

# Advanced Medical Home Program

Practice Contracting Guidance for CINs  
and Other Partners

April 30, 2019

# Introduction

## Objective of Today's Call:

Clarify expectations and responsibilities for CINs/other partners for the rollout of the AMH model to ensure alignment with the State's vision for AMH.

## Key Takeaways:

- The AMH model represents a **substantial increase in investment in care management** by the State.
- In making these additional investments in care management, the State hopes to see evidence of **improved and expanded local care management for beneficiaries**.
- The Department is closely monitoring the AMH rollout, especially related to **how investments translate into improved practice-level care**.

# Transition from Carolina ACCESS to AMH

AMH retains foundational elements of Carolina ACCESS design, but “raises the bar” in Tier 3 and increases total system investment to fund the improvements

## Carolina ACCESS

- After-hours medical advice
- Maximum enrollment limit
- Availability of oral interpretation services
- Minimum hours of operation
- Preventive and ancillary service availability (based on ages of beneficiaries served)

- Based on CCNC care management model

- Practices receive \$2.50/\$5 PMPM Medical Home Fees
- Practices contract with CCNC for care management functions

## Advanced Medical Home

- AMH Tiers 1 & 2: same as Carolina ACCESS
- AMH Tier 3: **practice or CIN/other partner must also:**
  - Conduct **comprehensive assessment**, including assessment of unmet, health-related resource needs
  - **Risk stratify** empaneled patients
  - Provide **CM to high-need patients**
  - Develop **care plans** for high-need patients receiving ongoing CM
  - Provide **short-term, transitional CM and medication reconciliation** to patients with an ED or inpatient admission
  - **Access claims and ADT feeds**

- Significantly **higher proportion** of population will receive local care management

- Practices receive \$2.50/\$5 PMPM Medical Home Fees
- Tier 2 practices coordinate with PHP
- Tier 3 practices receive **additional** Care Management Fees to fund the additional Tier 3 requirements

Practice Requirements

CM Penetration

CM Delivery

# What is a CIN/Other Partner?

The Department uses the term “CINs and Other Partners” to describe organizations that provide support to AMH practices, including managing data, supporting analytics, coordinating care, and providing local care management services, regardless of whether such organizations meet federal standards for “clinical integration”\*.

**The Department anticipates CINs and other partners will offer a wide range of services and supports to AMH practices, including:**

- Technology services
- Administrative support
- Clinical staffing resources

CINs/other partners may include hospitals, health systems, integrated delivery networks, IPAs, care management organizations and technology vendors

# The Role of CINs/Other Partners

CINs and Other Partners can play an important role in helping AMH Tier 3 practices meet program requirements and deliver data-driven, local care management.

## How can CINs/Other Partners Serve AMHs?

- Providing **local care management** staffing, functions and services
- Supporting **AMH analytics and data integration** from multiple PHPs and other sources, and providing actionable reports to AMH providers
- **Assisting in the contracting process** on behalf of AMHs

- **AMHs may provide all services in-house, or contract with a CIN/Other Partner** for support for some or all of these or other supports.
- Based on attestation data, **about 75% of all practices** intend to work with a CIN/other partner.

The State **does not currently require CINs/other partners to be certified** under the AMH model, but is **closely monitoring the market** to ensure CIN/other partner contracts are faithful to the AMH model.

# Department's Guardrails During Contracting Phase

NC Medicaid will monitor activities and provide additional guidance during the AMH rollout and contracting phase.

## Holding PHPs Accountable

Included in NC Medicaid's oversight and guidance of PHPs during the rollout phase:

- Emphasizing the **importance of the AMH program**
- Making sure PHPs understand that they **must make Care Management Fees and Performance Based Incentives available** to AMH Tier 3 practices
- Establishing **reporting requirements** and **ongoing monitoring**

## Emphasis on Monitoring

NC Medicaid will monitor the market closely, including:

- **Reviewing contracts** between PHPs and AMHs and PHPs and CINs/other partners for inclusion of key program requirements\*
- **Monitoring** contracts at a practice by practice level (beginning in the summer)
- **Monitoring PMPM amounts** paid by PHPs to AMHs and CINs/other partners
- **Engaging with the provider community and associations**
- **Assessing the amount** of local care management provided at the practice level

## Direct Guidance to Practices

Starting in May, NC Medicaid will refresh communications to the field with key messages:

- Practices should **see new CM investments (e.g., more populations receiving services, more robust care management services) reflected in their contract terms\*** from PHPs and CINs/other partners
- Practices may change their **CIN/other partner listed in their attestation**; they can "comparison shop" or consider contracting directly with PHPs
- Neither CINs/other partners nor PHPs should be locking practices into arbitrary deadlines

# Expectations of CINs/Other Partners

The Department will take measures to ensure that the rollout of the AMH program and CINs/other partners align with the State's vision.

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## Ensure the program/clinical model is appropriately reflected in contracting

- CIN/other partner contracts with practices should encompass all standard terms and conditions and use the specific terminology of the AMH model messaged to the field prior to PHP procurement\*
- Contracts that do not contain required AMH terms and conditions could result in PHPs withholding AMH payments from CINs/other partners

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## Provide transparency and flexibility

- Practices should not be locked into arbitrary deadlines with CINs/other partners that do not allow them to weigh their options
- PHPs are required to share rate sheets with AMHs; AMHs can terminate existing contracts with CINs/other partners if they receive a better offer

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## Support practices by developing “à la carte” options

- CIN contract options should not be “all or nothing”
- Practices need flexibility to contract for the services they need to meet AMH requirements (for example, a practice could contract with a CIN/other partner for population health IT functions but use Care Management Fees to hire their own care management staff)

\* I.e., related to payment (Medical Home Fees, Care Management Fees, Performance Incentive Payments) and service delivery (Care Needs Screening, Risk Stratification, Comprehensive Assessment, Care Plan, Care Team, etc.). See appendix for full standard terms and conditions.

# Moving Forward

The Department is closely monitoring the rollout of AMH and may introduce new requirements to ensure the integrity of the program

-  **Listening:** The Department will continue to engage with PHPs, practices and CINs/other partners to ensure successful rollout and fidelity to the program requirements. Please reach out to [medicaid.transformation@dhhs.nc.gov](mailto:medicaid.transformation@dhhs.nc.gov) with questions or concerns
-  **Monitoring and Evaluating:** DHHS will continuously draw upon findings from oversight activities (PHP reports, contract review, etc.) to assess whether Medicaid beneficiaries are getting value from the State's investments in this program
-  **Adjusting the Design, as Needed:** The Department will assess whether future adjustments to the AMH design are warranted



# Appendix

# Standard Terms and Conditions

## For contracts with all AMH practices

- Accept Members and be listed as a primary care provider in the PHP's Member-facing materials for the purpose of providing care to Members and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each Member, in accordance with PHP policies.
- 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.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services, in accordance with Section VII. Attachment M. Table 1: Required Preventive Services.
- Maintain a unified patient medical record for each Member following the PHP's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. h. Transfer the Member's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or PHP (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge.
- Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the PHP's network adequacy standards.
- Refer for a second opinion as requested by the Member, based on DHHS guidelines and PHP standards.
- Review and use Member 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.
- 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.

# AMH Tier 3 Contract Standard Terms and Conditions

- a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
  - i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the PHP are reconciled with the practice's panel list and up to date in the clinical system of record.
  - ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
  - iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the PHP with clinical information to score and stratify the patient panel.
  - iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.
  - v. The Tier 3 AMH practice must 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.
  - vi. The Tier 3 AMH practice must define the process and frequency of risk score review and validation.
- b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
  - i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
  - ii. The Tier 3 AMH practice must 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: 1. Patient's immediate care needs and current services; 2. Other state or local services currently used; 3. Physical health conditions, including dental; 4. Current and past behavioral and mental health and substance use status and/or disorders; 5. Physical, intellectual developmental disabilities; 6. Medications – prescribed and taken; 7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety); 8. Available informal, caregiver, or social supports, including peer supports.
  - iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN 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.
  - iv. For each high-need patient, the Tier 3 AMH practice must 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

# AMH Tier 3 Contract Standard Terms and Conditions

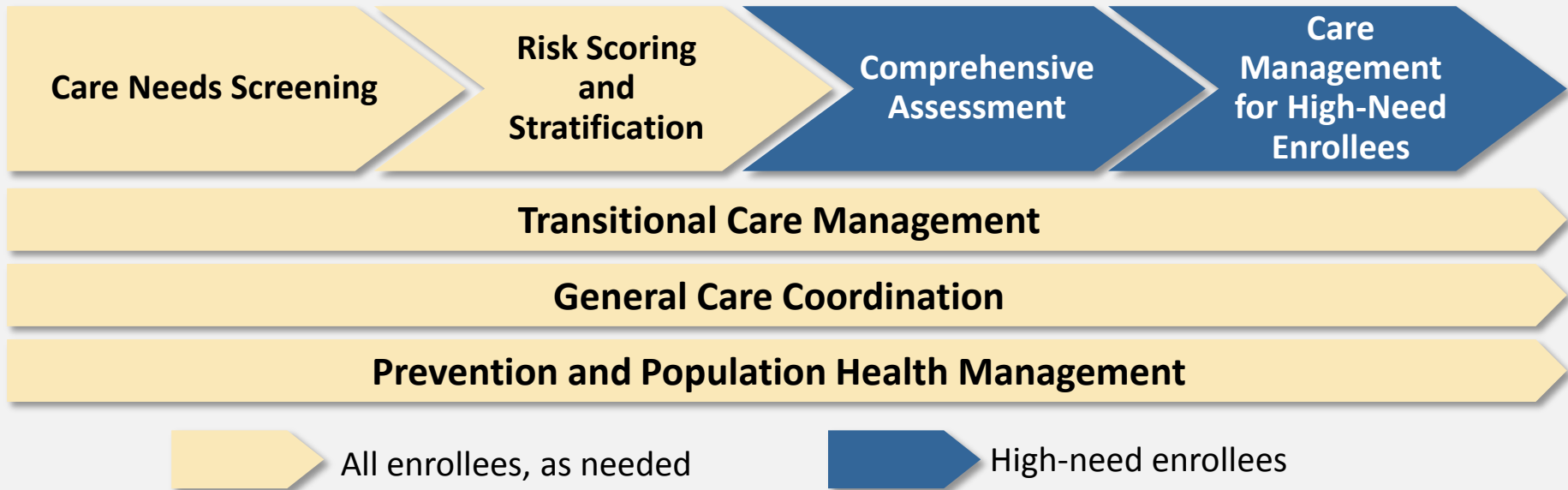
- c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.
  - i. The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.
  - ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and personcentered, using a collaborative approach including patient and family participation where possible.
  - iii. The Tier 3 AMH practice must 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.
  - iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan: 1. Measurable patient (or patient and caregiver) goals 2. Medical needs including any behavioral health and dental needs; 3. Interventions, including medication management and adherence; 4. Intended outcomes; and 5. Social, educational, and other services needed by the patient.
  - v. The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.
  - vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.
  - vii. The Tier 3 AMH practice must 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.
  - viii. The Tier 3 AMH practice must 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.
  - ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below) 1. 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. 2. 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; 3. 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)

# AMH Tier 3 Contract Standard Terms and Conditions

- d. 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.
  - i. The Tier 3 AMH practice must 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: 1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits 2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; 3. NICU discharges; 4. Clinical complexity, severity of condition, medications, risk score.
  - ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must 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.
  - iii. The Tier 3 AMH practice must include the following elements in transitional care management: 1. Ensuring that a care manager is assigned to manage the transition 2. Facilitating clinical handoffs; 3. Obtaining a copy of the discharge plan/summary; 4. Conducting medication reconciliation; 5. Following-up by the assigned care manager rapidly following discharge; 6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and 7. Developing a protocol for determining the appropriate timing and format of such outreach.
- e. Tier 3 AMH practices must use electronic data to promote care management.
  - i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

# Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management

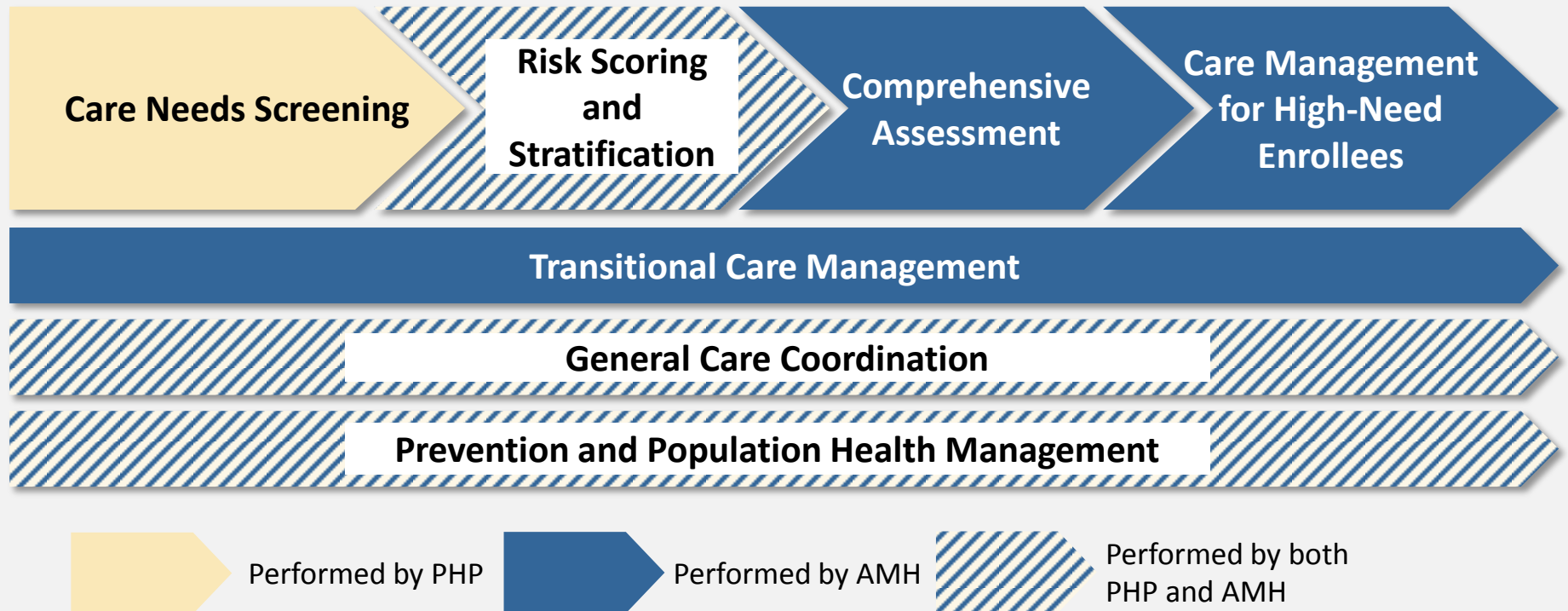


- **PHPs must also implement processes to identify priority populations, including:**
  - Children and adults with special health care needs\*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs
- **AMHs are required to use methods that identify priority populations “to the greatest extent possible”**

\*Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

# 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 or all of these responsibilities



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

# AMH Incentive Measures

PHPs should establish performance incentives payments for AMH practices based on the measures below.

NQF#	Measure Title
0038	Cervical Cancer Screening
0032	Childhood Immunization Status (Combination 10)
0059	Comprehensive Diabetes Care: HbA1c poor control (>9.0%)
1800	Asthma Medication Ratio
0576	Follow-up After Hospitalization for Mental Illness
0027	Medical Assistance With Smoking and Tobacco Use Cessation
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
1407	Immunization for Adolescents
0024	Weight Assessment and Counselling for Children and Adolescents
0018	Controlling High Blood Pressure
1604	Total Cost of Care
N/A (NYU/ Billings)	Avoidable/Preventable ED Utilization
N/A (AHRQ)	Avoidable/Preventable Hospital Utilization
N/A	PQI-01: Diabetes Short-Term Complication Admission Rate
N/A	PQI-05: COPD or Asthma in Older Adults Admission Rate
N/A	PQI-08: Heart Failure Admission Rate
N/A	PQI-15: Asthma in Younger Adults Admission Rate
N/A	PDI-14: Asthma Admission Rate
N/A	PDI-15: Diabetes Short-Term Complications Admission Rate
N/A	PDI-15: Gastroenteritis Admission Rate
N/A	PDI-18: Urinary Tract Infection Admission Rate
1768	Readmission Rates