Introduction to
Advanced Medical Homes

September 24, 2018

Asheville, NC Regional Training

Contents

Part I:
North Carolina's Medicaid Transformation

Overview of Managed Care Transition

Under managed care, approximately 8 out of 10 Medicaid/NC Health Choice* beneficiaries will receive health coverage through Prepaid Health Plans (PHPs)

- **North Carolina Medicaid providers will need to contract with PHPs and will be reimbursed by PHPs, rather than by the state directly**

- There will be **two types of PHPs**:
  1. Commercial plans
  2. Provider-led entities

> *Note:* Certain populations will **continue to receive fee-for-service (FFS) coverage** on an ongoing basis

- PHPs will offer **two types of products**:
  1. Standard plans for most beneficiaries
     - *Scheduled to launch in late 2019*
  2. Tailored plans for high-need populations
     - *Will include enrollees diagnosed with a serious mental illness (SMI), substance use disorder (SUD), or intellectual/developmental disability (I/DD) and those enrolled in the state's traumatic brain injury (TBI) waiver*
     - *Tentatively scheduled to launch in July 2021*

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* Note: References to "Medicaid" hereafter are intended to encompass both Medicaid and NC Health Choice.

Overview of Patient PHP and Primary Care Provider (PCP) Selection

Under managed care, beneficiaries will have the opportunity to choose their PHP and PCP or they will be auto-assigned

PHP Selection

- If beneficiaries do not select a PHP **by the end of their choice period**, they will be auto-assigned to a plan

- DHHS will design an algorithm that prioritizes **keeping families in the same PHP and preserves beneficiary-provider relationships**

  o Auto-assignment algorithm will also consider:

    - PHPs available in an individual's region
    - Eligibility category (e.g., special populations)
    - Previous PHP enrollment
    - Equitable distribution among PHPs

- All beneficiaries will have a **90-day "grace period"** – during both initial application and annual renewals – to re-assess their decision or assignment after selecting a plan

PCP Selection

- Beneficiaries that do not select a PCP **during the plan selection period** will be assigned a PCP by the PHP in which they enroll

- PCP auto-assignment will consider:

  o Enrollee claims history
  o Family member provider
  o Geography
  o Special medical needs
  o Language/cultural preference

- All beneficiaries will have a **30-day "grace period"** – after notification of their PCP assignment – to change their PCP without cause

- Beneficiaries can also change their PCP **without cause** after their initial PCP visit, and up to one additional time every 12 months; beneficiaries may change their PCP **with cause** at any time

Care Management Principles

Robust care management is a cornerstone of the State's managed care transition
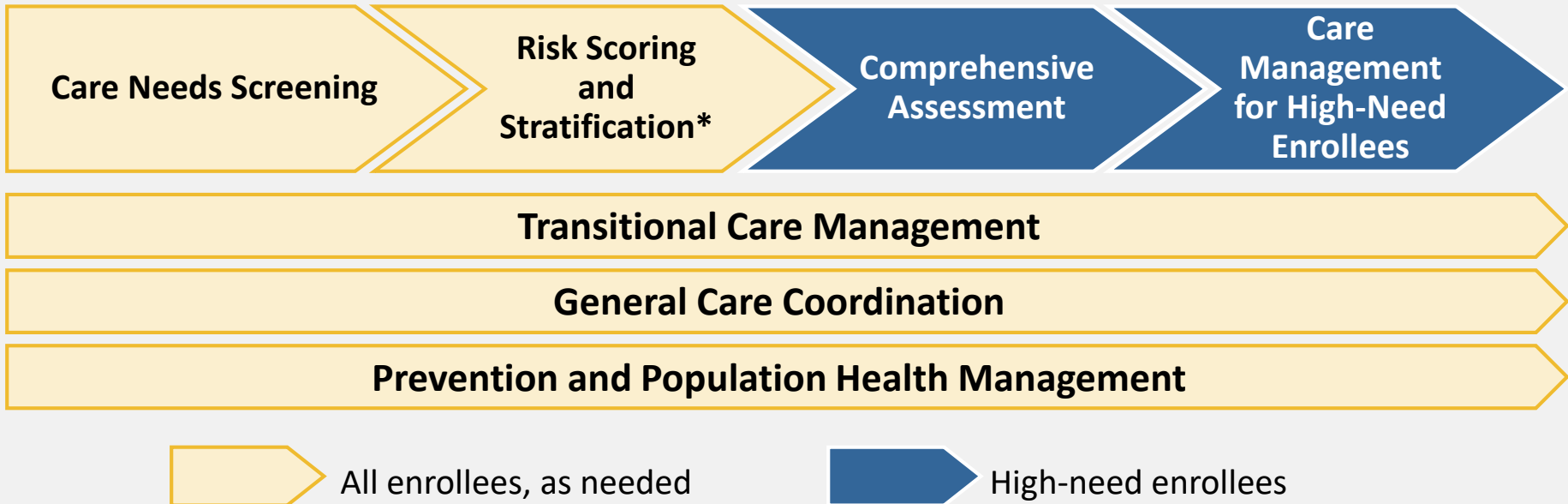
Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**

- ❑ Care management should involve **multidisciplinary care teams**

- ❑ **Local care management** is the preferred approach

- ❑ Care managers will have access to **timely and complete enrollee-level information**

- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**

- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

AMHs are designed to serve as **a vehicle for executing on this approach in a managed care context**

Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate care management

Care Needs Screening → Risk Scoring and Stratification* → **Comprehensive Assessment** → **Care Management for High-Need Enrollees**

Transitional Care Management

General Care Coordination

Prevention and Population Health Management

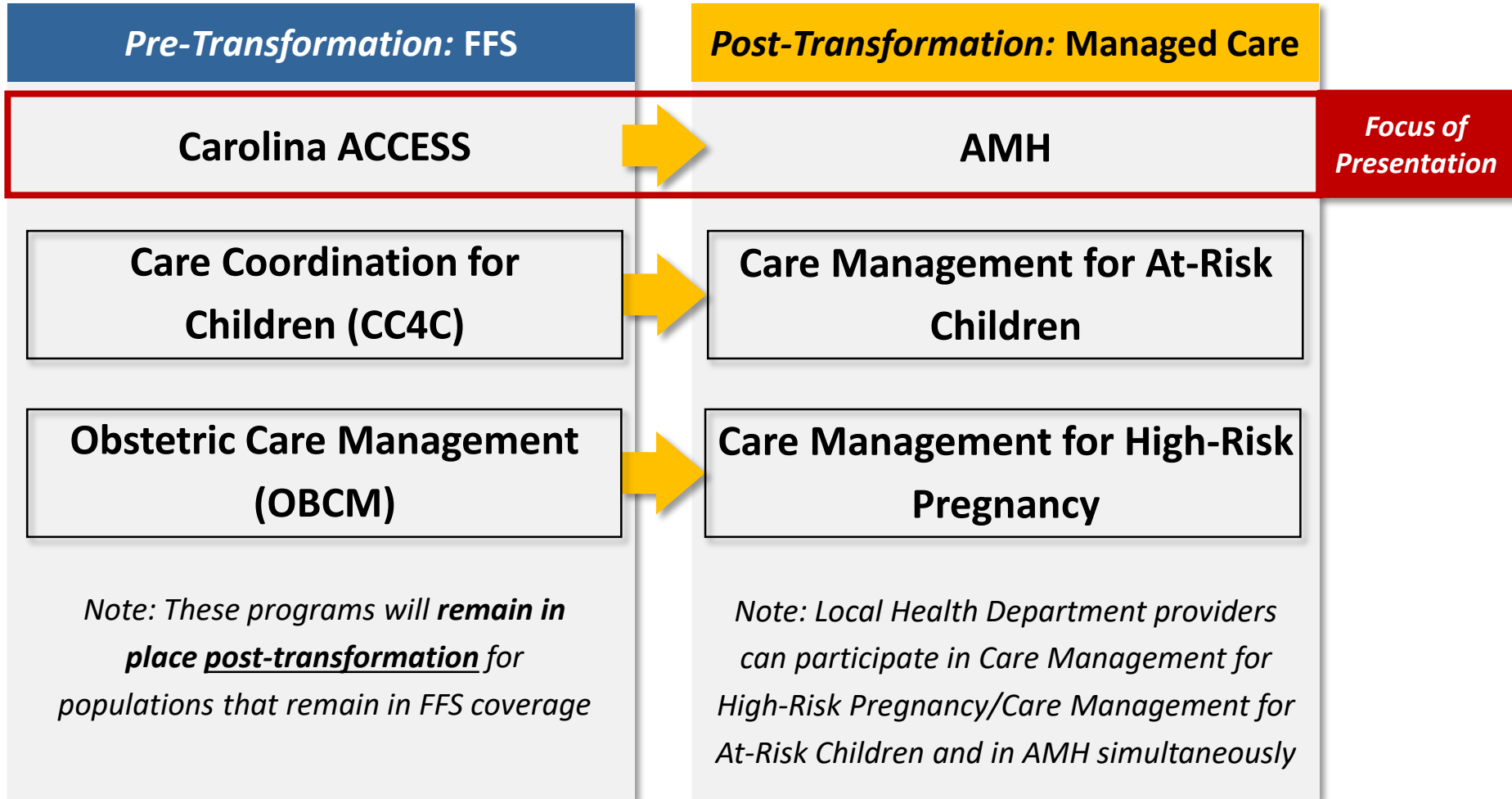All enrollees, as needed   High-need enrollees

*PHPs/AMHs must implement processes to identify priority populations, including:

- Children and adults with special health care needs**
- Individuals in need of long term services and supports (LTSS)
- Enrollees with rising risk
- Individuals with high unmet resource needs

**Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Evolution of Existing Programs Under Managed Care

The State will build on existing care management infrastructure under managed care

Pre-Transformation: FFS	Post-Transformation: Managed Care	
Carolina ACCESS	AMH	Focus of Presentation
Care Coordination for Children (CC4C)	Care Management for At-Risk Children	
Obstetric Care Management (OBCM)	Care Management for High-Risk Pregnancy	
*Note: These programs will **remain in place post-transformation** for populations that remain in FFS coverage*	*Note: Local Health Department providers can participate in Care Management for High-Risk Pregnancy/Care Management for At-Risk Children and in AMH simultaneously*	

Part II:
Overview of Carolina ACCESS Today

Transition of Carolina ACCESS to AMH

Carolina ACCESS has been North Carolina's PCCM program since the 1990s

What is Carolina ACCESS?

- North Carolina's regionally-based program that provides PCCM services to North Carolina Medicaid beneficiaries
- North Carolina DHHS contracts with Community Care of North Carolina (CCNC) to provide enhanced care management services

Carolina ACCESS Practice Requirements

- After-hours medical advice
- Maximum enrollment limit
- Availability of oral interpretation services
- Minimum hours of operation
- Preventive and ancillary service availability (based on ages of beneficiaries served)*

See Appendix A for complete list of required preventive and ancillary services.

Carolina ACCESS Has Two "Levels"

Carolina ACCESS I (CAI)

- CAI practices **must meet all necessary practice requirements** as determined by North Carolina DHHS

- **Payments to practices include $1.00 per member per month (PMPM)** for beneficiaries enrolled with the practice, in addition to fee-for-service (FFS) payments

Carolina ACCESS II (CAII/CCNC)

- CAII practices must meet all CAI practice requirements and sign a separate contract with their local CCNC network
- **Payments to practices, in addition to FFS payments:**
  - **$2.50 PMPM** for most Medicaid and North Carolina Health Choice beneficiaries enrolled with the practice
  - **$5.00 PMPM** for aged, blind, and disabled (ABD) beneficiaries

Commonly known as "CCNC"

Part III:
Overview of AMH

Introduction to AMH

Vision for Advanced Medical Homes

*Build on Carolina ACCESS to **preserve broad access to primary care services** for Medicaid enrollees and **strengthen the role of primary care in care management, care coordination, and quality improvement** as the state transitions to managed care.*

Practices will have <u>options</u> as AMHs:

- Current Carolina ACCESS practices may **continue as AMHs with few changes**; practices ready to take on more advanced care management functions **may be eligible for additional payments**

- Practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**.

- Unlike in Carolina ACCESS, **practices <u>WILL NOT</u> be required to contract with CCNC**

AMH Practice Eligibility Requirements

AMH practice eligibility requirements will be the same as those for Carolina ACCESS

- AMH-eligible practices must **provide primary care services** and **be enrolled in the North Carolina Medicaid program**
  o For a full list of required primary care services, see Appendix A
- Examples of eligible practices are single- and multi-specialty groups led by allopathic and osteopathic physicians in the following specialties:
  - General Practice
  - Family Medicine
  - Internal Medicine
  - OB/GYN
  - Pediatrics
  - Psychiatry and Neurology
- For a full list of permitted subspecialties, refer to NCTracks

AMH Tiers

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments
(paid by PHP to practice)

- **PMPM medical home fees**
  - Same as Carolina ACCESS
  - Non-negotiable

Tier 3

- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- **Single, consistent care management platform:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 PHP contracts

AMH Payments
(paid by PHP to practice)

- **PMPM medical home fees**
  - Same as Carolina ACCESS
  - Non-negotiable
- **Additional PMPM care management fees**
  - Negotiated between PHP and practice

Tier 4: To launch at a later date

AMH Payment Structure: Overview

AMH practices will continue to receive Medical Home Fees for assigned members and may earn additional care management fees

Tier	Practice Requirements	Primary Responsibility for Care Management	Clinical Services Payments	PMPM Medical Home Fee	Care Management Fee	PHP Performance Incentive to Practices
1	Same as for Carolina ACCESS	PHP	Will continue —PHPs must comply w/ minimum rate floors set at Medicaid FFS levels	$1.00	None	None required, but PHPs encouraged to begin offering performance payments based on AMH measures
2	Same as for Carolina ACCESS	PHP		$2.50 (most enrollees) or $5.00 (members of the aged, blind and disabled [ABD] eligibility group)	None	
3	Tier 1 and 2 requirements, and additional Tier 3 care management responsibilities	Practices responsible; AMH practices may arrange for care management functions to be performed by a CIN/other partner at their discretion		$2.50 (most enrollees) or $5.00 (members of the ABD eligibility group)	Negotiated between practices, or CINS 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
4	*Will launch after year 2—though PHPs and providers can go above and beyond Tier 3 requirements at any time*					

AMH Payment Structure: Performance Incentives

Tier 3 practices will be eligible for additional incentive payments based on their performance on State-approved AMH quality measures

Tier 3 Performance Incentive Guidelines

- For the first two years of the program, these incentives will be on an **"upside-only" basis.** Practices will **NOT** be at risk of losing money (i.e., "downside risk") if they do not meet specified performance targets

  o PHPs will not be permitted to require practices to pay back PMPM medical home fees, care management fees, or any other payments for medical services

- Practices are permitted to negotiate arrangements that include downside risk, **but PHPs may not mandate these terms**

- Payment arrangements must be guided by the Health Care Payment Learning and Action Network (HCP LAN) Categories 2 through 4, which reflect varying levels of value-based payments.

Sample AMH Measures*

- *How people rated their personal doctor*
- *Childhood immunization status*
- *Well child visits in third-sixth years of life*
- *Cervical cancer screening*
- *Follow-up after hospitalization for mental illness*
- *Comprehensive diabetes care, poor control*
- *Medication management for asthma*
- *Controlling high blood pressure*
- *Medical assistance with tobacco cessation*

* These measures are tentative. A final measure list will be provided prior to managed care go-live.

Practice Requirements: Tiers 1 and 2

Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS practices
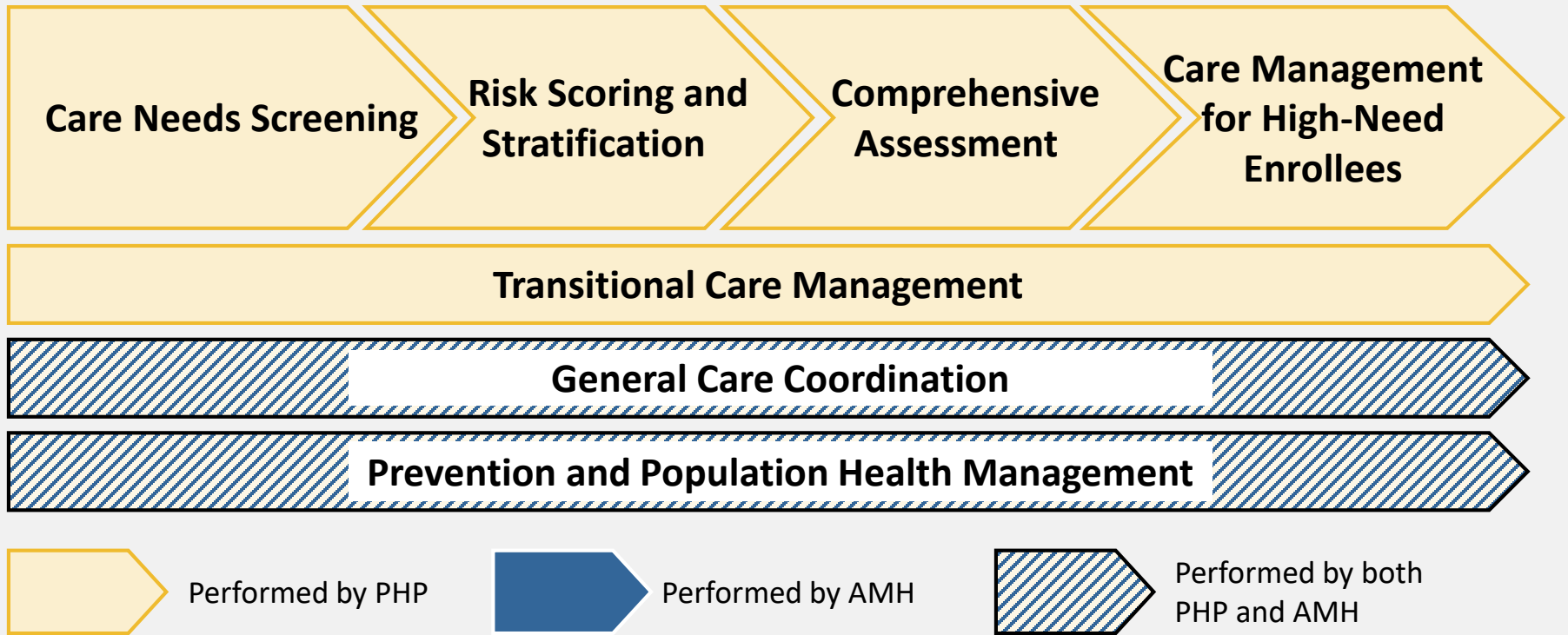
Requirements for AMH Tiers 1 and 2*

1. Perform **primary care services** that include certain preventive & ancillary services**

2. Create and maintain a **patient-clinician relationship**

3. Provide direct patient care a **minimum of 30 office hours per week**

4. Provide access to medical advice and services **24 hours per day, seven days per week**

5. **Refer to other providers** when service cannot be provided by PCP

6. Provide **oral interpretation for all non-English proficient beneficiaries and sign language** at no cost

* See Appendix B for standard terms and conditions for PHP contracts with AMH practices.
** See Appendix A for required services.

Care Management Approach: Tiers 1 and 2

Tier 1 and 2 practices will share responsibility for general care coordination and prevention/population health management with PHPs

Care Needs Screening	Risk Scoring and Stratification	Comprehensive Assessment	Care Management for High-Need Enrollees

Transitional Care Management

General Care Coordination

Prevention and Population Health Management

Performed by PHP

Performed by AMH

Performed by both PHP and AMH

Practice Requirements: Tier 3

PHPs may delegate care management responsibilities to AMH Tier 3 practices

Overview of Tier 3 Requirements

- Practice requirements for Tier 3 include all Tier 2 requirements **plus additional care management responsibilities**

- Services are provided by the **Tier 3 practice directly, or by a CIN/other partner** that has contracted with the Tier 3 Practice

- AMHs must attest that they or their contracted CINs/other partners are **capable of fulfilling these requirements** by the time managed care launches

Practice Requirements: Tier 3

AMH Tier 3 Practices Are Required to Perform the Following Activities*

- **Risk stratify** the patient panel
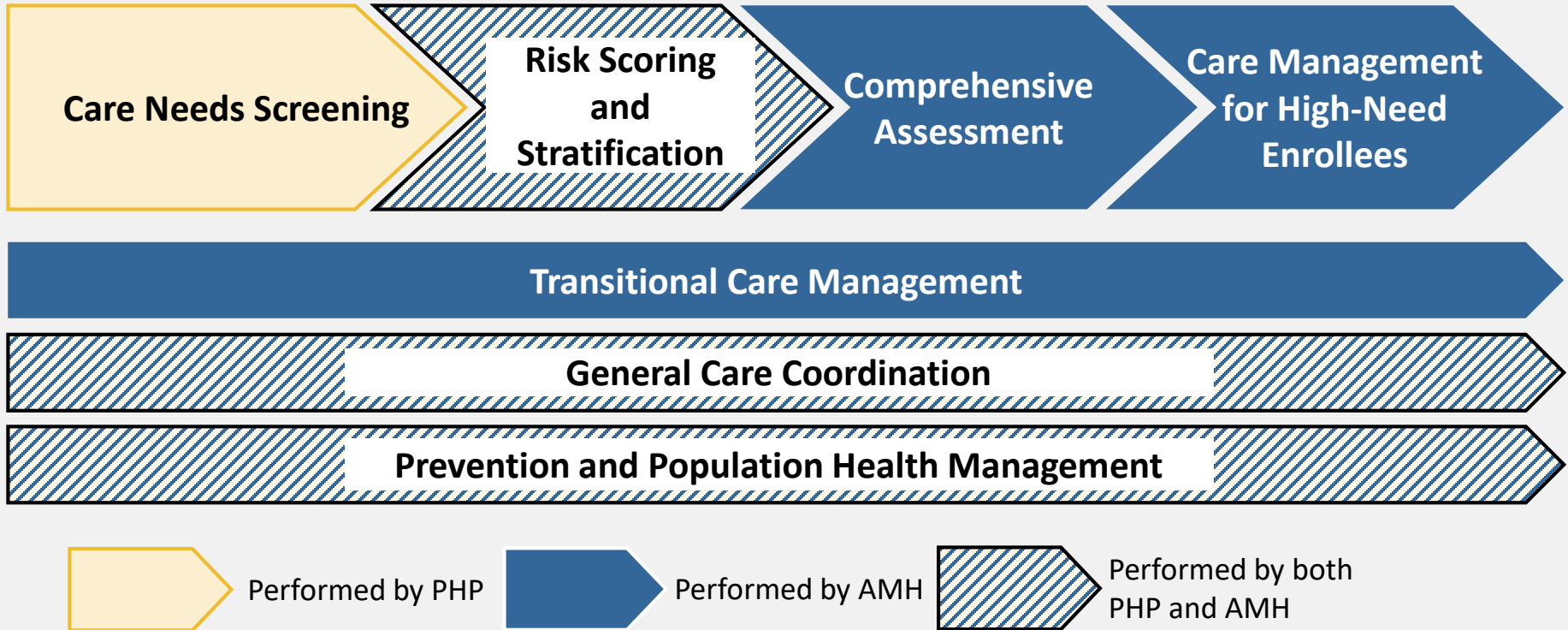
  - Practices must use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel; practices are not required to purchase a risk stratification tool

- Provide **care management to high-need patients**

  - Practices must be able to use risk scores to identify high-need patients and provide care management to these patients

  - For patients identified as high-need, practices must perform a Comprehensive Assessment to identify care needs

Practices must perform these activities themselves, or contract with a CIN/other partner to fulfill them. See Appendix C for full Tier 3 requirements.

Practice Requirements: Tier 3

- Develop a **Care Plan** for high-need patients receiving care management
  - Practices must incorporate findings from the PHP care needs screening/risk scoring, practice-based risk stratification and comprehensive assessment with clinical knowledge and must include, at a minimum, the following elements:
    - Measurable patient (or patient and caregiver) goals;
    - Medical needs including any behavioral health needs;
    - Interventions;
    - Intended outcomes; and,
    - Social, educational, and other services needed by the patient.

- Provide **short-term, transitional care management** along with **medication management** for all empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are high-risk of readmissions/other poor outcomes

- **Receive claims data feeds** (directly or via a CIN/other partner) and meet state-designated **security standards** for their storage and use**

Practices must perform these activities themselves, or contract with a CIN/other partner to fulfill them. See Appendix C for full Tier 3 requirements.
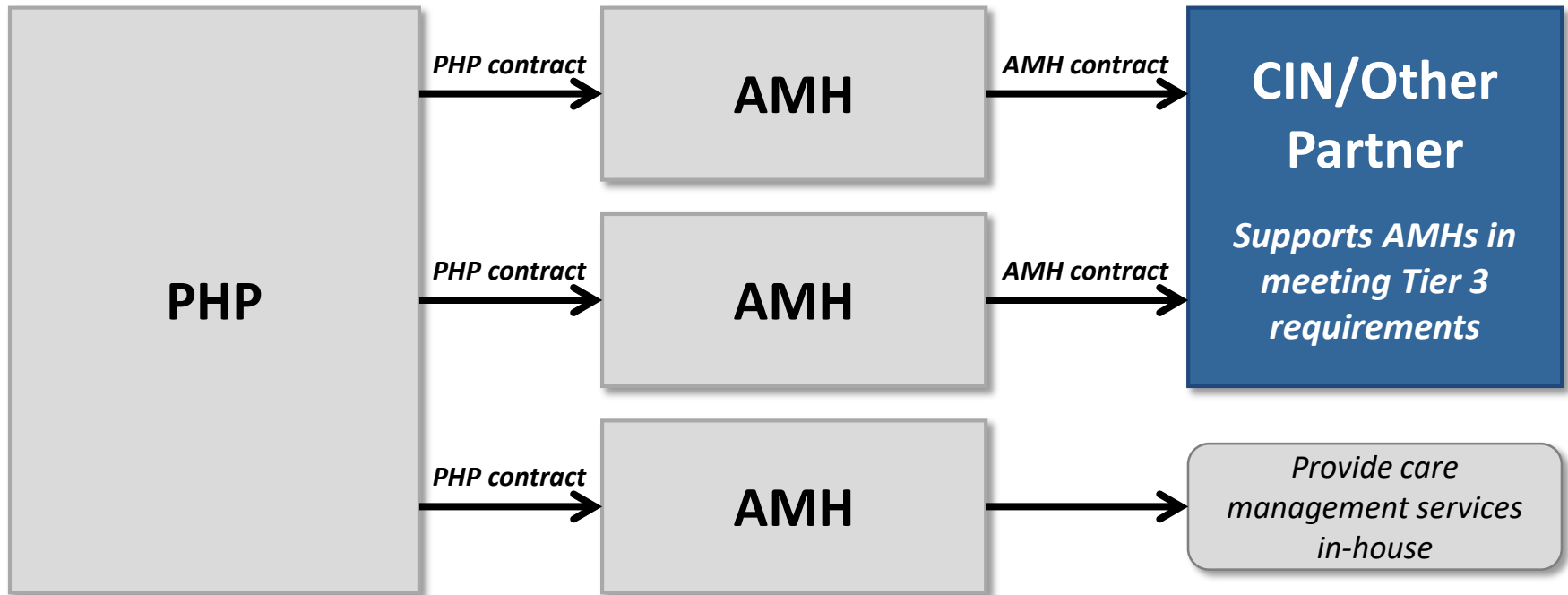*** More details on data requirements to follow in webinar on IT Needs and Data Sharing Capabilities.*

Care Management Approach: Tier 3

Tier 3 practices will assume additional responsibilities related to risk scoring and stratification; Comprehensive Assessments, and providing care management

Care Needs Screening → Risk Scoring and Stratification → Comprehensive Assessment → Care Management for High-Need Enrollees

Transitional Care Management

General Care Coordination

Prevention and Population Health Management

Performed by PHP Performed by AMH Performed by both PHP and AMH

AMH Accountability

- **Although they are ultimately responsible for ensuring patients receive care management, PHPs can delegate responsibilities to AMHs**
- **AMHs may then choose to have their care management operations supported by CINs/other partners**

PHP			
	→ PHP contract →	**AMH**	→ AMH contract → **CIN/Other Partner** *Supports AMHs in meeting Tier 3 requirements*
	→ PHP contract →	**AMH**	→ AMH contract →
	→ PHP contract →	**AMH**	→ *Provide care management services in-house*

Practices are free to use a CIN/other partner of their choice (or none at all) and are no longer required to contract with CCNC*

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*Practices will still be required to contract with their local CCNC network in order to participate in CAII/CCNC for FFS.

Working with CINs/Other Partners

The majority of Tier 3 practices are likely to elect to work with CINs/other partners

Working with CINs/Other Partners:

- CINs/other partners can support AMH practices in **handling data, performing analytics, and delivering advanced care coordination and care management** functions

- CINs can be **part of a hospital or health system** to which a practice already belongs or is otherwise affiliated, **or may be part of 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

- Although the majority of AMH Tier 3 practices will elect to work with CINs/other partners, **practices are not required to do so**

Part IV:
Transitioning from
Carolina ACCESS to AMH

Transition of Carolina ACCESS to AMH

AMH builds on existing infrastructure of Carolina ACCESS

- AMH Tiers 1 and 2 **incorporate Carolina ACCESS requirements** and **payment models** into managed care
  - o Providers in AMH Tiers 1 and 2 will continue to have the same practice requirements and receive the same PMPM payments

- Primary care practices participating in or eligible to participate in Carolina ACCESS are also eligible to participate as AMHs
  - o Providers **currently participating** in Carolina ACCESS will be **automatically grandfathered into the new program as AMHs**
  - o Medicaid providers not participating in Carolina ACCESS must **enroll in Carolina ACCESS through NCTracks** before they will be eligible for AMH certification
  - o Practices not currently enrolled in Medicaid will first need to **enroll in Medicaid <u>AND</u> complete the Carolina ACCESS supplemental application**

Role of Carolina ACCESS/FFS in North Carolina Medicaid Going Forward

Fee-For-Service (FFS)

- Carolina ACCESS will continue to **operate concurrently** with AMHs for **populations remaining in FFS coverage**
  - These include exempt/excluded beneficiaries and those that haven't yet rolled into managed care

- **CAI will sunset** for practices not currently in Carolina ACCESS

- **CAII will continue to require contracting with CCNC**

Managed Care

- AMH replaces Carolina ACCESS

- Practices must go through the Carolina ACCESS application process in order to participate in AMH
  - This can be accomplished through grandfathering or by completing a supplemental Carolina ACCESS application through NCTracks

- Carolina ACCESS status will **streamline** a practice's path to becoming an AMH
  - CAI practices are grandfathered into AMH Tier 1
  - CAII practices are grandfathered into AMH Tier 2

AMH Certification Process

- **NC DHHS is responsible for certifying that practices may participate in a given AMH Tier**
- **Medical home fees/care management fees to practices commence only once the practice has contracted with a PHP as an AMH**

Attestation
Practice attests to ability to fulfill requirements (possibly in partnership with a CIN/other partner) for a given AMH tier

Certification
NC DHHS certifies practice for a given AMH tier

PHP Contracting
Practice contracts as an AMH with one or more PHP

Payments Commence
PHPs begin providing medical home fees/care management fees to practices

Certification itself does not trigger payments

Contracting with PHPs

PHPs must contract with all willing providers that agree to accept FFS payment levels and are in good standing with the NC Medicaid program

In general, PHPs must honor AMH certifications given by the state

- PHPs **must accept Tier 1 and Tier 2 certifications "as is"** and may not choose to reclassify practices during the initial contracting period

- PHPs are **required to contract with 80% of Tier 3-certified practices** in their service areas*

- PHPs, however, are **responsible for oversight**

  o In limited instances, PHPs **can reclassify practices** that fail to satisfy requirements of their tier

Note: PHPs will not be required to contract with Tier 3-certified practices at a Tier 3 level if they are unable to reach mutually agreeable contract terms (although this would count against the PHP's 80% contracting requirement). PHPs must accept Tier 3 certified practices into their provider networks at a minimum Tier 2 level if they cannot reach agreement on Tier 3 contracting terms.

Roadmap for Practices New to Medicaid

Practices New to NC Medicaid

Option 1

Enroll in NC Medicaid through NCTracks and complete the Carolina ACCESS application

AMH Tier 2 Certified

Practice contracts with PHPs as AMH Tier 2 to receive AMH payments

Option 2

Completes Tier 3 Attestation in NCTracks

AMH Tier 3 Certified

Practice contracts with PHPs as AMH Tier 3 to receive AMH payments

Option 3

Do not participate as an AMH

No Action

Participate in AMH Tier 1

Not permitted

Roadmap for Non-CA Medicaid Practices

Medicaid-Enrolled Practices not in Carolina ACCESS

❌

Participate in AMH Tier 1

Not permitted

Option 1

Submit "Manage Change Request" through NCTracks to apply for Carolina ACCESS

AMH Tier 2 Certified

Practice contracts with PHPs as AMH Tier 2 to receive AMH payments

Option 2

Completes Tier 3 Attestation in NCTracks

AMH Tier 3 Certified

Practice contracts with PHPs as AMH Tier 3 to receive AMH payments

Option 3

Do not participate as an AMH

No Action

Roadmap for CAI Practices

CAI Practices

534 practices serving 38,609 beneficiaries

Option 1	Option 2	Option 3	Option 4
No Action	Elects to participate in Tier 2 in NCTracks	Completes Tier 3 Attestation in NCTracks	Do not participate as an AMH
AMH Tier 1 Certified	AMH Tier 2 Certified	AMH Tier 3 Certified	Opt Out
	Practice contracts with PHPs as AMH Tier 2 to receive AMH payments	Practice contracts with PHPs as AMH Tier 3 to receive AMH payments	
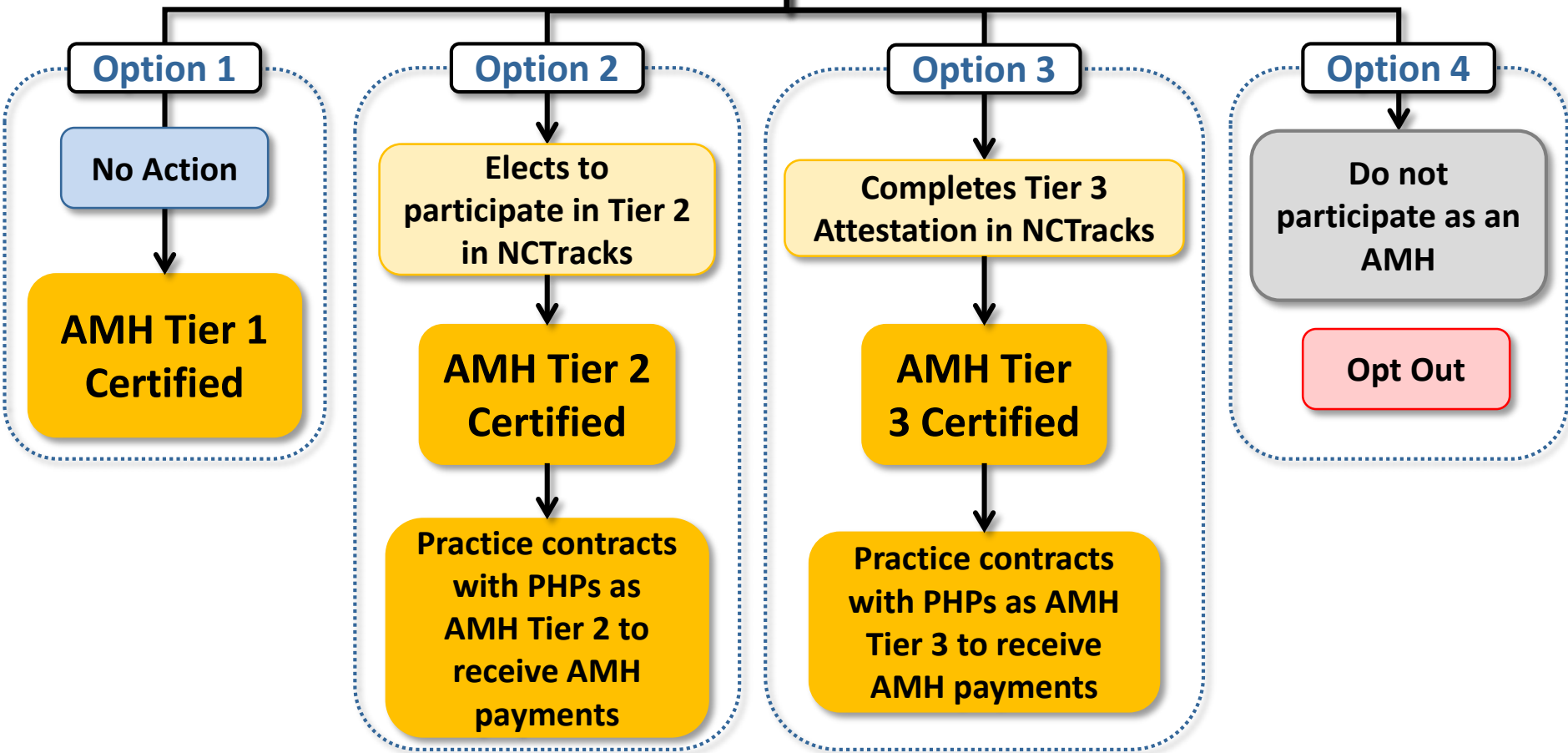
Roadmap for CAII/CCNC Practices

CAII/CCNC Practices

1,714 practices serving 1.6 million beneficiaries

Participate in AMH Tier 1

Not permitted

Option 1

No Action

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AMH Tier 2 Certified

↓

Practice contracts with PHPs as AMH Tier 2 to receive AMH payments

Option 2

Completes Tier 3 Attestation in NC Tracks

↓

AMH Tier 3 Certified

↓

Practice contracts with PHPs as AMH Tier 3 to receive AMH payments

Option 3

Do not participate as an AMH

Opt Out
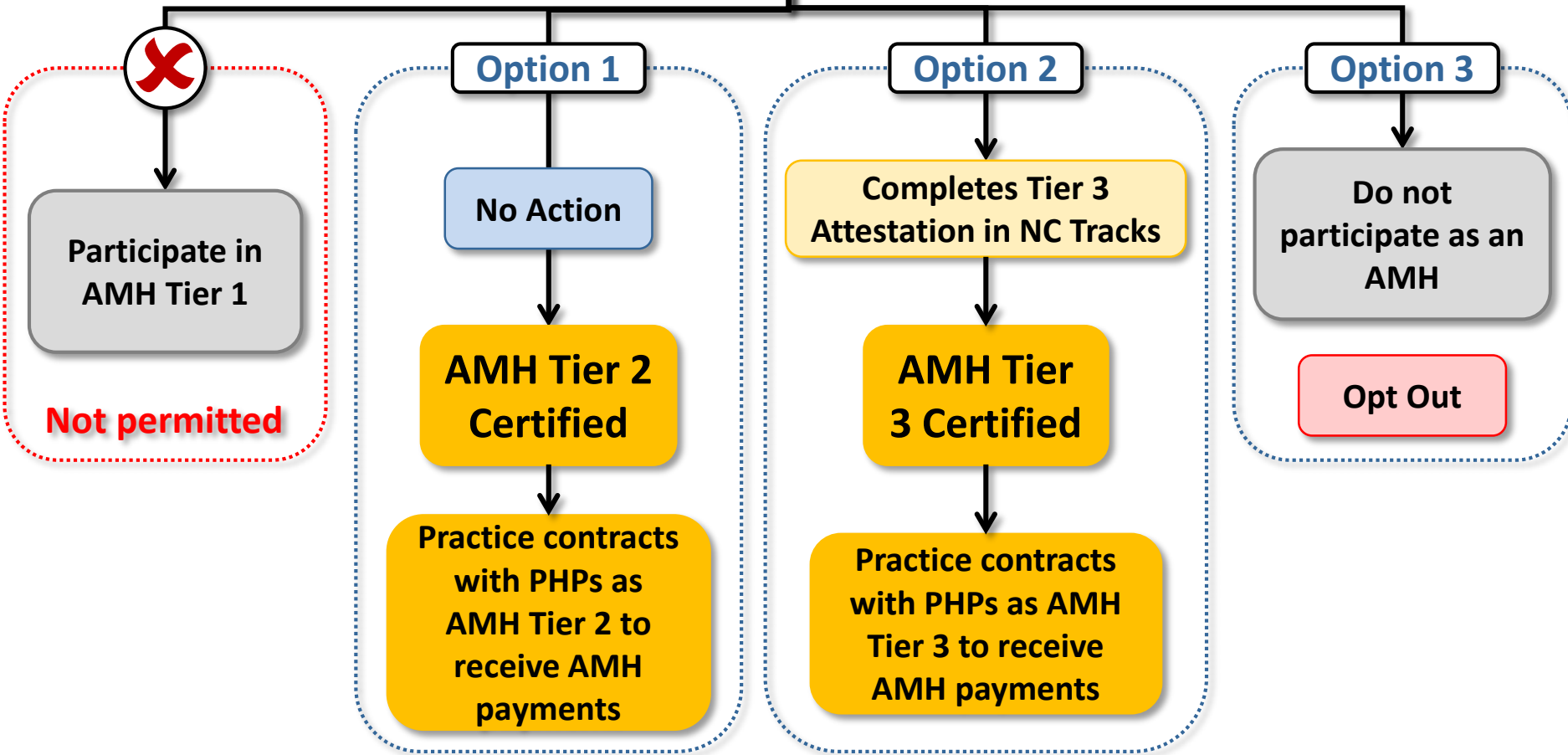
Timeline of AMH Program Launch*

PHPs will be required to contract with AMHs that are certified before Feb. 1, 2019

2/1/19:
- NC DHHS announces **PHP selection**
- State **finalizes list** of certified AMHs

10/1/18 – 1/31/19	Feb. '19 – Nov. '19	Nov. '19 +
Attestation (interested practices attest to meeting AMH capabilities)	**PHP Contracting** (PHPs form their provider networks; AMH-certified practices contract with PHPs as AMH practices)	**Managed Care and AMH Program Go Live** (Practices begin receiving payments from PHPs)

- Practices will still be able to attest after Feb. 1, 2019, but PHPs will not be contractually obligated to honor their certification
- The state will certify a list of AMH Tier 3 practices at the start of each contracting period in subsequent plan years

Part V:
Comparing Carolina ACCESS and AMH

Key Similarities Between Carolina ACCESS and AMH

1 **Types of practices eligible for Carolina ACCESS and AMH are the same**

2 **AMH Tier 2 requirements are the same as CAI/II requirements**

3 **Practices can continue to work with CCNC *if they choose***

4 **Payment structure for AMH Tiers 1 and 2 mirrors CAI and CAII/CCNC**

Key Differences Between Carolina ACCESS and AMH

Carolina ACCESS		AMH
Carolina ACCESS payments commence *as soon as practice is certified* as CAI or CAII/CCNC	**1**	**AMH payments to practice will not commence until contract with PHP is signed.** Attestation through NCTracks/grandfathering from Carolina ACCESS *only provides a certification status*
CCNC is the sole vendor of care management services	**2**	**CCNC is no longer the sole care management vendor.** Practices are free to contract with any CINs/partners
Practices must contract with CCNC to receive $2.50/$5 PMPM payments	**3**	**Practices do not need to contract with a CIN or other partner** and can perform care management in-house to receive medical home fees
Carolina ACCESS has only two levels, and practices only receive fixed PMPM medical home fees	**4**	**Practices can participate in AMH at the Tier 3 level and be eligible for additional care management fees.** Tier 3 requirements are above and beyond those for Carolina ACCESS, and performance incentive payments may be issued by PHPs

Part VI:
Practice Use Case

Practice Use Case

- **Most NC Medicaid practices eligible to participate in AMH will have beneficiaries that remain in FFS:**
  - Most beneficiaries will transition to managed care in 2019, **but beneficiaries in some regions will transition to managed care on a delayed timeline**
  - **Specified high-need beneficiaries will remain in FFS:** CAI and CAII practices will continue to receive Carolina ACCESS payments for these patients
- As in Carolina ACCESS, AMH practices will receive **higher medical home fees for aged, blind, and disabled (ABD) beneficiaries**

Patient Panel (Illustrative)				
Number of Patients	ABD	Transitioning to Managed Care in 2019	CAI or AMH Tier 1 payments	CAII/CCNC or AMH Tier 2 or 3 medical home fees
300		✓	$1.00 PMPM	$2.50 PMPM
50				
50	✓	✓		$5.00 PMPM
100	✓			

Even with the same panel composition, practices may receive different PMPM payment amounts based on their AMH/Carolina ACCESS designations.

Sample Practice: CAII/CCNC Practice

Example CAII/CCNC Practice

Current State Carolina ACCESS Payments: $19,500

Option 1

AMH Tier 2 (Default)

Future State Payments
Total Payments: $19,500

- *AMH medical home fees for Managed Care Enrollees: $12,000*
- *Carolina ACCESS Payments for Enrollees Remaining in FFS: $7,500*

Option 2

AMH Tier 3 (Attest)

Future State Payments
Total Payments: $19,500 + negotiated amt.

- *AMH medical home fees for Managed Care Enrollees: $12,000*
- *Additional Negotiated Care Management & Performance Payments*
- *Carolina ACCESS Payments for Enrollees Remaining in FFS: $7,500*

CAII/CCNC Practice – Medical Home Fees

PCCM Payments - NC Medicaid		
Provider Enrollment Status	**Eligibility Category**	**PMPM Payment**
Managed Care Beneficiaries		
AMH Tier 1	All	$1
AMH Tier 2/3	Non-ABD	$2.50
AMH Tier 2/3	ABD	$5
FFS Beneficiaries		
CAI	All	$1
CAII/CCNC	Non-ABD	$2.50
CAII/CCNC	ABD	$5

*This practice could also choose to attest to Tier 3 and become eligible for additional **care management fees***

Beneficiary Type	Program	Beneficiary Count	PMPM	Months per Member Empaneled	Medical Home Fee
Managed care, non-ABD	AMH	300	$2.50	12	$9,000
Managed care, ABD	AMH	50	$5.00	12	$3,000
FFS, non-ABD	Carolina ACCESS	50	$2.50	12	$1,500
FFS, ABD	Carolina ACCESS	100	$5.00	12	$6,000
				Total Medical Home Fees	**$19,500**

Part VII: Q & A

Part VIII: Next Steps

Overview of Upcoming Events

Upcoming AMH Webinars:

- **October 12:** AMH Oversight, Delegation, and Contracting
- **TBD:** Roles and Responsibilities of CINs and Other Provider Partners
- **TBD:** AMH Tier 3: Patient Identification, Assignment, and Tracking
- **TBD:** AMH Tier 3: Care Management
- **TBD:** AMH Tier 3: Care Planning
- **TBD:** IT Needs and Data Sharing Capabilities

Upcoming AMH Regional Trainings:

- **September 24:** Asheville, 11am–1pm
- **September 25:** Huntersville, 10am–12pm
- **October 2:** Greenboro, 10am–12pm
- **October 4:** Raleigh, 10am–12pm
- **October 8:** Greenville, 10am–12pm

For more information and to register for webinars/events, visit the AMH webpage:
https://medicaid.ncdhhs.gov/advanced-medical-home

Additional Information

- **Email:** Medicaid.Transformation@dhhs.nc.gov

- **U.S. Mail:** Dept. of Health and Human Services, Division of Health Benefits
  1950 Mail Service Center
  Raleigh NC 27699-1950

AMH Webpage

- https://medicaid.ncdhhs.gov/advanced-medical-home

White Papers, Manuals, and FAQs

- NC DHHS, North Carolina Advanced Medical Home (AMH) Program Frequently Asked Questions, September 5, 2018

- NC DHHS, Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers, August 28, 2018

- NC DHHS, "Data Strategy to Support the Advanced Medical Home Program in North Carolina," July 20, 2018

- NC DHHS, "North Carolina's Care Management Strategy under Managed Care," March 9, 2018

- NC DHHS, "North Carolina's Proposed Program Design for Medicaid Managed Care," August 2017

Appendix A:
AMH Required Preventive & Ancillary Services

AMH/Carolina ACCESS Required Preventive & Ancillary Services

		Required Preventive and Ancillary Services											
		Required for providers who serve the following age ranges											
NCTracks assigned #	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	All ages	3 to 17	7+	11+	11+	18+	21+
1	Adult Preventative & 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					

AMH/Carolina ACCESS Required Preventive & Ancillary Services

		Required for providers who serve the following age ranges											
NCTracks assigned #	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	All ages	3 to 17	7+	11+	11+	18+	21+
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 for PHP Contracts with AMHs

Standard Terms for PHP Contracts with AMHs

	Standard Terms and Conditions for PHP Contracts with Advanced Medical Home 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.
1	Accept enrollees and be listed as a primary care practice in the PHP's enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.
2	Provide Primary Care and Patient Care Coordination services to each enrollee.
3	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.
4	Provide direct patient care a minimum of 30 office hours per week.
5	Provide preventive services.
6	Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees.
7	Maintain a unified patient medical record for each enrollee following the PHP's medical record documentation guidelines.
8	Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
9	Transfer the enrollee's medical record to the receiving practice upon the change of primary care practice at the request of the new primary care practice or PHP (if applicable) and as authorized by the enrollee within 30 days of the date of the request , free of charge.

Standard Terms for PHP Contracts with AMHs (cont'd)

Standard Terms and Conditions for PHP Contracts with Advanced Medical Home Practices (cont'd)	
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.	
10	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.
11	Refer for a second opinion as requested by the patient, based on Department guidelines and PHP standards.
12	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.
13	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.

Appendix C:
AMH Tier 3 Attestation Requirements

AMH Tier 3 Attestation Requirements

Section I requirements (information required to link practices to existing IT records)		
#	**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	
N/A	If you are seeking to attest for multiple clinical service locations, please provide information for additional locations	The attesting administrator should have the authority to attest for all locations listed

AMH Tier 3 Attestation Requirements (cont'd)

	Section II: Medical Home Certification Process: Tier 3 Required Attestations	
#	**Requirement**	**Rationale/Description**
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:		
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.
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:		
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.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	**Requirement**	**Rationale/Description**
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: (cont'd)		
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 question 5 to provide further information): o Patient's immediate care needs and current services; o Other State or local services currently used; o Physical health conditions; o Current and past behavioral and mental health and substance use status and/or disorders; o Physical, intellectual developmental disabilities; o Medications; o Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety); o Available informal, caregiver, or social supports, including peer supports.	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 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. 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.
9	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?	Care managers must be assigned to the practice, but need not be physically embedded at the practice location.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	Requirement	Rationale/Description
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: (cont'd)		
10	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 diagnosis and treatment and who has the minimum credentials of RN or LCSW? (See supplemental question 6 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 routine visits.
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan.		
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? o Can your practice include, at a minimum, the following elements in the Care Plan o Measurable patient (or patient and caregiver) goals o Medical needs including any behavioral health needs; o Interventions; o Intended outcomes; and o Social, educational, and other services needed by the patient.	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.

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	Requirement	Rationale/Description
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan. (cont'd)		
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) .

AMH Tier 3 Attestation Requirements (cont'd)

	Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)	
#	**Requirement**	**Rationale/Description**
**For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan. (cont'd)**		
18	Can your practice or CIN implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)? ○ 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. ○ 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; ○ 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 reconciliations post discharge)	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.
**Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation 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.**		
19	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: ○ Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits ○ Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center; ○ NICU discharges; ○ Clinical complexity, severity of condition, medications, risk score	

AMH Tier 3 Attestation Requirements (cont'd)

Section II: Medical Home Certification Process: Tier 3 Required Attestations (cont'd)		
#	Requirement	Rationale/Description
Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation 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. (cont'd)		
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 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	Does your practice include the following elements in transitional care management? o Ensuring that a care manager is assigned to manage the transition o Facilitating clinical handoffs; o Obtaining a copy of the discharge plan/summary; o Conducting medication reconciliation; o Following-up by the assigned care manager rapidly following discharge; o Ensuring that a follow-up outpatient, home visit or face to face encounter occurs o Developing a protocol for determining the appropriate timing and format of such outreach	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.
Tier 3 AMH practices must use electronic data to promote care management		
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?	

AMH Tier 3 Attestation Requirements (cont'd)

	Supplemental Questions	
#	**Requirement**	**Rationale/Description**
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) 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) ❑ Employed practice staff ❑ Staff of the CIN ❑ Staff of a care management or population health vendor that is not part of a CIN ❑ 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 participate in the complex care management team within practice/CIN/partner? (Please indicate all that apply.) ❑ MD ❑ RN ❑ LCSW ❑ Medical Assistant/LPN ❑ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.

AMH Tier 3 Attestation Requirements (cont'd)

Supplemental Questions (cont'd)		
#	**Requirement**	**Rationale/Description**
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 participate in the transitional care management team within practice/CIN/partner? (Please indicate all that apply.) ❑ MD ❑ RN ❑ LCSW ❑ Medical Assistant/LPN ❑ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.

Appendix D: Additional Payment Use Cases

Sample Practice 2: Non-CA Practice

Example Non-CA Practice

Current State Carolina ACCESS Payments: $0

Option 1

AMH Tier 2 (Attest)

Future State Payments

Total Payments: $12,000

- *AMH medical home fees for managed care beneficiaries: $12,000*
- *No Carolina ACCESS payments for beneficiaries remaining in FFS (unless practice contracts with CCNC for FFS)*

Option 2

AMH Tier 3 (Attest)

Future State Payments

Total Payments: $12,000 + negotiated amt.

- *AMH payments for managed care beneficiaries: $12,000*
- *Additional negotiated care management & performance payments*
- *No Carolina ACCESS payments for beneficiaries remaining in FFS (unless practice contracts with CCNC for FFS)*

Non-CA Practice – Medical Home Fees

PCCM Payments - NC Medicaid		
Provider Enrollment Status	**Eligibility Category**	**PMPM Payment**
Managed Care Beneficiaries		
AMH Tier 1	All	$1
AMH Tier 2/3	Non-ABD	$2.50
AMH Tier 2/3	ABD	$5
FFS Beneficiaries		
CAI	All	$1
CAII/CCNC	Non-ABD	$2.50
CAII/CCNC	ABD	$5

*This practice could also choose to attest to Tier 3 and become eligible for additional **care management fees***

Beneficiary Type	Program	Beneficiary Count	PMPM	Months per Member Empaneled	Medical Home Fee
Managed care, non-ABD	AMH	300	$2.50	12	$9,000
Managed care, ABD	AMH	50	$5.00	12	$3,000
FFS, non-ABD	Carolina ACCESS	50	$0.00	12	$0
FFS, ABD	Carolina ACCESS	100	$0.00	12	$0

Total Medical Home Fees	**$12,000**

- Practices not currently enrolled in Carolina ACCESS will need to contract with their local CCNC network in FFS to receive medical home fees <u>in FFS</u>
- CAI will cease to exist for <u>new</u> practices

Sample Practice 3: CAI Practice

Example CAI Practice

Current State Carolina ACCESS Payments: $6,000

Option 1

AMH Tier 1 (Default)

Future State Payments

Total Payments: $6,000
- *AMH medical home fees for managed care beneficiaries: $4,200*
- *Carolina ACCESS payments for beneficiaries remaining in FFS: $1,800*

Option 2

AMH Tier 2 (Select option)

Future State Payments

Total Payments: $13,800
- *AMH medical home fees for managed care beneficiaries: $12,000*
- *Carolina ACCESS payments for beneficiaries remaining in FFS: $1,800*

Option 3

AMH Tier 3 (Attest)

Future State Payments

Total Payments: $13,800 + negotiated amt.
- *AMH medical home fees for managed care beneficiaries: $12,000*
- *Additional negotiated care management & performance payments*
- *Carolina ACCESS payments for beneficiaries remaining in FFS: $1,800*

CAI Practice – Medical Home Fees

PCCM Payments - NC Medicaid		
Provider Enrollment Status	**Eligibility Category**	**PMPM Payment**
Managed Care Beneficiaries		
AMH Tier 1	All	$1
AMH Tier 2/3	Non-ABD	$2.50
AMH Tier 2/3	ABD	$5
FFS Beneficiaries		
CAI	All	$1
CAII/CCNC	Non-ABD	$2.50
CAII/CCNC	ABD	$5

*This practice could also choose to attest to Tier 3 and become eligible for additional **care management fees***

Practice does nothing

Beneficiary Type	Beneficiary Count	Program	PMPM	Months per Member Empaneled	Medical Home Fee
Managed care, non-ABD	300	AMH	$1.00	12	$3,600
Managed care, ABD	50	AMH	$1.00	12	$600
FFS, non-ABD	50	Carolina ACCESS	$1.00	12	$600
FFS, ABD	100	Carolina ACCESS	$1.00	12	$1,200
				Total Medical Home Fees	**$6,000**

Practice enters AMH Tier 2

Beneficiary Type	Beneficiary Count	Program	PMPM	Months per Member Empaneled	Medical Home Fee
Managed care, non-ABD	300	AMH	$2.50	12	$9,000
Managed care, ABD	50	AMH	$5.00	12	$3,000
FFS, non-ABD	50	Carolina ACCESS	$1.00	12	$600
FFS, ABD	100	Carolina ACCESS	$1.00	12	$1,200
				Total Medical Home Fees	**$13,800**