UNCW CENTER FOR HEALTHY COMMUNITIES

MEDICAID MANAGED CARE: READINESS ROADMAP

PREPARED & PRESENTED BY:

ATRÓMITOS

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PURPOSE

To comply with state and federal Medicaid managed care regulations, North Carolina's Prepaid Health Plans (PHPs) must conduct delegation oversight activities throughout the course of their contracts. Delegation occurs when a health plan gives another entity the authority to perform certain functions on its behalf. In the case of the NC Medicaid Transformation, the PHPs are delegating the role of certain care management programs and services to providers in the state, including LHDs ("Delegates"). Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately. Therefore, oversight is required on the part of the PHPs.

While each PHP's approach and timeline for conducting oversight activities will vary, audits of delegated partners (i.e., local health departments (LHDs), advanced medical homes (AMH)) will be conducted to ensure they are adhering to **regulatory**, **contractual**, and **operational** requirements issued by the Centers for Medicare and Medicaid Services (CMS) and the North Carolina Department of Health and Human Services (DHHS) NC Medicaid Division of Health Benefits. The oversight is intended to assess the Delegates' performance against benchmarks and thresholds and to validate regulatory and contractual compliance.

Delegates will also be expected to submit monthly and quarterly reports and support the PHP's quality improvement activities. While the specifics of these activities are forthcoming, this will likely include utilizing reports to monitor and manage care for referred members, and to provide PHPs with key process and quality metrics on a routine basis.

To prove readiness to perform delegated duties, the Delegate must be able to produce documentation that demonstrates **compliance** with state and federal law, regulation, and contracts as well as operational **accountability** and **capability**.

HOW TO USE THIS DOCUMENT

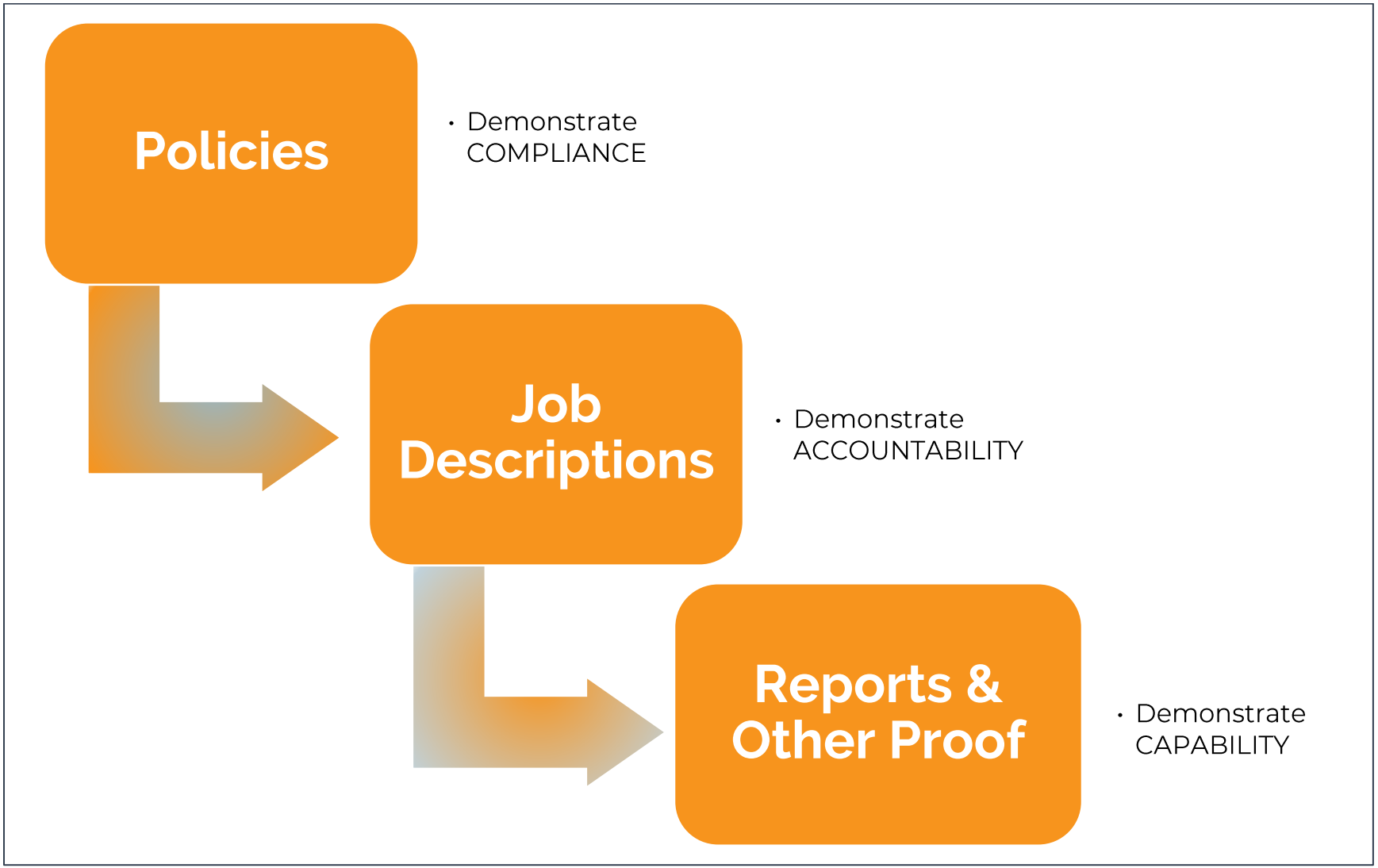
Based on our experience with Medicaid managed care compliance and audit activities, Atrómitos has developed this roadmap to help guide the LHDs to achieving readiness for the following three care management programs: Care Management for High-Risk Pregnancies (CMHRP), Care Management for At-Risk Children (CMARC), and the Pregnancy Medical Program (PMP). The roadmap begins with high-level guidance about the types of documentation that PHPs will expect a delegated entity to have, what each type of documentation demonstrates, and a pathway for prioritizing their completion.

This high-level guidance should be shared across all staff working in the care management programs to help them understand the importance of these materials. As these materials should not be viewed simply as documentation of readiness but rather as day-to-day touchpoints for ensuring **compliance**, **operational accountability and efficiency**, and **programmatic consistency**.

Later sections of the roadmap will provide detailed descriptions of each type of documentation and a template or tool that can be used to support the development or refinement of such materials. These sections can be disseminated to both staff and management that work in each of the programs to establish expectations for their day-to-day activities and lines of accountability among management.

Finally, following a review of each LHD's submitted documentation, Atrómitos has developed tailored guidance about the organization's level of readiness and a recommended approach to achieving readiness given our understanding of local resources and expectations of the PHPs.

Medicaid Managed Care Roadmap: Types of Documentation and Prioritization



STEP 1: DEMONSTRATING COMPLIANCE THROUGH POLICY

If something is important to the success of your organization, then it should be documented. The idea of documenting policies—especially creating them from scratch—easily overwhelms people when they try to craft the perfect policy language on the first draft. The fact is, your policies and procedures do not have to be sophisticated. The most important aspect is *having* documentation—establishing the procedures and policies in writing, and then continually tweaking them over time.

1. **Developing a formal policy structure.** Developing a policy template is an important first step in policy development, particularly because it will prevent missing any key element when drafting a policy document. It has the added benefit of making the policy documents immediately recognizable to everyone. The following general policy structure is suggested for development of LHD policy and procedure documents, with items 1-5 being the most critical to demonstrating compliance.

    A. **Header Block**. The header block should include several things, including but not necessarily limited to
        i. The title of the policy document;
        ii. Identity of the department responsible for drafting, reviewing, and enforcement of the policy;
        iii. Effective date of the policy;
        iv. Policy number;
        v. Date of approval;
        vi. Identity of approval authority;
        vii. Whether it replaces or modifies and existing policy; and
        viii. Number of pages inclusive in the document.

    The title should clearly identify the general topic of the policy and assist those who may be searching for guidance on the policy's topic area. It should also indicate whether the policy is replacing an existing policy as well as the last revision date. All this information is critical to proper policy management. The effective dates of implementation and revisions must be maintained. If an issue arises, the dates of implementation and applicable revisions are essential.

    B. **Purpose**. The purpose statement outlines what the policy document is designed to achieve. When developing a policy document, begin with a statement of purpose that defines the intent and objectives of the policy.

It should be relatively short and direct. It is suggested that it begin with an active verb such as, "To promote…., To comply…., To ensure….," etc.

C. **Scope**. The scope explains the range of application of the document in terms of covered persons, facilities, sites, etc.

D. **Definitions**. In many cases there will be terminology used that requires understanding and clarification to meet the intention of the policy document. These may be of a legal nature or specific to the organization or the type of work. Therefore, inclusion of definitions provides a clear understanding of key terms used in the policy document. It is advisable to cite the authority for the definitions being used.

E. **Policy Statements**. Each policy statement should reflect the basic objectives of the organization and a description of the general guiding principles or rules. In terms of the LHD Medicaid Care Management Program policy development, the policy statement should include the specific contractual requirements dictated in the Program Guide for the Management of High-Risk Pregnancies and At-Risk Children in Managed Care Appendices. To ensure compliance the language can be copied **verbatim** from the contract requirements.

F. **Related Policies**. It is important that policies addressing similar or related issues be linked to ensure that they are consistent. There is nothing worse than having issues or incidents arise only to find the written guidance on the subject is in conflict. Furthermore, including related documents provides additional documents that may be helpful to covered persons in complying with the policy.

G. **References/Citations**. The references or citation section is used for legal and regulatory citations and government guidance documents, as well as citing internal organization documents. If the policy document was in response to legal or regulatory authority, that authority should be noted along with a list of supporting and source documentation used to validate the policies and procedures.

H. **Appendices**. As policies may be supported through procedures, guidelines, and forms, add/identify these documents at the end of the policy.

See **Appendix A** for a sample policy template.

2. **Mapping policy development to achieve compliance.** As previously stated, the PHPs will be assessing the LHDs compliance with state and federal law, regulation, and contracts. Therefore, LHD policies should reflect key contractual requirements for each program (i.e., CMHRP, CMARC and Pregnancy).

The table below was developed based on the Standard Contracting Requirements for each program as included in Appendix A–C of the Division of Health Benefits NC Medicaid Program Guide for the Management of High-Risk Pregnancies and At-Risk Children in Managed Care. These reflect the high-level policy topics that must be created for each program.

It is up the LHD to determine whether it will create a separate program specific policy (therefore having three separate policies) for each functional area (e.g., Care Management Services) or whether it will have a single policy for each area that reflects specifics for the individual programs. Atrómitos recommends starting simple to achieve compliance with requirements and then over time developing more sophisticated policies as needed. This simplified approach would, therefore, lead to the development of eight policies for Medicaid compliance.

	Programs		
Policy Area	**CMHRP**	**CMARC**	**Pregnancy**
Outreach & Referrals	X	X	
Population Identification & engagement	X	X	
Assessment and risk stratification	X	X	X
Care Management Services (interventions, plan of care)	X	X	X
Integration & Collaboration	X	X	X
Staffing & Training	X	X	
Clinical			X
Data Management	X	X	X

To aid in LHD policy development, Atrómitos has further broken down these seven policy areas to include the specific contractual requirements that must be reflected to demonstrate compliance.

LHD Medicaid Care Management Program(s) Policy Checklist

	Contractual Requirements (Program Guide Appendices)		
Policy Area & Readiness Assessment Policies	**CMHRP**	**CMARC**	**Pregnancy**
Outreach & Referrals	**B.2.a-b**	**C.2.a-e**	
Health Education		X	
Population Identification & Engagement	**B.3.a-e**	**C.3.a-c, C.4.a-c**	
Insurance Enrollment	X	X	
Family Engagement		X	
Assessment and Risk Stratification	**B.4.a-e**	**C.5.a-c**	**A.1.a A.1.e**
Assessment	X	X	
Risk Screening	X		X
Care Management Services (interventions, plan of care, service provision)	**B.5a-f**	**C.6.a-e, C.8.a-b**	**A.1.e**
Condition-specific intervention	X	X	
Care Plan	X	X	X
Out-of-Clinic face-to-face encounter	X	X	
Telephonic encounter	X	X	
Integration & Collaboration	**B.6.a-f, B.7.a-e**	**C.7.a-f**	
Referral/Collaboration	X	X	
PHP Engagement	X	X	X
Staffing & Training	**B.8.a-d, B.9.a-j**	**C.9.a-b, C.10.a-m**	
Training	X	X	
Vacancy Contingency	X	X	
Clinical			**A.1.c-g**
17p clinical			X
Data Management policy and procedure	**B.2.b, B.3.a & d B.4.a & c, B.5.f B.7.b**	**C.3.a C.5.b C.8.a**	**A.1.b-f**
Data Collection, Monitoring, and Reporting	X	X	X

3. **Prioritizing order of policy development.** As the LHD prepares for a programmatic audit, the following prioritization is recommended:
    i. Create policies not currently in existent within the LHD; then,
    ii. Revise current policies to include specific requirements of the care management programs.

Refer to the tailored guidance provided by Atrómitos regarding assessment of your existing policies to aid in the mapping out of your policy development efforts.

STEP 2: DEMONSTRATING ACCOUNTABILITY THROUGH JOB DESCRIPTIONS

When completing a programmatic audit, it is essential to prove an infrastructure that outlines who is responsible for completing specific tasks. Having job descriptions that clearly identify which staff are responsible for clearly stated program requirements will be essential. The following recommendations are provided to LHDs as they develop and refine job descriptions in anticipation of audits of their care management programs by Prepaid Health Plans.

1. **Deciding how staff will be used across programs.** Before developing or refining any job description, LHDs need to determine how, if at all, staff will be shared across care management programs. Within the PMP, CMHRP, and CMARC programs, staff within the following departments will be necessary to successfully execute all program responsibilities:
    - Care Management
    - Clinical Services
    - Finance & Billing
    - Information Technology
    - Patient Services

    Generally, it is recommended positions within the following departments can easily be shared across care management programs, as well as other functions of the LHD, given their responsibilities are not anticipated to equate to a 1.0 FTE position:
    - Clinical Services
    - Finance & Billing
    - Information Technology
    - Patient Services

    The specific positions and the number to employ within the LHD will be a decision unique to each LHD based on, among other potential factors:

- What positions currently exist in the LHD;
- Current workloads of LHD positions; and,
- The LHD's budget.

The decision to share staff in the Care Management department across care management programs will be unique to each individual LHD. This decision will primarily be based on:

- The anticipated number of beneficiaries attributed to the LHD across care management programs during a performance period;
- The LHD's budget; and,
- The LHD's internal capabilities to ensure all responsibilities within each care management program are successfully being fulfilled.

There is no preferred model to follow regarding whether or not to share Care Management staff across care management programs, thus allowing LHDs to make staffing decisions resulting in optimal local implementation of the programs.

2. **Job Description Content**. Job descriptions that clearly state program responsibilities in language closely mirroring program guides and contracts help facilitate completion of programmatic audits. When available, language from program guides and contracts can be used **verbatim** in job descriptions to prevent missing any key element. Of equal importance as responsibilities for the care management programs are the credentials, qualifications, and training requirements for staff specified in program guidance and contract language. As with specific responsibilities, language related to these three components can also be used **verbatim** to prevent missing any key element.

   For the PMP, CMHRP, and CMARC programs, the Management of High-Risk Pregnancies and At-Risk Children in Managed Care Program Guide, with specific attention paid to the document's appendices, should be used to identify relevant language to include in all applicable job descriptions. LHDs may also refer to **Appendix B** for an assignment of program responsibilities and staff credentials, qualifications, and training to identified departments.

3. **Job Description Format**. Generally, job descriptions should clearly identify when responsibilities are associated with the specific care management programs. This is especially true when a position is shared across care management programs, or across other initiatives within the LHD. It is recommended to delineate specific responsibilities within the job description as relevant to a care management program in one of two ways:

i. Creating a set of responsibilities specific to the care management programs; or
ii. Identifying specific responsibilities as related to the care management program

The LHD needs to ensure each individual job description accurately reflects the responsibilities that staff person is individually required to perform across any and all relevant care management programs. Additionally, responsibilities for care management programs must be clearly identified within the job description. Atrómitos recommends starting simple to achieve compliance with the program requirements and then over time altering job descriptions, as necessary, to better optimize performance within the specific LHD environment.

4. **Prioritization of Job Descriptions**. As the LHD prepares for a programmatic audit, the following prioritization is recommended:
   i. Create job descriptions for positions not currently in existent within the LHD
   ii. Revise current job descriptions to include specific requirements of the care management programs
   iii. Assess the credentials and qualifications of current staff to those required by program guidance and contract manuals, adjust staffing plans as necessary to ensure compliance with requirements

Refer to the tailored guidance provided by Atrómitos regarding assessment of your existing job descriptions to aid in the mapping out of your job description development efforts.

STEP 3: DEMONSTRATING CAPABILITY THROUGH REPORTS AND OTHER PROOF

Once the LHD is able to demonstrate its compliance with and how it accounts for all requirements within a program, there will still be necessity to show it is capable of implementing the program. While policies and job descriptions are important, they do not ensure that the program is functioning as intended. As a result, it will be necessary to provide additional evidence to PHPs that can, effectually, prove components of the care management programs are being implemented as expected.

For the purposes of a programmatic audit for the CMHRP, CMARC, and PMP care management programs, LHDs may be able to demonstrate their capability to

implement the programs in a variety of ways. It is important to note, however, that PHPs may each identify its own unique way it will ask LHDs to demonstrate their capabilities. As such, LHDs should identify the full range of options they have to prove the care management programs are being implemented as intended. When identifying the options through which to demonstrate capabilities, it is important to keep the following in consideration:

1. **System reports are commonly asked for**. If the program requires utilization of a specific platform, database, or other technology environment, it is common for auditors to request reports directly from the system. These reports may range from a list of the most recent login for all users within the LHD to the calculated performance of the LHD for a specific quality measure. LHDs may not have the capability to run reports out of all of the systems utilized for the CMHRP, CMARC, and PMP care management programs; as a result, it will be imperative for LHDs to work with the vendors or owners of each system to ensure identified reports are able to be produced and under what specified timeline.

2. **Screen shots can show how a system is used**. Not all data within a system or platform can easily be pulled or queried for a report. Instead, auditors may request to see *how* program staff use a platform to perform program responsibilities. In such instances, auditors may request screen shots which capture templates, data fields, or other components of a system that clearly show:
    a. What data are collected within the platform; and
    b. How the data are stored once collected.

    In addition to screen shots, auditors may also ask for blank versions of a data collection tool, utilized either within or external to a platform. These, like screen shots, can demonstrate to auditors how necessary data are collected and stored.

3. **Signed agreements can prove a working relationship exists**. Care management programs are programs based on relationships between LHDs and auxiliary providers. There are multiple programmatic requirements across the care management programs that require LHDs show they collaborate, partner, or in some other way work with a non-affiliated provider to care for patients. A fully executed agreement demonstrates for auditors that the parties to the agreement have mutually agreed to perform specified activities for specific intended outcomes.

4. **Meeting minutes can demonstrate program oversight**. There are a number of departments within the LHD that must work together in order to successfully implement care management programs. As such, communication between each of these departments regarding how each is managing their specified responsibilities will be crucial. This communication oftentimes occurs during department, committee, or program meetings. Meeting minutes that clearly identify when programmatic requirements are being addressed can demonstrate to auditors that specific responsibilities are being fulfilled.

5. **When in doubt, ask**. The oversight of the CMHRP, CMARC, and PMP care management programs by PHPs is new for North Carolina, PHPs, and LHDs. As a result, there is expected to be need for clarification during the audit process to clearly identify what way(s) LHDs can and should demonstrate capabilities to implement the programs. When there is uncertainty regarding how to best demonstrate a capability, it is recommended to directly engage the PHPs for their guidance.

Based on our experience with Medicaid managed care compliance and audit activities, Atrómitos has developed an initial list of documentation LHDs can consider when identifying how to most effectively demonstrate capabilities within the care management programs. This list can be found in **Appendix C**. It is to be noted, however, that over time, PHPs are expected to refine the list of documentation acceptable to demonstrate capabilities within the programs.

When preparing for a programmatic audit, the ability to demonstrate a capability may rely on partners outside the LHD. As such, it is recommended LHDs should use the following prioritization for the collection of these demonstrations:

i. Identify which demonstrations are able to be collected internally versus those which require non-LHD partners.
ii. Outreach to non-LHD partners to establish timelines and processes to collect the necessary information.
iii. Complete the collection of all internal demonstration documents.

Refer to the tailored guidance provided by Atrómitos regarding assessment of your existing documentation to aid in the mapping out of your capability demonstration efforts.

APPENDIX A: POLICY TEMPLATE

<table>
<tr><td rowspan="3"><<Organization Name>>

<<Department>>

Policy & Procedure Manual</td><td>Number:</td><td>Page: X of X</td></tr>
<tr><td colspan="2">Approved By:</td></tr>
<tr><td>Effective Date:</td><td>Approval Date:</td></tr>
<tr><td>Section:</td><td colspan="2">Subject/Title:</td></tr>
</table>

PURPOSE OF POLICY

The purpose statement outlines what the policy document is designed to achieve in a paragraph or two at most. Does it protect the organization from a risk or ensure compliance with a program goal?

In general terms, why is this policy required?

SCOPE

The scope explains the range of application of the document in terms of covered persons, programs, facilities, sites, etc.
To what part of the organization does this policy apply? Is it organization wide or targeting a particular program(s)?

DEFINITIONS

The inclusion of definitions provides a clear understanding of key terms used in the policy document. Include any jargon, acronyms or definitions used in the policy that are not fully explained in the text of the policy.

<<Term>>: <<Definition>>

POLICY STATEMENT

The policy statement should reflect the basic objectives of the organization and a description of the general guiding principles or rules. Should be written in third person.

In terms of the LHD Medicaid Care Management Program policy development, the policy statement should include the specific contractual requirements dictated in the Program Guide for the Management of High-Risk Pregnancies and At-Risk Children in Managed Care Appendices. To ensure compliance the language can be copied verbatim from the contract requirements.

Related Policies:	*It is important that policies addressing similar or related issues be linked to ensure that they are consistent.*
References:	*The references or citation section is used for legal and regulatory citations and government guidance documents. If the policy document was in response to legal or regulatory authority, that authority should be noted.*
Appendices:	*As policies may be supported through procedures, guidelines, and forms, add/identify these documents at the end of the policy.*

APPENDIX B: JOB DESCRIPTION RESPONSIBILITIES BY DEPARTMENT

	Contractual Requirements (Program Guide Appendices)		
Department[1]	**CMHRP**	**CMARC**	**PMP**
Care Management	**B.1.a** **B.2.a – b** **B.3.a, B.3.c – e** **B.4.a – c, B.4.e** **B.5.c, B.5.e** **B.6.d** **B.7.b – c, B.7.e** **B.8** **B.9.a, B.9.g, B.9.h**	**C.1.a** **C.2.a – d** **C.3.a** **C.5** **C.6.a – c, C.6.e** **C.7.a, C.7.c** **C.8** **C.9** **C.10.a – c, C.10.k**	**A.1.a** **A.1.b**
Clinical Services			**A.1.f** **A.1.h**
Information Technology[2]	**B.3.d** **B.5.d**	**C.2.e**	**A.1.c**
Patient Services	**B.2.a** **B.6.f**	**C.7.f**	

1. LHDs should also ensure Finance and Billing staff are familiar with and can adhere to the specific billing guidelines for each PHP.
2. In addition to those responsibilities as laid out in the Program Guidance Appendices, Information Technology staff should also ensure the LHD is able to send and receive data from PHPs as described in the Requirements for Sharing Data to Support CMARC & CMHRP Programs.

APPENDIX C: INITIAL CAPABILITY DEMONSTRATION DOCUMENTATION LIST

CMHRP		
Contractual Requirement (Program Guide Appendices)		**Example of Capability Demonstration Documentation**
B.1.a, B.3.c	Document referrals from: PHPs, PMPs, Non-PMP providers of prenatal care, Community referrals (e.g., DSS, WIC), Patient self-referrals	**1**: Screenshot from EMR/Care Management Documentation System **2**: Referral Tracking List outside EMR/Care Management Documentation System
B.2.b	Identify patients with priority risk factors for referral to prenatal care and engagement in care management.	**1**:Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
B.3.a	Enter pregnancy risk screenings from Pregnancy Management Programs into care management documentation system within five (5) calendar days of receipt	**1**: Report from Care Management Documentation System showing: (1) date of receipt of risk screening; and (2) date risk screening entered into system

B.3.d	Capability to absorb data from the Obstetric Admission, Discharge and Transfer (OB ADT) report	**1**: Executed Data Use Agreements**2**: EMR/Care Management Data System report showing related data fields
B.3.e	Process for collaborating with: PMPs (within and out-of-couty), Out-of-county CMHRP teams	**1**: MOUs/Agreements with PMPs and CMHRP teams
B.4.b	Assessment of level of need for care management	**1**: Level of Need Assessment Template **2**: Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
B.4.b	Determine level of need for care management support for all patients	**1**: Level of Need Assessment template **2**: EMR/Care Management Documentation System report showing Risk Factor(s), Level of Need, and Case Status
B.4.c	Document Assessment findings in care management documentation system	**1**: Screenshot from Care Management Documentation System

B.5.a	Process for engaging patients in condition-specific pathway interventions	**1**: Care Plan template
B.5.c	Development of patient-centered care plans, to include: Goals, Interventions, Tasks, Agreement of services provided by LHD/PHP/AMH	**1**: Care Plan template
B.5.d	System connectivity to: NCCARE360	**1**: List of active users and most recent login **2**: Executed Data Use Agreements
B.5.e	Identify patients eligible for PHP network services, including: Childbirth education, Oral Health, Behavioral Health	**1**:Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
B.6.a	Assigned schedule for Care Manager to be onsite with each of their PMP providers	**1**: Screenshot of Care Manager schedule with assigned times onsite with PMP providers
B.6.d	Participation in PHP-hosted Pregnancy Care Management meetings	**1**: List of LHD attendees to meetings
B.7.c	Process to report to PHPs communication/coordination challenges with PMP and non-PMP prenatal care providers	**1**: Tracking List (within or outside of EMR/Care Management Documentation System) of reported challenges

Appendix H	CMHRP Quality Measures	**1**: Quality report from EMR/Care Management Documentation System **2**: Minutes from Quality Committee meetings

CMARC		
Contractual Requirement (Program Guide Appendices)		**Example of Capability Demonstration Documentation**
C.1.a	Document referrals from: PHPs	**1**: Screenshot from EMR/Care Management Documentation System **2**: Referral Tracking List outside EMR/Care Management Documentation System
C.2.a	Provide community education to: AMHs, Patients, Providers/Other Practices, Community Organizations	**1**: MOUs/Agreements with AMHs, Providers/Other Practices, and Community Agencies/Resources
C.2.a	Provide community education about: Benefits of CMARC Program, Target population(s), Referral process(es)	**1**: MOUs/Agreements with AMHs, Providers/Other Practices, and Community Agencies/Resources
C.2.b	Collaboration with: AMHs (within and out-of-county), Providers/Other Practices (within and out-of-county), Community Agencies/Resources	**1**: MOUs/Agreements with AMHs, Providers/Other Practices, and Community Agencies/Resources

C.2.c	Collaboration for: Implementing patient-centered care plans, Achieving goals targeted to meet the individual needs of CMARC children, Communication on changes to care management level of care, Communication on need for patient support and follow-up	**1**: MOUs/Agreements with AMHs, Providers/Other Practices, and Community Agencies/Resources
C.2.d	Development of community resources available to meet specific needs of CMARC Program population	**1**: Referral report from EMR/Care Management Document System **2**: Referral List (outside of EMR/Care Management Documentation System)
C.2.e	System connectivity to: NCCARE360	**1**: List of active users and most recent login **2**: Executed Data Use Agreements
C.3.a	Analyzing claims-based reports and other information from PHPs to identify priority populations	**1**: Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status

C.3.a	Analyzing CMARC Referral Forms to identify priority populations	**1**: Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
C.5.a	Verify eligibility during Assessment	**1**: Level of Need Assessment Template
C.5.c	Determine level of service for each patient	**1**: Level of Need Assessment Template **2**: Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
C.6.a	Ensure materials used with families and CMARC children meet literacy standards	**1**: Examples of materials provided
C.6.a	Provide education to families on self-management	**1**: Examples of materials provided

C.6.b	Ensure CMARC children are well-linked to AMH or other practice	**1**: MOUs/Agreements with AMHs and Providers/Other Practices **2**: Referral Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Document System Referral Report
C.6.b	Provide education to families and CMARC children on importance of medical homes	**1**: Examples of materials provided
C.6.c	Process for engaging patients in condition-specific pathway interventions	**1**: Care Plan template
C.6.e	Ongoing assessment to determine relevant level of need	**1**: Level of Need Assessment Template **2**: Patient Tracking List (outside of EMR/Care Management Documentation System) or EMR/Care Management Documentation System Report showing Risk Factor(s), Level of Need, and Case Status
C.7.c	Development of patient-centered care plans, to include: Agreement of services provided by LHD/PHP/AMH	**1**: Care Plan template
C.8.a	Document care management activities in care management documentation system	**1**: Screenshot from Care Management Documentation System

C.8.a	Document care management activities in care management documentation system in a timely manner as described by LHD agency policy	**1**: Screenshot from Care Management Documentation System **2**: Report from Care Management Documentation System showing: (1) date of care management activity; (2) description of care management activity; and (3) date activity entered into system
C.8.b	Document specific need each service provided addresses	**1**: Care Plan template
Appendix I	CMARC Quality Measures	**1:** Quality report from EMR/Care Management Documentation System **2:** Minutes from Quality Committee meetings

PMP		
Contractual Requirement (Program Guide Appendices)		**Example of Capability Demonstration Documentation**
A.1.a	Complete standardized risk-screening tool at each initial visit	**1** : EMR/Care Management Documentation System report showing: (1) type of visit; and (2) completion status of risk screening

A.1.b	Integrate the plan of care with local pregnancy care management	**1**: EMR/Care Management Documentation System report showing care management engagement status
A.1.f	Offer and provider 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation	**1**: EMR/Care Management Documentation System report identifying PMP patients receiving 17p
A.1.h	Conduct comprehensive post-partum visits within 56 days of delivery	**1**: Report from Care Management Documentation System showing: (1) date of comprehensive post-partum visit; and (2) delivery date