North Carolina Advanced Medical Home (AMH) Program

Frequently Asked Questions

12.11.2019

Please refer to the glossary at the end of this document for a list of terms, definitions, and acronyms described in these FAQs.

No.	Category	Question	Answer
G1	General (G)	What is the AMH program?	DHHS has developed the AMH program as the primary vehicle for delivering care management as the State transitions its Medicaid program to managed care and to incentivize, over time, increased provider responsibility for population health and total cost of care. The AMH program requires PHPs to coordinate care management functions with enrolled providers, which may in some cases be performed directly by the practice, or through an affiliated CIN or other partner. In general, practice requirements and Medical Home Fees will remain unchanged from Carolina ACCESS (the State's current PCCM program). However, there will be opportunities for practices to take on additional care management responsibilities in exchange for higher reimbursement.
G2	General	What populations are rolling into managed care and when?	Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs beginning in February 2020 There will be limited exceptions to mandatory enrollment for certain populations who may be better served outside of Medicaid managed care. These populations may be either exempt—meaning that they may choose to enroll in either fee-for-service or Medicaid managed care—or excluded—meaning they must remain enrolled in fee-for-service. Additionally, certain high-need populations that will be mandatorily-enrolled in managed care will be allowed to do so on a delayed timeline. See below for population by managed care status: **Exempt/Excluded:** • Beneficiaries dually-eligible for Medicaid and Medicare • PACE beneficiaries • Medically needy beneficiaries • Beneficiaries only eligible for emergency services • Presumptively eligible beneficiaries, during the period of presumptive eligibility Health Insurance Premium Payment (HIPP) beneficiaries • Members of federally recognized tribes Certain exempt/excluded populations will have the option to enroll in managed care beginning in 2020, while others will only have the option to enroll in fee-for-service or an LME-MCO. **Delayed Mandatory Enrollment for Special Populations (Year 1 begins in February 2020):** • Year 3: Children in foster care and adoptive placements • Year 3: Certain Medicaid and NC Health Choice beneficiaries with an SMI, SUD or I/DD

No.	Category	Question	Answer
			diagnosis and those enrolled in the TBI waiver • No earlier than Year 5: Medicaid-only beneficiaries receiving long-stay nursing home services • No earlier than Year 5: Medicaid-only CAP/C and CAP/DA waiver beneficiaries • No earlier than Year 5: Individuals who are dually-eligible for Medicare and Medicaid
G3	General	How will beneficiaries that are exempt or excluded or are on a delayed managed care timeline receive Medicaid coverage?	Medicaid-eligible beneficiaries that are not transitioning to managed care will remain enrolled in the Medicaid fee-for-service program.
G4	General	Are practices required to participate in AMH in order to enroll in the Medicaid program or continue to see Medicaid patients?	No. Participation in AMH is voluntary. Practices may join one or more PHP provider networks as a non-AMH practice if they wish to participate in managed care but not AMH. Participation in AMH also has no bearing on a practice's ability to participate in fee-for-service.
G5	General	Where can I find more information about North Carolina's transition to managed care?	A policy paper describing key programmatic features of the State's transition to managed care can be found here. DHHS has also created a Medicaid Transformation homepage, containing additional informational resources, 1115 waiver documents, and procurement materials. It can be found here.
G6	General	How will the AMH program fit into North Carolina's existing care management infrastructure?	The AMH program will replace Carolina ACCESS in the managed care environment. Carolina ACCESS will continue to operate for certain beneficiaries that remain in fee-for-service. Existing care management programs for pregnant women and at-risk children, including PMH, OBCM, and CC4C, will continue to operate under managed care, although under new names (Pregnancy Management Program (PMP), Care Management for High-Risk Pregnancy (CMHRP), and Care Management for At-Risk Children (CMARC), respectively). Additional information on these programs can be found in the recently released Program Guide: Management of High-Risk Pregnancies and At-Risk Children in Managed Care.
G7	General	What is the difference between the AMH "Tiers"?	Under AMH Tiers 1 and 2, PHPs retain primary responsibility for ensuring that beneficiaries receive appropriate care management services: • AMH Tier 1 is open only to practices that are currently enrolled in CAI and will sunset after two years from the launch of managed care (see here for additional information about

No.	Category	Question	Answer
			"grandfathering"). Practice requirements are the same as for Carolina ACCESS and for AMH Tier 2 (see here for more information on practice requirements). Practices in AMH Tier 1 will receive Medical Home Fees equal to those in CAI (see below for a detailed overview of AMH payments). • AMH Tier 2 is open to all eligible practices and has the same practice requirements as Carolina ACCESS and AMH Tier 1. Practices in AMH Tier 2 will receive Medical Home Fees equal to those in CAII/CCNC. Under AMH Tier 3, practices assume primary responsibility for care management, delivered either directly or through a CIN or other partner. These requirements are *in addition to* Tier 1 and 2 requirements. To compensate practices for taking on additional responsibility, Tier 3 practices will be eligible for additional Care Management Fees and Performance Incentive Payments paid by the PHP. Additional information about Care Management Fees can be found in the glossary here and information about Performance Incentive Payments can be found here. A practice's AMH tier certification will not have any impact on the practice's status in Carolina ACCESS.
G8	General	Can rural health clinics participate as AMH Tier 3 practices?	Yes. If rural health clinics attest to Tier 3, provide primary care services, and meet all of the Tier 3 requirements, they can participate as an AMH Tier 3 practice and receive additional payments. For a full list of permitted subspecialties, see here.
R1	Practice Requirements (R)	What are the practice requirements for AMH Tiers 1 and 2?	Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS. All AMH practices must: • Perform primary care services that include certain preventive and ancillary services (for more information on these services, refer to the AMH Provider Manual) • Create and maintain a patient-clinician relationship • Provide direct patient care a minimum of 30 office hours per week • Provide access to medical advice and services 24 hours per day, seven days per week • Refer to other providers when service cannot be provided by the PCP • Provide oral interpretation for all non-English proficient beneficiaries at no cost
R2	Practice Requirements	What are the practice requirements for AMH Tier 3?	Under Tier 3, practices assume primary care management responsibility. Requirements for Tier 3 include Tier 2 requirements plus additional care management responsibilities. All AMH Tier 3 practices must: • Risk stratify all empaneled patients • Provide care management to high-need patients • Develop a Care Plan for all patients receiving high-need care management • Provide short-term, transitional care management along with medication management to all empaneled patients who are discharged from the ED or an inpatient setting

No.	Category	Question	Answer
			• Demonstrate that, at a minimum, they have active access to an ADT data source that correctly identifies specific empaneled Medicaid managed care members' admissions, discharges or transfers to/from an ED or hospital in real time or near real time • Receive claims data feeds (directly or via a CIN or other partner) and meet State-designated security standards for their storage and use For a full list of requirements, refer to the AMH Provider Manual.
R3	Practice Requirements	Do AMHs need to have all of the required care management capabilities in-house?	No. Practices may contract with a CIN or other partner to provide care management services and other operational support in order to satisfy AMH practice requirements. However, participating practices are accountable for ensuring that patients are receiving required services, either directly from the practice or through a CIN or other partner. For more information on CINs and other partners, refer to recent AMH webinar on this topic.
R4	Practice Requirements	How closely will the AMH program align with the PCMH program? Will PCMH recognition qualify practices for participation in AMH?	Attestation requirements for AMH Tier 3 are closely aligned with guidelines for NCQA Level 3 PCMH recognition. However, NCQA PCMH certification alone will not qualify practices for participation in AMH. PCMH-certified practices that wish to participate in AMH will need to follow the process for becoming AMH-certified, as described in the FAQ here.
R5	Practice Requirements	Will practices have to interface with multiple care managers (i.e., a care manager for each PHP)?	Most likely, if in Tier 1 or 2. In Tiers 1 and 2, PHPs will be accountable for ensuring that beneficiaries receive required care management services. Since most practices are likely to contract with multiple PHPs, it is possible that these practices will have to interface with different care managers across multiple PHP contracts. For Tier 3 practices, PHPs will delegate care management responsibility to the practice level. This will allow practices to establish a unified care management platform across all of its PHP contracts. Tier 3 AMHs will have the opportunity conduct care management for all of their patients in-house but may also choose to work with a CIN or other partner to assist with aggregating care management functions.
R6	Practice Requirements	What are the technology and data-sharing requirements for participation in the AMH program?	There are no lists of certified technologies that providers must adopt for the AMH program. However, to be certified as a Tier 3 AMH, providers must be able to receive claims and encounter data feeds, access ED and hospital Admission, Transfer, and Discharge (ADT) information, and risk stratify their patient panels using Care Needs Screenings and PHP risk scores. These capabilities may be fulfilled by the AMH practice directly or through a CIN or other partner. See the recent concept paper entitled "Data Strategy to Support the Advanced Medical Home Program in North Carolina" and the "Data Strategy in Support of Care Management" FAQs for more information on this topic.

No.	Category	Question	Answer
R7	Practice Requirements	Will patients empaneled by Tier 1 and 2 practices receive the same care management services as those empaneled by Tier 3 practices?	Yes. Patients empaneled by AMH Tier 1 and 2 practices (and non-AMH, managed care-enrolled practices) will receive the same level of care management services as those empaneled by Tier 3 practices. Patients empaneled by non-AMH/AMH Tier 1/AMH Tier 2 practices will receive local care management services provided either directly by the PHP or through an entity contracted by the PHP. Patients empaneled by Tier 3 practices will receive the same level of care management but with services provided by the Tier 3 practice directly or by a CIN/other partner that has contracted with the Tier 3 practice (instead of the PHP).
R8	Practice Requirements	Will a care manager need to be physically embedded in the practice for any amount of time?	Tier 3 practices must have a care manager that is assigned to the practice, and care managers should have dedicated face-to-face interactions with their assigned patients when appropriate. Care managers do not, however, need to be exclusively embedded within a single practice. They may serve multiple AMH practices, and must be able to serve patients at other points of care including at hospitals, post-acute care facilities, in the patient's homes, etc. The care manager may be employed directly by the AMH practice, or be employed by a CIN or other partner organization that supports the Tier 3 practice. See page 14, question 9 of the AMH Provider Manual for more information on this point.
R9	Practice Requirements	Will patients have the option of opting out of care management? Will AMHs be held accountable for providing care management services even if patients opt out?	Patients may decline to engage in care management. If a patient declines care management, the practice or CIN/other partner should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during routine visits.
R10	Practice Requirements	What are the required qualifications for staff to lead the delivery of care management?	Each high-need patient (as identified by the Comprehensive Assessment) and each patient in transition identified as high risk for admission or other poor outcome must be assigned a care manager with a minimum credential of an RN or LCSW. The individual leading the care management process should have the full credentials, i.e. must not be an individual in training (e.g., LCSW-A). Individuals in training and other non-licensed staff may appropriately participate in certain elements of care management, but should not lead the care team or perform clinically-focused assessments (such as medication management). 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. Staff with other qualifications may appropriately assist in this process.(Note: Separate staffing requirements apply to LHDs for the administration of CMHRP and CMARC programs)
R11	Practice	Does the care	No. The only requirement is for Tier 3 AMHs to document and store Care Plans in the clinical system of

No.	Category	Question	Answer
	Requirements	management documentation system need to be the same as an electronic health record (EHR) system?	record. The clinical system of record does not necessarily need to be an EHR. While some EHRs may be able to meet the requirements of documenting and storing a Care Plan, practices may choose to use a separate care management documentation system to meet the requirement.
R12	Practice Requirements	Do practices need to re-stratify a patient after a certain period of time?	No. Practices are not required to re-stratify patients over any set period of time, but practices must have a process or defined methodology to determine when it is necessary to re-stratify all of their attributed patients.
R13	Practice Requirements	Do all AMHs have to connect to the statewide HIE network, NC HealthConnex?	State law and subsequent regulations require providers and PHPs to connect to NC HealthConnex, a statewide HIE that is overseen by the NC HIEA housed within the North Carolina Department of Information Technology. Per Session Law (S.L.) 2015-241, as of June 1, 2018, hospitals, mid-level physicians and Nurse Practitioners who currently have an EHR system must be connected to NC HealthConnex to continue to receive payments for Medicaid and NC HealthChoice services. All other Medicaid and state-funded providers must be connected by June 1, 2019, including those that are participating in the State Health Plan, PACE, and state grants. The NC HIEA hosts "How to Connect" webinars at 12:00 pm on the last Monday of each month to educate providers affected by this law, describe the technical and onboarding requirements, and answer questions about the Participation Agreement that governs the data connection. For more information, see here.
P1	Payment (P)	How will payment for primary care case management services change following North Carolina's transition to managed care?	For most of North Carolina's Medicaid beneficiaries, the current PCCM program – Carolina ACCESS – will be replaced under managed care by the AMH program. The AMH program will be similar in many respects to Carolina ACCESS, except AMH payments will be issued to practices by PHPs instead of directly from DHHS (as under Carolina ACCESS). Tier 3 AMHs will also be eligible for additional Care Management Fees and Performance Incentive Payments. Carolina ACCESS payments will continue unchanged for beneficiaries that remain in fee-for-service.
P2	Payment	What is the AMH payment structure?	Medical Home Fees under the AMH program will initially be the same as those established under Carolina ACCESS. All AMHs will receive Medical Home Fees (see below for amounts by tier). In exchange for taking on additional care management functions, Tier 3 AMHs will also be eligible for an additional, negotiated Care Management Fee from PHPs. All practices will be eligible to earn negotiated Performance Incentive Payments. These payments are optional for Tier 1 and 2 AMHs. PHPs are required to offer opportunities for such payments to Tier 3 AMHs.

No.	Category	Question	Answer
			Tier-specific Requirements AMH Tier 1 • Medical Home Fee: $1 PMPM – all assigned beneficiaries • *Optional: negotiated Performance Incentive Payment* AMH Tier 2 • Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries • Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group • *Optional: negotiated Performance Incentive Payment* AMH Tier 3 • Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries • Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group • Care Management Fee: negotiated amount with PHP • Performance Incentive Payments: conditions of payment negotiated with PHP

P3	Payment	What are the AMH Performance Incentive Payments?	PHPs are required to offer opportunities to earn Performance Incentive Payment with all contracted Tier 3 AMHs. While not required, opportunities to earn Performance Incentive Payments are also encouraged for Tier 1 and Tier 2 AMHs.
			
			DHHS will provide PHPs and AMHs broad flexibility to design and implement different Performance Incentive Payment arrangements, subject to the following guidelines:
			• Performance Incentive Payment arrangements must be based on Health Care Payment Learning and Action Network (HCP LAN) Levels 2 through 4:
			  ○ HCP-LAN Category 1 arrangements – or fee-for-service with no link to quality or value – would NOT count as Performance Incentive Payments for the purposes of the AMH program.
			  ○ PHPs must offer Tier 3 AMHs the opportunity to participate in arrangements that fall within HCP-LAN Levels 2A-C or 3A (i.e., arrangements with upside risk only).
			  ○ PHPs may NOT require that any AMH take on downside risk (HCP-LAN Levels 3B and 4A-C) but are permitted to establish such arrangements by mutual agreement with the AMH.
			
			• Performance Incentive Payments should generally be tied to the AMH quality measure set, but PHPs and AMHs may use other measures or metrics by mutual agreement and subject to approval by the Department. PHPs must account for and report on Performance Incentive Payments separately from Medical Home Fees and Care Management Fees.

No.	Category	Question	Answer
P4	Payment	Will the AMH program impact medical services payments in Medicaid?	No. The AMH program will not have any effect on medical services payments and will only impact how PMPM payments for primary care case management services are delivered (i.e., those currently delivered through Carolina ACCESS).
P5	Payment	Are there opportunities for practices to receive compensation in excess of Medical Home Fees that currently exist under the Carolina ACCESS program?	Yes. In addition to PMPM Medical Home Fees, which will be set at the same levels as Carolina ACCESS Medical Home Fees, Tier 3 AMHs will have the opportunity to receive Care Management Fees that are negotiated between the practice and the PHP. Tier 3 practices will also be eligible to earn upside-only Performance Incentive Payments from PHPs.
P6	Payment	When will practices begin receiving AMH Medical Home Fees and Care Management Fees?	Medical Home Fees and Care Management Fees will commence once the practice has contracted with a PHP and no earlier than February 2020 (see below for more information on PHP contracting). DHHS is only responsible for **certifying** that practices are eligible to contract with PHPs as AMHs. Certification does **not** mean that payments are automatically triggered, as these will only be issued once the practice contracts with one or more PHPs.
P7	Payment	Are Medical Home Fees and Care Management Fees negotiable?	Medical Home Fee amounts are intended to serve as payment floors and PHPs are required to pay no less than published Medical Home Fees. Practices in any AMH tier are free to negotiate higher Medical Home Fees with PHPs. The State has not set minimum payment amounts for Care Management Fees or Performance Incentive Payments paid to Tier 3 practices by PHPs. However, the requirement that PHPs contract with all Tier 3-certified practices in their service areas (see C2 below) will serve as a basis for practices to negotiate fees that are appropriate given the additional practice requirements associated with this tier. See here for additional information on the care management component of PHP capitation payments. AMHs may wish to use information in this memorandum to inform contracting and Care Management Fee negotiations.
P8	Payment	If a patient refuses care management, will practices still receive Medical Home Fees and/or Care Management Fees?	Yes. Medical Home Fees and Care Management Fees both will be made on a PMPM basis regardless of whether patients actually utilize care management services. Practices are free to negotiate separate arrangements with PHPs where they receive reimbursement contingent upon delivery of specific care management services. However, PHPs will not be permitted to pay less than the Medical Home Fee payment floors.

No.	Category	Question	Answer
P9	Payment	Can practices receive PMPM care management payments through other programs at the same time they are receiving AMH medical home payments?	Yes. Participation in AMH does not preclude participation in other care management programs through North Carolina Medicaid (including care management programs for high-risk pregnant women or at-risk children) or any other payer.
P10	Payment	What are AMH quality measures?	AMH Tier 3 practices will be eligible for additional Performance Incentive Payments based on their performance on State-approved AMH quality measures (or other measures subject to Departmental approval). For additional information on the AMH quality measures, see page 16 of North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual.
P11	Payment	If my practice decides to contract with a CIN/other partner, can we designate funds to flow directly to them from the PHP (i.e., bypassing the practice)?	Yes. AMHs may designate CINs or other partners to receive AMH payments (including Medical Home Fees, Care Management Fees, and Performance Incentive Payments) directly from PHPs. DHHS will not establish funds flow parameters between AMHs, CINs/other partners, and PHPs (although AMHs must consent to the CIN/other partner being the recipient of any AMH payments).
P12	Payment	If a patient is seen by Practice A but is assigned to Practice B, will Practice A be paid for the visit?	Yes. Assignment does not impact whether a practice will be paid for the visit. Rather, assignment determines the flow of AMH payments (Medical Home Fees, Care Management Fees, and Performance Incentive Payments).

No.	Category	Question	Answer
A1	Attestation & Certification (A)	What types of practices are eligible to participate in AMH? How do practices become AMH-certified?	In order to be eligible to participate in the AMH program, practices must provide primary care services and be enrolled in the North Carolina Medicaid program. Eligible practices are single- and multi-specialty groups led by allopathic and osteopathic physicians in the following specialties: • General Practice • Family Medicine • Internal Medicine • OB/GYN • Pediatrics • Psychiatry and Neurology For a full list of permitted subspecialties, see here. Eligible practices **must also be certified** by DHHS to participate in the AMH program. Practices that are already participating in Carolina ACCESS will be grandfathered into the AMH program. Practices that are not currently participating in Carolina ACCESS or wish to participate in a higher AMH tier will need to complete an application through NCTracks in order to become certified or change their certification status.
A2	Attestation & Certification	When will practices be able to begin the certification process? When is the certification deadline?	Today! The AMH certification portal is available through NCTracks. DHHS previously encouraged practices interested participating in Tier 3 at the start of managed care to attest through NCTracks by January 31, 2019. However, any practices that are interested in participating in Tier 3 but have not yet attested are still encouraged to do so as soon as possible. There is no deadline for attestation to Tier 2. PHPs will be required to honor these certifications on an ongoing basis. However, practices interested in participating in Tier 2 are encouraged to attest through NCTracks as soon as possible. All practices must be enrolled in Medicaid before they can be certified to participate in AMH.
A3	Attestation & Certification	Will participation in Carolina ACCESS streamline AMH certification?	Yes. Practices that were enrolled in Carolina ACCESS as of January 2019 were automatically provided an AMH certification status through a grandfathering process. CAI practices were placed in AMH Tier 1, and CAII/CCNC practices were placed in AMH Tier 2. Practices that joined Carolina ACCESS after January 2019 will not be grandfathered into the AMH program and will need to elect to participate in AMH via NCTracks. There is no grandfathering into Tier 3. All practices, including those currently participating in Carolina

No.	Category	Question	Answer
			ACCESS, will need to complete the Tier 3 attestation process through NCTracks in order to become certified.
A4	Attestation & Certification	Can any practice participate in Tier 1? How long will Tier 1 remain an option?	No. Only practices participating in CAI as of January 2019 were permitted to enter AMH Tier 1 and did so via a grandfathering process. Practices not currently participating in Carolina ACCESS will **not** be able to participate in AMH Tier 1. Additionally, CAII/CCNC practices will also **not** be able to participate in AMH Tier 1. AMH Tier 1 will be phased out two years following managed care launch, at which time Tier 1 practices will be required to elect to participate in Tier 2 or attest to Tier 3.
A5	Attestation & Certification	Can any practice participate in Tier 3?	Yes. All Medicaid-enrolled primary care practices in permitted specialties that attest to meeting Tier 3 practice requirements (described above) may participate in Tier 3.
A6	Attestation & Certification	Will practices be required to contract with CCNC in order to participate in the AMH program?	No. Contracting with CCNC (or any CIN or other partner) is not a requirement of participation in the AMH program at any tier level. However, DHHS anticipates that most practices electing to participate in Tier 3 will do so with the assistance of a CIN or other partner, as Tier 3 will require significant operational, care management, and technological capacity. Tier 3 practices are free to work with CCNC, a different partner, or carry out required care management functions in-house.
A7	Attestation & Certification	Will DHHS produce a list of approved CINs and other partners?	No. Practices are responsible for ensuring that CINs/other partners can fulfill AMH requirements for enrolled patients they serve, regardless of whether care management services are delivered directly by the practice or through a CIN or other partner.
A8	Attestation & Certification	Can LHDs participate in the AMH program?	Yes. LHDs that provide primary care services and meet the requirements described above are eligible to participate as AMHs.
A9	Attestation & Certification	Do practices need to be enrolled in Carolina ACCESS in order to participate in the AMH program?	Yes. All practices must have completed the Carolina ACCESS enrollment process through NCTracks before they will be permitted to enroll in an AMH tier. Practices not currently enrolled in Carolina ACCESS may apply to participate through NCTracks at any time. Practices will **not** be required to contract with CCNC (i.e., become a CAII practice) in order to participate in the AMH program.
A10	Attestation & Certification	What is the unit of enrollment for the AMH program?	Practices will enroll in the AMH program at the NPI/location level. For organizational NPIs, each service location must certify and enroll separately. Practices will **not** have the ability to "batch attest" for multiple service locations under a single NPI.
A11	Attestation & Certification	Will group NPIs be required to participate in the AMH program across all of their service locations?	No. Practices will be required to be certified for the AMH program for each NPI/location combination and may choose to participate at only some of these locations. Practices may also have different tier certifications for different locations within an organizational NPI.
A12	Attestation & Certification	Will practices be required to have attested care management capacity at the time of attestation?	Practices **are not** required to have attested care management capacity in place *at the time of attestation* but should plan to have this capacity in place by managed care launch (and no later than 90 days following managed care launch). The Department recognizes that many practices require time to ensure all care management capabilities are in place; within the first ninety (90) days following

No.	Category	Question	Answer
		Is this capacity required by the time managed care goes live in February 2020?	managed care launch, the Department will not permit the PHP to stop paying Care Management Fees or Medical Home Fees (as applicable based on tier status) or downgrade the tier status of the AMH. During this time period, the PHP must honor each AMH's tier status as certified by the Department. However, after 90 days following managed care launch, PHPs will be permitted to downgrade the tier status of AMHs that are out of compliance with all program requirements.
A13	Attestation & Certification	Are practices that have already completed the AMH attestation through NCTracks required to notify DHHS if they: (1) change their CIN/other partner; (2) begin working with a new CIN/other partner; or, (3) terminate their relationship with a CIN/other partner?	No. Practices are not required to update their attestation information in NCTracks if existing arrangements with CINs/other partners change (NCTracks currently lacks this functionality). Practices may choose to supply DHHS with this information by emailing Medicaid.Transformation@NC.DHHS.gov, but this is not a requirement. As a reminder, DHHS will not directly oversee CINs/other partners, and practices are ultimately responsible for ensuring that contracted partners are equipped to fulfill all AMH responsibilities.
C1	PHP Contracting (C)	How will practices be assigned beneficiaries under the AMH program?	Following enrollment in a PHP, Medicaid beneficiaries will have the opportunity to select a PCP or will be auto-assigned to one by the PHP. DHHS will require PHPs to use a methodology for auto-assigning beneficiaries to PCPs. The methodology will be required to consider beneficiary claims history, family member providers, geography, special medical needs, and language/cultural preference. Beneficiary assignment to an AMH will be dependent on PCP assignment. For example, an organizational NPI that enrolls in the AMH program will be assigned beneficiaries for all PCPs that practice under that NPI.
C2	PHP Contracting	Will PHPs be required to accept the certified tier status of each AMH?	In general, yes. During the initial contracting period, PHPs will be required to accept Tier 1 and Tier 2 certifications "as is" and may not choose to downgrade these practices. PHPs are required to contract with all Tier 3-certified AMHs at a Tier 3 level and may not downgrade these practices to Tier 2 for any reason until 90 days following managed care launch. Only after 90 days following managed care launch will PHPs be permitted to downgrade the tier status of an AMH.
C3	PHP Contracting	Are practices locked-in to participating as an AMH Tier 3 practice if they attest to meeting Tier 3 requirements?	No. Practices are free to decline Tier 3 responsibilities if they are not able to reach mutually agreeable contract terms with the PHP *even if the practice has attested to meeting Tier 3 requirements*. Before contracting at a Tier 3 level, practices should consider whether agreed upon Care Management Fees are adequate to cover the costs of additional care management responsibilities. For additional information on how practices can voluntarily revert to Tier 2, please see here.
C4	PHP Contracting	Who will oversee AMHs	PHPs will be required to include certain language in contracts with AMH practices. The State will

No.	Category	Question	Answer
		to ensure that they are meeting all program requirements?	require PHPs to submit template contracts for use with AMHs to ensure that standard contract terms are incorporated. The State will not review each individual PHP/AMH contract, but PHPs will be expected to include contract language that tracks closely with one or more of the templates approved by the State. For additional information on standard contract terms, see Appendices A and B of the AMH Provider Manual. PHPs will be required to monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms. PHPs will be permitted to assess the capabilities of Tier 3-certified practices as part of the initial contracting process and prior to managed care go-live. Activities by PHPs may include conducting an onsite review, telephone consultation, documentation review, or other virtual/offsite reviews. PHPs may perform evaluations of the CIN or other partner instead of or in addition to the AMH if the AMH contracts with a third party to provide any of the Tier 3 care management required services. PHPs will have broad discretion in ongoing oversight and monitoring of AMH practices' performance against tier-specific AMH requirements, as reflected in contracts with AMH practices. After launch, and as part of the ongoing AMH Tier 3 design process, the State may consider if collaborative approaches to monitoring for AMH Tier 3 practices should be implemented in future years. Such collaboration may involve alignment among PHPs and could consider ways to streamline and conduct annual file audits to streamline the process for both AMH Tier 3 practices and PHPs. Prior to January 1, 2021, PHPs will not be permitted to audit AMHs against compliance standards that are beyond the scope of the AMH program requirements, including requirements imposed as part of National Committee for Quality Assurance (NCQA) pre-delegation auditing.
C5	PHP Contracting	Can AMH practices be downgraded to a different tier by the PHP?	Yes, in limited instances. In the event that an AMH practice is unable to perform the activities of the AMH tier to which it initially attested, the PHP may downgrade the tier status of an AMH subject to the following conditions: 1. The PHP shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms. 2. Prior to January 1, 2021, the Department shall not permit the PHP to audit AMHs against compliance standards that are beyond the scope of the AMH program requirements, including but not limited to NCQA Case Management Accreditation requirements. 3. The PHP shall provide AMHs a minimum of thirty (30) days to remediate noncompliance with Tier-specific AMH requirements and any other mutually agreed upon contract terms prior to the PHP

No.	Category	Question	Answer
			taking any further compliance actions against the AMH. 4. In the event of underperformance by an AMH practice, the PHP shall send a notice of underperformance to the AMH practice and copy the Department. 5. In the event of continued underperformance (i.e., non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the PHP to stop paying the Care Management Fee and/or Medical Home Fee (as applicable based on Tier status) and downgrade the Tier status of the AMH for that PHP, only. 6. Within the first ninety (90) days following managed care launch, the Department shall not permit the PHP to stop paying the Care Management Fee or Medical Home Fee (as applicable based on Tier status) or downgrade the Tier status of the AMH. During this time period, the PHP must honor each AMH's Tier status as certified by the Department. 7. In the event that the PHP notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Fee that would otherwise be required by the Department, the PHP shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification. 8. In the event a practice is downgraded from Tier 3 to Tier 2, the PHP shall ensure that there are no gaps in care management functions for Members assigned to the practice. This would **not** impact an AMH practice's tier certification from the perspective of the State or any contracted arrangements with other PHPs. A PHP cannot lower the tier level of other AMH practice locations associated with the same organizational NPI or TIN without an assessment, nor can it lower the tier level of an AMH practice location based on a different PHP's findings. The Department will maintain in its system of record an indicator showing the tier level of each AMH practice's contracts with PHPs in their region. In the event that a PHP contracts with a Tier 3-certified AMH at a Tier 2 level, this contract will count against PHP's minimum Tier 3 contracting requirements. Note: For other aspects of underperformance not related to care management or other AMH functions, such as fraud or negligence, PHPs and the State would follow their usual processes.
C6	PHP Contracting	What appeal rights do AMH practices have?	AMH practices will have the right to appeal any tier certification downgrades to the PHP by going through their regular appeals process, but will **not** be able to appeal directly to the State (practices only have appeal rights to the State for the State-designated practice certification process). However, the State will monitor PHPs' downgrade decisions as part of its overall monitoring of PHP activities, and may consider PHPs' pattern of downgrading in its ongoing compliance activities and in subsequent contracting decisions.
C7	PHP Contracting	What happens to Tier 3-certified practices that	PHPs **must accept** Tier 3-certified practices into their provider networks at a **minimum Tier 2 level** if

No.	Category	Question	Answer
		are unable to reach agreement on Tier 3 contracting terms?	they cannot reach agreement on Tier 3 contracting terms.
C8	PHP Contracting	If a practice determines the negotiated Care Management Fees are not sufficient, can the practice renegotiate with the PHP?	Yes. Practices can negotiate AMH contracts with PHPs each year and re-determine Care Management Fees and Performance Incentive Payments. Practices have broad flexibility to use CINs/other partners to help negotiate AMH contracts with PHPs.
C9	PHP Contracting	When will DHHS provide specifications for the encounter data that PHPs send to AMHs?	To streamline information exchange and reduce costs and administrative burden for AMHs, DHHS will eventually release detailed specifications and technical guides for the PHPs' transmission of encounter data to AMHs.

AMH Glossary

- **1115 Demonstration Waiver:** Provides states with additional flexibility to design and improve their Medicaid programs by demonstrating and evaluating state-specific policy approaches to better serve Medicaid populations. North Carolina's amended 1115 demonstration waiver application focuses on the specific items of the Medicaid Managed Care transformation that require approval from the federal government.
- **Admission, discharge, transfer (ADT) feed:** Data feed notifying practices when members have been admitted, transferred or discharged from a hospital or ED. Tier 3 AMHs must attest that, at a minimum, they have active access to an ADT data source that correctly identifies specific empaneled Medicaid managed care members' admissions, discharges or transfers to/from an ED or hospital in real time or near real time. At the outset of the AMH program, Tier 1 and Tier 2 AMHs are also strongly encouraged (but not required) to make use of ADT feeds.
- **Advanced Medical Home (AMH) program:** The primary vehicle for delivering care management as North Carolina transitions to managed care. The AMH program requires PHPs to coordinate care management functions with enrolled practices, which may in some cases be performed directly by the practice or through an affiliated CIN or other partner.
- **Aged, Blind, Disabled (ABD):** Medicaid eligibility group for individuals who are categorically eligible for Medicaid on the basis of being aged, blind, or disabled.
- **Care Coordination for Children (CC4C):** Care management program provided by LHDs for at-risk children ages zero to five. The program provides coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports.
- **Care management:** Team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions. PHPs will maintain ultimate accountability for care management but will have the ability to delegate responsibility for these functions to the practice level through the AMH program. Key functions of care management include: risk stratifying all empaneled patients; providing care management to high-need patients; developing a Care Plan for all patients receiving care management; providing short-term, transitional care management along with medication management to all empaneled patients who have an ED visit or hospital ADT event and who are high-risk of readmissions and other poor outcomes; and receiving claims data feeds (directly or via a CIN/other partner) and meeting State-designated security standards for their storage and use.
- **Care Management Fee:** Tier 3-certified practices will have the opportunity to negotiate Care Management Fees *in addition* to regular AMH Medical Home Fees. Care Management Fees are required to be a per member per month payment that is a minimum guaranteed revenue to the practice and may not be placed at risk based on measures of utilization, cost, or quality. PHPs must account for and report on Care Management Fees separately from Medical Home Fees and Performance Incentive Payments. While PHPs will not be *required* to offer Tier 3 practices a minimum Care Management Fee, PHPs are required to contract with all Tier 3-certified AMHs in each region. This will provide practices with leverage to negotiate fees that are appropriate given the additional care management functions that Tier 3 AMHs are required to take on.
- **Care Plan:** AMH Tier 3 practices are required to develop Care Plans for each high-need patient receiving care management. Care Plans must be individualized and person-centered, using a collaborative approach including patient and family participation where possible. Care Plans must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge and must include, at a minimum, the following elements:
    - 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.

- **Carolina ACCESS:** North Carolina's PCCM program since the early 1990s. Under Carolina ACCESS, practices certified as meeting certain standards for clinical access and care management receive a monthly PMPM fee; the standards and payments are tiered into two levels (CAI and CAII). Since the late 1990s, DHHS has contracted with Community Care of North Carolina (CCNC) to provide care management and enhanced services for practices and beneficiaries through a regionally-based care management model.
  - **Carolina ACCESS I (CAI):** Practices that enroll in Carolina ACCESS through NCTracks but do not enter into a contract with their local CCNC network are enrolled in CAI. CAI practices must meet all necessary practice requirements as determined by DHHS, including after-hours availability, panel size, the availability of interpretation services, hours of operation, and the availability of certain preventive and ancillary services that vary by age. In addition to fee-for-service payments, CAI practices receive $1.00 PMPM for beneficiaries enrolled with their practice.
  - **Carolina ACCESS II (CAII/CCNC):** Practices that enroll in Carolina ACCESS through NCTracks and sign a separate contract with their local CCNC network are enrolled in CAII. This track is often referred to simply as "CCNC". The practice requirements for CAII are identical to those in CAI with the only difference being the agreement with CCNC, which entails engagement in quality improvement and care management activities. In addition to fee-for-service payments, CAII practices receive $2.50 PMPM for non-ABD beneficiaries and $5.00 PMPM for ABD beneficiaries.
- **Clinically integrated network (CIN) or other partner:** Organization that provides support to AMH practices in areas such as handling data, performing analytics, and in the delivery of advanced care coordination and care management functions. DHHS does not intend for independent practices' gaps in data/analytics, care management and related capabilities to serve as barriers for participation in more advanced AMH tiers. Rather, DHHS seeks to ensure that such practices can team with other practices and third-party partners that demonstrate high levels of competency and expertise in several areas to fulfill the responsibilities of the AMH program. AMH practices may choose to partner with CCNC (or any other partner) to fulfill these functions but are not required to do so for any level of participation in AMH. Other Tier 3 practices are free to serve as a CIN/ other partner for other Tier 3 practices.
- **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
- **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages 18 and older to receive support services in their own home, as an alternative to nursing home placement.
- **Dual-eligible beneficiaries:** Beneficiaries who are eligible for both Medicare and Medicaid, including those enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing.
- **Emergency department (ED):** Treatment facility specializing in emergency medicine and treating patients with acute needs.
- **Federally Recognized Tribes:** Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. In North Carolina, this includes the Eastern Band of Cherokee Indians.
- **Fee-for-service:** A payment model in which providers are paid for each service provided.
- **Grandfathering:** Process by which practices that are currently enrolled in Carolina ACCESS will be automatically moved into AMH. CAI practices will be moved into AMH Tier 1, and CAII/CCNC practices will be moved into Tier 2.
- **Health Information Exchange (HIE):** A secure electronic service that gives authorized health care providers the ability to access and share patient information across a statewide information network. Created by the North Carolina General Assembly (NCGS 90-414.7), NC HealthConnex is the state-designated HIE in North Carolina.

- **Health Insurance Premium Payment (HIPP) program:** In some cases, DHHS will pay private health insurance premiums for certain individuals who are eligible for Medicaid, have private health insurance through their employer, have a high-risk illness, and are at risk of losing private coverage.
- **Intellectual/Developmental Disability (I/DD):** Category of disorders that negatively affect the trajectory of an individual's physical, intellectual, and/or emotional development. These are usually present at birth and often affect multiple body parts or systems.
- **Local Health Departments (LHDs):** LHDs have long played a critical role in North Carolina in the provision of care management services for high-risk pregnant women and at-risk children, in addition to primary care services and other critical public health functions. LHDs that provide primary care services are permitted to participate in Carolina ACCESS and AMH.
- **Managed Care:** In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure in order to advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs. Beginning in February 2020, DHHS will delegate the direct management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members.
- **Medicaid:** Provides health coverage to over 2 million North Carolinians, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. References to "Medicaid" in this document also encompass NC Health Choice, the State's comprehensive health coverage program for low-income children.
- **Medical Home Fees:** PMPM payment to Carolina ACCESS and AMH practices that meet certain standards for clinical access and care management. Fees vary between CAI and CAII/CCNC. Additionally, CAII/CCNC and AMH practices receive increased Medical Home Fees for ABD beneficiaries.
- **Medically needy:** Medicaid eligibility pathway for families, children, aged, blind, or disabled individuals, and pregnant women with income that is too high to qualify for Medicaid but who have significant medical expenses and limited assets.
- **National Provider Identifier (NPI):** Standard unique health identifier for health care providers adopted by the Secretary of US Department of Health and Human Services. NPIs are established at the individual provider-level or at the organization-level.
- **North Carolina Department of Health and Human Services (DHHS):** DHHS manages the delivery of health- and human-related services for all North Carolinians, including the State's most vulnerable citizens – children, elderly, disabled and low-income families. It administers the State's Medicaid and NC Health Choice programs as well as a number of other programs and initiatives aimed at improving the health, safety and well-being of residents.
- **North Carolina Health Choice (NC Health Choice):** North Carolina's CHIP program. NC Health Choice provides comprehensive health coverage program for low-income children.
- **North Carolina Health Information Exchange Authority (NC HIEA):** The North Carolina General Assembly created the NC HIEA to oversee and administer the state-designated HIE (NCGS 90-414.7). NC HIEA receives input and advice from its Advisory Board, which consists of patients, hospital personnel, physicians, technology experts, public health officials and other key stakeholders to continuously improve NC HealthConnex.
- **Obstetric Care Management (OBCM):** Care management program provided by LHDs for pregnant Medicaid beneficiaries identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to other services and management of high-risk behavior that may have an impact on birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care and services through the end of the post-partum period.
- **Obstetrics and Gynecology (OB/GYN):** A medical specialty that deals primarily with maternal and infant health, although many OB/GYN providers in North Carolina provide primary care services. OB/GYNs that provide primary care services are permitted to participate in Carolina ACCESS and AMH.
- **Patient-Centered Medical Home (PCMH)**: PCMH is a widely used primary care medical home model developed and recognized by the National Committee for Quality Assurance (NCQA). PCMH contains similar requirements those used in AMH but recognition has no bearing on AMH certification.

- **Performance Incentive Payments:** Payments additional to fee for service, Care Management Fees And Medical Home Fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics. Any measures or other metrics on which Performance Incentive Payments to AMH practices are based must be approved by the Department. Performance Incentive Payments must be accounted for and reported to the Department separately from Medical Home Fees and Care Management Fees.
- **Practice:** Term is intended to encompass a broad range of healthcare facilities, clinics, and providers that deliver medical care services to North Carolina Medicaid beneficiaries. Practices will participate in the AMH program at the NPI/location level. For practices that enroll through organizational NPIs, individual AMH practices may include multiple providers.
- **Pregnancy Medical Home (PMH) Program:** Launched in 2011, the PMH program provides comprehensive, coordinated maternity care to pregnant women, with a special focus on preterm birth prevention. Today, the PMH program operates through CCNC, who provides regionally-based support to enrolled practices and convenes clinicians on a routine basis and in conjunction with Department leadership to review programmatic requirements, performance and other items. To qualify for participation as a PMH, the provider must agree to meet certain requirements, such as: ensuring that no elective deliveries are performed before 39 weeks of gestation; decreasing the cesarean section rate among nulliparous women; completing a Department-specified high-risk screening on each pregnant Medicaid enrollee in the program and integrating the plan of care with local care management; and cooperating with open chart audits. The PMH program pays providers incentive payments for 1) completing a standardized risk-screening tool at initial visit ($50), and (2) conducting a postpartum visit ($150). All providers who bill for perinatal services are eligible to enroll in the program. Currently, more than 90% of all perinatal care provided to pregnant Medicaid patients in North Carolina is through a PMH.
- **Prepaid Health Plan (PHP):** A PHP is managed care organization to which DHHS will delegate the direct management of certain health services and financial risk. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program.
- **Presumptive eligibility:** Permits qualified entities to immediately extend temporary Medicaid coverage to uninsured individuals if they appear to be eligible based on income.
- **Primary care case management (PCCM):** Model of managed care in which the State pays population-based, PMPM payments to practices that agree to meet certain standards for clinical access and care management.
- **Primary care provider (PCP):** Physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by the beneficiary or assigned by the PHP to provide and coordinate all the beneficiary's health care needs and to initiate and monitor referrals for specialized services, when required.
- **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age 55 and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.
- **Risk stratification:** Method for identifying high-risk patients who would benefit from care management. Tier 3 practices (or their designated CIN/other partner) are required to use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel. Practices are not required to purchase a risk stratification tool. Applying clinical judgment to risk scores received from the PHP will suffice.
- **Serious mental illness (SMI):** Characterized by persons 18 years and older who, at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Diagnoses commonly associated with SMI include major depression, schizophrenia, and bipolar disorder.
- **Short-term, transitional care management:** Management of beneficiary needs during transitions of care (e.g., from hospital to home).

- **Substance use disorder (SUD):** Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- **Traumatic Brain Injury (TBI) Waiver:** A North Carolina Medicaid 1915(c) Waiver program that established pilot project in Cumberland, Durham, Johnston and Wake counties to offer rehabilitation services for adults who have suffered TBI on or after their 22nd birthday.
- **Upside-only risk:** Tier 3 practices will be eligible for Performance Incentive Payments from PHPs based on performance on State-approved AMH quality measures (more information on measures will be provided in the fall of 2018). For at least the first two years of the AMH program, these incentives will be on an "upside-only" basis, meaning that practices will be eligible to earn additional payments if they meet specified cost of care, quality and patient experience measure benchmarks. Practices will NOT be at risk of losing money if they do not meet specified performance targets (i.e., they will not be exposed to "downside risk"). In other words, PHPs will not be permitted to require practices to pay back PMPM Medical Home Fees, Care Management Fees or any other payments for medical services. Practices are permitted to negotiate arrangements that include downside risk, but PHPs may not mandate that practices accept these terms.