Introduction to Advanced Medical Homes

AMH Accountability: Certification, Contracting, and Oversight

October 12, 2018

Contents

Part I: Overview of North Carolina's Medicaid Transformation and AMH

Overview of Managed Care Transition

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

- **North Carolina Medicaid providers will need to contract with PHPs and will be reimbursed by PHPs, rather than by the state directly**
- There will be **two types of PHPs**:
  1. Commercial plans
  2. Provider-led entities
- PHPs will offer **two types of products**:
  1. Standard plans for most beneficiaries
     - *Scheduled to launch in late 2019*
  2. Tailored plans for high-need populations
     - *Tentatively scheduled to launch in July 2021*
     - *Will include enrollees diagnosed with a serious mental illness (SMI), substance use disorder (SUD) or intellectual/developmental disability (I/DD), those enrolled in the state's traumatic brain injury (TBI) waiver, and/or those enrolled in the state's Medicaid Innovations Waiver*

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

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

Introduction to AMH

Vision for Advanced Medical Homes

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

Practices will have <u>options</u> as AMHs:

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

AMH Tiers

Tiers 1 and 2

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

AMH Payments
(paid by PHP to practice)

- **PMPM Medical Home Fees***
  - Same as Carolina ACCESS
  - Minimum payment floor

Tier 3

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

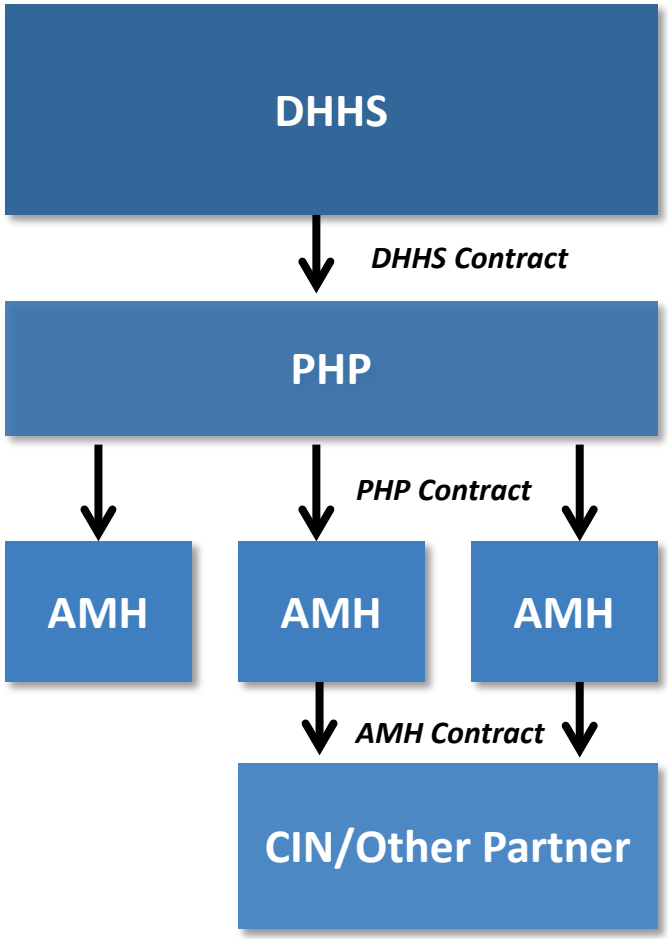
AMH Payments
(paid by PHP to practice)

- **PMPM Medical Home Fees**
  - Same as Carolina ACCESS
  - Minimum payment floor
- **Additional PMPM Care Management Fees***
  - Negotiated between PHP and practice (i.e., no floor)
- **Performance Incentive Payments**

Tier 4: To launch at a later date

**Note: Medical Home Fees and Care Management Fees will commence once the practice has contracted with a PHP and no earlier than Nov. 2019*

AMH Accountability Structure Overview



- Incorporates care management requirements in PHP contracts
- Oversees and monitors PHPs
- Requires select terms/conditions in PHPs contracts with AMHs
- Certifies AMH practices

- Establishes specific terms/conditions in contracts with AMHs
- Oversees and monitors AMHs

- Attests to specific AMH tier to DHHS
- As necessary, contracts with CIN/other partner to support PHP contracting, care management and other support

- Provides ongoing support to AMHs around clinical operations, data requirements and other activities
- Assists AMHs in negotiating and executing contracts with PHPs

DHHS does not place direct requirements on CINS/other partners or have an attestation/certification process for CINs/other partners

Part II: Certification

AMH Certification

Certification requires practices to attest that they are capable of supporting a set of care management requirements, either alone or as part of a CIN/other partner

Practice Certification Requirements*

- Practices become certified by:
  - **Attesting through NCTracks** that they or a CIN/other partner can fulfill tier-specific requirements; or
  - **Being grandfathered into** the program through participation in Carolina ACCESS.
- Certification must be completed for **each participating practice NPI/location combination;** there is **no batch attestation functionality**
- Certification does **NOT** obligate practices to participate in the AMH program

Q: My practice is not ready to be an AMH today but will make necessary preparations in the coming months. Can my practice still attest to meeting AMH requirements?

A: **YES!** However, practices must have attested capabilities in place by the time managed care launches in November 2019.

** See Appendix A for full AMH practice requirements by tier*

AMH Certification Status is Different From Contracted Status

AMH Certification Status

- Represents the highest tier at which an AMH may contract with a PHP
- Each AMH will only have ONE such designation
- Separate from contracting and does not trigger PHP payments
- Managed by the State; PHPs cannot change practice AMH certification status but may change a practice's tier level with that specific PHP in limited instances

AMH Contracted Status

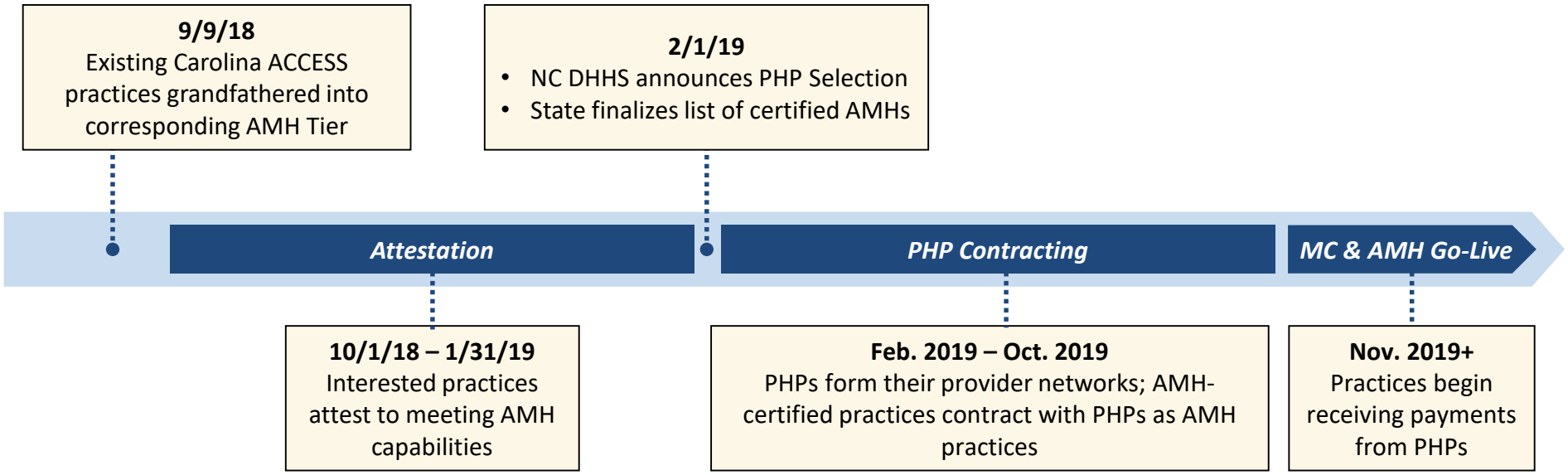
- Practices may choose to contract at different tiers with each PHP; though they may NOT exceed their highest tier with any PHP
- The State will track contracted tier levels with each PHP individually

Example AMH - Tier 3 Certification Status

- *PHP #1 contract:* Tier 3
- *PHP #2 contract:* Tier 3
- *PHP #3 contract:* Tier 2
- *PHP #4 contract:* not in PHP network

Timeline of AMH Program Launch*

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



- ***Practices can log into NCTracks and attest to a specified AMH tier***
- Practices will still be able to attest after Feb. 1, 2019, **but PHPs will not be contractually obligated to honor Tier 3 certifications** after this date*
- ***Practices are strongly encouraged to check and update as necessary their certification statuses as soon as possible***

**Note: There is no deadline for attestation to Tier 2 – PHPs will be required to honor these certifications on an ongoing basis*

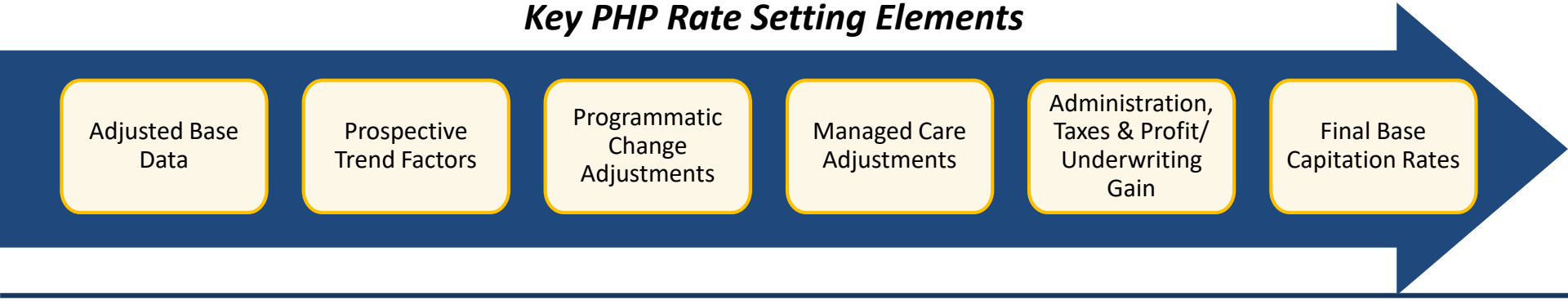
Part III:
PHP Contracting

Role of PHP in NC Medicaid

The State will delegate the management of specified health services to PHPs

- On Feb. 1, 2019, the State will award contracts to PHPs
- PHPs will be paid per person "capitation" rates by the State
- Capitation rates are set using actuarial principles and are meant to provide a reimbursement structure that will **match payment to the expected financial risk assumed by the PHPs**
- Final capitation rates for the first year of the PHP contract will be set **prior to program launch** and will reflect more recent program data, provider reimbursement levels, and legislative and other PHP requirements

Key PHP Rate Setting Elements



Contracting Requirements

PHPs must contract with all willing providers that agree to accept FFS payment levels and are in good standing with the NC Medicaid program

AMH Contracting Requirements

- PHPs must accept Tier 1 and Tier 2 certifications **"as is"** and may <u>not</u> reclassify practices during the initial contracting period
- PHPs are **required to contract with 80% of all AMH Tier 3 practices** located in each PHP Region*
  - PHPs will <u>not</u> be required to contract with Tier 3-certified practices at a Tier 3 level if they are **unable to reach mutually agreeable contract terms,** although this would count against the PHP's 80% contracting requirement
  - **PHPs must accept Tier 3 certified practices into their provider networks at a minimum Tier 2 level** if they cannot reach agreement on Tier 3 contracting terms

**Note: PHPs will not be contractually obligated to honor a practice's AMH Tier 3 certification if practice attests after Feb. 1, 2019.*

State Oversight of AMH Contracts

PHP contracts with AMHs must contain standard contract terms; the State will produce standard contract language and clauses, but will not review contracts*

Payment Terms

- Must provide sufficient detail regarding Medical Home Fees, Care Management Fees, and Performance Incentive Payments, as appropriate
- Must adhere to payment floors as established by the State

Other Requirements

- Must be mutually agreeable
- Must specify responsibilities of activities performed by an AMH vs. retained by the PHP
- Must describe responsibilities for all required AMH tiers
- Must specify reporting standards and performance monitoring in alignment with State standards
- Must specify consequences for underperformance, including appeals rights
- Must include data sharing and provisions for privacy/security, in alignment with the State's data sharing policies

* *See Appendix B for standard AMH contract terms.*

Contract Requirements: Medical Home Fees

Medical Home Fees are intended to serve as payment floors and PHPs are required to pay no less than published Medical Home Fees

- Practices in any AMH tier may **negotiate higher** Medical Home Fees with PHPs
  - E.g., A PHP may agree to pay a practice $4 PMPM for non-ABD beneficiaries and $8 PMPM for ABD beneficiaries would be permitted
- Medical Home Fees may **NOT** be tied to delivery of care management services to specific beneficiaries or to achievement of value-based benchmarks
  - E.g., a PHP may NOT require that a practice score above the 50th percentile on AMH quality measures to receive full Medical Home Fees

Tier	Minimum PMPM Medical Home Fee
1	• $1.00 (all enrollees)
2	• $2.50 (most enrollees) • $5.00 (members of the ABD eligibility group)
3	• $2.50 (most enrollees) • $5.00 (members of the ABD eligibility group)

ABD is the aged, blind and disabled eligibility group

AMH Tier 3 Contracting: Negotiating Care Management Fees

Tier 3 AMHs should consider assigned care management responsibilities, regional cost variation, and other factors when negotiating Care Management Fees

- Additional costs associated with supporting Tier 3 care management responsibilities are intended to be covered by Care Management Fees
- The State has not set minimum payment amounts for Care Management Fees paid to Tier 3 practices by PHPs; these will be negotiated between PHPs and AMHs
- Negotiation considerations:
  - PHPs are required to contract with 80% of AMH Tier 3 practices located in each region in which the PHP operates; providing an incentive to offer fair rates
  - Practices may wish to base negotiations for Care Management Fees off of the care management component of PHP capitation rates (i.e., the amount PHPs are being paid to perform care management)*
  - AMHs may work with CINs/other partners to assist with contracting

*For further information on PHP rates, see: Section IX. Medicaid Managed Care Draft Rate Book

AMH Payment Structure: Performance Incentives

Tier 3 practices will be eligible for additional incentive payments based on their performance on State-approved AMH quality measures

Tier 3 Performance Incentive Guidelines

- For the first two years of the program, these incentives will be on an **"upside-only" basis.** Practices will **NOT** be at risk of losing money (i.e., "downside risk") if they do not meet specified performance targets
  - PHPs will not be permitted to require practices to pay back PMPM Medical Home Fees, Care Management Fees, or any other payments for medical services
- Practices are permitted to negotiate arrangements that include downside risk, **but PHPs may not mandate them**
- Payment arrangements must be guided by the Health Care Payment Learning and Action Network (HCP LAN) Categories 2 through 4, which reflect varying levels of value-based payments[1]

Sample AMH Measures*

- *How people rated their personal doctor*
- *Childhood immunization status*
- *Well child visits in third-sixth years of life*
- *Cervical cancer screening*
- *Follow-up after hospitalization for mental illness*
- *Comprehensive diabetes care, poor control*
- *Medication management for asthma*
- *Controlling high blood pressure*
- *Medical assistance with tobacco cessation*

** These measures are tentative. A final measure list will be provided prior to managed care go-live.*

[1] *See Appendix C for more information*

AMH Tier 3 Contracting: Process

PHPs may assess the capabilities of Tier 3-certified practices as part of the initial contracting process and prior to managed care go-live

Permissible PHP Assessment Activities

- On-site reviews
- Telephone consultations
- Documentation reviews
- Other virtual/off-site reviews

Role of CINs/Other Partners

- CINs/other partners may assist with PHP contract negotiation on behalf of AMHs
- 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
- Even if contracting through a CIN/other partner, **AMHs are ultimately accountable to the PHP for fulfilling contractual obligations and achieving quality outcomes**

Preparing for PHP Contracting

AMHs should begin preliminary conversations with PHPs as soon as possible to understand payment terms and other considerations prior to PHP awards in February 2019

Contracting Considerations

- How the PHP envisions working with providers to help improve quality of care
- Reimbursement rates and opportunities for alternative payment arrangements (e.g., pay-for-performance, value-based payments, etc.)
- Reporting requirements
- Dispute resolution processes
- Data tools and other resources that will be available to contracted providers (e.g., business intelligence tools)
- Prior authorization processes and timely filing requirements
- Contract renewal and termination clauses and timeframes

AMH-Specific Contracting Elements

- *Care management roles and responsibilities*
- *Medical Home Fee amounts*
- *Care Management Fees, if applicable*
- *Performance Incentive Payments*
  - *Measures and performance benchmarks*
  - *Reporting requirements*
  - *Payment terms*
- *Data sharing requirements*

Part IV:
AMH Oversight

AMH Oversight Responsibilities

PHPs will be primarily responsible for ongoing oversight of AMHs in their networks

PHP Oversight

- PHPs will have **broad discretion** in ongoing oversight and monitoring of AMH practices' performance against Tier-specific AMH requirements
- In future years, the State may consider collaborative approaches to streamlining monitoring with the help of PHPs
- PHPs that delegate functions to AMH Tier 3 practices will have additional requirements as part of National Committee for Quality Assurance (NCQA) accreditation beginning in Year 3 of managed care

NCQA Requirements Related to Delegation

- Reviewing parts of the program where delegation occurs
- Conducting an annual file audit
- Performing an annual evaluation
- Performing an evaluation of population health management reports

AMH Underperformance and Reclassification

If an AMH is unable to perform activities associated with its assigned tier, PHPs may re-classify the practice and cease AMH payments

PHPs CAN

- Reclassify Tier 3 practices as Tier 2 or Tier 2 practices as non-AMH
- Cease payment of Medical Home Fees, Care Management Fees, and/or Performance Incentive Payments if practices are not meeting contractual obligations

PHPs CAN'T

- Lower the tier level of other AMH practice locations associated with the same organizational NPI or CIN without an assessment
- 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

Notification Requirements

PHPs must send notices of cancellation of Medical Home Fees to both the State and the AMH

Appealing AMH Reclassification

AMH practices have the right to appeal reclassifications for underperformance through each PHPs appeal process

- Practices have appeal rights to the State for the **State-designated practice certification process, but not for PHP reclassification of their tier**
- However, the **State will monitor PHPs' reclassification decisions** as part of its overall monitoring of PHP activities
- The State may consider **PHPs' pattern of AMH reclassification** in its ongoing compliance activities and contracting decisions

In the event that a PHP reclassifies a Tier 3-certified AMH to a Tier 2 level (or to a non-AMH level), this contract will not be counted in the numerator or denominator of the PHP's 80% Tier 3 contracting requirement

AMH Accountability for CINs/other Partners

AMHs may choose to delegate certain AMH practice operations to CINs/other partners

AMH Considerations

- AMH practices are **ultimately accountable to PHPs** for fulfilling contractual obligations and for quality outcomes regardless of if they choose to work with a CIN/other partner
- Practices must ensure **proper care management oversight of contracted CINs/other partners**
- State and PHP **do not have official oversight of CINs** – they will not maintain lists of CINs/other partners, validate their authenticity, etc.

CIN/Other Partner Considerations

- The State envisions that **many Tier 3 AMHs will work with CINs/other partners** to support practice operations and deliver required care management services
- Practices will have **broad flexibility** to use CINs/other partners and may wish to utilize them to help **negotiate AMH contracts** with PHPs

Note: Subsequent webinars will provide greater detail regarding how AMHs may work with CINs/other partners

Part V: Q & A

Part VI: Next Steps

Overview of Upcoming Events

*Upcoming AMH Webinars**

- **November 1:** Roles and Responsibilities of CINs and Other Provider Partners
- **Mid November:** AMH Tier 3: Patient Identification, Assignment, and Tracking
- **Early December:** AMH Tier 3: Care Management
- **Mid December:** AMH Tier 3: Care Planning
- **Early January:** IT Needs and Data Sharing Capabilities

**Final dates TBD*

For more information and to register for webinars/events, 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

- NC DHHS, North Carolina Advanced Medical Home (AMH) Program Frequently Asked Questions, September 5, 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 with AMHs

Standard Terms for PHP Contracts with AMHs

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

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

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

Appendix C:
HCP LAN Framework

HCP LAN Framework

HCP LAN Alternative Payment Models (APM) Framework

The HCP LAN APM framework is a tool used by many states, and supported by the Centers for Medicare and Medicaid Services (CMS), to better align multi-payer efforts by classifying value-based payment into four categories that each contain sub-categories largely based on the level of risk assumed by providers.

Category 1 Fee-for-service – No Link to Quality and Value	**Category 2** Fee for Service – Link to Quality and Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-based Payment
	A	**A**	**A**
	Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for health information technology investments)	APMs with shared savings (e.g., shared savings with upside risk only)	Condition-specific population-based payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)	APMs with shared savings and downside risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	Comprehensive population-based payment (e.g., global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-performance (e.g., bonuses for quality performance)		Integrated finance and delivery system (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N	**4N**
		Risk based payments NOT linked to quality	Capitated payments NOT linked to quality

Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf