[DRAFT for Feedback] AMH Standardized Performance Incentive Program Policy Guide

North Carolina Department of Health and Human Services

March 21, 2025

AMH Standardized Performance Incentive Program Policy Guide

Updated as of 3/20/25

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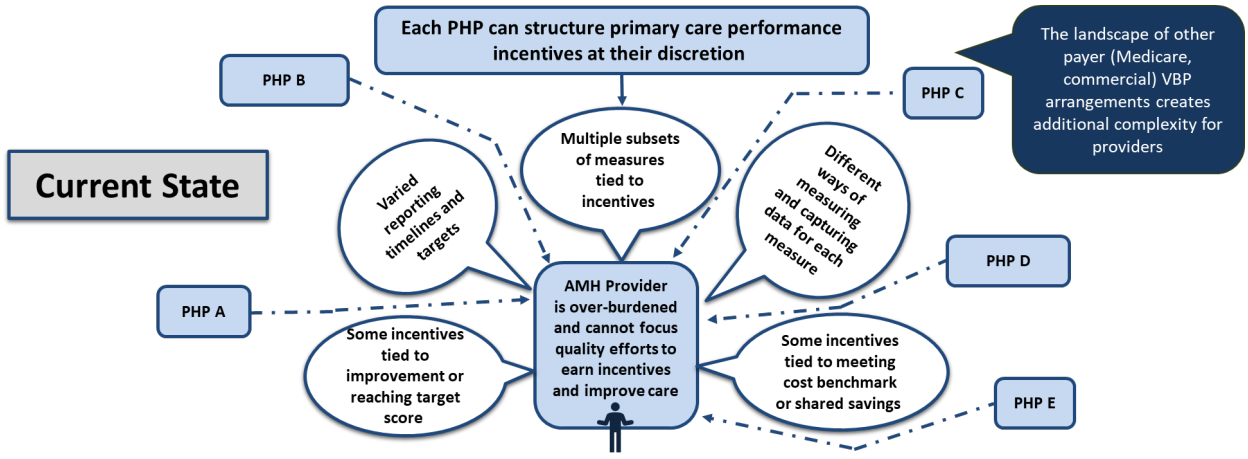
Introduction & Background

The Advanced Medical Home (AMH) is NC Medicaid's cornerstone primary care program, serving more than two million Medicaid beneficiaries across the state. To improve program sustainability and more clearly align incentives between state policy makers, providers and health plans, NC Medicaid is evaluating changes to reimbursement and payment models in the AMH program. Innovative primary care payment is critical to supporting practice improvements that lead to the outcomes that matter to Medicaid enrollees and their families.

NC Medicaid has long encouraged AMHs and the prepaid health plans (PHPs) – which include Standard Plans and Behavioral Health Intellectual/ Developmental Disabilities (I/DD) Tailored Plans – to enter value-based payment (VBP) arrangements, which incentivize high value care, improve program efficiency, and align with the goals set forth in North Carolina's Quality Strategy. Specifically, Standard Plans and Tailored Plans are currently required to offer performance incentive payment arrangements to AMH practices based on a defined set of AMH quality measures (additional details on AMH program requirements can be found in the AMH Provider Manual). However, provider feedback and formal Standard Plan reporting indicate that individual approaches to these arrangements vary widely – while some are meaningful, others have paid out very little in performance incentives. The arrangements often incentivize different measures and have varied practice qualifications. This variability makes it difficult for AMH practices to consistently participate in incentive arrangements across plans, and to focus and align their quality improvement efforts for Medicaid patients.

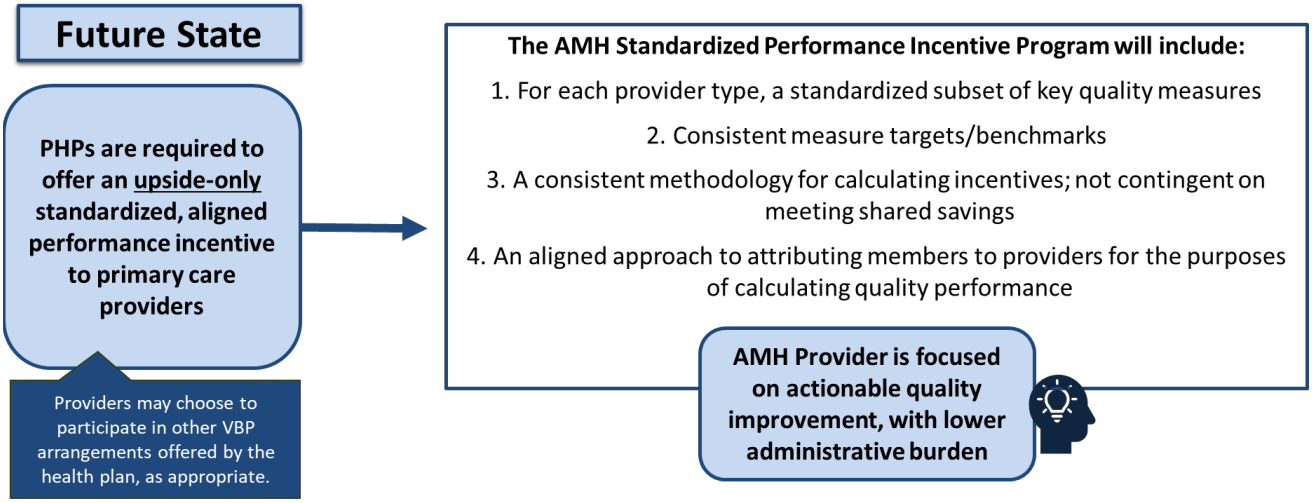
Current State of AMH Performance Incentive Payment Arrangements



In response to these challenges, **NC Medicaid plans to implement an AMH Standardized Performance Incentive program in 2026, described in more detail in this draft Policy Guide for community partner input**. Further standardization will help lower administrative burden for AMH practices, allowing practices to focus their quality improvement efforts on select key outcomes. The Department intends to require that Standard Plans and Behavioral Health and

I/DD Tailored Plans offer the Standardized Performance Incentive program to all AMHs; however, this policy may depend on funding and CMS approvals (see "Incentive Payments" section for more detail). The requirement for Standard Plans and Tailored Plans to offer this program would be an evolution of current requirements for health plans to offer performance incentives to AMH Tier 3 practices. However, participation in this program is optional for AMH practices, and PHPs and AMHs may agree to other VBP models in addition to or in lieu of this program, if desired. To enable all AMHs, including smaller practices and those with limited VBP experience, to successfully participate in this new program, the AMH Standardized Incentive program will be upside-only, meaning AMH practices will not be at risk for any penalties or shared losses, and eligibility for performance incentive payments will not be contingent upon achieving cost savings or care utilization reductions.[1]

AMH Standardized Performance Incentive Payments



The AMH Standardized Performance Incentive program was also developed in consideration of North Carolina's participation in the Centers for Medicare & Medicaid Services (CMS) Making Care Primary (MCP) model – a multi-payer model aimed at strengthening primary care and reducing overall total cost of care by aligning Medicare, Medicaid, and commercial payers. North Carolina was selected as one of eight participating MCP states in 2023. **On March 12, 2025, CMS announced the Making Care Primary model will be terminated by Dec. 31, 2025,**

[1] The upside-only nature of this Standardized Performance Incentive program is meant to allow all AMHs, including smaller practices and those with limited VBP experience, to successfully participate in this new program. Historically, VBP arrangements with savings targets are typically limited to larger practice groups, clinical networks, and/or systems that have panel sizes sufficient to calculate savings reliably (these types of entities generally have more experience with VBP). These practices that are more experienced with VBP can continue to participate in shared savings models and other models with risk components with PHPs, and this proposed model design is not intended to reduce AMH participation in risk-based VBP models but serve as a glidepath to more adoption longer term.

ending nine years earlier than planned. The AMH program was already aligned with MCP in several ways, including emphasis on local care management, advanced, team-based primary care, quality improvement, incorporating social determinants of health screening, and increasing investments in primary care through payments beyond fee-for-service. **While the Medicare Making Care Primary model will not be continuing, the Department's proposed AMH Standardized Performance Incentive program remains an important step to advance NC Medicaid's goals of reducing provider burden and improving health outcomes.** NC Medicaid will consider future primary care payment and care delivery reforms, including prospective payment, based on learnings from other states, market readiness, and sufficient state capacity to implement more advanced VBP models.

The AMH Standardized Performance Incentive program will include consistent:

- Performance periods and payment timelines
- Broad AMH practice eligibility to participate
- A single, common set of quality performance measures for each practice type (i.e., Adult Practice, Child Practice, Mixed-Age Practice)
- Quality performance attribution methodology
- Measure performance targets
- Methodology for calculating incentives

NC Medicaid is also considering prescribing a standard and transparent minimum performance incentive dollar amount that providers would earn for achieving targets on each of the specified measures. A standard incentive amount would help ensure that incentive payments are meaningful enough to drive quality improvement and available to all AMH practices who wish to participate in the program. However, the Department would only prescribe a minimum incentive amount if supported by available state funding and dependent on CMS approval.

Additional detail on each of these proposed program elements is found in this draft Policy Guide for community partner input. Additional details on the AMH program and existing VBP requirements for Standard Plans and Tailored Plans in the program can be found in the AMH Provider Manual.

Goals of the AMH Standardized Performance Incentive Program

The AMH Standardized Performance Incentive program is aligned with several existing NC Medicaid initiatives, including the Quality Strategy and Standard Plan Withhold Program. The goals for the AMH Standardized Performance Incentive program are to:

1. Support continued investments in primary care;
2. Improve quality outcomes and reduce disparities;

3. Maintain strong access to primary care and improve member engagement;
4. Further integrate behavioral health and health-related resource needs in primary care; and
5. Increase provider flexibility and payment transparency while lowering administrative burden

Seeking Feedback on the AMH Standardized Performance Incentive Program

Since Fall 2023, NC Medicaid has convened community partners, including providers, Standard Plans and Tailored Plans, and Clinically Integrated Networks (CINs)[2] to discuss the current landscape of VBP arrangements and identify further opportunities for alignment between the AMH program and the Medicare MCP model, and has conducted an intensive design process to develop the AMH Standardized Performance Incentive program. With this draft policy guide, NC Medicaid is seeking additional feedback from community partners on the design of the program. Specifically, NC Medicaid requests feedback on the following questions:

- What about the AMH Standardized Performance Incentive program is attractive to your organization? Would AMH providers and CINs be interested in participating in the program?
- Are there elements that would be challenging to implement, or make it burdensome for AMH practices to participate in the program? How could those challenges be addressed?
- Given your past experience with VBP models, are there any lessons learned that should be reflected in the design of this model?
- Is there interest in the AMH Standardized Performance Incentive program despite the termination of the Medicare Making Care Primary model?

All policies described in this draft are subject to change based on community partner feedback, available State budget, and CMS approval to support implementation of the program. Written feedback can be sent to Medicaid.NCEngagement@dhhs.nc.gov with the subject line "AMH Standardized Performance Incentive Program Feedback" by **April 21, 2025**.

Proposed Performance Periods and Payment Timeline

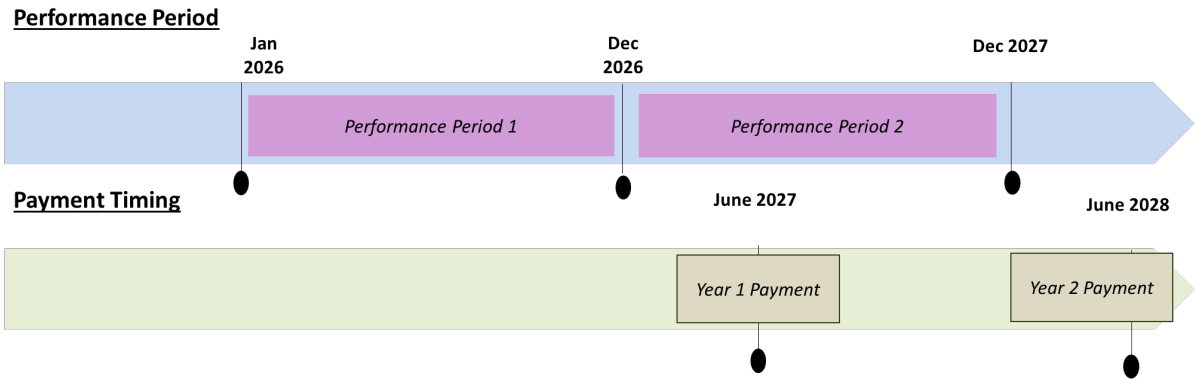
Performance periods for the AMH Standardized Performance Incentive program will align with the calendar year. NC Medicaid anticipates the first performance measurement period will begin Jan. 1, 2026, and end Dec. 31, 2026. Standard Plans and Tailored Plans will be required to distribute incentive payments to AMH practices no later than six months after the completion of

[2] AMH practices may choose to work with CINs and other partners to help collect, compile, analyze, and exchange data. CINs may include hospitals, health systems, integrated delivery networks, independent practice associations, and other provider-based networks and associations, and may offer a wide range of administrative support to AMH practices, clinical staffing resources, care delivery wraparound services, and/or technology services.

each performance period (e.g., anticipated to be no later than June 31, 2027, for the first year of the program).

Figure 1 summarizes the proposed AMH Standardized Performance Incentive program timeline for the first two performance years.

Figure 1: Proposed Timeline for AMH Standardized Performance Incentive program



AMH Practice Participation

The Department intends to require that Standard Plans and Behavioral Health and I/DD Tailored Plans offer the Standardized Performance Incentive program to all AMHs, regardless of practice size; however, this policy may depend on funding and CMS approvals (see "Incentive Payments" section for more detail). This approach would allow practices with no or minimal VBP experience to participate in the program.

AMH participation in the program is *optional*. Standard Plans and Tailored Plans can continue to offer AMH practices other VBP arrangements and AMHs may choose to participate in other VBP arrangements. These other VBP arrangements may include shared savings/risk arrangements, prospective payment models, or performance incentive programs that include other AMH measures not proposed for this program.

AMH practices will participate in the program using a Taxpayer Identification Number (TIN), giving practices the opportunity to participate as part of a larger health system or CIN if they choose. Information on participation for practices with small panel sizes is included in the section below. In instances where an AMH practice is affiliated with multiple TINs (e.g., at the practice level and at the health system level), the AMH practice will have the discretion to decide which TIN to use when contracting with Standard Plans and Tailored Plans.

Recognizing that AMH practices include internal medicine practices, pediatricians, family practices, community health centers, and other types of primary care practices, NC Medicaid developed the program with three measure sets—adult, child, and mixed-age— each specific to

the population of members a practice sees *(more information on measure sets below).* Participating AMH practice TINs (henceforth referred to as "participants") will be assigned to a measure set based on the reported ages of their member populations in NCTracks. For example, if a participant reports they serve members ages 0-120, they will participate in the program using the mixed-age measure set; if a participant reports they provide services only to patients under the age of 18, they will participate using the child measure set. If a participating TIN includes multiple practices that serve both adults and children (e.g., a health system with pediatrics, internal medicine, and family medicine practices), the TIN will participate in the program using the mixed-age measure set.

Quality Measure Sets

Measure Set Selection Criteria

NC Medicaid has developed three measure sets, derived from a common set of quality measures, for inclusion in the AMH Standardized Performance Incentive program. The three measure sets are for three participant types: the adult measure set, the child measure set, and the mixed-age measure set. As described above, a participant would only be assigned to one measure set for this program, based on the reported ages of their member populations in NC Tracks.

NC Medicaid used several guiding principles to select quality measures for this program, in alignment with stakeholder feedback, including:

1. Performance on the measures should align with NC Medicaid's Quality Strategy, advance overall Medicaid performance improvement, and/or close disparities in outcomes.
2. Measures should be AMH-sensitive; participants should be able to influence outcomes directly or indirectly through the provision of high-quality, advanced primary care as envisioned under the AMH model.
3. Measures should align with other measure sets (e.g., Standard Plan Withhold, CMS Universal Foundation) where appropriate and feasible, to reduce administrative burden and reinforce shared quality goals across PHPs and AMH practices.
4. Measures should be applicable to all AMH practices, including those that do not have delegated care management responsibilities.

Adult, Child, and Mixed-Age Measure Sets

Using these criteria, NC Medicaid identified measures for inclusion across the three measure sets. Each measure set contains between five and eight measures, including no more than four pay-for-performance measures and a small set of pay-for-reporting measures. The list of

selected measures is outlined in Table 1, with information on the rationale for including each measure outlined in Table 2.

Table 1: AMH Standardized Performance Incentive Measures

Adult Measures	Child Measures	Family Practices
Pay-For-Performance Measures		
Adults' Access to Preventive/Ambulatory Health Services		Adults' Access to Preventive/Ambulatory Health Services
Cervical Cancer Screening		Cervical Cancer Screening
Colorectal Cancer Screening		
	Child and Adolescent Well Care Visit (WCV)	Child and Adolescent Well Care Visit (WCV)
	Childhood Immunization Status (CIS) – Combo 10	Childhood Immunization Status (CIS) – Comb. 10
	Well-child Visits in First 30 Months of Life (0-15 months)	
	Immunizations for Adolescents (IMA) – Combo 2	
Pay-for-Reporting Measures		
Screening for Depression & Follow Up	Screening for Depression & Follow Up	Screening for Depression & Follow Up
Controlling High Blood Pressure		Controlling High Blood Pressure
Glycemic Status Assessment for Patients With Diabetes		Glycemic Status Assessment for Patients With Diabetes
Person-Centered Primary Care Survey*	Person-Centered Primary Care Survey*	Person-Centered Primary Care Survey*

*Person-Centered Primary Care Survey is an optional measure for Year 1 of the program.

Table 2: Measure Descriptions and Rationale for Inclusion

Measure	Description	Rationale for Inclusion
Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit.	• Promotes the Quality Strategy goal to ensure appropriate access to care • AMH sensitive
Colorectal Cancer Screening	Percentage of beneficiaries ages 45 to 75 who had appropriate screening for colorectal cancer.	• Promotes the Quality Strategy objective to ensure timely access to care • AMH sensitive •
Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using any of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last three years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years	• Aligns with the Quality Strategy objective to promote women's health • AMH sensitive • Aligns with proposed 2026 Medicaid Withhold program measures • Opportunity to advance improvement; NC Medicaid's current performance is below the national median of Medicaid HMO performance

	• Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years	
Immunizations for Adolescents (Combo 2)	Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	• Aligns with the Quality Strategy objective to promote child health and wellness • AMH sensitive • Aligns with proposed 2026 Medicaid Withhold program measures • Opportunity to advance improvement and close disparities; NC Medicaid's current performance is below the national median of Medicaid HMO performance and there are identified disparities in measure performance among the Black/African American population
Child Immunization Status (Combo 10)	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	• Aligns with the Quality Strategy objective to promote child health and wellness • AMH sensitive • Aligns with proposed 2026 Medicaid Withhold program measures • Opportunity to advance improvement and close disparities; NC Medicaid's current performance is below the national median of Medicaid HMO performance and there are identified disparities in measure performance among the Black/African American population
Well-child Visits (0-15 mo.)	The percentage of children who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider (PCP) during the last 15 months.	• Aligns with the Quality Strategy objective to promote child health and wellness • AMH sensitive • Aligns with proposed 2026 Medicaid Withhold program measures • Opportunity to advance improvement and close disparities; NC Medicaid's current

		performance is below the national median of Medicaid HMO performance and there identified are disparities in measure performance among the Black/African American population
Child and Adolescent Well-Care Visits (WCV)	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	• Aligns with the Quality Strategy objective to promote child health and wellness • AMH sensitive
Person-Centered Primary Care (PCPCM)	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.	• Promotes the Quality Strategy objective to promote patient engagement • AMH sensitive • Pay for Reporting and optional in Year 1, because this is a new survey which will require AMH practice resources to implement
Controlling High Blood Pressure	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	• Aligns with the Quality Strategy objective to improve hypertension management • AMH sensitive • Pay for reporting in Year 1, because of insufficient data quality as a digitally reported measure through NC HealthConnex
Glycemic Status Assessment for Patients With Diabetes	Percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) >9.0% during the measurement year. Note: Lower rates indicate better performance for this indicator	• Aligns with the Quality Strategy objective to improve diabetes management • AMH sensitive • Pay for reporting in Year 1, because of insufficient data quality as a digitally reported measure through NC HealthConnex

Screening for Depression and Follow-up	Percentage of beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter. Ages reported are: • 12 – 17 years old • 18+ years old	• Aligns with the Quality Strategy objective to improve behavioral health care • AMH sensitive • Pay for reporting in Year 1, because of insufficient data quality as a digitally reported measure through NC HealthConnex

Note: While several measures will be pay-for-reporting in the first year because of currently insufficient data quality, improving the data quality of these measures as digitally reported measures through NC HealthConnex (North Carolina's health information exchange) is a high priority for NC Medicaid, and aligns with efforts to achieve digital quality reporting under the State Transformation Collaborative. NC Medicaid intends to transition the pay-for-reporting measures to pay-for-performance, as digitally reported measures, as soon as appropriate. For additional detail on pay-for-reporting measures, see the Pay-for-Reporting Targets section below.

Specifications for each performance measure can be found in NC Medicaid's Quality Measurement Technical Specifications Manual available on NC Medicaid's Quality Management and Improvement page. Additional specifications for Person-Centered Primary Care will be included in a forthcoming update to the Technical Specifications.

Attribution Approach

In the AMH Standardized Performance Incentive program, participants will be accountable for their performance against measures for their attributed members.[3] NC Medicaid has developed an approach to defining attributed members that is based upon AMH member assignment at the TIN level. Attributed members for this model will be those that have been assigned[4] to the participating TIN for the longest amount of time within the performance period. For example, if a member is assigned to TIN "A" from Jan. 1, 2026 – March 15, 2026, and is then assigned to TIN

[3] Attribution is the process to associate a member to the TIN accountable for the member's care and quality outcomes. Depending on program rules, not all members who are assigned to a TIN at a given time *(see assignment description below)* may be attributed to the TIN.

[4] In the NC Medicaid program, members can choose their primary care provider/AMH when they enroll with their Plan. If they do not select a primary care provider, they are assigned to an AMH using an algorithm that considers their care history, family member primary care assignment, geographic location, and special medical needs or language preferences. Assignment ensures all members have a provider available to serve as a medical home but does not guarantee the member will see that assigned provider.

"B" from March 16, 2026 – Dec. 31, 2026, they would be attributed to TIN B for the purposes of the program. In the case of a tie, the member will be assigned based on the participating TIN that provided the most recent primary care services. Measure technical specifications align with the Healthcare Effectiveness Data and Information Set (HEDIS) requirements for continuous coverage eligibility (e.g., rules specifying the maximum amount of time a member can have a gap in coverage). Measure technical specifications, including requirements for continuous coverage eligibility, define the subset of members assigned to an AMH practice that are eligible for a given quality measure. In the case of members assigned to multiple AMH practices during a measurement year, the AMH Standardized Performance Incentive program will leverage the attribution rules (described above), to ensure each member is only attributed to one provider per measurement year.

This approach recognizes the intent for AMH practices to serve as medical homes for the members assigned to them and aligns accountability for the quality of member care with this foundational AMH assignment.

Standard Plans and Tailored Plans will be required to share interim attribution lists with participants on a quarterly basis, based on the calendar year (i.e., Q1 list by March 31, Q2 list by June 30, Q3 list by September 30, Q4 list by December 31). This regular communication will support participants in conducting outreach to new or unengaged members.

Performance Targets

Incentive payments will be calculated based on the performance of each participant (i.e., each participating TIN). The AMH Standardized Performance Incentive program will utilize a scoring approach that incentivizes both achievement and improvement, providing clear performance targets while also encouraging lower performing practices to improve. Participants can earn incentive payments proportional to their assigned member panels and the number of measure targets they achieve, based on standardized measure weights. The following measures will be pay-for-performance in year 1 of the program: Adults' Access to Preventive/Ambulatory Health Services, Colorectal Cancer Screening, Cervical Cancer Screening, Immunizations for Adolescents (Combo 2), Child Immunization Status (Combo 10), Well-child Visits (0-15 mo.), and Child and Adolescent Well-Care Visits (WCV). See Table 3 for an overview of the performance targets for each measure.

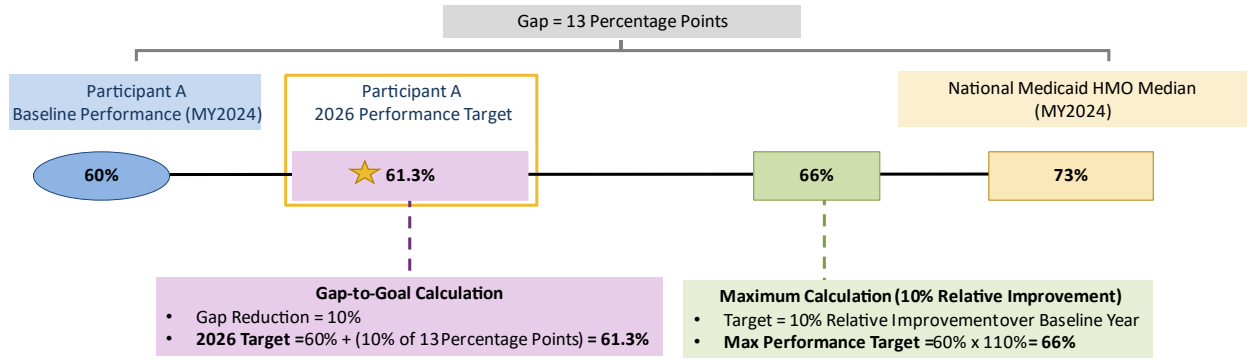
Pay-for-Performance Targets

Gap-to-Goal Methodology

For all pay-for-performance measures except Child Immunization Status (Combo 10), participants can achieve the incentive by either:

1. Meeting a standardized benchmark of the national Medicaid Health Maintenance Organizations (HMO) median performance[5], or
2. Reducing the gap between baseline year performance and the standardized benchmark by 10%, up to a maximum of 10% relative improvement over the baseline year performance

Figure 2: Example of Pay-for-Performance Improvement Target Calculation



With a baseline performance of 60%, Participant A will have a 2026 performance target of 61.3% (i.e., the gap -to-goal calculation).

For example, if the national median Medicare HMO performance for a measure is 73%, the participant would achieve the incentive if they performed at or above that level. In addition, they would have the opportunity to achieve the incentive by demonstrating improvement over a baseline performance. In the same scenario (national benchmark is 73%), with participant A's baseline performance being below the benchmark at 67%, the improvement target would be calculated as follows: Baseline performance + (10% × gap between baseline performance and the national Medicaid HMO median performance). See Figure 2 for a visual example of how improvement targets are calculated. The baseline year for the performance improvement targets will be two years prior to the program performance year. For example, in the first proposed performance year (January 2026 – December 2026), the baseline year for improvement calculation will be January 2024 – December 2024.

This "gap-to-goal" approach aligns with the proposed methodology for NC Medicaid's 2026 Standard Plan Withhold program and may be updated, based on final plan-level targeting methodology.

Population-Specific Targets

The child and mixed-age practice measure sets include measures with identified disparities in performance among specified populations (there were no measures with identified disparities in the adult measure set). NC Medicaid defines "disparity" as greater than 10% relative

[5] DHHS will use the NCQA Quality Compass as the source for national Medicaid Health Maintenance Organizations (HMO) median performance

difference in performance between the specified population (group of interest) and the reference group, as outlined in the NC Medicaid's Quality Measurement Technical Specifications Manual. For measures where there are identified disparities, NC Medicaid will also include a population-specific target in the AMH Standardized Performance Incentive program. Based on the latest NC Medicaid performance against the proposed measures, there are population-specific targets for the Black/African American population in the proposed child and mixed-age practice measure sets. Population-specific targets will be calculated using the same methodology as the overall population targets, using data only from attributed members within the population of focus. For measures with a population-specific target and for which NC Medicaid performance is below the national median, participants will be incentivized to meet both the overall and the population-specific targets. For Well-Child Visits (0-15 mo.), participants are only incentivized to meet a population-specific target, because North Carolina's Medicaid performance is above the national median.

Child Immunization Status Performance Calculation

In recognition of declining national performance trends for the Child Immunization Status (Combo 10) measure[6], NC Medicaid will use a scoring methodology that allows participants to achieve the benchmark by outperforming concurrent national trends. During the first measurement year of the program, the participant's performance relative change from

Figure 3: Example Combo 10 Minimum Performance Target Calculation

measurement year 2025 to measurement year 2026 must outperform national Medicaid HMO median trends during those same measurement years by 60%. See Figure 3 for an example of how the minimum performance target is calculated for a provider, if the relative change for the National Medicaid Median HMO is a decline of 11%. This methodology aligns with NC Medicaid's approach to Combo 10 measurement in the 2025 Standard Plan Withhold program. NC Medicaid will continue to consider the targeting approaches for this program and any plan-level withhold programs in future years to support aligned performance targets for both Plans and AMH practices.

[6] The Combo 10 measure includes the following vaccines: Diphtheria, tetanus and acellular pertussis (DTaP), polio (IPV), measles, mumps and rubella (MMR), haemophilus influenza type B (HiB), hepatitis B (Hep B), chicken pox (VZV), pneumococcal conjugate (PCV), hepatitis A (HepA), rotavirus (RV), and influenza (flu). See technical specifications for additional detail.

Population	Combo 10: Overall Performance Relative Change from MY 2024 – MY2025	Combo 10 Overall Performance: Standard Plan Relative Change Compared to National Median Relative Change
National Medicaid HMO Median	**-11.0%**	N/A
Minimum Performance Target for Provider A	**-4.4%**	[(-11.0%) – (-4.4%)] / (-11.0%) *100 = 60.0%
If the National Medicaid HMO Median Performance declines by 11.0% between MY 2024 and MY 2025, Provider A's performance must decline by 4.4% or less over that same period.		

Pay-for-Reporting Targets

Year 1 Reporting Criteria

For the first year of the program, participants will receive credit for one or more measures by reporting any valid value[7] (i.e., pay-for-reporting). The following measures will be pay-for-reporting in year 1 of the AMH Standardized Performance Incentive program: Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes, Screening for Depression and Follow-up, and Person-Centered Primary Care (optional).

For measure sets with more than one required pay-for-reporting measure (e.g., adult measure set, mixed-age measure set), participants must meet the standards for all required pay-for-reporting measures to receive the pay-for-reporting incentive amount. For example, if a participant in the adult measures set reports valid data for Controlling for High Blood Pressure and Screening for Depression and Follow-up, but not Glycemic Status Assessment for Patients With Diabetes, they will not meet the pay-for-reporting requirements and will not receive the portion of the incentive tied to pay-for-reporting measures. The proposed child measure set includes only one required pay-for-reporting measure in the first year of the program.

Pay for Reporting Measures in Year 2 and Beyond

NC Medicaid will continue to evolve the AMH Standardized Performance Incentive program to support further improvements in data quality, including prioritizing incorporation of dQMs reported through the HIE, in alignment with Department priorities and the North Carolina State Transformation Collaborative. NC Medicaid will update pay-for-reporting targets to require full, complete, and timely reporting of measures through the HIE, starting with Controlling for High Blood Pressure, Screening for Depression and Follow-up, and Glycemic Status Assessment for Patients With Diabetes, as soon as appropriate following the first year. Additionally, NC Medicaid intends to transition these measures to pay-for-performance measures as soon as appropriate. These measures are key indicators of high-quality, advanced primary care delivery. NC Medicaid continues to work with AMH practices to implement dQM reporting of these

[7] The any valid value reporting standard requires participants to report data for all required pay-for-reporting measures. This standard does not require participants to report measure performance data in a specific file format or structure, nor do participants have to report complete measure data for all members.

measures and support practices in building the infrastructure to report timely, accurate, and valid data through the HIE.

Person-Centered Primary Care Measure

NC Medicaid proposes including the Person-Centered Primary Care measure as an optional pay-for-reporting measure during the first year of the program. Measuring patient experience with their primary care medical home is a priority of NC Medicaid. The measure was well-aligned with the Medicare Making Care Primary model, and NC Medicaid intended in future years to make the measure a requirement of the program, and eventually a pay-for-performance measure. However, NC Medicaid has received feedback from many Medicaid providers that they do not have experience with this measure, and it may require additional supports to administer the measure survey to patients in the first years of the program. **NC Medicaid welcomes feedback regarding whether there is support for including the measure considering the termination of the Medicare Making Care Primary model, and if there are supports providers would need to adopt the measure in the early years of the program.**

Table 3: Overview of Measure Performance Populations and Targets

Measure	Population(s)	Performance Target
Adults' Access to Preventive/ Ambulatory Health Services	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance
Colorectal Cancer Screening	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance
Cervical Cancer Screening	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance
Immunizations for Adolescents (Combo 2)	Overall and Priority	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative

		improvement over the baseline year performance
Child Immunization Status (Combo 10)	Overall and Priority	Overperformance of national Medicaid HMO trends (previous year vs. current performance year) by at least 60% (see Figure 4 above)
Well-child Visits (0-15 mo.)	Priority	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance
Child and Adolescent Well-Care Visits (WCV)	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance
Controlling High Blood Pressure	Overall	Any valid value
Glycemic Status Assessment for Patients With Diabetes	Overall	Any valid value
Screening for Depression and Follow-up	Overall	Any valid value
Person-Centered Primary Care *(optional)*	Overall	Any valid value (collected and reported survey data)

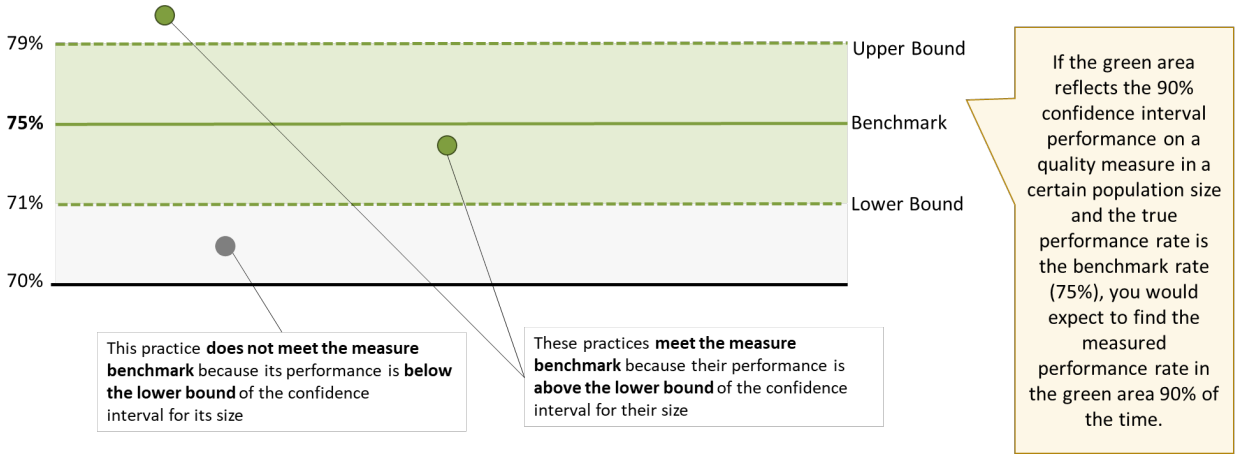
Small Denominator Approach

Some TINs serve many more members than others. In an analysis of data on North Carolina primary care provider patient panel size, NC Medicaid found that nearly half of all primary care providers (inclusive of AMHs and non-AMHs) have a panel size of fewer than 25 members. In a small population, unpredictable events affecting just a few attributed members can substantially increase or decrease a participant's measured performance rates in a given performance period. NC Medicaid believes it is important and appropriate to allow smaller TINs to participate in this AMH Standardized Performance Incentive program, however NC Medicaid also recognizes the need to adjust for such unpredictability.

As such, in instances where a participant has fewer than 11 eligible attributable members for a given measure, measure performance will be suppressed and not included in the overall performance evaluation for the participant. The weight for that measure will be equally redistributed across the remaining measures for which the participant does have a sufficient attributable population. Additionally, in instances where a participant has fewer than 25 eligible

attributable members for a given measure, Plans will implement a statistical adjustment to measure performance utilizing a 90 percent confidence interval approach to assess if participants with smaller panel sizes meet the performance targets, given that smaller practices experience more variation in measured performance rates due to chance alone. For example, TIN "A" has 100 assigned members from "Plan C", but only 20 members that met eligibility for the Cervical Cancer Screening measure. For this measure, Plan C will use a 90% confidence interval range to account for the variation in performance that could occur due to the small sample size. TIN A will meet the performance target for a measure so long as its measured performance is within the 90% confidence interval of the target. If TIN A's measured performance rate for Cervical Cancer Screening is below the national Medicaid median, it may still fall within the predetermined confidence interval, and TIN A will achieve the incentive. See Figure 4 for a visual for this example.

Figure 4: Example Confidence Interval Adjustment



Calculating Incentives

NC Medicaid has developed a payment approach for the AMH Standardized Performance Incentive program that uses consistent weights to calculate the incentive amount available to participants. Incentive payments would be calculated based on participant assignment[8] and paid to participants annually.

[8] See Footnote 4 for a description of the primary care assignment process in the NC Medicaid program. Assignment will be used as a measure of practice size for the purposes of calculating incentive payments. There may be scenarios where individuals assigned to an AMH are not attributed to that AMH for the purposes of evaluating practice performance. See attribution section above for additional detail, and Appendix B for a visual that defines the attribution process.

Measure Weights

Each measure has an assigned measure weight, which determines the proportional amount of incentive dollars each participant can earn by achieving the performance or improvement target (i.e., a measure with a weight of 25% is worth 25% of the total incentive amount). NC Medicaid has designed the program so each pay-for-performance measure is evenly weighted. For measures where there is a sub-measure (i.e., a measure with overall and population-specific targets), the weight is split evenly between performance on those sub-measures. The pay-for-reporting measures are assigned a "bundled" weight, as participants must achieve the criteria for all required measures to receive the allocated incentive for these measures. The tables below outline the measure weights for each measure set.

Table 4: Adult Measure Set Weights

	Measure	Population	Measure Weight
Pay-for-Performance	Adults' Access to Preventive/ Ambulatory Health Services	Overall Population	**25%** of total incentive amount
	Colorectal Cancer Screening	Overall Population	**25%** of total incentive amount
	Cervical Cancer Screening	Overall Population	**25%** of total incentive amount
Pay-for-Reporting	• Screening for Depression and Follow-up, • Controlling High Blood Pressure, • Glycemic Status Assessment for Patients With Diabetes	Overall Population	**25%** of total incentive amount
	Person-Centered Primary Care (optional)	Overall Population	**N/A** – Optional
			100%

Table 5: Child Measure Set Weights

	Measure	Population	Measure Weight
Pay for Performance	Immunizations for Adolescents (Combo 2)	Overall Population	**11%** of total incentive amount

		Population-Specific	**11%** of total incentive amount
	Child Immunization Status (Combo 10)	Overall Population	**11%** of total incentive amount
		Population-Specific	**11%** of total incentive amount
	Well-child Visits (0-15 mo.)	Population-Specific	**22%** of total incentive amount
	Child and Adolescent Well-Care Visits (WCV)	Overall Population	**22%** of total incentive amount
Pay for Reporting	Screening for Depression and Follow-up	Overall Population	**12%** of total incentive amount
	Person-Centered Primary Care (optional)	Overall Population	**N/A** – Optional
			100%

Table 6: Mixed-Age Measure Set Weights

	Measure	Population	Measure Weight
Pay-for-Performance	Adults' Access to Preventive/ Ambulatory Health Services	Overall Population	**20%** of total incentive amount
	Cervical Cancer Screening	Overall Population	**20%** of total incentive amount
	Child Immunization Status (Combo 10)	Overall Population	**10%** of total incentive amount
		Population-Specific	**10%** of total incentive amount
	Child and Adolescent Well-Care Visits (WCV)	Overall Population	**20%** of total incentive amount

Pay-for-Reporting	• Screening for Depression and Follow-up (adult + children) • Controlling High Blood Pressure, • Glycemic Status Assessment for Patients With Diabetes	Overall Population	**20%** of total incentive amount
	Person-Centered Primary Care *(optional)*	Overall Population	**N/A** – Optional
			100%

Incentive Payments

PHPs would be responsible for calculating participant performance against the standardized criteria outlined above and paying incentives to participants directly. Standard Plans and Tailored Plans would be required to distribute one annual lump sum incentive payment to qualifying participants within six months of the end of the performance period.

NC Medicaid is also considering prescribing a standard and transparent minimum performance incentive dollar amount that participants would earn for achieving targets on each of the specified measures. However, the Department's ability to prescribe the incentive amount will depend on funding availability and CMS approval. The current funding environment is challenging. The Department recognizes that a standard incentive amount would help ensure incentive payments are meaningful enough to drive quality improvement and available to all AMH practices who wish to participate in the program. However, if the Department is not able to identify additional funding for this model and/or secure the CMS approvals needed, the Department would not be able to direct a minimum incentive amount. In this latter scenario, Plans would use existing financial resources to fund the program for at least the initial program year, and thus, there may be variability in the value of incentives offered by each plan. Thus, if there is no additional Department funding for this program, NC Medicaid may consider narrowing the scope of eligible practices at launch to ensure that participants are able to receive a meaningful incentive amount (e.g., by only requiring Standard Plans and Tailored Plans to offer the program to Tier 3 AMHs, consistent with current contract requirements).

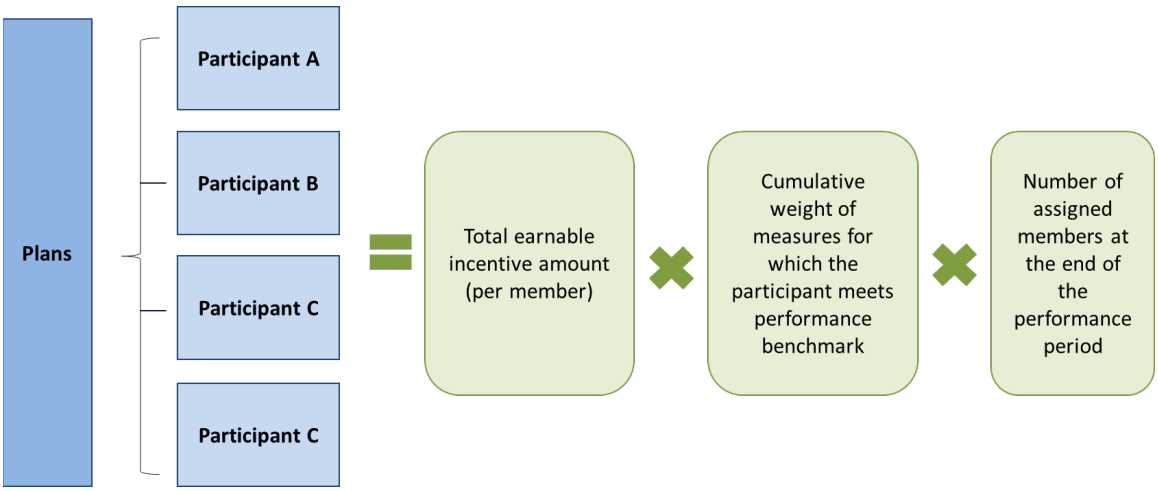
NC Medicaid welcomes feedback from Standard Plans and Tailored Plans on whether it would be possible to offer the AMH Standardized Performance Incentive program to all AMHs using existing resources, and whether they would be able to offer meaningful incentive amounts under such a program. NC Medicaid welcomes feedback from community partners on what

would be a meaningful level for the minimum earnable incentive amount and on the value to AMHs of a standardized incentive amount.

If applicable, NC Medicaid will release information on the minimum earnable incentive amounts that participants can achieve in future guidance. The minimum earnable incentive amount would be calculated as a per-member payment, based on the number of assigned members the participant serves for that Standard Plan or Tailored Plan at the end of the performance period.

See Figure 5 for an illustrative example of how the payments would be paid to participants by Standard Plans and Tailored Plans.

Figure 5: Payment Flow Overview



Program Monitoring and Reporting Guidelines

NC Medicaid will release detailed guidance on program monitoring and Plan reporting guidelines at a future date. In particular, the success of the program will rely upon timely and accurate reporting of encounter data in accordance with Department and CMS guidance (89 FR 41002). This includes accurate reporting of incentive payments made by PHPs to AMH practices.

Conclusion and Request for Feedback

NC Medicaid appreciates the collaboration of its community partners in its efforts to evolve the Advanced Medical Home program and advanced value-based payment models. NC Medicaid will continue to engage with key partners as the AMH Standardized Performance Incentive program is finalized and implemented. Written feedback on this draft policy guide can be sent to Medicaid.NCEngagement@dhhs.nc.gov with the subject line "AMH Standardized Performance Incentive Program Feedback" by **April 21, 2025**.

Appendix A. Summary of Measure Sets and Performance Methodology

Adult Measure Set					
	Measure	**Description**	**Population(s)**	**Performance Target**	**Measure Weight**
Pay-For-Performance	Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit.	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**25%** of total incentive amount
	Colorectal Cancer Screening	Percentage of beneficiaries ages 45 to 75 who had appropriate screening for colorectal cancer	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**25%** of total incentive amount
	Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using any of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last 3 years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**25%** of total incentive amount

		performed within the last five years • Women ages 30 to 64 who had cervical cytology/hrHPV co-testing within the last 5 years			
Pay-for-Reporting	Screening for Depression and Follow-up	Percentage of beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter. Ages reported are: • 12 – 17 years old • 18+ years old	Overall	Any valid value	**25%** of total incentive amount
	Controlling High Blood Pressure	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Overall	Any valid value	
	Glycemic Status Assessment for Patients With Diabetes	Percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) >9.0% during the measurement year.	Overall	Any valid value	
	Person-Centered Primary Care *(optional)*	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set	Overall	Any valid value	**N/A** – optional

		of 11 patient reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.			
Child Measure Set					
	Measure	**Description**	**Population(s)**	**Performance Target**	**Measure Weight**
Pay-For-Performance	Immunizations for Adolescents (Combo 2)	Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**11%** of total incentive amount
			Priority		**11%** of total incentive amount
	Child Immunization Status (Combo 10)	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Overall	Overperformance of national Medicaid HMO trends (previous year vs. current performance year) by at least 60%	**11%** of total incentive amount
			Priority		**11%** of total incentive amount
	Well-child Visits (0-15 mo.)	The percentage of children who turned 15 months old during the measurement year and had six or more	Priority	National Medicaid HMO Median **or**	**22%** of total incentive amount

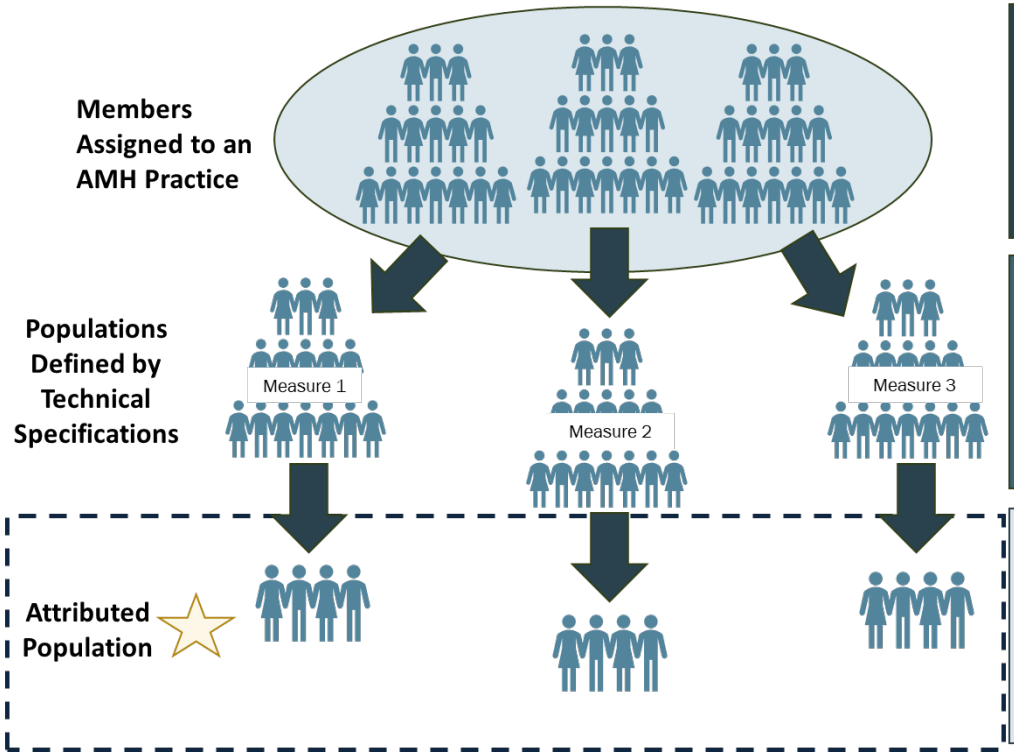
		well-child visits with a primary care provider (PCP) during the last 15 months.		10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	
	Child and Adolescent Well-Care Visits (WCV)	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**22%** of total incentive amount
Pay-for-Reporting	Screening for Depression and Follow-up	Percentage of beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter. Ages reported are: • 12 – 17 years old • 18+ years old	Overall	Any valid value	**12%** of total incentive amount
	Person-Centered Primary Care *(optional)*	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.	Person-Centered Primary Care *(optional)*	Any valid value	**N/A –** optional

Mixed-Age Practice Set					
	Measure	**Description**	**Population(s)**	**Performance Target**	**Measure Weight**
Pay-for-Performance	Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit.	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**20%** of total incentive amount
	Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using any of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last three years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**20%** of total incentive amount
	Child Immunization Status (Combo 10)	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV);	Overall	Overperformance of national Medicaid HMO trends (previous year vs. current performance year) by at least 60%	**10%** of total incentive amount
			Priority		**10%** of total incentive amount

		and two influenza (flu) vaccines by their second birthday.			
	Child and Adolescent Well-Care Visits (WCV)	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.	Overall	National Medicaid HMO Median **or** 10% reduction in gap between baseline performance and target, up to a maximum of 10% relative improvement over the baseline year performance	**20%** of total incentive amount
Pay-for-Reporting	Screening for Depression and Follow-up	Percentage of beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter. Ages reported are: • 12 – 17 years old • 18+ years old	Overall	Any valid value	**20%** of total incentive amount
	Controlling High Blood Pressure	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	Overall	Any valid value	
	Glycemic Status Assessment for Patients With Diabetes	Percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) >9.0% during the measurement year.	Overall	Any valid value	
	Person-Centered Primary Care *(optional)*	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-	Person-Centered Primary Care	Any valid value	**N/A –** optional

		PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.	*(optional)*		

Appendix B. Defining an Attributed Population



This layer includes all members assigned to an AMH practice over the course of the year. Members in this layer may also have been assigned to other practices, and/or may have been assigned only briefly. Attribution rules will aim to address these situations.

This layer includes all assigned members who are eligible for quality measures. Each measure contains specification elements related to continuous eligibility and demographic clinical characteristics (e.g., Combo 10 looks at children in a specific age range).

Finally, this layer applies attribution rules so that each member is attributed to only one provider per measurement year. Rules can apply to all measure or be measure-specific.