CCPN Supporting Advanced Medical Homes

Advanced Medical Home Tier 3 - Medicaid Reform Is Your Practice Ready?

North Carolina's Medicaid Transformation created three tiers of Advanced Medical Homes (AMHs). Tier 3 practices can receive care management revenue and value-based payments from health plans for meeting quality targets.

Being a Tier 3 practice, however, involves taking on significant population health functions such as risk stratification and care management. For many practices, this will be new territory, so achieving Tier 3 could be cost prohibitive and time-consuming.

But there's a safer route: partnering with Community Care Physician Network, a statewide, physician-led clinically integrated network. As a CCPN member, you can rely on a trusted, experienced partner to meet obligations and open the door to Tier 3 reimbursement levels.

CCPN leverages Community Care of North Carolina's (CCNC) award winning care management and actionable analytics, to work in collaboration with our provider services and ensure your practice thrives in a value-based care environment.

Here's a quick summary of the Tier 3 responsibilities and the ways that we will help you.

Risk Stratification

Risk stratify all empaneled patients. We utilize an evidence-based and scientifically-validated analytics model that risk-stratifies patients based on impactability.

Care Management

Provide care management to high-need patients. We have a robust care management program that has served the Medicaid population statewide, for over two decades. CCNC's care management program is nationally accredited by the National Committee for Quality Assurance (NCQA).

Key components of the care management program include, but are not limited to:

- Local, licensed, and trained care management staff
- Patient assessment and screening
- Utilization of a patient-centered care plan and web-based care management documentation platform
- Communication and strong relationships with primary care clinicians
- Patient education
- Medication management
- Relationships and referral contacts established with community partners to address social determinants of health

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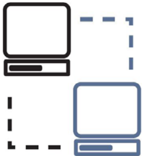
Care Plan

Use a documented care plan for high need patients. We use a person-centered care plan, also known as the Map to Wellness, for patients. A comprehensive needs assessment, clinical guidelines, and patient goals help to inform the Care Plan.



Admissions, Discharges, and Transfers (ADT)

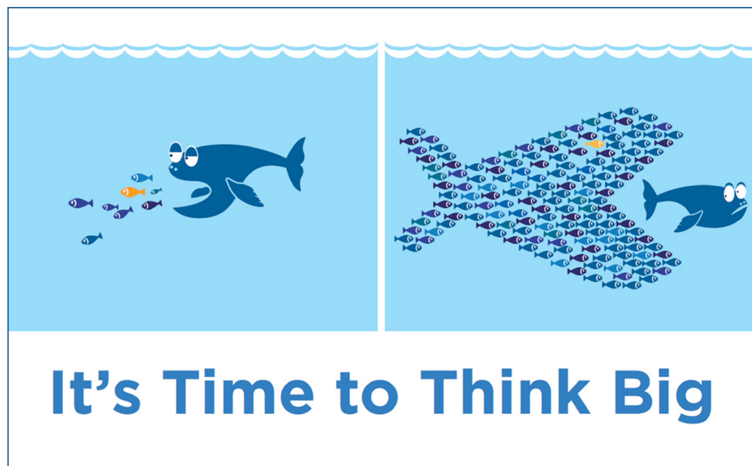
Track beneficiary utilization, including ADT for empaneled patients. We receive ADT notifications three times a day from most hospitals across the state, allowing care managers to utilize real time admission data to perform transitional care for high-need patients.

Transitional Care Management

Provide short-term, transitional care management. We utilize ADT and other supplemental information to initiate transitional care management for patients at risk for re-admission and other patients who are considered high risk post-discharge. Our standardized processes optimize the effectiveness of transitional care management, resulting in a 27% reduction in inpatient admissions and a 48% reduction in potentially preventable readmissions.

“My practice intends to attest as a Tier 3 Advanced Medical Home through CCPN. Why would we try to build in-house care management, amid all this Medicaid change, when we have access to our local, accredited, proven, and world-class care managers who know our practice and our patients!”

- Dr. William Stewart
Sandhill Pediatrics



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