



## Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers

### Contents

SECTION I: INTRODUCTION.....	2
SECTION II: CAROLINA ACCESS AND AMH OVERVIEW AND INTERSECTION WITH CAROLINA ACCESS.....	3
Carolina ACCESS Overview.....	4
AMH Overview .....	6
Required PHP Contracting with Tier 3 AMHs .....	7
Overlap of Carolina ACCESS with AMH.....	8
Practice Eligibility .....	8
Practice Requirements.....	9
Practice Designations Once Managed Care Launches.....	10
SECTION III: AMH TIER 3 CERTIFICATION AND REQUIREMENTS .....	11
SECTION IV: AMH ATTESTATION AND CERTIFICATION PROCESS .....	19
Medical Home Process.....	21
Non-Carolina ACCESS Practices .....	22
Carolina ACCESS I Practices.....	24
Carolina ACCESS II Practices.....	25
Opting out of the AMH Program.....	<b>Error! Bookmark not defined.</b>
SECTION V. ROLE OF PHP IN AMH PRACTICE CERTIFICATION, CONTRACTING AND OVERSIGHT.....	26
Initial Contracting.....	27
Ongoing Oversight .....	28
AMH Underperformance .....	28
SECTION VI: CERTIFICATION TIMELINE .....	29
APPENDIX A: STANDARD TERMS AND CONDITIONS FOR PHP CONTRACTS WITH ADVANCED MEDICAL HOME TIER 1 AND 2 PRACTICES .....	30
APPENDIX B: STANDARD TERMS AND CONDITIONS FOR PHP CONTRACTS WITH TIER 3 AMH PRACTICES.....	32

## **Section I: Introduction**

North Carolina Department of Health and Human Services (hereafter referred to as the Department) developed the Advanced Medical Home (AMH) model as the primary vehicle for delivering care management as the state transitions to managed care. The AMH program requires prepaid health plans (PHPs) to coordinate care management functions with enrolled practices, which may in some cases be performed directly by the practice, through an affiliated Clinically Integrated Network (CIN) or through another partner. The Department has described the AMH program and other aspects of the managed care transition in a series of concept papers that can be found [here](#).

This manual provides information on how to achieve certification as Advanced Medical Homes (AMH). Specifically, this manual includes:

- A review of the AMH and Carolina ACCESS programs
- How the AMH program will overlap with Carolina ACCESS
- The pathways for entry into the AMH program
- Detail on AMH Tier 3 practice requirements
- The oversight model of the AMH program

This manual is intended to be a resource for primary care practices (PCPs) and their CIN partners, or other partners with which PCPs may choose to work. In particular, practices<sup>1</sup> interested in participating in Tier 3 of the AMH program should review Section II to understand the expectations associated with that tier. The manual also covers, at a high level, the pathways by which practices can attain different AMH tiers. More detailed information about the specific attestation process, including web-based links for how practices should attest, will be made available on the AMH webpage at <https://medicaid.ncdhhs.gov/advanced-medical-home>.

Please note that the attestation and certification processes described in this manual apply to the initial years of managed care launch, and may change for subsequent years.

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<sup>1</sup>In this document, a practice is defined as a group of providers working together under a single organizational NPI at a single location.

### ***Clinically Integrated Networks (CINs)***

Clinically Integrated Networks (CIN) are entities with which provider practices can voluntarily choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH. Examples of these functions and capabilities include data aggregation, risk stratification, and care management. A CIN could be part of a hospital or health system to which a practice already belongs or is otherwise affiliated, or a group of practices. CINs can partner with other entities, such as independent non-profit organizations delivering multi-PHP data/analytic support and local care management to a practice or group of practices, or population health companies that have the capability to connect practices as integrated networks of care. While the Department expects that the majority of AMH Tier 3 practices will elect to work with CINs, as well as other partners, practices are not required to work with a CIN. Practices that do work with CINs have the freedom to choose any CIN that meets their needs. AMH practices intending to work with a CIN must sign a formal agreement with their CIN that ensures the CIN can safely receive and use patient data in compliance with HIPAA and state regulations, as well as any other elements mutually agreed upon by the practice and the CIN/partners.

## **Section II: Carolina ACCESS and AMH Overview and Intersection with Carolina ACCESS**

Strong primary care is essential to the success of any health care system. Through AMHs, North Carolina seeks to build on the Carolina ACCESS program to preserve broad access to primary care services for Medicaid enrollees and North Carolina Health Choice enrollees, as applicable and to strengthen the role of primary care in care management, care coordination, and quality improvement as the state transitions to managed care. The AMH program provides clear financial alignment for practices to be able to focus more on cost and quality outcomes over time by gradually aligning incentive payments for practices to specified quality and outcome measures. PHPs will have similar incentives. The Department understands that payment reform takes time and that it is essential to preserve the strengths of today's system in the transition to managed care. Therefore, the AMH design also includes a central commitment to maintaining high levels of practice participation in Medicaid to preserve access for patients; to introducing changes to payment models with sufficient time for practices to prepare; and to providing support to practices in this transition. Different populations will roll into managed care at different times, [as described in this concept paper](#).

The AMH program offers practices a range of options for partnering with PHPs in the provision of care management. Practices may choose to not take on the responsibility of care management and will have the ability to directly contract and coordinate with different PHPs' care management strategies. Practices may want to take on the responsibility of care management and therefore have a uniform platform of care management across the different PHPs. Practices may choose to take on this responsibility and capacity on their own or with a network of other practices through an affiliated CIN and partners. Practices may also choose not to participate in the AMH program. This section reviews the current Carolina ACCESS model

and an overview of the proposed AMH model, and discusses how these two programs will overlap when managed care is launched.

**Carolina ACCESS Overview**

Since the early 1990s, North Carolina has operated a primary care case management (PCCM) program. Since the late 1990s, the Department 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. This program, referred to as Carolina ACCESS in this manual, serves the majority of North Carolina's Medicaid population. Under Carolina ACCESS, practices certified as meeting certain standards for clinical access and care management receive a monthly per member per month (PMPM) fee; the standards and payments are tiered into two levels. The AMH program leverages the Carolina ACCESS standards and certification structure to ensure a smooth transition to Advanced Medical Homes as populations roll into managed care over time.

The Carolina ACCESS program has two levels:

- *Carolina ACCESS I (CAI)*: CAI practices must meet all necessary practice requirements as determined by the Department. Requirements include 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 per member per month (PMPM) for beneficiaries enrolled with their practice.
- *Carolina ACCESS II (CAII) [commonly known as 'Carolina ACCESS/CCNC' or 'CCNC']*: CAII practices must meet all CAI practice requirements and sign a separate contract with their local CCNC network. (North Carolina providers may know this model as 'CCNC'.) The practice requirements for CAII practices 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-aged, blind, and disabled (non-ABD) Medicaid beneficiaries and North Carolina Health Choice beneficiaries enrolled with their practice. They receive \$5.00 PMPM for aged, blind, and disabled (ABD) Medicaid beneficiaries enrolled with their practice.

<i>Table 1: Current Carolina ACCESS PMPM Management Fees</i>	
<b>Enrolled Population</b>	<b>Per Member Per Month Fee</b>
<i>CAI</i>	
All Beneficiaries	\$1.00
<i>CAII (CCNC)</i>	
ABD Beneficiaries	\$5.00
Non-ABD Medicaid Beneficiaries	\$2.50
North Carolina Health Choice Beneficiaries	\$2.50

Currently, practices interested in serving as a North Carolina Medicaid PCP must complete an online application through NTracks. North Carolina Medicaid practices may apply to participate in Carolina ACCESS during their initial provider enrollment application, or through a “Manage Change Request” (MCR). For detailed instruction on how to apply for Carolina ACCESS participation, see the [How to Enroll, Update, or Terminate CCNC/CA Managed Care Plans](#) user guide.

The Carolina ACCESS enrollment component of the NTracks application asks a series of questions related to the following:

- a. After hours medical advice availability
- b. Maximum enrollment limit
- c. Availability of oral interpretation services
- d. Hours of operation
- e. Preventive and Ancillary service availability (based on ages served)

The Department reviews applications and MCRs to ensure the above criteria are met. If application criteria are not fully met, or if the Department notes a discrepancy, it may contact the practice to discuss the availability of required services.

Practices that are approved for participation in Carolina ACCESS then begin receiving CAI PMPM Management fees (\$1 PMPM) for enrolled beneficiaries who are assigned to them. Practices that are denied entry into the program receive notification by the Department, and may reapply at any time.

Once Carolina ACCESS participation is approved, practices may choose to participate in their local CCNC network as a CAII practice. In order to complete this step, the practice must sign a separate agreement with the CCNC network.<sup>2</sup>

Once a practice is designated as CAII, it will begin receiving the enhanced CAII Management fee (\$2.50 PMPM for non-ABD enrollees; \$5.00 PMPM for ABD enrollees).

Generally, Carolina ACCESS will continue to operate concurrently with the AMH program, because some enrollee populations (for example, dually-eligible beneficiaries) will not transition into managed care. CAI will continue operating for two years following managed care launch, at which point it will phase out and CAI practices will need to transition to CAII or exit the program. Practices that wish to continue participating in CAII for these populations must continue to work with CCNC as they have done in the past, separate from their AMH efforts.

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<sup>2</sup> A list of CCNC networks and contacts is available at <https://www.communitycarenc.org/networks>.

## AMH Overview

As previously noted, the AMH program offers practices a range of options for partnering with PHPs in the provision of care management.

A practice's care management responsibilities will vary by AMH tier. In AMH Tier 1 and 2 practices, PHPs will retain primary responsibility for care management, and practices will be required to closely coordinate and interact with each PHP with which they have a contract. AMH Tier 3 is a more advanced phase for practices ready to take on care management responsibility, either alone or as part of a network of practices affiliated with a CIN. PHPs will provide oversight for care management delivered in or on behalf of Tier 3 practices, but will otherwise delegate day to day care management responsibilities to the Tier 3 AMH practice or the system or CIN/partners with which they are affiliated. Practices will not be required to contract with CCNC to participate in the AMH program.

Practices are eligible to participate in the AMH program if they are PCPs as defined by the current requirements for participation in the Carolina ACCESS program.<sup>3</sup> The set of qualifications for AMHs varies based on their tier.

- Tiers 1 and 2 are designed to incorporate the Carolina ACCESS program requirements and payment models into a managed care environment, allowing practices the ability to operate in a manner similar to how they operate today, with the difference that they will need to coordinate with PHPs that will assume primary responsibility for care management and will not be required to contract with CCNC to initiate medical home payments. To provide stability, the Department will hold the requirements for Tier 1 and 2 practices consistent with the current Carolina ACCESS requirements for a transitional period encompassing the first two years after managed care is launched. Current CAI practices will be automatically designated as Tier 1 practices (unless they apply to a higher tier), and current CAII practices will similarly be designated as AMH Tier 2 practices under managed care.
- Tier 3 is designed to be a more advanced tier for practices ready to take on care management responsibility, in addition to the requirements in Tier 2. To receive designation as an AMH Tier 3 certified practice, a practice must attest that it is adequately equipped—either alone or through participation in a network of practices that may be affiliated with a CIN or other partners—to take on an additional set of care management responsibilities for their enrolled population. In this tier, a practice is able to have a consistent care management system for their Medicaid population across multiple PHPs. See Appendix B for the full list of Tier 3 practice requirements.

The below table compares the care management responsibilities and payment structures across AMH Tiers.

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<sup>3</sup> In the process of attesting to an AMH tier, practices that are new to Carolina ACCESS will also complete the process of Carolina ACCESS enrollment.

<b>Table 2: Payment Structure by Advanced Medical Home Tier</b>						
<b>Tier</b>	<b>Practice Requirements</b>	<b>Primary Responsibility for Care Management</b>	<b>Clinical Services Payments</b>	<b>PMPM Medical Home Fee</b>	<b>Care Management Fee</b>	<b>PHP Performance Incentive to Practices</b>
1	CAI requirements	PHP	Will continue— PHPs must comply w/ minimum rate floors of set at Medicaid FFS-levels	\$1.00	None	None required, but PHPs encouraged to begin offering performance payments based on AMH measures
2	CAII requirements	PHP	Will continue — PHPs must comply w/ minimum rate floors set at Medicaid FFS-levels	\$2.50 (non-ABD enrollees) or \$5.00 (ABD enrollees)	None	
3	CAII Requirements + Tier 3 Care Management Practice Requirements	Practice responsible; AMH practices may arrange for care management functions to be performed at the CIN/partner level	Will continue — PHPs must comply w/ minimum rate floors set at Medicaid FFS-levels	\$2.50 (non-ABD enrollees) or \$5.00 (ABD enrollees)	Negotiated between practices or CIN/partners on behalf of practices and PHPs	PHP must pay performance incentive payments to practices if practices meet performance thresholds on standard AMH measures, which may include total cost of care

The Department will be responsible for certifying that practices are eligible to participate in a particular AMH Tier. PHPs, not the Department, will pay AMH practices their contracted PMPM Medical Home Fees and Care Management Fees (if applicable). These fees will begin following the effective date of the agreement between the PHP and AMH and the assignment of enrolled beneficiaries.

*Required PHP Contracting with Tier 3 AMHs*

The Department requires PHPs to contract with all AMH Tier 3 practices in each of their service areas. In future years, the Department will establish a withhold program (see Box for further details) to hold PHPs accountable for performance in a number of different priority areas, including contracting with Tier 3 AMH practices, and to provide incentives for performance

beyond minimum compliance thresholds. Contracting with Tier 3 AMH practices will be one of those priority areas identified in the withhold program.

The Tier 3 contracting requirement allows PHPs and practices to enter into mutually agreeable contract terms. Practices will have contracting leverage to negotiate acceptable Care Management Fees, while PHPs will have flexibility to contract with any AMH practices and, conversely, decline to contract with practices with which they cannot identify agreeable terms, so long as they meet the contracting threshold overall. Once managed care starts and the AMH program is operational, PHPs will be allowed to perform oversight and reclassify a Tier 3 practice to Tier 2 status, if it finds that the practice's capabilities do not meet Department-defined AMH Tier 3 standards.<sup>4</sup> However, reclassifying a practice to a AMH tier below their Department certification tier should be an infrequent occurrence. Practices that disagree with the PHP on the appropriate AMH tier classification will have the option to appeal the decision to the PHP; because the relationship between the PHP and practice is governed by the PHP contract, the practice will not have appeal rights to the Department. Section III covers AMH oversight in greater detail.

### **AMH Reversion from Tier 3 to Tier 2**

If a practice certified for AMH Tier 3 determines that it requires additional time to meet the Tier 3 requirements prior to managed care launch, it may change its certification status with the Department to Tier 2 without penalty.

If a practice successfully undergoes this process, that practice will no longer count in the denominator of AMH Tier 3 practices for which PHPs are accountable for contracting in each PHP region. However, changes to a practice's AMH Tier status will not impact providers' standing as Medicaid enrolled providers, nor will it impact their ability to see patients or have patients attributed to them in auto-assignment. For more information on Tier 2 Reversion, please view the official DHHS guidance linked [here](#).

### **Overlap of Carolina ACCESS with AMH**

#### *Practice Eligibility*

Practices providing primary care as defined by the current requirements for participation in the Carolina ACCESS program and participating in the North Carolina Medicaid program will be eligible for the AMH program. In general, AMH eligibility remains identical to Carolina ACCESS eligibility, with single and multi-specialty groups led by allopathic and osteopathic physicians in the following specialties, including certain subspecialties<sup>5</sup>, eligible for participation:

- General Practice

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<sup>4</sup> Additionally, PHPs may reclassify a Tier 1 or Tier 2 practice based on performance.

<sup>5</sup> The full CCNC/CA Eligibility list is available at <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information.html>.

- Family Medicine
- Internal Medicine
- OB/GYN
- Pediatrics
- Psychiatry and Neurology

AMH practices can also include Physician Assistants and Advanced Practice Nursing Providers, such as Advanced Practice Midwives and Nurse Practitioners. Certain ambulatory health care facilities can become AMH, including Federally-Qualified Health Centers, Local Health Departments, Public Health Clinics and Rural Health Clinics.

All providers participating in an AMH practice must be enrolled in the State’s Medicaid program. All practices must provide primary care services, although they may provide other services as well. There are no minimum panel size requirements, although practices serving only a small number of Medicaid enrollees may wish to consider how AMH participation can complement their practice transformation efforts with other payers to ensure sustainability. PCPs that do not want to participate in the AMH program can still operate as PCPs within fee-for-service, and within managed care by contracting with PHPs in their region.

*Practice Requirements*

For Tier 1, only existing CAI practices can enter (through grandfathering); there is no other path to Tier 1 status.

For Tier 2, practices already participating in Carolina ACCESS may be grandfathered in based on their standing in CAI or II. CAII practices will be grandfathered in, while current CAI practices will be required to indicate their intent to join Tier 2 by selecting an option on the NCTracks site. Practices enrolled as Medicaid providers but not yet participating in Carolina ACCESS must join Carolina ACCESS using a managed change request (MCR), at which point they will be automatically entered into Tier 2. Providers seeking to enroll in Medicaid for the first time can elect to join Carolina ACCESS as part of their initial Medicaid enrollment. There are no

<p><b><i>Medical Home Process</i></b></p> <p>The Medical Home Process is a new term that describes the process of meeting AMH requirements; practices that complete this process will be certified for any of the following:</p> <ul style="list-style-type: none"> <li>• Tier 2 AMH status for their patients enrolled in Medicaid managed care, if they contract with a PHP as an AMH Tier 2 practice</li> <li>• Tier 3 AMH status for their patients enrolled in Medicaid managed care, if they complete the Tier 3 attestation and contract with a PHP as an AMH Tier 3 practice</li> </ul>
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additional steps required for Tier 2 AMH certification. AMH Tier 2 practices are expected to demonstrate capabilities similar to those demonstrated by Carolina ACCESS practices in FFS,

which are described above and can be found in Appendix A. There are no additional requirements, unlike Tier 3.

In contrast, Tier 3 AMH, which lacks an equivalent Carolina ACCESS level, has new attestation requirements that are described in Section III. All practices that want to become Tier 3 AMH providers will need to attest.

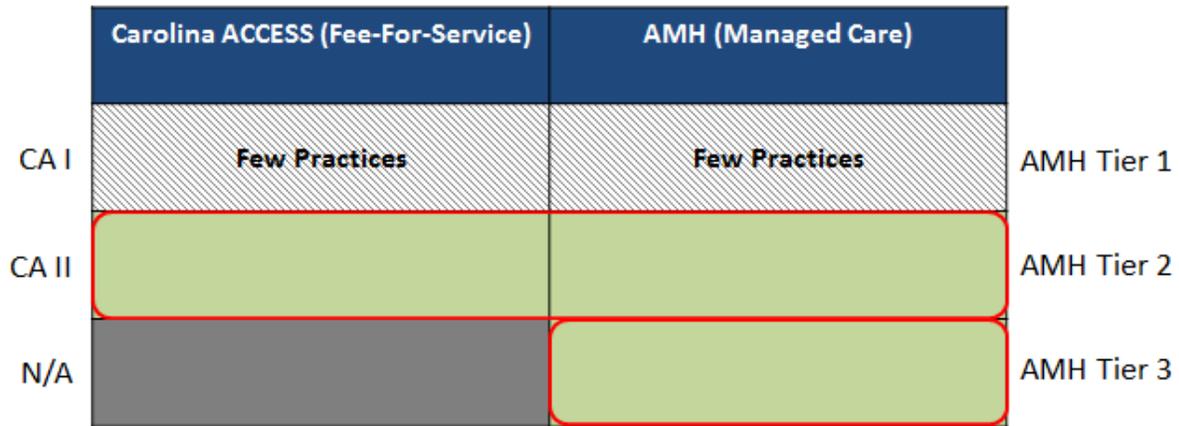
*Practice Designations Once Managed Care Launches*

The Department has established a high-level transition roadmap and timeline to guide Carolina ACCESS practices into the AMH program. Although there is considerable detail surrounding how the Carolina ACCESS and AMH program will coexist during the transition to managed care, it is critical to understand that the majority of practices will obtain the following designations:

- **CAII** (for fee-for-service populations)
- **AMH Tier 2** or **AMH Tier 3** (for managed care enrollees)

Figure 1 below illustrates the expected landscape of how Carolina ACCESS and AMH practices will coexist once managed care launches.

*Figure 1: Carolina ACCESS and AMH Landscape in Managed Care*



 **Vast majority of practices will fall in these designations**

Although it is anticipated that CAII, AMH Tier 2, and AMH Tier 3 will dominate the new Medicaid environment, the Department will permit practices currently in CAI to remain in CAI and enter AMH Tier 1. It is possible for practices to have different statuses in Fee For Service (FFS) Medicaid and managed care. For example, it is possible for a practice to be a AMH Tier 3 and also be a CAII practice.

### **Section III: AMH Tier 3 Certification and Requirements**

Tier 3 AMH requirements are meant to capture the core elements of care management that Tier 3 AMH practices will be required to perform, either alone or as part of a network of practices that may affiliate with a CIN/partners. These requirements were adapted from the [CMS Comprehensive Primary Care Plus Initiative](#), the largest federal patient-centered medical home payment initiative, and modified to address the needs and characteristics of North Carolina's Medicaid beneficiaries. These requirements are also designed to mirror the requirements PHPs will observe when providing care management to enrollees assigned to AMH Tier 1 and 2 practices or practices that are not AMH. Practices considering Tier 3 status should carefully review these requirements and determine how they would be able to fulfill them, as they will form the basis of PHP contracting language. (See Section V for further information on how PHPs will be expected to contract with Tier 3 practices.) Practices that elect to work with a CIN/partners should conduct any inquiries necessary to ensure that their CIN/partners can perform all delegated functions.

AMH Tier 3 has a formal attestation process. Tier 3 builds on Tier 2, meaning that before attesting to Tier 3 capabilities, new entrants will also attest to Tier 2 capabilities (through enrollment in CA, whose requirements mirror Tier 2). Tier 3 itself has no equivalent CA level, which means that all interested practices must complete an attestation; there is no grandfathering for this tier.

Tier 3 requirements are more extensive than Tier 2 requirements, reflecting the additional care management capabilities expected of Tier 3 practices and the negotiated Care Management Fees they will receive. The attestation form includes three sections.

- **Section A** of the Tier 3 requirements contains required contact information.
- **Section B** of the Tier 3 requirements includes required attestations, which reflect Tier 3 AMHs' core care management responsibilities and will be reflected in PHPs' contracting language with AMH practices.
- **Section C** of the Tier 3 requirements includes supplemental questions associated with selected requirements.

For a practice to achieve Tier 3 status, the practice must affirmatively attest that they or the CIN/partners with which they are affiliating, have the capacity to perform all of the activities described in Section B.

***All questions in all sections are required, and practices that do not affirm capacity to perform all of the required activities described in Section B will not be placed in Tier 3.*** Practices must provide accurate responses to each supplemental question, located in Section C. The Department will record their response, but will not use it to determine their Tier 3 placement. Each element is further discussed in the table below. In cases where the Department denies a practice's AMH application, the Department will notify the practice by letter and the practice will have the right to appeal the denial to the Department. Practices seeking additional

assistance around AMH attestation should contact CSRA Call Center at 1-800-688-6696 for support.

Practices planning to complete Tier 3 attestation may wish to review the table as they prepare the form, as it provides additional context regarding required and supplemental elements. Required elements may only be answered ‘yes’ or ‘no’; all required elements must have a ‘yes’ response for Tier 3 certification. Supplemental elements may be answered with free text, ‘yes’ or ‘no’, or checking all response boxes that apply, depending on the element.

### Tier 3 Attestation Requirements

Section A of the Tier 3 attestation form requests information required to identify the practice and link it to NCTracks records.

<b>Section A requirements (contact information)</b>		
#	Requirement	Rationale/Description
N/A	Organization Name	The organization’s legal name should be entered exactly as it appears in NCTracks, to facilitate matching
N/A	Name and Title of Office Administrator Completing the Form	The form should be completed by the individual who has the electronic PIN required to submit data to NCTracks on behalf of the practice.
N/A	Contact Information of Office Administrator Completing the Form (e-mail and phone number)	
N/A	Organization NPI (or Individual NPI, for practitioners who do not bill through an organizational NPI):	
N/A	Phone Number:	This should be the general number and address used to reach the practice, as opposed to the specific contact information requested for the office administrator (above)
N/A	E-mail Address	

Section B includes attestations that relate to practices’ care management capabilities, including their ability to provide transitional care management, and their ability to access and use data around admissions, discharges and transfers.

<b>Section B: Medical Home Certification Process: Tier 3 Required Attestations</b>		
<b>Please indicate if your practice, contracted CIN/partners, or system, can perform the following functions. (See supplemental questions 1-4 to provide more information about CIN/partner participation.)</b>		
#	Requirement	Rationale
<b>Tier 3 AMH practices must be able to risk stratify all empaneled patients. To meet this requirement, the practice must attest to doing the following:</b>		

1	Can your practice ensure that assignment lists transmitted to the practice by each PHP are reconciled with the practice's panel list and up to date in the clinical system of record?	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate. The clinical system of record is an electronic health record or equivalent.
2	Does your practice use a consistent method to assign and adjust risk status for each assigned patient?	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/partner or system would meet this requirement or application of clinical judgment to risk scores received from the PHP or another source will suffice.
3	Can your practice use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel? (See supplemental question 5 to provide more information.)	
4	To the greatest extent possible, can your practice ensure that the method is consistent with the Department's program Policy of identifying "priority populations" for care management?	Not all care team members need to be able to perform risk stratification (for example, risk stratification will most likely be done at the CIN/partner level, or may be performed exclusively by physicians if done independently at the practice level), but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
5	Can your practice ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently?	
6	Can your practice define the process and frequency of risk score review and validation?	Practices should be prepared to describe these elements for PHPs.
<b>Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following:</b>		
7	Using the practice's risk stratification method, can your practice identify patients who may benefit from care management?	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management designations need not precisely mirror risk stratification levels.
8	Can your practice perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs? The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum (see supplemental	In preparation for the assessment, care team members may consolidate information from a variety of sources, and must review the Initial Care Needs Screening performed by the PHP (if available). The clinician

	<p>question 5 to provide further information):</p> <ul style="list-style-type: none"> <li>○ Patient’s immediate care needs and current services;</li> <li>○ Other State or local services currently used;</li> <li>○ Physical health conditions;</li> <li>○ Current and past behavioral and mental health and substance use status and/or disorders;</li> <li>○ Physical, intellectual developmental disabilities;</li> <li>○ Medications;</li> <li>○ Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);</li> <li>○ Available informal, caregiver, or social supports, including peer supports.</li> </ul>	<p>performing the assessment should confirm the information with the enrollee. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the enrollee's claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously.</p> <p>This section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The enrollee may be referred for formal diagnostic evaluation. The practice or CIN/partners administering the Comprehensive Assessment should develop a protocol for situations when an enrollee discloses information during the Assessment indicating an immediate risk to self or others. The review of medications should include a medication reconciliation on the first Comprehensive Assessment, as well as on subsequent Assessments if the enrollee has not had a recent medication reconciliation related to a care transition or for another reason. The medication reconciliation should be performed by an individual with appropriate clinical training.</p>
9	<p>Does your practice have North Carolina licensed, trained staff organized at the practice level (or at the CIN/partner level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients?</p>	<p>Care managers must be assigned to the practice, but need not be physically embedded at the practice location.</p>
10	<p>For each high-need patient, can your practice assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical</p>	<p>An enrollee may decline to engage in care management, but the practice or CIN/partners should</p>

	diagnosis and treatment and who has the minimum credentials of RN or LCSW? (See supplemental question 6 to provide further information.)	still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and their clinician during routine visits.
<b>For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan.</b>		
11	Can your practice develop the Care Plan within 30 days of Comprehensive Assessment or sooner if feasible while ensuring that needed treatment is not delayed by the development of the Care Plan?	30 days is the maximum interval for developing a Care Plan. If there are clinical benefits to developing a Care Plan more quickly, practices should do so whenever feasible.
12	Can your practice develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible?	Practice may identify their own definitions of 'individualized', 'person-centered' and 'collaborative', but should be able to describe how their care planning process demonstrates these attributes,
13	Can your practice incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan? <ul style="list-style-type: none"> <li>○ Can your practice include, at a minimum, the following elements in the Care Plan</li> <li>○ Measurable patient (or patient and caregiver) goals</li> <li>○ Medical needs including any behavioral health needs;</li> <li>○ Interventions;</li> <li>○ Intended outcomes; and</li> <li>○ Social, educational, and other services needed by the patient.</li> </ul>	Intended outcomes can be understood as clinical steps identified by the care team that will lead to the enrollee/caregiver-defined goal. For example, the enrollee may set a goal of no longer needing frequent fingersticks and injected insulin. The care team may develop an intended clinical outcome that represents the level of glycemic control at which the enrollee could attempt a trial of oral hypoglycemics, and a second intended clinical outcome that represents the level of control on oral hypoglycemics that would allow the enrollee to continue with the regimen.
14	Does your practice have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment? (See supplemental question 7 to provide more information.)	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate.

15	Does your practice have a process to document and store each Care Plan in the clinical system of record?	The clinical system of record may include an electronic health record.
16	Can your practice periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary?	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate.
17	Can your practice track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time?	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s)
18	<p>Can your practice or CIN/partners implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)?</p> <ul style="list-style-type: none"> <li>○ Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.</li> <li>○ Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;</li> <li>○ Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication management post discharge)</li> </ul>	Practices (directly or via CIN/partners) are not required to respond to all ADT alerts in these categories, but they are required to have a process in place to determine which notifications merit a response and to ensure that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough with regard to the designation of ADT alerts as requiring or not requiring follow-up; the interval within which follow-up should occur; and the documentation that follow-up took place that

		an external observer could easily determine whether the process is being followed.
<b>Tier 3 AMHs must be able to provide short-term, transitional care management along with medication management to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.</b>		
19	<p>Does your practice have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:</p> <ul style="list-style-type: none"> <li>○ Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits</li> <li>○ Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;</li> <li>○ NICU discharges;</li> <li>○ Clinical complexity, severity of condition, medications, risk score</li> </ul>	
20	For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, can your practice assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW? (Please see supplemental question 8 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and their clinician during the transition period.
21	<p>Does your practice include the following elements in transitional care management?</p> <ul style="list-style-type: none"> <li>○ Ensuring that a care manager is assigned to manage the transition</li> <li>○ Facilitating clinical handoffs;</li> <li>○ Obtaining a copy of the discharge plan/summary;</li> <li>○ Conducting medication management;</li> <li>○ Following-up by the assigned care manager rapidly following discharge;</li> <li>○ Ensuring that a follow-up outpatient, home visit or face to face encounter occurs</li> <li>○ Developing a protocol for determining the appropriate timing and format of such outreach</li> </ul>	The AMH practice is not required to ensure that follow-up visits occur within a specific time window because enrollees' needs may vary. However, the practice must have a process for determining a clinically-appropriate follow-up interval for each enrollee that is specific enough with regard to the interval within which follow-up should occur and the documentation that follow-up took place that an external observer could easily determine whether the process is being followed.

<b>Tier 3 AMH practices must use electronic data to promote care management</b>		
22	Can your practice receive claims data feeds (directly or via a CIN/partner) and meet Department-designated security standards for their storage and use?	

Section C includes supplemental questions that practices are required to answer, although the content of their answers will not affect their tier placement. The Department will use this information to track how AMH practices perform their core care management functions and work with CINs/partners.

<b>Supplemental Questions</b>		
<b>Please indicate if your practice, or contracted CIN, can perform the following functions. (See supplemental questions 1-3 to provide more information about CIN participation.)</b>		
S1	Will your practice work with a CIN or other partners?	This element must be completed, but responses will not affect certification.
S2	If yes, please list the names and regions of the CIN(s) or other partners you are working with	This element must be completed, but responses will not affect certification. This list should include the full legal name of each CIN.
S3	Who will provide care management services for your AMH? (e.g., CIN or other CM vendor)  <input type="checkbox"/> Employed practice staff <input type="checkbox"/> Staff of the CIN <input type="checkbox"/> Staff of a care management or population health vendor that is not part of a CIN <input type="checkbox"/> Other (Please specify: _____)	This element must be completed, but responses will not affect certification.
S4	If you are working with more than one CIN/partner, please describe how CINs/partners will share accountability for your assigned population	This element must be completed, but responses will not affect certification. When practices elect to work with multiple CINs/partners, they can divide their population among CINs/partners based on regional or other categorizations, but should ensure that they can readily identify which CINs/partners have primary accountability for which patients.

S5	Practices/CINs/partners will have the option to assess adverse childhood experiences (ACEs). Can your practice/CIN/partner assess adults for ACEs?	This element must be completed, but responses will not affect certification.
S6	What are the credentials of the staff that will <u>participate</u> in the complex care management team within practice/CIN/partner? (Please indicate all that apply.) <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> LCSW <input type="checkbox"/> Medical Assistant/LPN <input type="checkbox"/> Other (Please specify: _____)	This element must be completed, but responses will not affect certification.
S7	For patients who need LTSS, can your practice coordinate with the PHP to develop the Care Plan?	This element must be completed, but responses will not affect certification. Practices and CINs/partners are not required to have same capabilities as PHPs for screening and management of LTSS populations.
S8	What are the credentials of the staff that will <u>participate</u> in the transitional care management team within the practice/CIN/partner? (Please indicate all that apply.) <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> LCSW <input type="checkbox"/> Medical Assistant/LPN <input type="checkbox"/> Other (Please specify: _____)	This element must be completed, but responses will not affect certification.

**Section IV: AMH Attestation and Certification Process**

AMH certification is a noncompetitive process whereby practices that complete a series of steps are certified by the Department as eligible for participation in the corresponding tier. These practices can then contract with PHPs in their region to activate their AMH status in that tier. To receive Medical Home Fees and Care Management Fees for AMH activities, practices must not only be certified by the Department, but also contract with PHPs as AMH practices. The Department has required that PHPs recognize practices designated as AMH in their contracting. Unlike the Carolina ACCESS program, the Department does not make any direct payments to AMH practices. The Department encourages all PCPs who will contract with PHPs to consider participation in the AMH program.

Practices' path to entry into the AMH program will depend on which tier they intend to enter and on their current level of participation in the Carolina ACCESS program. Practices can attest

into whatever AMH Tier level best describes their capabilities, with the exception of Tier 1 which is open only to current CAI practices. Figure 2 shows how Carolina ACCESS participants and nonparticipants can join the AMH program.

Figure 2: Transition roadmap for Carolina ACCESS practices

		Eligibility for AMH program			
		Not AMH Eligible	AMH Tier 1 Certified	AMH Tier 2 Certified	AMH Tier 3 Certified
Practice's Current Carolina ACCESS Status	Not participating in CA	Default placement	[Not permitted]	✓ If successfully meet Tier 2 requirements	✓ If successfully Attest to Tier 3 requirements
	CA I	If request to be removed from master list	Default placement	✓ If select option to join Tier 2 in NCTracks	✓ If successfully Attest to Tier 3 requirements
	CA II	If request to be removed from master list	[Not permitted]	Default placement	✓ If successfully Attest to Tier 3 requirements

The Department has designed a plan to make it as easy as possible for practices to either be grandfathered based on their current CA status into managed care or to meet AMH Tier 2 or 3 requirements.

- Only currently enrolled CAI practices will be eligible to enter into AMH Tier 1. No other practices (e.g. CAII or a non-CA PCP) will be able to enter into AMH Tier 1.
- For practices currently in CAI that wish be certified as a Tier 1 practice, no action is necessary. CAI practices will be grandfathered into AMH Tier 1 and retain their status as a CAI practice.<sup>6</sup> Practices currently in CAI that wish to enter Tier 2 will need to meet Tier 2 requirements (shown in Appendix A) on the NCTracks site. If these practices also want to participate in CAII and begin receiving higher medical home payments on the FFS side, they must also sign an agreement with CCNC<sup>7</sup>.

<sup>6</sup> Once attestation launches, new practices will no longer be able to enter CAI.

<sup>7</sup> As previously noted, new practices wanting to be an AMH Tier 2 practice do not need to sign an agreement with CCNC. Practices only need to sign an agreement with CCNC if they want to be considered a CAII practice in fee for service.

- For practices currently in CAII that wish be certified as a Tier 2 practice, no action is necessary. Practices will be grandfathered into AMH Tier 2 and will retain their status as a CAII practice in FFS.
- All practices seeking Tier 3 certification must attest to Tier 3 requirements using the Tier 3 Attestation form, available on the NCTracks Provider Portal. Each Tier 3 requirement is discussed in detail in section II, above.

The Department will manage the attestation and certification process. Following certification, the Department will assign each participating practice to an AMH tier, will notify the practice of its status and will make this information available to PHPs. AMHs will then contract separately with each PHP. Contracting with a PHP is the final necessary step for a practice that has been enrolled in Medicaid and certified by the Department to a specific AMH tier to ‘count’ as an AMH practice under managed care and to receive PMPM Medical Home Fees and Care Management Fees, as applicable. Figure 3 shows, at a high level, the steps a prospective AMH practice must take to become an active AMH.

*Figure 3: High level path to AMH status*



Each practice (defined as an organizational NPI and location) must separately attest to the requirements of its intended tier.

### **Medical Home Process**

The below sections depict the specific steps practices will take based on where the practice currently sits in relationship to the Carolina ACCESS program versus how they will specifically move into an AMH Tier. The process may have one or more steps, depending on the tier to which a practice means to move. The process for entry into AMH Tier 2 is generally identical to the process for entry into the Carolina ACCESS program<sup>8</sup> Practices that are already enrolled in Carolina ACCESS can choose to complete the attestation for Tier 3 after selecting the option to enter Tier 2.

Entry into Tier 3, which involves attesting to a new set of requirements that have not previously been included in Carolina ACCESS, will involve an additional attestation. The following

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<sup>8</sup> Unlike CAII, no agreement with CCNC is required.

subsections explain how this process will work for different practices, based on their current Carolina ACCESS status. Practices that have not yet enrolled in Medicaid, or practices experiencing special circumstances such as a change in ownership, may need to complete additional steps not described here as part of the Medicaid enrollment or reenrollment process.

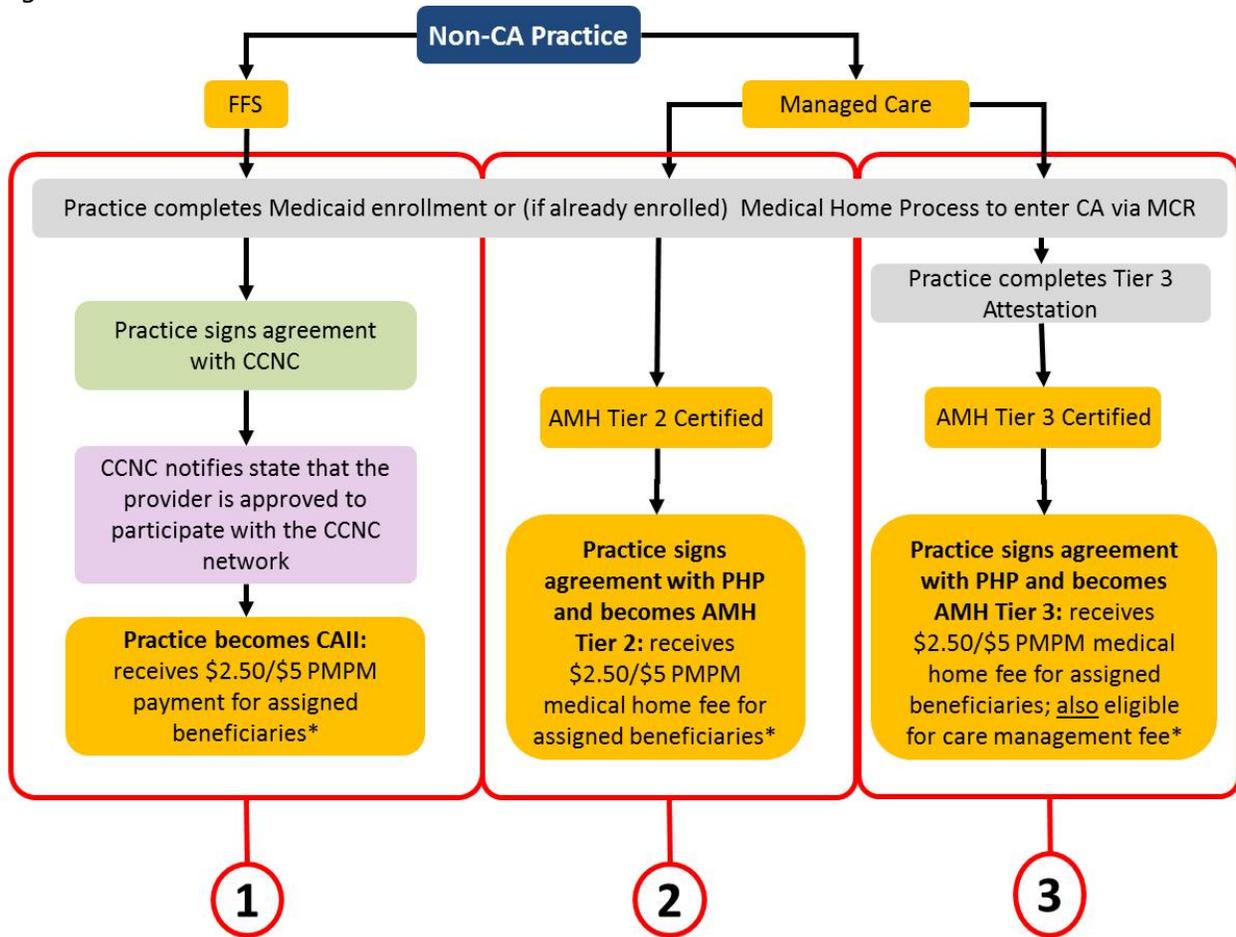
#### *Non-Carolina ACCESS Practices*

Some practices that wish to become AMH are not currently participating in Carolina ACCESS at any level. This includes practices that participate in Medicaid, but are not Carolina ACCESS practices, as well as newly formed practices and practices that are new to North Carolina. Figure 4 describes the AMH certification process for these practices.

As noted previously, a new practice will not be able to receive a payment for Carolina ACCESS I (CAI) status or be grandfathered into an AMH Tier 1 practice. Thus, once managed care begins, practices must elect to participate in CAII for FFS patients and/or AMH Tier 2 or 3 for managed care patients.

Below are the specific process steps to take if a practice intends to participate in CAII and/or AMH Tiers 2 or 3.

Figure 4: Non-CA Practice



\*Fees associated with Carolina ACCESS and AMH status will be in addition to routine billing.

In order to enter Tier 2, these practices will need to join Carolina ACCESS (Box 2 in Figure 4). If the Department determines that the practice meets the Carolina ACCESS requirements, the Department will automatically assign the practice a Tier 2 certification status. Certified practices can then contract with PHPs to effectuate their Tier status with the PHP and begin receiving PMPM AMH Medical Home fees (Box 2 in Figure 4). These practices can also contract with CCNC to become a CAII practice for their FFS patients.

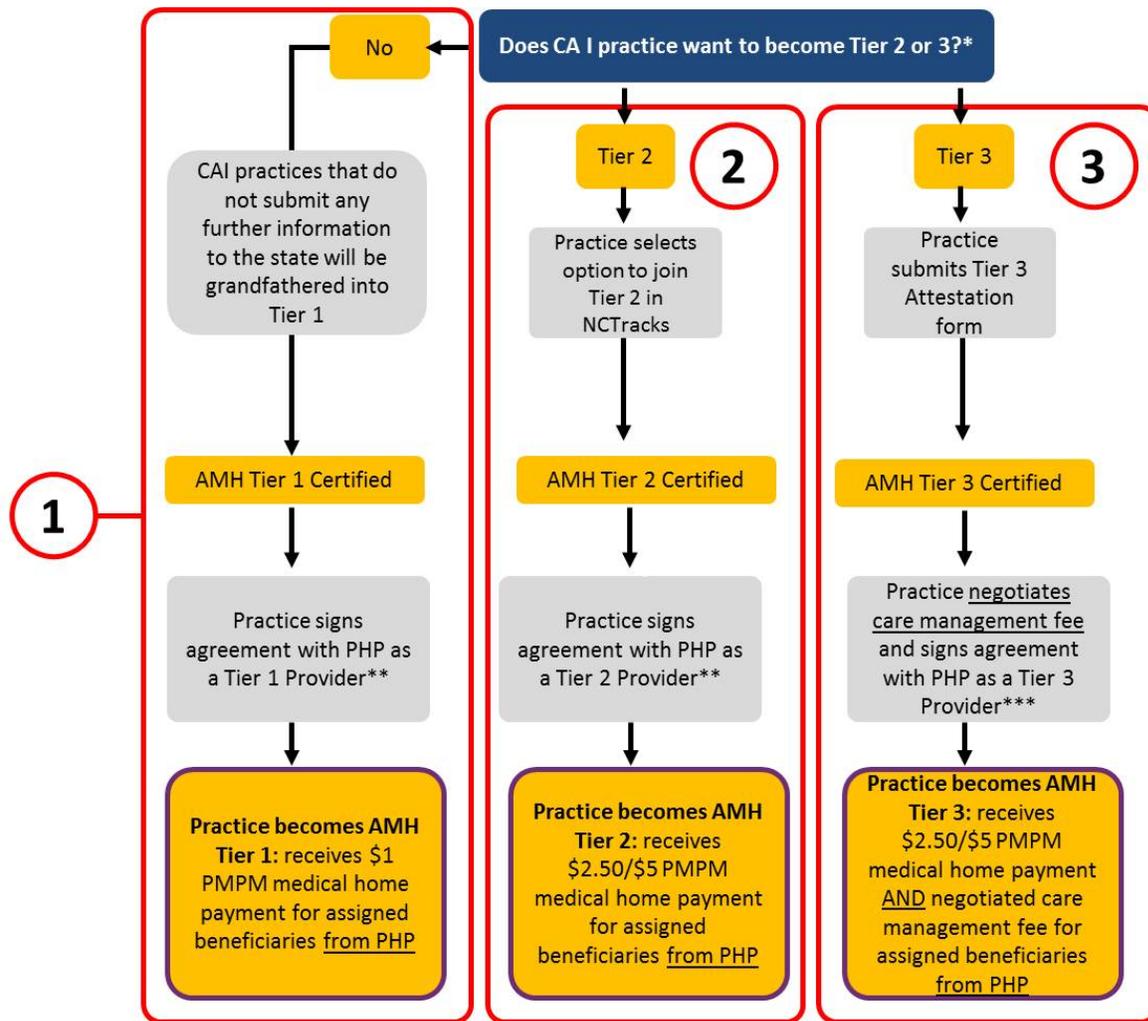
In order to enter Tier 3, non-CA practices will follow the Medical Home Process described above and will also attest to the Tier 3 requirements (Box 3 in Figure 4). If the Department determines that the practice meets the Tier 3 requirements based on the review process described in Section II, the Department will assign the practice a Tier 3 certification status. Practices that seek entry into Tier 3, but only meet the requirements for Tier 2, will be assigned to Tier 2; practices that do not meet the requirements for any available tier will not be assigned to a tier.

In addition to AMH certification, the Department will maintain its current process for reviewing these practices for entry in Carolina ACCESS for FFS populations, via the same process used to seek Tier 2 certification (Box 1 in Figure 4).

### Carolina ACCESS I Practices

Practices that are currently enrolled in Carolina ACCESS but have not signed an agreement with CCNC to become a CAII practice (i.e., they are CAI practices) will be grandfathered into Tier 1, or may elect to enter into Tier 2 (by indicating their intention on NCTracks) or Tier 3 (if they attest to Tier 3 requirements). This process is described in Figure 5 below.

Figure 5: Current CAI Practice Certification Process



\* CAI practices wishing to become CAII practices for FFS populations must sign an agreement with CCNC

\*\* Agreement requires Current CA requirements (e.g., 24/7 ACCESS)

\*\*\* Agreement requires current CA requirements plus contractual language on Tier 3 functions and responsibilities

Current CAI practices are the only practices permitted in AMH Tier 1. CAI practices that do nothing following the launch of the AMH program will automatically be grandfathered into

AMH Tier 1 certification status (Box 1 in Figure 5). These practices will still need to contract with PHPs as Tier 1 AMHs in order to effectuate payment of medical home payments (\$1 PMPM in the case of a Tier 1 practice), but the Department will ensure that current CAI practices that take no action are moved to the “master list” at a Tier 1 certification status.

To move into Tier 2, current CAI practices will be required to notify the Department of their intention to contract at the Tier 2 level by selecting an indicator on the NCTracks website, but they will not be required to complete the full Medical Home process as if they were a new practice, because they will have previously attested to the Carolina ACCESS requirements when they first entered CAI (Box 2 in Figure 5).

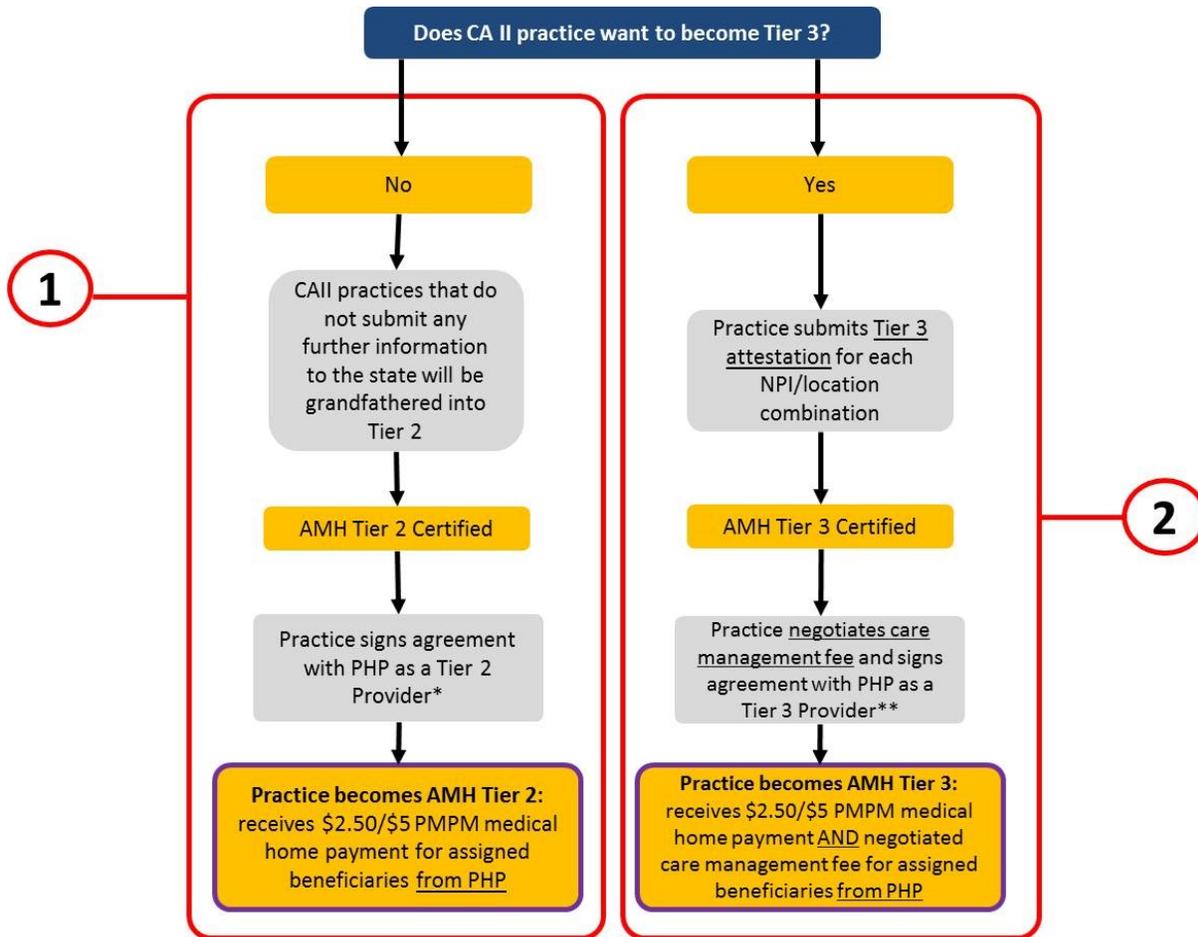
To enter Tier 3, CAI practices will be required to complete the Advanced Medical Home Tier 3 attestation (Box 3 in Figure 5).

CAI practices will also retain the option to enter CAII for FFS patients. As before, practices would need to sign an agreement with their local CCNC network; this will not affect their Department-assigned AMH tier status.

#### *Carolina ACCESS II Practices*

CAII practices that do nothing following the launch of the AMH program will automatically be grandfathered into AMH Tier 2 certification status for managed care. These practices will still need to contract with PHPs as Tier 2 AMHs in order to receive AMH Medical Home fees (\$2.50 PMPM for non-ABD enrollees; \$5 PMPM for ABD enrollees). This process is described in Figure 6 below.

Figure 6: Current CAII Department Certification Process



\*\* Agreement requires Current CA requirements (e.g., 24/7 ACCESS)

\*\* Agreement requires current CA requirements plus contractual language on Tier 3 functions and responsibilities

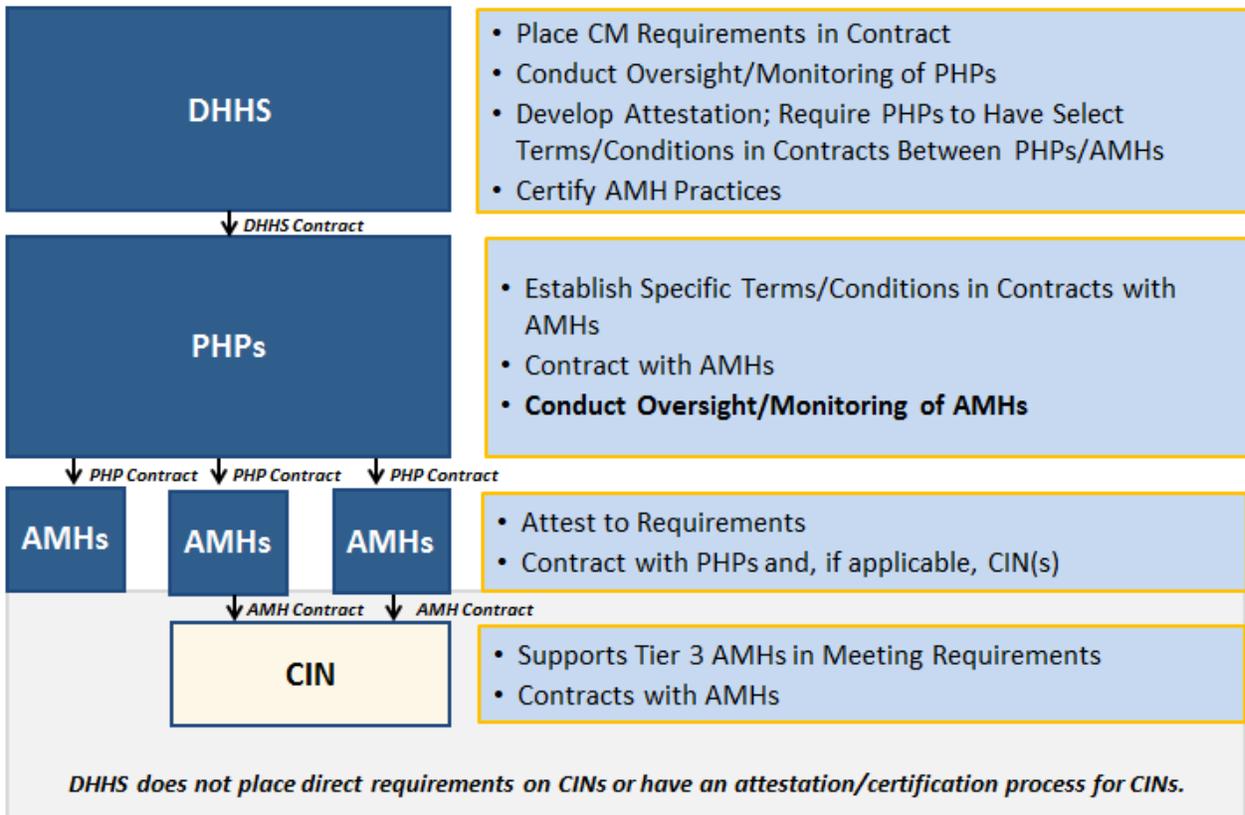
To enter into Tier 3, CAII practices will be required to complete the AMH Tier 3 attestation (Box 2 in Figure 6). CAII practices will retain their CAII status in FFS unless they elect to change it.

### **Section V. Role of PHP in AMH Practice Certification, Contracting and Oversight**

The Department, PHPs and AMHs will have different roles within the accountability structure of the AMH program. As noted throughout this manual, the Department will be responsible for development of the AMH attestation process and the certification of AMH practices. AMHs will be required to attest to the practice requirements of their desired tier, contract with PHPs, and enter into agreements with CINs, as applicable.

PHPs will be required to contract with AMHs in their service areas, including the requirement to contract with all Tier 3 practices. PHPs will conduct AMH practice oversight. Figure 7 depicts these roles and responsibilities, and the remainder of this section outlines PHP responsibilities for conducting oversight AMH practices.

Figure 7: Department, PHP and Practice Roles and Responsibilities



### Initial Contracting

For AMH Tiers 1 and 2, PHPs will be required to enter into contracts with those practices which meet the requirements described in Section II. For AMH Tiers 1 and 2, PHPs must accept the certification “as is” without the ability to review during the initial contracting process. If a practice is listed on the Master List as a AMH Tier 1 or 2, PHPs will be required to initially contract with that AMH practice at that Tier level.

PHPs will be required to include certain language in contracts with AMH practices, shown in Appendices A and B. The Department will review and approve all PHP/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated. The contracts must:

- Be of mutual agreement
- Assign responsibilities (details of activities performed vs. retained) and specify responsibilities.
- Responsibilities must contain all required elements included in the Appendix A (for all AMH practices) and Appendix B (for Tier 3 AMH practices)
- Specify reporting standards and performance monitoring (in alignment with the Department’s standards)

- Specify consequences for underperformance, including appeals rights
- Include data sharing and provisions for privacy/security, in alignment with the Department’s data sharing policies.

For AMH Tier 3, PHPs will be required to enter into contracts with those practices which meet the requirements described in Section II. PHPs may wish to, and 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.<sup>9</sup> Activities by PHPs may include conducting an onsite review, telephone consultation, documentation review, or other virtual/offsite reviews. Based on the extent to which functions are delegated by the AMH (i.e., to a CIN), the PHP may perform an initial evaluation of the CIN instead of or in addition to the AMH.

### **Ongoing Oversight**

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.

As part of NCQA accreditation requirements, PHPs that delegate functions to AMH Tier 3 practices will be required to:

1. Review parts of the program where delegation occurs;
2. Conduct an annual file audit;
3. Perform an annual evaluation; and
4. Perform an evaluation of reports regarding population health management.

After launch and as part of the ongoing AMH Tier 3 design process, the Department will consider if collaborative approaches to monitoring for AMH Tier 3 practices can be implemented in future years. Such collaboration may involve alignment among PHPs (once awarded) and could consider ways to streamline and conduct annual file audits to streamline the process for both AMH Tier 3 practices and PHPs.

### **AMH Underperformance**

After managed care launch and in the event that an AMH practice is unable to perform the activities of the AMH Tier to which it initially attested, the Department will require the PHP to send a notice to the AMH practice.<sup>10</sup> If the AMH is not able to perform the activities associated with their AMH Tier, the Department will permit the PHP to stop paying the Medical Home Fee (and care management fees, as applicable) and change (lower) the Tier status of the AMH. This

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<sup>9</sup> NCQA requires that plans conduct an “initial evaluation” for all delegated functions. However, since NCQA accreditation is not required until Year 3, PHPs may vary in their approach to this.

<sup>10</sup> For other aspects of underperformance not related to care management or other AMH functions, such as fraud or negligence, PHPs and the Department would follow their usual processes.

could involve moving to Tier 2 status or moving out of the AMH program altogether. This will not impact an AMH practice's Tier certification from the perspective of the Department 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 CIN without an assessment, nor can it lower the Tier level of an AMH practice location based on a different PHP's findings.

AMH practices have the right to appeal any such downgrades to the PHP, by going through their regular appeals process, but will not be able to appeal directly to the Department.<sup>11</sup> However, the Department 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. The Department will maintain in its system of record an indicator showing the tiering 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 not be counted towards the Tier 3 contracting requirement.

**In the event that a PHP notifies an AMH practice that it will no longer pay Medical Home Fees, the PHP will alert the Department that it has made a change in the Tier status for the practice. This notification will be for the purposes of cancelling the payment of the Medical Home fee to the PHP and, as noted, will not impact the AMH's Certification status for other PHPs. Section VI: Certification Timeline**

Practices will have a set period of time to attest to an AMH level prior to PHP awards and the beginning of the PHP contracting period. Prior to the Department issuing PHP awards, practices will have a designated period to complete their attestations, which will be followed by a certification period for the Department to review and approve practice attestations. Once PHP awards are made, PHPs and practices will have a contracting period to enter into mutually agreeable contract terms around network participation and AMH status prior to the active launch of managed care. This sequence will be staggered for regions of the state where managed care is rolling out on a delayed timeline, but the process will follow the same sequence of events.

The Department will notify practices during the attestation stage of any actions the Department will take if the practice "does nothing" (i.e., informing the practice that it will be grandfathered into an AMH Tier or not). The Department will also notify practices of their certification status after the practice completes the Medical Home process in real-time (to the extent feasible) and will send written notice to all practices advising them of their AMH certification status.

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<sup>11</sup> The practice only has appeals rights to the Department for the Department-designated practice certification process.

**Appendix A: Standard Terms and Conditions for PHP Contracts With Advanced Medical Home Tier 1 and 2 Practices**

PHPs will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices’ agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all PHP/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated:

- Accept enrollees and be listed as a PCP in the PHP’s enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each enrollee.
- Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services. (See Preventive Health Requirements table below.)
- Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees.
- Maintain a unified patient medical record for each enrollee following the PHP’s medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the enrollee's medical record to the receiving practice upon the change of PCP at the request of the new PCP or PHP (if applicable) and as authorized by the enrollee within 30 days of the date of the request.
- Authorize care for the enrollee or provide care for the enrollee based on the standards of appointment availability as defined by the PHP’s network adequacy standards.
- Refer for a second opinion as requested by the patient, based on Department guidelines and PHP standards.
- Review and use enrollee utilization and cost reports provided by the PHP for the purpose of AMH level utilization management and advise the PHP of errors, omissions, or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the PHP for the purpose of participating in PHP or practice-based population health or care management activities.

**Preventive Health Requirements:**

		<b>Required for providers who serve the following age ranges</b>											
<b>NCTracks assigned Number</b>	<b>Requirement</b>	<b>0 to 3</b>	<b>0 to 6</b>	<b>0 to 11</b>	<b>0 to 18</b>	<b>0 to 21</b>	<b>0 to 121</b>	<b>3 to 17</b>	<b>7 to 120</b>	<b>11 to 18</b>	<b>11 to 121</b>	<b>18 to 121</b>	<b>21 to 121</b>

1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

## **Appendix B: Standard Terms and Conditions for PHP Contracts With Tier 3 AMH Practices**

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements.

- a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
  - i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the PHP are reconciled with the practice's panel list and up to date in the clinical system of record.
  - ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
  - iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel.
  - iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Department's program Policy of identifying "priority populations" for care management.
  - v. The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
  - vi. The Tier 3 AMH practice must define the process and frequency of risk score review and validation.
- b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
  - i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
  - ii. The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
    - 1. Patient's immediate care needs and current services;
    - 2. Other State or local services currently used;
    - 3. Physical health conditions;
    - 4. Current and past behavioral and mental health and substance use status and/or disorders;
    - 5. Physical, intellectual developmental disabilities;
    - 6. Medications;
    - 7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);

- 8. Available informal, caregiver, or social supports, including peer supports.
- iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.
- iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
- c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.
  - i. The Tier 3 AMH practice must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.
  - ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.
  - iii. The Tier 3 AMH practice must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.
  - iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:
    - 1. Measurable patient (or patient and caregiver) goals
    - 2. Medical needs including any behavioral health needs;
    - 3. Interventions;
    - 4. Intended outcomes; and
    - 5. Social, educational, and other services needed by the patient.
  - v. The Tier 3 AMH practice must have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.
  - vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.
  - vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.
  - viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted,

discharged, or transferred to/from an emergency department or hospital in real time or near real time.

- ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)
  - 1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
  - 2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
  - 3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication management post discharge)
- d. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication management to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.
  - i. The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:
    - 1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits
    - 2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
    - 3. NICU discharges;
    - 4. Clinical complexity, severity of condition, medications, risk score.
  - ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
  - iii. The Tier 3 AMH practice must include the following elements in transitional care management:
    - 1. Ensuring that a care manager is assigned to manage the transition
    - 2. Facilitating clinical handoffs;
    - 3. Obtaining a copy of the discharge plan/summary;
    - 4. Conducting medication management;
    - 5. Following-up by the assigned care manager rapidly following discharge;
    - 6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs

7. Developing a protocol for determining the appropriate timing and format of such outreach.
- e. Tier 3 AMH practices must use electronic data to promote care management.
  - i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.