Introduction to Advanced Medical Homes

Roles and Responsibilities of Clinically Integrated Networks and Other Partners

November 1, 2018

Contents

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

Care Management Principles

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

Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

AMHs are designed to serve as **a vehicle for executing on this approach in a managed care context**

Local Care Management

PHPs must ensure a robust system of local care management that is performed at the site of care, in the home, or in the community with face-to-face interaction wherever possible

Requirements for Local Care Management

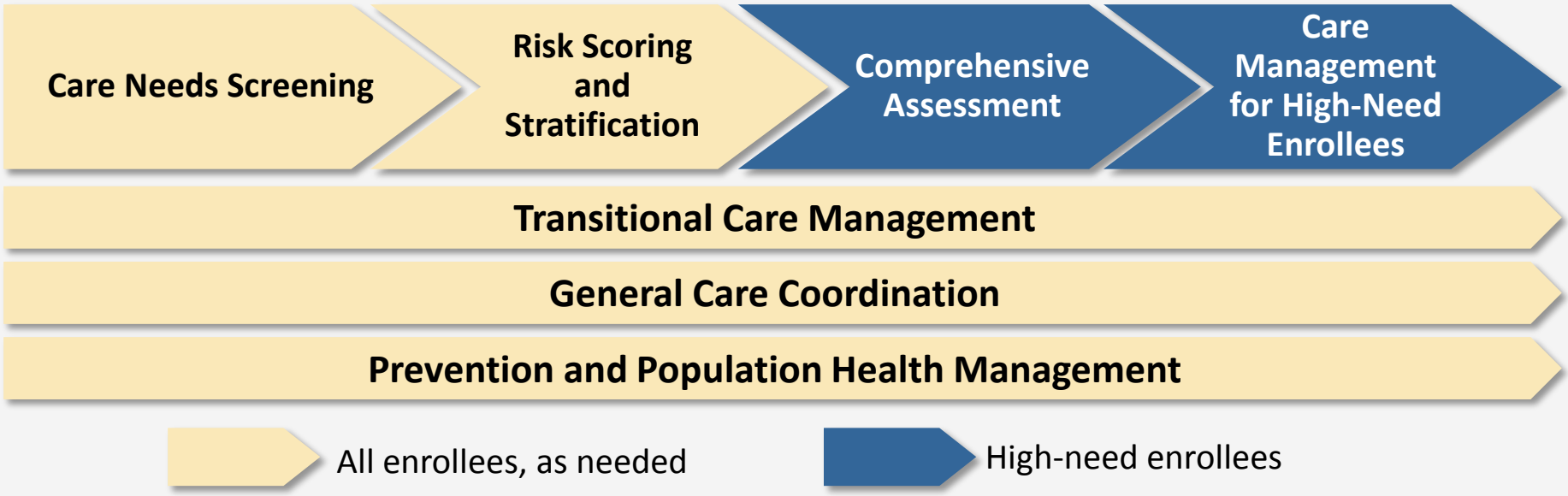
- PHPs must have an **established system of local care management** through AMHs, Local Health Departments (LHDs) as well as care management provided by the PHP that delivers high quality care
- PHPs are responsible for **oversight of local care management**, but can delegate primary responsibility to AMH Tier 3 practices
- If Medicaid enrollees receive care management from more than one entity, the PHP must ensure care plans detail the **roles and responsibilities of local care managers** (e.g., AMHs and LHDs)

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

Part II:
Roles and Responsibilities:
PHPs, AMHs, and CINs

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

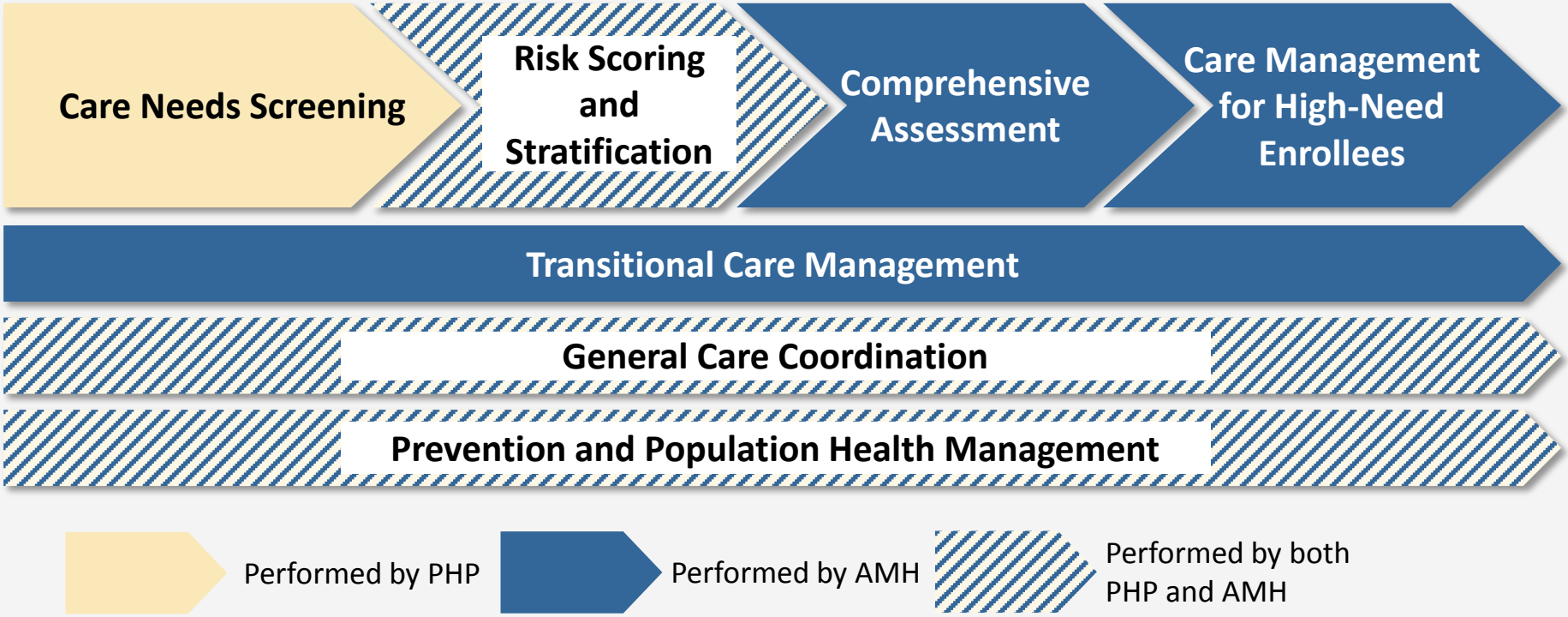


- **PHPs must also implement processes to identify priority populations, including:**
  - Children and adults with special health care needs*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs
- **AMHs are required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

What are CINs/Other Partners?

Practices that choose to work with CINs/other partners will have the freedom to choose any CIN that meets their unique needs

Types of Practices

- Employed physician groups – employed directly by health system or faculty practice plan
- Independent group practices – single or multi-specialty group practices, community clinics, and Federally Qualified Health Centers (FQHCs)
- Local health departments (LHDs)

Types of CINs

- Hospitals, health systems, integrated delivery networks, Independent Practice Associations (IPAs) and other provider-based networks and associations
- Care management organizations and technology vendors

Practices must consider whether their in-house capabilities are sufficient to meet AMH Tier 3 requirements and how CINs/other partners may support them

How Can CINs/Other Partners Help AMHs?

CINs/other partners can offer a wide range of capabilities but practices will need to determine their precise gaps and needs

CINs/Other Partner Services May Include:

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

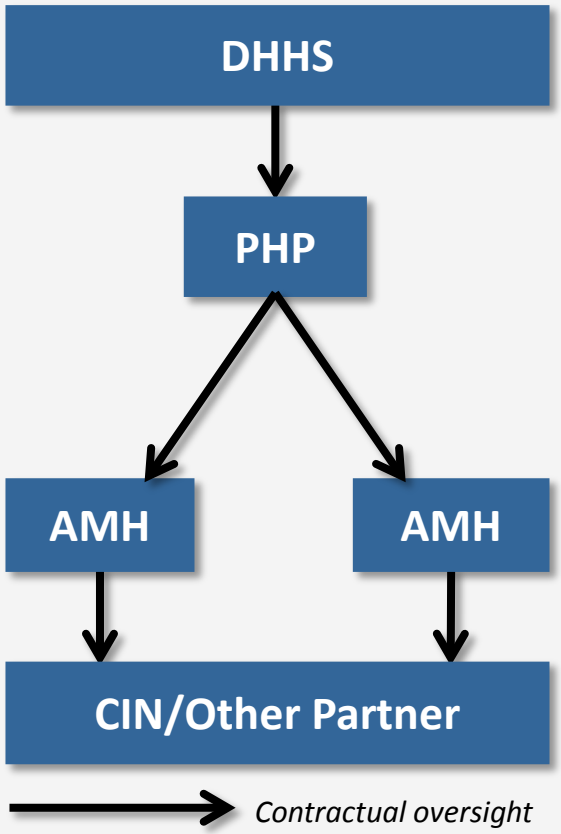
Although the majority of AMH Tier 3 practices may elect to contract with CINs/other partners for support, practices are not required to do so

AMH Accountability for CINs/Other Partners

Tier 3 AMH practices are ultimately accountable to PHPs regardless of whether they delegate care management responsibilities to CINs/other partners

AMH Tier 3 Considerations

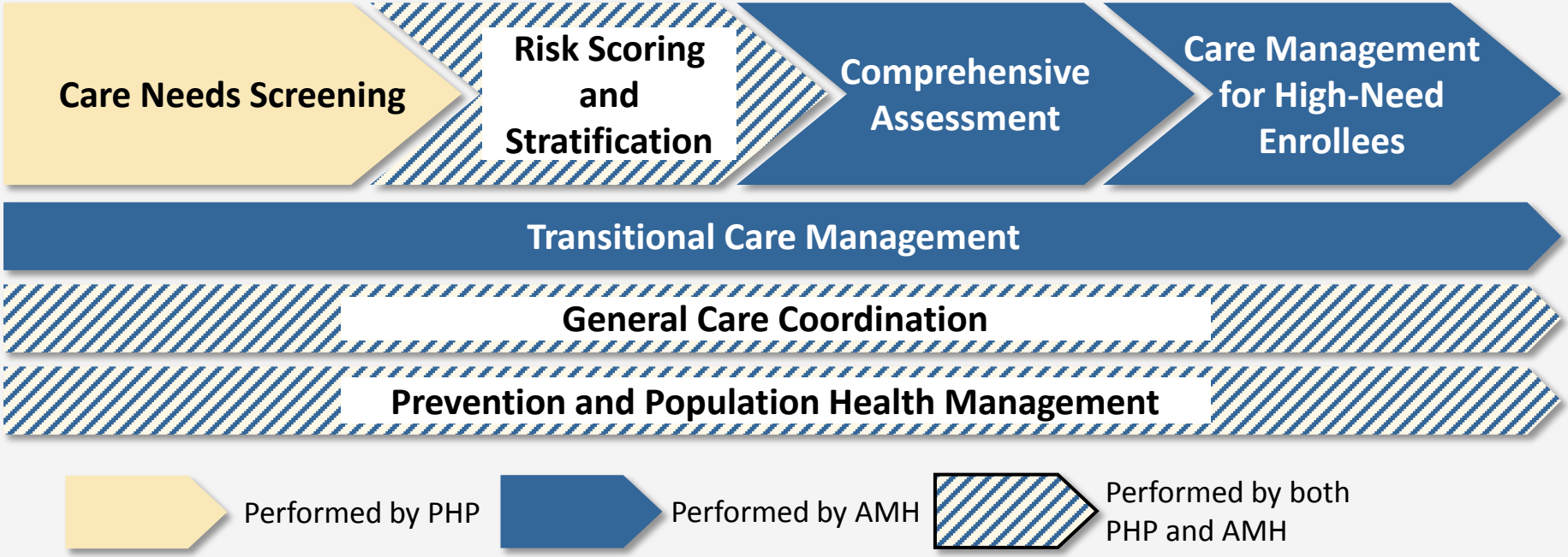
- AMH Tier 3 Practices must ensure **proper oversight of contracted CINs/other partners** to ensure that patients are receiving required care management services
- The **State will not have oversight of CINs** (e.g., they will not certify CINs, validate their capabilities, etc.)
- For AMH Tier 3 practices that partner with CINs, the **State will certify individual practices as AMH Tier 3** rather than the entire CIN



Part III:
CIN Capabilities: Care Management

Tier 3 Care Management Responsibilities and CINs/Other Partners

CINs/other partners may support practices in the delivery of local care management



Potential ways that CINs/other partners can support AMHs

- Local staffing support
- Performing Comprehensive Assessments and Care Planning
- Providing same day outreach and managing care transitions

Staffing

CINs/other partners can help Tier 3 AMHs meet specified local care management staffing requirements

Tier 3 Local Care Management Staffing Requirements

- Have licensed, trained local care management staff work closely with clinicians in a team-based approach for high-need patients
- Assign all high-need patients a care manager with minimum RN or LCSW credentials who is accountable for active, ongoing care management
- Assign patients identified as high risk for admission or other poor outcome with transitional care needs a local care manager

Potential CIN Delegated Responsibilities

- Provide local care management staff and other infrastructure through a health system, integrated delivery network or other care management partner
- Provide access to remote, on-demand care management staff to supplement local resources

Comprehensive Assessments and Care Planning

Tier 3 AMHs will be required to conduct a Comprehensive Assessment and develop a Care Plan for all patients identified as high-need

Tier 3 Comprehensive Assessment and Care Plan Requirements

- **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
  - Must be reviewed by the care team
  - Must develop protocols for situations where patients are at immediate risk
- **The Care Plan:**
  - Must be developed within 30 days of the Comprehensive Assessment
  - Must be individualized and person-centered and developed using a collaborative approach
  - Must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification, and Comprehensive Assessment
  - Must include a process to update the Care Plan

Potential CIN Tasks

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

Same Day Outreach and Managing Transitions of Care

Tier 3 AMHs must support patient care transitions in real or near real-time

Tier 3 Patient Care Transition Requirements

- Implement systematic, clinically appropriate care management processes for responding to high-risk ADT alerts
- Provide local care management for patients in transition that are identified as high risk

Potential CIN Delegated Responsibilities

- Develop clinical protocols for responding to high-risk ADT alerts
- Develop transitional care management protocols and provide staffing support
- Provide local on-demand care management capacity for ADT events that require real-time or near real-time responses

Part IV: CIN Capabilities: Data Management and Analytic Support

AMH Data Flows

PHPs Data Flows to Practices

- **PHPs must share the following with <u>all</u> practices:**
  - Beneficiary assignment information
  - PHP risk scoring and stratification results
  - Initial Care Needs Screening information
  - Quality measure performance information
- **PHPs must share the following with <u>Tier 3 practices</u>:**
  - Encounter data

Other AMH Data Flows

- AMH Tier 3 practices will be required to access **Admission, Discharge, and Transfer (ADT) information***
- All practices should **collect and process relevant clinical information** for population health/care management processes
- AMHs are encouraged **to share protected health information safely and securely with members**

Note: PHPs and AMH practices will be responsible for complying with all federal and State privacy and security requirements regarding the collection, storage, transmission, use, and destruction of data

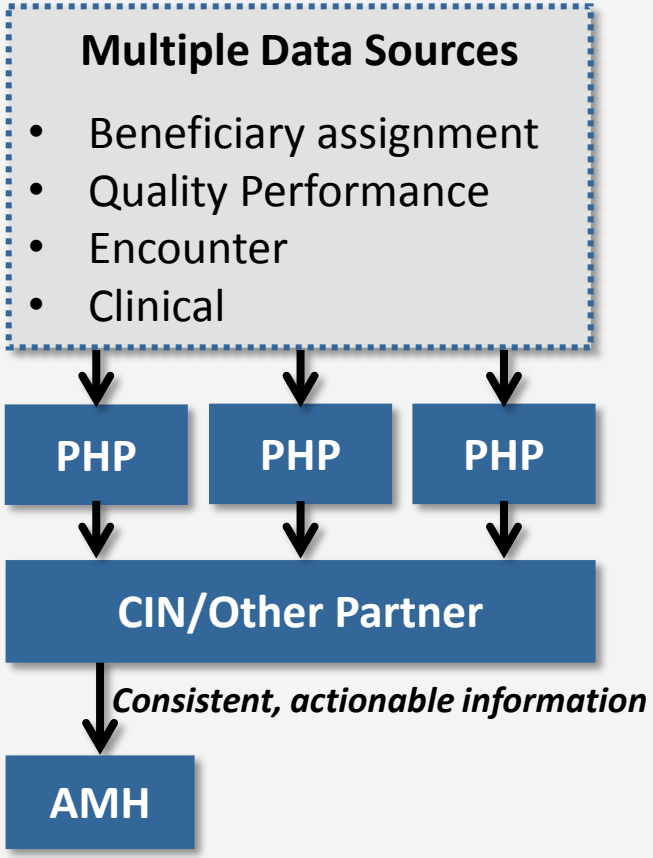
*Tier 1 and 2 practices will not be required, but will be encouraged to access ADT information

Potential CIN/Other Partner Data and Analytics Support

CINs/other partners can support AMHs in processing multiple data flows needed to support care management and related functions

Potential CINs/Other Partner Support

- Assisting with **risk scoring and stratification**
- Accessing and utilizing **ADT information**
- Compiling data for **comprehensive assessments and care management**
- **Receiving**, **aggregating**, and **transmitting**:
  - Beneficiary assignment data
  - Quality performance data
  - Encounter data
  - Clinical data



Assisting with Risk Scoring and Stratification

Each PHP will conduct risk scoring and stratification for all members and perform initial Care Needs Screening*

AMH Tier 3 Risk Scoring Requirements

- Use PHP assessments to inform delivery of care management
- Use a consistent method to **assign and adjust risk** status
- Use a consistent method to **combine risk scoring information** from PHPs with clinical information to score and stratify empaneled patients
- Identify **priority populations**
- Ensure entire care team understands basis of **risk scoring methodology**
- Define the **process of risk score review** and validation

Potential CIN Delegated Tasks

- Assist in defining process for risk score review and validation
- Adjust risk status for each assigned patient based on risk scoring data from multiple PHPs
- Assist in educating care team on risk scoring methodology
- Perform or assist in identification of priority populations based on risk scoring
- Incorporate risk-stratification findings into the Care Plan, once a risk level has been assigned to a member
- Use analytics to develop more detailed risk assessments and customized care management approaches

** See Appendix B for more information on required data sources.*

Accessing and Utilizing ADT Information

CINs/other partners can help Tier 3 AMHs access ADT data through a health information exchange (HIE) or other source

AMH Tier 3 ADT Requirements

- Track empaneled patients' ED and inpatient utilization by **accessing real- or near real-time ADT feeds**
- Implement a **systematic, clinically appropriate care management** process for responding to high-risk ADT alerts

- AMHs and their CINs/other partners are encouraged to work with NC HealthConnex or other ADT sources including the North Carolina Healthcare Association

Health Information Exchange (HIE):

A secure electronic network that enables the safe and secure transmission of protected patient health information between authorized health care providers.

Accessing ADT Information: Opportunities for CINs/Other Partners

AMHs and their CINs/other partners are encouraged to work with HIEs to establish data use agreements to enable data sharing

Potential CIN Tasks

- **Facilitate access to an ADT feed** for the AMHs' assigned beneficiaries
- Develop systems and process to **incorporate ADT information** into the AMH's electronic health records (EHR) and/or care management systems
- **Develop workflows and alerts** to facilitate follow-up and outreach for member in need of care management based on ADT alerts
- Incorporate ADT information into **risk stratification and risk-scoring** processes

Transferring, Accessing, and Aggregating Other Data Sources

CINs can help Tier 3 AMHs manage and create actionable information from PHP claims and other data sources

Potential Delegated CIN Tasks

- Acquire, process, manage, standardize and securely store claims data from **multiple PHPs**
- Support the creation of **Comprehensive Assessments** and **Care Plans**
- Perform analytics to develop **targeted care management approaches**
- Provide **actionable information** to care managers

AMH Data Flows

- Beneficiary assignment data from PHPs
- Quality performance data from and reporting to PHPs
- Encounter data from PHPs
- Clinical data from other providers

Part V:
CIN Capabilities: Contracting

General PHP Contracting Requirements

PHPs are required to contract with 80% of all AMH Tier 3 practices located in each PHP Region

PHP Contracting Requirements

- PHPs will **not 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

Contracting Roles of CINs/Other Partners

Subject to applicable laws, some CINs may help AMHs negotiate Medical Home Fees, Care Management Fees, Performance Incentive Payments, and payment terms and reimbursement rates*

CINs/Other Partner Considerations

- AMHs should **discuss contracting options with potential CIN partners**, and **seek legal counsel to clarify** any potential antitrust or anti-kickback concerns
- **AMHs may designate CINs to receive their payments** for Medical Home Fees, Care Management Fees and Performance Incentive Payments **services directly from PHPs**
  - The Department will not establish funds flow parameters between AMHs/CINs/PHPs

Note: PHPs may perform evaluations of the CIN if the AMH contracts with a third party to provide any of the Tier 3 care management required services

** Medical Home Fees have state-prescribed floors but can be negotiated up by mutual agreement between the PHP and the AMH*

AMH Tier 3 Contracting: Negotiating Care Management Fees

Tier 3 AMHs will need to consider care management responsibilities, regional cost variation, and other factors when negotiating Care Management Fees

Overview of Care Management Fees

- Tier 3 **involves PHPs passing care management responsibilities down to the practice level**; additional costs associated with these activities 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
- **AMHs are ultimately responsible** for any commitments made to a PHP

Potential CIN/Other Partner Tasks

- Subject to applicable laws, AMHs may choose to delegate contracting for Care Management Fees to CINs/other partners
- AMHs that delegate contracting should understand and set terms/conditions for funds flow; example up-front questions include:
  - *How should the Care Management Fees be shared between the CIN/other partner and the AMH?*
  - *What must AMH practices do to meet Care Management and Performance Incentive Payment milestones?*

** Medical Home Fees have state-prescribed floors but can be negotiated up by mutual agreement between the PHP and the AMH.*

AMH Tier 3 Contracting: Performance Incentives

PHPs must offer Performance Incentive Payments to Tier 3 AMHs

Tier 3 Performance Incentive Guidelines

- 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*
- For the first two years of the program, PHPs must offer **these incentives 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
- Practices and PHPs may negotiate arrangements that include downside risk, **but PHPs must also give practices the option of upside only**
- Incentives must be **based on the State-approved AMH quality measure set***

Roles of CINs/Other Partners

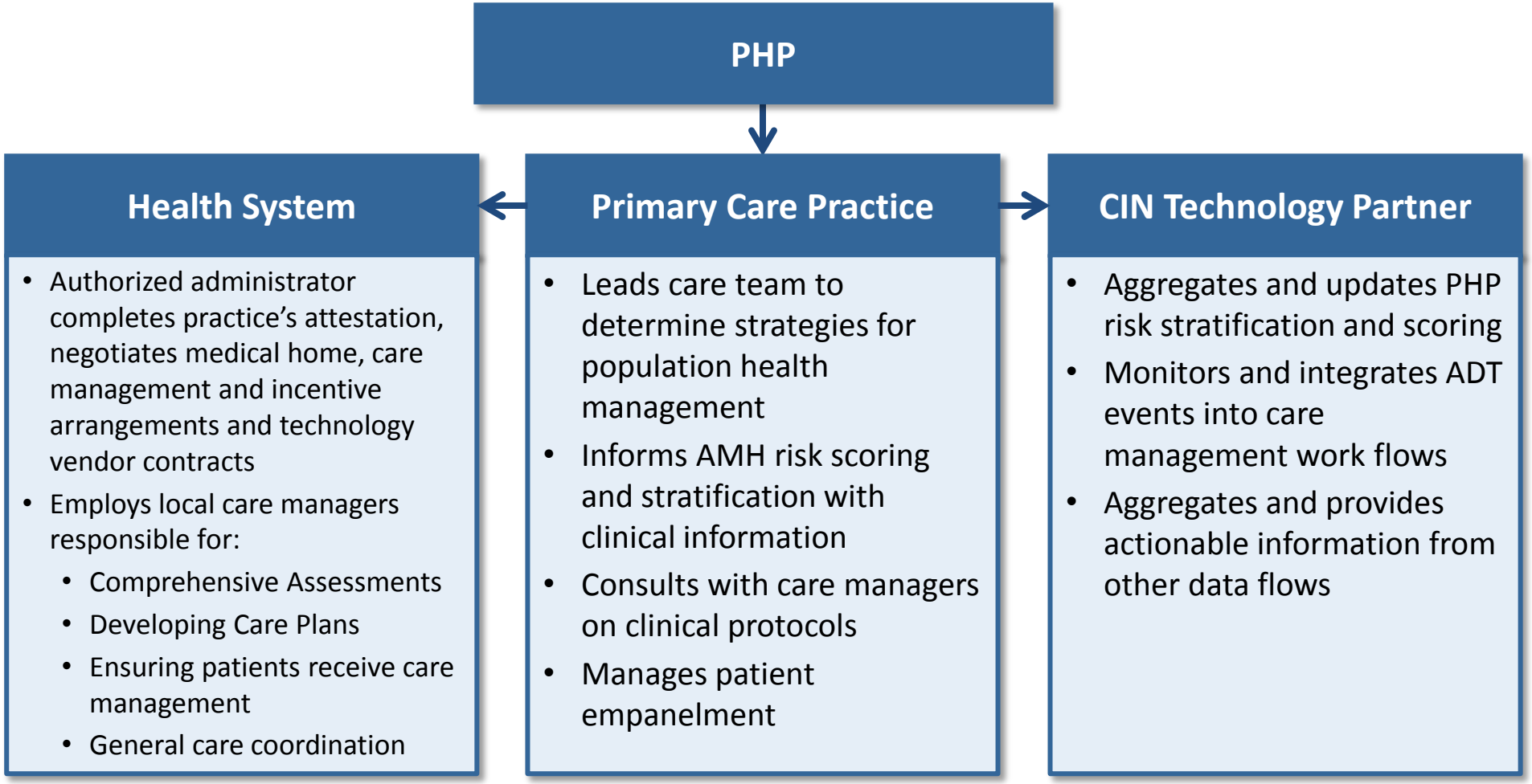
- Subject to applicable laws, CINs may support negotiation, management and monitoring of performance incentive contracts across multiple PHPs
- CINs can help AMHs understand performance incentive payment terms and potential risks and benefits associated with different arrangements
- CIN's may assist practices in choosing performance reporting measures

** See Appendix C for HCP LAN Framework and categories.*

Part VI:
CIN Use Cases

CIN/Other Partner Use Case 1

***Scenario*: Practice affiliated with a health system has limited practice-based care management functionality**



CIN/Other Partner Use Case 2

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

PHP

Primary Care Practice

- Office administrator completes practice's Tier 3 attestation
- Clinical staff provide most local care management, including:
  - Comprehensive Assessments
  - Developing Care Plans
  - Ensuring patients receive care management
  - General care coordination
- Leads care team to determine strategies for population health management
- Informs AMH risk scoring and stratification
- Develops clinical protocols
- Negotiates Medical Home Fees, Care Management Fees, And Performance Incentive Payments

CIN/Other Partner

- Aggregates and updates PHP risk stratification and scoring
- Monitors and integrates ADT events into care management work flows
- Aggregates and provides actionable information from other data flows

CIN/Other Partner Use Case 3

***Scenario*: Independent, unaffiliated practices, FQHCs, LHDs that have minimal primary care, care management functionality in-house**

PHP

Primary Care Practice

- Office administrator completes practice's Tier 3 attestation
- Care team develops population health management strategies
- Supports AMH risk-scoring and stratification with CIN partner
- Consults with and advises care managers on clinical protocols
- Manages patient empanelment
- Ensure patients receive care management

CIN/Other Partner

- Provides local care management including:
  - Comprehensive Assessments
  - Care Plans
  - General care coordination
  - Clinical protocols in consultation with practice
- Negotiates Medical Home Fees, Care Management Fees, And Performance Incentive Payments
- Aggregates/updates PHP risk stratification scoring
- Monitors and integrates ADT events, claims and other information from other data flows into care management processes

Part VII:
Q & A

Part VIII:
Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars

- **November 15, 2018:** AMH Tier 3: Patient Identification and Assessment
- **December 3, 2018:** AMH Tier 3: High Need Care Management
- **December 18, 2018:** AMH Tier 3: Transitional Care Management
- **January 10, 2019:** IT Needs and Data Sharing Capabilities

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

Additional Information

Questions?

- **Email:** Medicaid.Transformation@dhhs.nc.gov
- **U.S. Mail:** Dept. of Health and Human Services, Division of Health Benefits
  1950 Mail Service Center
  Raleigh NC 27699-1950

AMH Webpage

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

White Papers, Manuals, and FAQs

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

Part IX: 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: Data Sources and Definitions

Data Sources and Definitions

Multiple data flows will be needed to support AMH practices in carrying out care management and related functions for their populations. Where helpful to reduce administrative burden, the Department will set uniform expectations and standards upfront to which PHPs and AMHs (either directly or through their designated CIN or other partner) will conform using a minimum set of standards for data elements, interchange formats and terminology. Where available, the Department will use nationally standards.

Data Source	Description
PHP Risk Scoring and Stratification Results	A key aspect of Medicaid Managed Care is the PHPs' use of data and analytics to identify which members need various types of intervention. The Department expects that PHPs will use their own proprietary risk scoring and stratification capabilities for care management, population health and related purposes. PHPs are encouraged to develop and/or use their own innovative methodologies. This could include modeling techniques to predict outcomes or service utilization to deploy proactive care interventions to members who receptive. While each PHP will utilize its own risk scoring and stratification methodology and classification approach, their models and processes must take into account, at a minimum, a common set of information that includes: care needs screening results; claims history; claims analysis; pharmacy data; immunizations; lab results; ADT feed information; provider referrals; referrals from social services; member's zip code; member's race and ethnicity; and member or caretaker self-referral.
Initial Care Needs Screening	As described in "North Carolina's Care Management Strategy under Managed Care" policy paper, it is a federal requirement that Medicaid Managed Care plans make best efforts to conduct initial enrollee health and unmet resource need screenings within 90 days of enrollment. In North Carolina, this step will be known as the "Initial Care Needs Screening." PHPs will be required to share the results of available Initial Care Needs Screenings with primary care providers within seven days of screening, or within seven days of assignment of a new PCP, whichever is earlier. Note that this requirement extends to all primary care practices, even those not participating in the AMH program. PHPs will have discretion regarding specific mechanisms for sharing these data with AMHs, including combining it with other types of data they are sharing with AMHs.
Quality Measure Performance	In the Department's Draft Quality Strategy, the Department defined a common set of quality measures that PHPs will be required to regularly track and report. The Department envisions that PHPs will use a subset of these standard Medicaid Managed Care quality measures (8 to 10 AMH-focused measures included in the priority measure set, which will be consistently used across all PHPs) to assess the quality of AMH practices and, where applicable, to develop and calculate performance-based payments. Tier 3 practices will also be eligible for additional incentive payments based on their performance on State-approved AMH quality measures. Sample AMH Measures include: how people rated their personal doctor; childhood immunizations 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. Note: these measures are tentative; a final measure list will be provided prior to manage care go-live.

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