Following

- **Frequency, duration, and acuity of visits to resource-intensive settings**, such as inpatient, ED, skilled nursing facility (SNF), and Long Term Services and Supports (LTSS) admissions
- **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, and risk score

Responding to Admission, Discharge, and Transfer (ADT) Feeds Critical for Managing Patient Transitions

Practices or their CIN/other partners must track empaneled patients' utilization in local EDs and hospitals through active access to an ADT feed

Accessing ADT Data

- Health Information Exchanges (HIEs):
  - Enable secure transfer of protected patient health information between health care providers
  - 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 sources of ADT information, including the North Carolina Healthcare 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 who have been discharged from a hospital or ED

* Practices or their CIN/other partners must have a process in place for responding to ADT Alerts in real-time or near real-time

Supporting Patients in Transition

Transitional Care Management has specific required elements, whether delivered at the PHP or AMH practice level

Required Elements

- 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**
- **Follow-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
- Conducting the **Comprehensive Assessment** again after completion of the transition, including re-assessment for enrollees already assigned to care management
    - Includes assessment for the four priority unmet health-related resource needs: housing, food, transportation, and interpersonal safety

What is Medication Reconciliation?

Medication reconciliation is both the process of creating the most accurate possible list of all medications that a patient is taking and identifying possible adverse medication interactions

- Goal is to ensure that correct medications are delivered to the patient at all transition points
- Compares list of current medications against medications given when patient discharged from the ED or an inpatient admission
- Ensures members of care team and ED or inpatient providers are aware of patient's medications
- Safeguards against adverse medication interactions

Recap: Care Manager Training and Qualifications

AMHs must assign a care manager for each patient in transition identified as high risk for admission or other poor outcome with transitional care needs

- Consistent with requirements for **high-need care management**
- Accountable for active, ongoing care management that goes beyond **office-based clinical diagnosis and treatment**
- Must have minimum credentials 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 strive for local, face-to-face interaction whenever possible
- If a patient **declines to engage in care management**, the AMH 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

Working with a CIN/Other Partner to Provide Transitional Care Management

CINs/other partners can help Tier 3 AMHs implement systematic, clinically appropriate care management processes for responding to high-risk ADT alerts

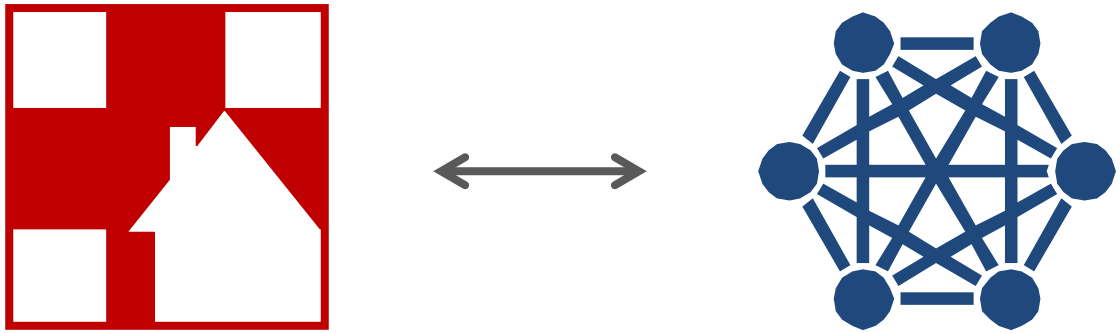
Potential CIN/Other Partners Roles

- **Linking with and ingesting** ADT information
- **Monitoring and developing protocols** for responding to ADT feeds
- **Providing access to local care management staff** that can help respond to ADT events in real-time or near real-time
- **Developing methodologies** for identifying patients at high-risk of readmission or other poor outcomes

Part III:
Real Life Example

Example Scenario

A Tier 3 AMH has partnered with a CIN/other partner to support the delivery of local care management



AMH

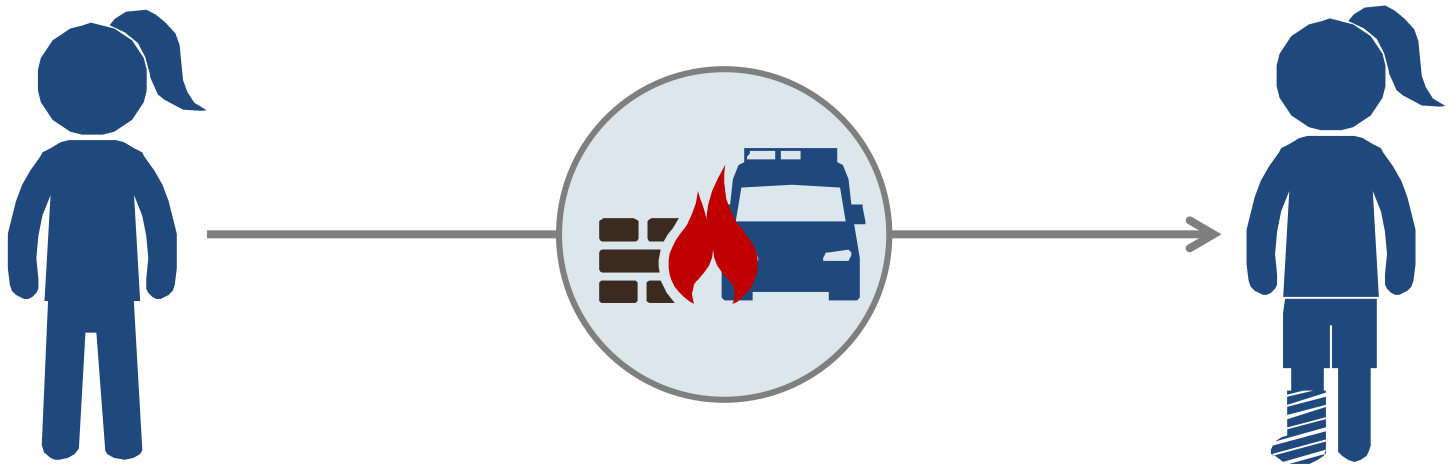
- Conducts care planning and multi-disciplinary local care management with the help of CIN/other partner
- Leads transitional care management with assistance from CIN/other partner

CIN/Other Partner

- Aggregates data from PHP and conducts risk stratification
- Receives and responds to high-risk ADT alerts; incorporates into practice workflow for responding to ADT alerts
- Conducts care planning with AMH and provides or supports multi-disciplinary local care management

Example Scenario (cont'd)

Parent is enrolled in a Standard Plan PHP and she selects the Tier 3 AMH as her primary care provider (PCP). She is not stratified as high risk at baseline.



Patient

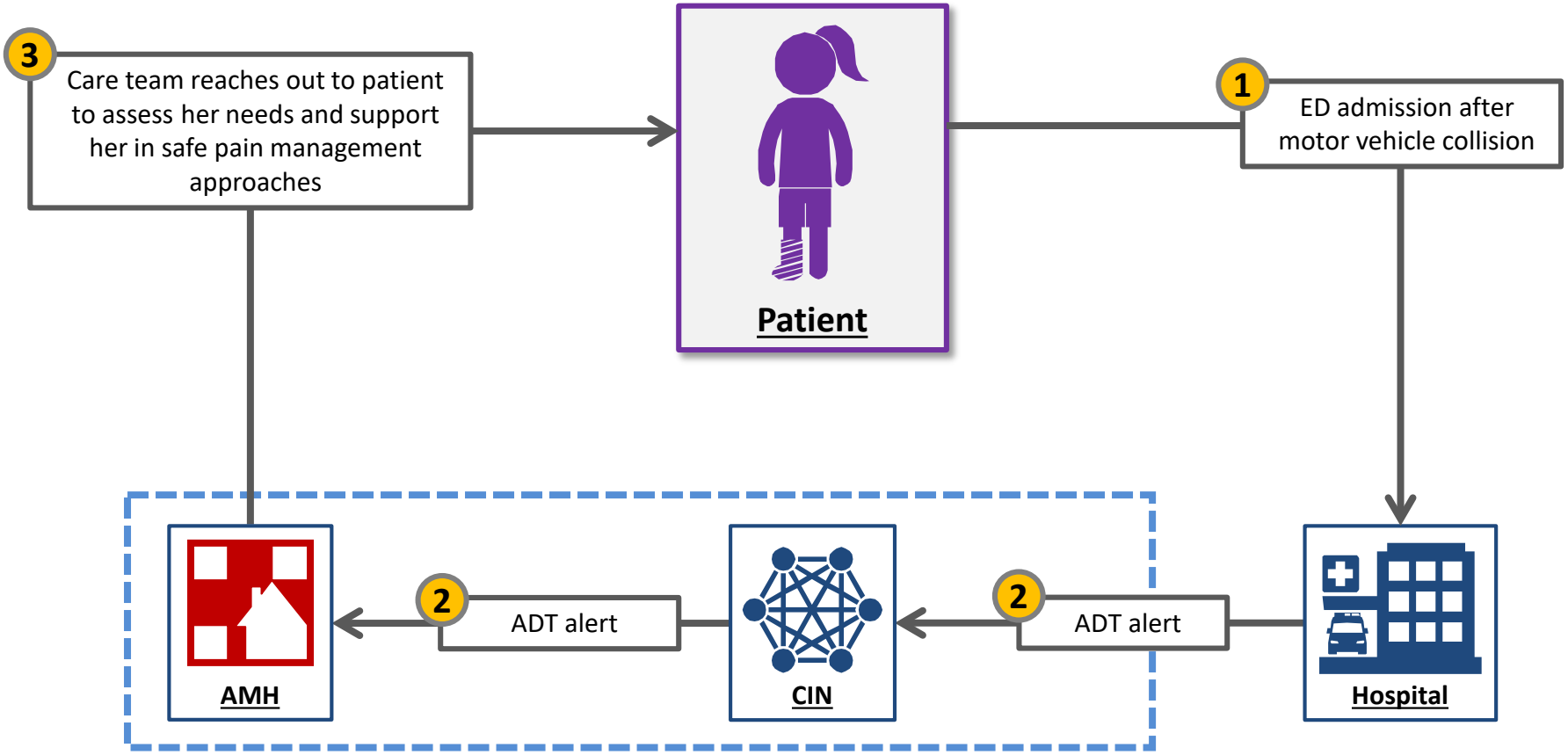
- Parent with very low income, eligible for Medicaid
- History of opioid use disorder, not on MAT
- Stable, but at risk for relapse

Scenario

- Injured in car crash
- Discharged from ED with nonoperative fracture
- At risk of untreated pain or relapse due to self-medication

Example Scenario (cont'd)

***Situation*: After ED discharge, AMH Tier 3 practice engages in transitional care management to ensure patient has good pain relief and avoids relapse**



Part IV:
Q & A on Transitional Care Management

Part V:
AMH FAQs

FAQ 1: Attestation and Certification

"Am I allowed to attest for Tier 3 now if my practice does not have the required capabilities in place today? What happens if I attest to Tier 3 by 1/31/19 but don't have the capabilities in place by the time managed care launches?"

- Attestation indicates that a practice will have the required capabilities in place **by the launch of managed care, which is scheduled for November 2019**
- Practices should attest by 1/31/19. Practices may change their status to Tier 2 at any time between 1/31/19 and the launch of managed care without penalty
- If a practice chooses to change to a Tier 2 status, **PHPs will be required to contract with that practice at a Tier 2 level**

FAQ 2: Attestation and Certification

"Does Tier 3 attestation guarantee our practice a contract with each PHP in our region?"

- DHHS' general expectation is that PHPs will contract with ALL certified Tier 3 practices at a Tier 3 level (i.e., include all the required contract language and payments)
- There are two scenarios that DHHS will accept as reasons for not contracting with Tier 3 AMH practices:
    1. The PHP and AMH practice are unable to reach an agreement on AMH payment amounts (i.e., Care Management Fees and Performance Incentive Payments); or
    2. The PHP determines through its own auditing process that the State-certified AMH practice lacks the required capabilities set by DHHS for Tier 3
- **DHHS will not review each contract between PHPs and AMHs.** However, DHHS will closely monitor the progress of contracting between PHPs and AMH practices through reporting requirements on PHPs

FAQ 3: Attestation and Certification

"Can an individual PHP perform its own checks of whether my practice meets Tier 3 requirements?"

- Yes. PHPs will be permitted to assess Tier 3 practices as part of the initial contracting process, prior to managed care go-live and on an ongoing basis
- Activities by PHPs may include conducting an onsite review, telephone consultation, documentation review, or other virtual/offsite reviews
- **PHPs may perform evaluations of the CIN/other partner instead of or in addition to the AMH** if the AMH contracts with a third party to provide any of the Tier 3 care management required services.
- **However, PHPs cannot:**
  - Lower the tier level of all AMH practice locations associated with the same organizational NPI or TIN without an assessment of each individual practice location
  - Lower the tier level of an AMH practice location based on a different PHP's findings and reclassification
  - Change an AMH's certification status with respect to other PHPs
  - Reclassify practices to Tier 1 status

FAQ 4: Attestation and Certification

"What if the PHP concludes that my practice does not meet Tier 3 requirements?"

- If the AMH is not able to perform the activities associated with their AMH tier, **DHHS will permit the PHP to change (lower) the tier status of the AMH** and stop making applicable AMH payments (e.g., ceasing Care Management Fees and Performance Incentive Payments for a practice being reclassified from Tier 3 to Tier 2)

- After managed care launch, and in the event that an AMH practice is unable to perform the activities of the AMH tier to which it initially attested, the DHHS will require the PHP to send a notice to the AMH practice

- Note: For other aspects of underperformance not related to care management or other AMH functions, such as fraud or negligence, PHPs and the DHHS would follow their usual processes.

FAQ 5: Attestation and Certification

"If our practice enters Tier 3, how can we be assured that we will receive adequate reimbursement from PHPs for performing care management?"

- DHHS is expecting that PHPs will contract with every Tier 3 except in specified instances; this will provide PHPs with incentives to enter into contracts with Tier 3 practices that adequately fund care management capacity

- **DHHS will also be monitoring the tier level of contracts** in each region across certified Tier 3 practices and the **dollar amounts associated with those contracts**

- As part of this process, DHHS will ensure that PHPs are not excluding Tier 3 practices in ways that are in conflict with the spirit of the AMH program

FAQ 6: CINs/Other Partners

"If my practice decides to contract with a CIN/other partner, can we designate funds to flow directly to them from the PHP?"

- **Yes. AMHs may designate CINs/other partners to receive AMH payments** (i.e., Medical Home Fees, Care Management Fees, and Performance Incentive Payments) directly from PHPs

- AMHs must **consent to funds being redirected** to a different entity

- DHHS **will not** establish funds flow parameters between AMHs/CINs/PHPs

FAQ 7: Data Requirements

"Will PHPs and Tier 3 AMHs be a required to use a specific data source or HIE service for ADT-based alerts?"

- No. DHHS is **not seeking to impose restrictions** on where practices obtain their HIE services
  - State law requires providers who receive state funds (e.g., Medicaid, NC Health Choice, etc.) and PHPs to connect to HealthConnex, a statewide HIE that is overseen by the North Carolina Health Authority (NC HIEA) housed within the North Carolina Department of Information Technology
  - Participation with HealthConnex will provide AMHs with **access to an ADT feed at no additional cost**

- While HealthConnex serves as a centralized, statewide resource that does not charge a fee for access, **providers have alternative options for HIE services**
  - AMHs could contract with CINs/other partners to receive ADT feeds and compile them to produce actionable information that integrates into the AMHs' workflows

Part VI:
Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars

- **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, FAQs, and Guidance

- Programmatic Guidance on PHP Contracting Requirements for Tier 3 AMH Practices, December 17, 2018
- *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: Appendix

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.