NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #01

February 10, 2026

Agenda

1. Roll Call

2. CMARC/CMHRP Transition

3. AMH Measure Updates

4. NC InCK Updates

5. Public Facing Quality Measurement Dashboard

6. Revisiting Purpose of AMH TAG

AMH TAG Member Welcome and Roll Call

Name	Organization	Stakeholder
Charles Crawford, MD, MBA	*Pediatrician*, Coastal Children's Clinic	Provider (Independent)
David Rinehart, MD	*Past President*, North Carolina Academy of Family Physicians	Provider (Independent)
Richard Bunio, MD; Kimberly Reed, and Blake Few	*Representatives*, Cherokee Indian Hospital	Provider
Tommy Newton, MD, FAAFP	*Regional Medical Director*, Community Care Physician Network (CCPN)	Provider (CIN)
Jennifer A Houlihan	*Vice President Enterprise Population Health*, Atrium Health Wake Forest Baptist	Provider (CIN)
Karen Roby and Ramin Sadeghian	*Representatives*, Mission Health Partners (MHP)	Provider (CIN)
Lauren Lowery, MPH	*Director of Operations*, Carolina Medical Home Network	Provider (CIN)
Derrick Stiller	*Representative*, CHESS Health Solutions	Provider (CIN)
Tara Kinard, DNP, RN, and Carolyn Avery, MD, MHS	*Representatives*, Duke Connected Care	Provider (CIN)
Jason Foltz, DO	*Chief Medical Officer*, ECU Health Physicians	Provider (CIN)
Dr. Steve Spalding	*Chief Medical Officer*, AmeriHealth Caritas North Carolina, Inc.	Health Plan
Michael Ogden, MD	*Chief Medical Officer*, Blue Cross and Blue Shield of North Carolina	Health Plan
Chris Weathington, MHA	*Director of Practice Support*, NC Area Health Education Centers (NC AHEC)	AHEC
Eugenie Komives, MD	*Chief Medical Officer*, WellCare of North Carolina, Inc.	Health Plan
William Lawrence Jr., MD	*Chief Medical Officer*, Carolina Complete Health, Inc.	Health Plan
Dr. Derrick Hoover	*Chief Medical Officer*, United Healthcare	Health Plan
Chris Magryta, MD	*Chairman*, Children First of North Carolina	Provider

Meeting Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.

Reminders

Please note that we are not recording this call, and request that no one record this call or use an AI software/device to record or transcribe the call. DHHS is awaiting additional direction from our Privacy and Security Office on how we may need to support these AI tools. Thank you for your cooperation.

HIPAA-covered DHHS agencies which become aware of a suspected or known unauthorized acquisition, access, use, or disclosure of PHI shall immediately notify the DHHS Privacy and Security Office (PSO) by reporting the incident or complaint to the following link: https://security.ncdhhs.gov/

CMARC/CMHRP Transition

CMARC/CMHRP Transition Background

The Care Management for High-Risk Pregnancies (CMHRP) program provides care management services to eligible pregnant members (ages 14-44) determined to be at high-risk for adverse birth outcomes.

The Care Management for At-Risk Children (CMARC) program provides care management services for eligible children (ages 0 to 5) at risk for poor outcomes due to specific medical conditions, adverse childhood events, or physician referral.

Local Health Departments (LHDs) have historically provided care management to these populations. On July 1, 2026, contract language requiring PHPs to contract with Local Health Departments to deliver care management for these populations will expire. The PHPs will have discretion to determine how to best meet their members' care management needs in alignment with contract requirements and the Department's clinical coverage policies, while facilitating Member access to services as close to the point of care as feasible.

The Department had previously communicated messaging for PHPs and providers to stop sending referrals to LHDs on 3/1/25 for CMARC and CMHRP eligible members. DHB would like to update the last day of referrals for these members to be on 6/30/26 to the LHDs if there will be a change to the contract arrangement for these members. The currently contra
cted LHDs should be expected to manage the at-risk children and high-risk pregnant Medicaid members assigned to them through their contracted period, which the Department expects ends no sooner than 6/30/26.

Direction on referral process starting on 6/30/26 for situations where contract arrangements change will be clarified to PHPs, LHDs, and providers in coming months.

Future Vision: CMHRP and CMARC Programs

At-risk members should receive quality care management appropriate for their needs:

1. At-risk members should be identified early, to provide maximum opportunity for support and interventions.

2. Members must be risk-stratified, so that those with the highest needs receive intensive care sooner.

3. Members should receive the appropriate duration of care based on population need.

4. Members should receive continuity of care management support during and after the expiration of these contract requirements to work with LHDs.

5. Plans will be responsible for ensuring these members get the right support at the right time. SPs and TPs can serve these members either in-house, or can choose to contract with care management entities, including AMH Tier 3s, AMH+/CMAs, and/or LHDs.

- At-risk children and high-risk pregnant members continue to be NC Medicaid priority populations. Despite the expiration of contract requirements to work with LHDs, Standard Plans and Tailored Plans will ultimately be accountable for these populations receiving needed services.

- Target date for implementation is July 1, 2026 for contract and policy changes impacting this population.

- On July 1, 2026, the Department will no longer finance the platform Virtual Health for LHD Care Management documentation.

Downstream Implications

The expiration of contract requirements for Standard Plans and Tailored Plans to work exclusively with Local Health Departments to provide these services have a number of downstream impacts.

1. PHPs will need to determine how to meet the requirements to serve these populations. PHPs who maintain delegated arrangements to care manage these populations may need to update contracts or establish new contracts

2. DHB is reviewing the costs associated with meeting these members' needs using data from our managed care experience. This may result in updates to the capitation provided to Plans for these services.

3. Providers may no longer have a single county entity to which they will send Pregnancy Risk Screening forms, and PHPs will need to be able to quickly identify high risk-pregnant people and at-risk children.

4. LHDs will no longer have Department-funded care management technology to use for documenting care management services.

AMH Measure Updates

Introduction to AMH Tables

Note: All AMH Measures are stratified by three things: Black Binary, AI/AN Binary, and Ethnicity

2026 AMH Tables have been published!

The AMH measure set is meant to focus specifically on **primary care and care coordination**. Purpose is to provide some standardization to measures used in incentive arrangements for AMH providers.

All quality measures that Health Plans incorporate into contracts with AMH practices (all Tiers) must be taken from the AMH Measure Set. While Health Plans are not required to use all the AMH measures, any quality measure they choose must be drawn from this set.

Table1 : Current AMH Measure Set (2026)

Count	Measure Name	Steward
1	Adults' Access to Primary/Preventive Health Services (AAP)	NCQA
2	Cervical Cancer Screening (CCS-E)	NCQA
3	Child and Adolescent Well-Care Visits (WCV)	NCQA
4	Childhood Immunization Status (Combination 10) (CIS-E)	NCQA
5	Chlamydia Screening (CHL)	NCQA
6	Colorectal Cancer Screening (COL-E)	NCQA
7	Controlling High Blood Pressure (CBP)	NCQA
8	Glycemic Status Assessment for Patients with Diabetes (GSD)**	NCQA
9	Immunizations for Adolescents (Combination 2) (IMA-E)	NCQA
10	Prenatal and Postpartum Care (PPC)	NCQA
11	Well-Child Visits in the First 30 Months of Life (W30)	NCQA

**Previously known as Hemoglobin A1c Control for Patients with Diabetes (HBD), this measure title and its associated specifications have been slightly modified by the measure steward.

PPC added to the AMH set in the 2023 tech specs. As such, the first measurement year in which this measure can be incentivized as an AMH measure is 2024.
COL added to the AMH set in the 2024 tech specs. As such, the first measurement year in which this measure can be incentivized as an AMH measure is 2025.
AAP added to the AMH set in the 2025 tech specs. As such, the first measurement year in which this measure can be incentivized as an AMH measure in 2026.

Summary of Trends (MY2023-2024) Total NC Medicaid

Priority Area	Measure Name	Trend
Women's Health	Cervical Cancer Screening (CCS-E)	↓
	Chlamydia Screening (CHL) - Total	↑
	Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	↑
	Prenatal and Postpartum Care (PPC) - Postpartum Care	↑
Child & Adolescent Health	Child and Adolescent Well-Care Visits (WCV) - Total	↑
	Childhood Immunization Status (CIS-E) - Combination 10	↓
	Immunizations for Adolescents (IMA-E) - Combination 2	↑
	Well-Child Visits in the First 30 Months of Life (W30) - First 15 Months	↑
	Well-Child Visits in the First 30 Months of Life (W30) - 15-30 Months	↑
Chronic Health/ General Access	Colorectal Cancer Screening (COL-E)	↑
	Controlling High Blood Pressure (CBP)	↑
	Glycemic Status Assessment for Patients with Diabetes (GSD)** <8.0%	↑
	Glycemic Status Assessment for Patients with Diabetes (GSD)** >9.0%	↑
	Adult Access to Preventive and Ambulatory Health Services (AAP)	↑

**Previously known as Hemoglobin A1c Control for Patients with Diabetes (HBD), this measure title and its associated specifications have been slightly modified by the measure steward.

NC Medicaid | Advanced Medical Home (AMH) Measure Set

NC InCK Updates

InCK Updates and Closeout

1. The previously announced NC InCK PMPM reduction will not go into effect and the PMPM will remain unchanged from the amount provided prior to 10/1/25.

2. NC InCK care management process and procedures are the same.

3. DHB is still proposing a reduction in InCK APM measures from six to two. Only the Kindergarten Readiness Bundle and the Food Insecurity and Housing Instability Screening measures would be tied to incentive payments.

4. The NC InCK pilot will end on December 31, 2026, and DHB will begin to provide guidance on care management transition and program closeout procedures.

5. More specific details will follow but DHB expects new InCK care management enrollment to end this summer and transition planning to begin this fall.

Public Facing Quality Measurement Dashboard

Public Facing Quality Measurement Dashboard

Promote transparency around quality measurement performance
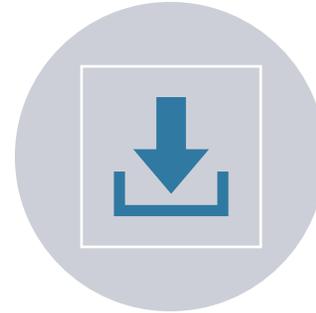
Reduce burden from ad-hoc data pulls

Increase **stakeholder engagement and awareness** of performance

User friendly tool that can be tailored to interests

QM Dashboard

To provide greater visibility into North Carolina Medicaid's quality measurement performance, NC Medicaid developed a public-facing Quality Measures Dashboard.

The dashboard enables users to:
- visualize quality measurement data,
- compare performance across managed care plans, and
- stratify quality measures by race, gender, language, age, and geography.
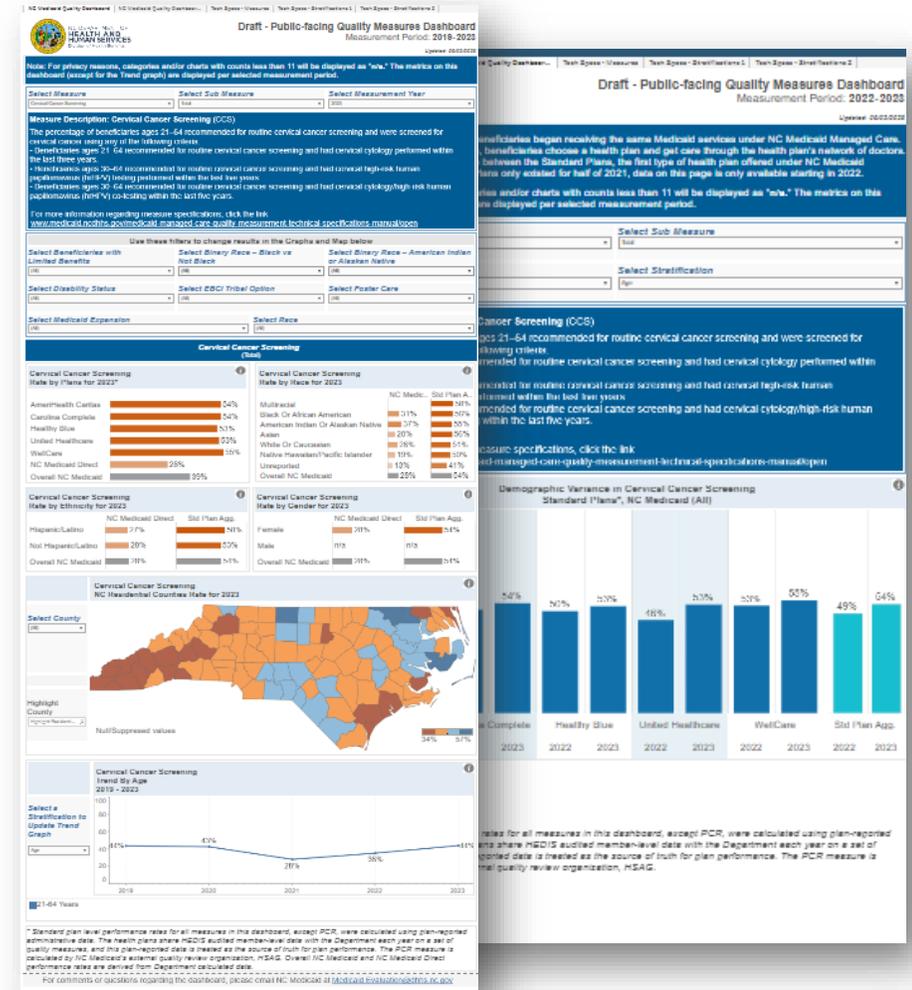
Measures Included in the Dashboard

Measure Steward	Measure Name
First Phase (available now)	
NCQA	*Prenatal and Postpartum Care (PPC)*
NCQA	*Follow-Up After Hospitalization for Mental Illness (FUH)*
NCQA	*Well-Child Visits in the First 30 Months of Life (W30)*
NCQA	*Child and Adolescent WellCare Visits (WCV)*
NCQA	*Cervical Cancer Screening (CCS)*
NCQA	*Colorectal Cancer Screening (COL)*
NCQA	*Childhood Immunization Status (CIS)*
NCQA	*Chlamydia Screening in Women (CHL)*
NCQA	*Immunizations for Adolescents (IMA)*
NCQA	*Plan All-Cause Readmission (PCR)*
Second Phase (coming soon)	
DQA	*Oral Evaluation, Dental Services (OEV)*
NCQA	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*
NCQA	*Initiation and Engagement of Substance Use Disorder (SUD) Treatment (IET)*
NCQA	*Asthma Medication Ratio (AMR)*
OPA	*Contraceptive Care - Postpartum Women (CCP)*

Stratifications

- Measurement Year
- Beneficiaries with Limited Benefits
- Binary Race or separate race(s)
- Disability Status
- EBCI Tribal Option
- Foster Care
- Medicaid Expansion

Dashboard Link

https://medicaid.ncdhhs.gov/reports/dashboards/quality-measures-dashboard

Revisiting Purpose and Intent of AMH TAG

Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Purpose
- Advise and inform NC Medicaid on key aspects of the design and evolution of the Advanced Medical Home (AMH) program and related quality, evaluation and population health topics

Representation
- Advisory body of approximately fifteen (15) invited participants from PHPs, AMH practices, and other AMH partners including CINs
- Chaired by NC Medicaid staff

Process
- Meet every other month, virtually or in-person
- Weigh in on strategic and policy issues related to NC Medicaid's population health, quality, and evaluation
- Create ad-hoc technical groups ("subcommittees"), as needed and as NC Medicaid capacity allows, to develop formal recommendations on technical aspects of the program that require greater degrees of expertise
- Participate in dialogue to provide inputs and updates on NC Medicaid initiatives

AMH TAG Meetings and Member Expectations

Meetings

Recommendations of the AMH TAG are advisory only

Decisions to act upon any recommendations are made at the sole discretion of NC Medicaid

For each meeting topic, DHHS will brief the TAG and then through a discussion, solicit recommendations from a range of options

Designated Participants

Will have a one-year term with an optional second year

At the one-year mark, may choose to continue serving on the TAG or forfeit their seat to NC Medicaid to select a replacement candidate

Are expected to attend consistently and participate in meetings to provide meaningful feedback on policy and programmatic issues related to AMH implementation

Will take issues raised in the TAG back to their organizations to promote dialog and communication between the TAG and a broader group of stakeholders

Attendee Expectations

All attendees (designated participants, other attendees, and DHHS staff) are expected to abide by the AMH TAG expectations

Participants are expected to engage professionally and respectfully with presenters and other attendees at all times, even when there is not agreement

Harassing, demeaning, or threatening language toward presenters or participants will not be tolerated

Attendees should remain muted until they are called on to speak

Attendees may share questions or comments in the chat at any time

The chair or facilitator may mute, remove, or limit participation of attendees who disrupt the meeting

Recording meetings, including use of AI tools, is not allowed unless pre-approved

Discussions of non-publicly available rates are not allowed

Questions

Wrap-Up

AMH TAG Wrap-Up and Future Topics

AMH TAG meetings will generally take place the second Tuesday of every other month from 4PM - 5PM.

Upcoming 2026 Meetings
Tuesday, April 14, 2026 4pm – 5pm

Potential Upcoming AMH TAG Topics
** Please submit discussion topics to Medicaid.AdvancedMedicalHome@dhhs.nc.gov **

CMARC/CMHRP 2026 Transition – Key Milestones

Jan 2026 – July 2026

Contract Amendments
- ◆ SP/TP 2026-1 Contract Amendments Submitted **(12/1/25 - 1/16/26)**
- ◆ PCCME 2026-1 Contract Amendment Submitted **(2/1/26 – 3/1/26)**

Medicaid Direct Approach
- ◆ Finalize Medicaid Direct Vendor and log decision **(1/15/26 – 2/20/26)**

SP/TP Payment Updates
- ◆ Share updated CM rate assumptions with Plans **(12/1/25 – 2/9/26)**
- ◆ Plans notify DHB of their LHD contracting status **(2/9/26 – 2/20/26)**

PRS Direction
- ◆ Decision for PRS incentive payments and Provider direction **(2/15/26)**
- ◆ New PRS workflow communicated to Plans and Providers **(3/1/26 – 4/1/26)**

Documentation Updates
- ◆ Updated AMH Provider Manual / new Care Management model published **(2/1/26 – 4/1/26)**

Integration and Report Updates
- ◆ File Decommissioning Kickoff with Plans **(12/1/25 – 3/1/26)**
- ◆ Updated Reporting Guides published **(3/1/26 – 4/1/26)**

Communications
- ◆ Publish Provider Bulletin explaining LHD's role **(1/15/26 – 2/6/26)**
- ◆ LHD Winddown Update **(1/27/26 – 2/6/26)**

Plan of Safe Care (POSC)
- ◆ Finalize Population Health's role and next steps **(2/5/26)**
- ◆ Log decision on POSC approach **(4/1/26)**