



Targeted  
Investments

# Core Component #3 Adult PCP Area of Concentration

Utilizing Practice Care  
Managers for Members in  
the High Risk Registry



# Key Concepts

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TI participants will utilize practice care managers to:

- assess **high risk** member needs
- play an active role in developing and implementing care plans
- collaboratively support hospital transitions of care
- coordinate **high risk** members' medical and behavioral health services
- assure optimal communication and collaboration with other MCO's and or practices
- work with **high risk** members and families to facilitate linkages to community organizations

# Key Concepts Cont.

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- Core Component #3 requires a dedicated staff member to perform the care management functions. It is the most resource intensive and requires the most investment by TI participants. Participants are expected to use their TI payments to support this dedicated resource.
- Care Managers will be focusing on high risk members in the high-risk registry (CC #2 requirement) with a case load **not to exceed a ratio of 1:100.**

# Core Component #3

<p>3. Utilize practice care managers<sup>2</sup> for members included in the high-risk registry, with a case load not to exceed a ratio of 1:100. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system), or contracted by the practice from external sources. Practice-level care management functions should include:</p> <ol style="list-style-type: none"> <li>1) Assessing and periodically reassessing member needs.</li> <li>2) Playing an active role in developing and implementing integrated care plans.</li> <li>3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).</li> <li>4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.</li> <li>5) Working with members and their families to facilitate linkages to community organizations, including social service agencies.</li> </ol>	
<p><b>Milestone Measurement Period 1</b> (October 1, 2017–September 30, 2018*)</p> <p>◀—▶ x 11</p> <p><b>Practice Reporting Requirement to State</b></p>	<p><b>Milestone Measurement Period 2</b> (October 1, 2018–September 30, 2019*)</p> <p>◀—▶ x 6</p> <p><b>Practice Reporting Requirement to State</b></p>
<p>A. By September 30, 2018, identify at least one care manager assigned to provide integrated care management services for members listed in the practice high risk registry. Indicate the caseload per care manager full time equivalent (FTE), <b>AND</b></p> <p>B. By September 30, 2018, document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management, consistent with Core Component 2, <b>AND</b></p> <p>C. By September 30, 2018, demonstrate that the care manager(s) has been trained in:</p> <ul style="list-style-type: none"> <li>• Comprehensive assessment of member needs and goals;             <ul style="list-style-type: none"> <li>• Use of integrated care plans;</li> <li>• Member and family education; and</li> <li>• Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10.</li> </ul> </li> </ul>	<p>A. By March 31, 2019, document that care managers have been trained in motivational interviewing, including member activation and self-management support, <b>AND</b></p> <p>B. Based on a practice record review of a random sample of 20 members listed in the high-risk registry during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating members, c) conducting motivational interviewing, d) appropriately facilitating linkages to community-based organizations, and e) whether the member already received integrated care/case management from other practices and/or MCOs, at least 85% of the time.</p>

# Care Manager Requirements

Responsible For	<ul style="list-style-type: none"><li>• Care managers are responsible for high-risk patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams.</li></ul>
Located	<ul style="list-style-type: none"><li>• Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means.</li></ul>
Required Designation	<ul style="list-style-type: none"><li>• A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker.</li></ul>
Acceptable Designations	<ul style="list-style-type: none"><li>• In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a Bachelor's in health or social services is acceptable.</li></ul>

# Care Manager Role and Education Requirements cont.

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- Care managers are responsible for **high-risk** patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams.
- Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means.
- A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable.

# Future Practice with Care Manager



In the future, your Care Manager and High Risk Registry will enable your practice to provide more coordinated and integrated care for high risk members.

# TI Year 2 Measurement Period

## October 1, 2017 – September 30, 2018

### **Reporting Requirement to the State:**

### **By September 30, 2018:**

- Identify at least one care manager assigned to provide integrated care management services for members listed in the practice high risk registry. Indicate the caseload per care manager full time equivalent (FTE)

### **AND**

- Document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management, consistent with Core Component 2
- Demonstrate that the care manager(s) has been trained in:
  - Use of integrated care plans
  - Member and family education
  - Facilitating linkages to community-based organizations, utilizing resources identified in Core Component 10.



# Attestation and Validation Documentation

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- AHCCCS will be opening a TI Attestation Portal through **AHCCCS Online** (<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>)
- The portal will be available for milestone attestation in June 2018.
- Not all of the Milestones will require providers to upload documentation through the Attestation Portal for review by AHCCCS.
- In order to attest to meeting this Core Component, participants will need to show they have to identify a care manager(s), document duties, and demonstrate the care managers are skilled in certain requirements.
- More detailed information and guidance about how to use the TI Attestation Portal will be available prior to June 2018.

# Sneak Peak of TI Year 3



# Sneak Peek: TI Year 3 Measurement Period 2 October 1, 2018 – September 30, 2019

<p>3. Utilize practice care managers for members included in the high-risk registry, with a case load not to exceed a ratio of 1:100. Care managers may be employed directly by the practice, an affiliated entity (for example, Accountable Care Organization, integrated health system), or contracted by the practice from external sources. Practice-level care management functions should include:</p> <ol style="list-style-type: none"> <li>1) Assessing and periodically reassessing member needs.</li> <li>2) Playing an active role in developing and implementing integrated care plans.</li> <li>3) Collaboratively supporting hospital transitions of care (especially following hospitalization for mental illness).</li> <li>4) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible.</li> <li>5) Working with members and their families to facilitate linkages to community organizations, including social service agencies.</li> </ol>	
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# Sneak Peek: TI Year 3 Measurement Period October 1, 2018 – September 30, 2019

## **Practice Reporting Requirement to State By September 30, 2019:**

- Document that care managers have been trained in motivational interviewing, including member activation and self-management support
- AND**
- Based on a practice record review of a random sample of 20 members listed in the high-risk registry during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating members, c) conducting motivational interviewing, d) appropriately facilitating linkages to community-based organizations, and e) whether the member already received integrated care/case management from other practices and/or MCOs, at least 85% of the time.

# Questions?

Please contact us at  
[targetedinvestments@azahcccs.gov](mailto:targetedinvestments@azahcccs.gov)  
if you have any questions



# Thank You.

