NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advanced Medical Home Provider Manual
May 2024

This document was updated on May 16, 2024. This Provider Manual supersedes previous versions.
Any questions about Advanced Medical Home should be submitted to:
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Contents

Section I: Introduction

The North Carolina Department of Health and Human Services ("the Department") developed the Advanced Medical Home (AMH) model as the primary vehicle for care management as the state transitioned to Medicaid Managed Care. Launching alongside NC Medicaid Managed Care, the AMH model supports the Department's transformation vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community. AMHs are providers of primary care services who meet requirements for serving as a Medicaid member's medical home and providing a minimum set of care coordination services and may elect to be delegated for broader care management services that strengthen the medical home in meeting quality improvement goals. By supporting the delivery of appropriate and timely health care that meets each member's needs, high-quality primary care with the capacity to manage population health is foundational to the success of North Carolina's Medicaid Transformation.

On July 1, 2021, approximately 1.6 million Medicaid enrollees moved into Managed Care and that number grew to 2 million as of March 2024.[1] The Department's contract with Standard Plan health plans[2] establishes the AMH program as the vehicle for local care management integrated with primary care. The Standard Plan contract establishes the health plan requirements associated with the AMH program, as well as the mechanisms by which the Department will oversee the program.[3]

This manual[4] is a resource for AMH practices, non-AMH Primary Care Providers (PCPs), Clinically Integrated Networks (CINs), and other partners working with AMHs and PCPs.

[1] NC Medicaid Enrollment Dashboard

[2] The information in this manual applies to practices participating in Standard Plans. Practice requirements and other information for practices providing Tailored Care Management (TCM) can be found in the Tailored Care Management Manual.

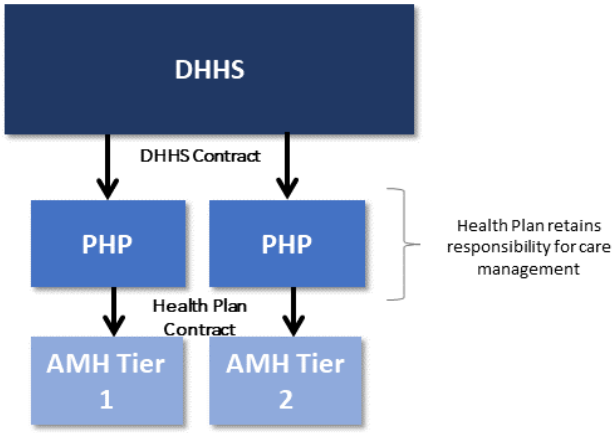
[3] AMH requirements are found within the Standard Plan Scope of Services, Sections V.C.6.b and Attachment M.2.

[4] This manual applies to the AMH program for Standard Plans. For TCM under the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans / Local Management Entities/Managed Care Organizations (LME/MCOs), please refer to the Department's Behavioral Health I/DD Tailored Plan website.

As described in more detail in Section II of this manual, the AMH program contains four Tiers, as follows:

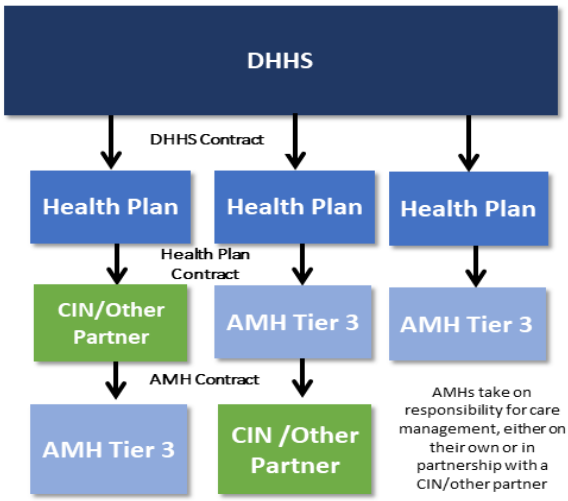
AMH Tier 1 or 2: These PCPs choosing to participate in the AMH program meet minimum care coordination and beneficiary access requirements. The AMH Tier 1 and 2 practices that contract for services with multiple health plans interface and coordinate with each of those health plans' care management programs for high need patients. AMH Tier 1 and 2 practices receive medical home fees as described in **Section III.**

Figure 1: AMH Tier 1 or 2



AMH Tier 3: Practices opting into AMH Tier 3 meet the same minimum requirements as AMH Tier 1 and 2 providers and, additionally, accept responsibility for high need care management and population health for their Medicaid managed care patients. CINs and other partners often play a role in contracting, organizing the work across Tier 3 practices, or helping practices carry out the required responsibilities. Examples of functions typically assumed by the CIN or other partners are risk stratification, data aggregation and care management staffing. In addition to medical home fees, health plans must pay per-member-per-month (PMPM) fees to AMH Tier 3 practices, or the CIN/other partner on the practices' behalf, to reflect the delegated care management function.

Figure 2: AMH Tier 3



AMH+: AMH+ practices are primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the (TCM eligible population or can otherwise demonstrate strong competency to serve that population. More information on AMH+ Practices and their requirements can be found in the TCM Provider Manual.

Non-AMH Network PCP: Practices can choose to be in-network with one or more health plans but not participate in the AMH program. These practices will receive only fee-for-service payments for services without the additional medical home fee) payments associated with the AMH program.

Primary care practices serving managed care members must be contracted with health plans as AMH practices in order to receive AMH payments applicable by AMH Tier.

The AMH program is integrated with the Department's broader quality strategy under which health plans must meet population health targets. See **Section IV** for the AMH quality measures.

The AMH model was designed to spur the development of modernized, data-driven primary care that aligns with the Department's vision for advancing value-based payments over time. To promote care management that is well integrated with primary care, the AMH program requires health plans to work closely with AMH practices and regularly share data to support outreach and improved outcomes for beneficiaries. AMH Tier 3 practices must report data back to health plans in a standardized format. These data flows are described in **Section V.**

DHHS reserves the right to update the manual or guidance at any time. Practices should regularly check DHHS' Medicaid bulletins and AMH website for additional guidance, updates and information.

Section II: AMH Practice Requirements

AMH Eligibility

Practices providing primary care are eligible for the AMH program if they are single and multispecialty groups led by allopathic and osteopathic physicians[5] in the following specialties, including certain subspecialties[6]:

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

Federally Qualified Health Centers, Local Health Departments, Public Health Clinics and Rural Health Clinics are also eligible to be AMHs.

AMH Practices must be enrolled in the state's Medicaid program. All practices must provide primary care services, although they may provide other services as well. There are no minimum panel size requirements, although practices serving only a small number of Medicaid enrollees may wish to consider how AMH participation can complement their practice transformation efforts with other payers to ensure sustainability. Currently, practices are not expected to have gained National Committee for Quality Assurance (NCQA) or other external accreditor's patient-centered medical home certification, or equivalent, to participate in the AMH program. The Department will review this expectation annually and provide updates related to AMH oversight designed to ensure members are receiving high-quality and consistent care management.

In early 2019, practices were asked to attest directly to the Department whether they would participate in AMH Tier 1, 2 or 3. If practices did not attest at that time, they were grandfathered in as follows:

- Carolina ACCESS I practices were recorded as AMH Tier 1s.
- Carolina ACCESS II practices were recorded as AMH Tier 2s.

No practices were automatically recorded as AMH Tier 3s. Tier 3 status always requires affirmative attestation. Health plans receive continuous feeds from NCTracks conveying any updates to attestations.

Practices that wish to become AMH practices should refer to **Section VI** for details on AMH attestation. For information on how to check the tier status that is logged with DHHS, how DHHS will keep track of practices' tier status and how to changetier, if needed, see **Section VII.**

[5] AMH practices can also include Physician Assistants and Advanced Practice Nursing Providers, such as Advanced Practice Midwives and Nurse Practitioners

[6] For a full list of permitted subspecialties, please refer to NCTracks. The Carolina ACCESS program will remain in place as long as North Carolina Medicaid has enrollees receiving care under a fee-for-service model.

AMH Tier 1 and 2 Practice Requirements

AMH Tier 1 and 2 were designed to provide continuity with pre-managed care launch programs, such as Carolina ACCESS. In the AMH program, Tier 1 and 2 practices must continue to meet the same requirements Carolina ACCESS required prior to Medicaid Transformation. These requirements are incorporated into the Department's contract with health plans, and health plans are required to include them in their contracts with all AMH practices.

The current AMH requirements are as follows:[7]

- Accept members and be listed as a PCP in the health plan's member-facing materials for the purpose of providing care to members and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each member, in accordance with Health Plan policies.
- Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, seven days per week. Automatic referral to the hospital emergency department (ED) for services does not satisfy this requirement.
- Provide direct patient care a minimum of 30 office hours per week, some of which may be provided virtually.
- Provide preventive services (see **Appendix A**).
- Maintain a unified patient medical record for each member following the health plan's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or health plan (if applicable) andas authorized by the member within 30 days of the date of the request, free of charge.
- Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the health plan's network adequacy standards.
- Refer for a second opinion as requested by the member, based on the Department's guidelines and health plan standards.
- Review and use member utilization and cost reports provided by the health plan for the purpose of AMH-level utilization management, and advise the health plan of errors, omissions or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the health plan for the purpose of participating in health plan or practice-based population health or care management activities.

For their members assigned to AMH Tier 1 and 2 practices, the health plans are responsible for care management of high-need members, care coordination across settings, transitional care management and other bridging functions that go beyond the Carolina ACCESS requirements above. AMH Tier 1 and 2 practices may interface with multiple plan-based care management programs and staff if they contract with multiple health plans.

The only difference between AMH Tier 1 and 2 is each practice's status prior to managed care launch and whether the practice completed an attestation in NCTracks. AMH Tier 1 is for practices that were grandfathered in from Carolina ACCESS I and is no longer an option for other practices. AMH Tier 2 is

[7] Standard Plan Contract Section VII. Attachment M.2; see also **Appendix A** of this manual.

for practices that were grandfathered in from Carolina ACCESS II. Practices that were previously in Carolina ACCESS I or were not in the Carolina ACCESS program can choose to enroll in AMH Tier 2 via NCTracks. AMH Tier 1 will be discontinued two years after managed care launch.

AMH Tier 3 Practice Requirements

AMH Tier 3 practices must meet all Tier 1-2 requirements above plus additional requirements that reflect capacity for data-driven care management and population health capabilities for their assigned populations.

The AMH Tier 3 practice requirements are incorporated into the Department's contract with health plans. Health plans must include these requirements in their contracts with AMH Tier 3 practices without changes and must monitor AMH practices' compliance with these same Tier 3 requirements. For additional information on monitoring and oversight of AMH practices, see **Section VII.** While Tier 3 standards contain significant overlaps with NCQA recognition (or other external primary care certification programs), such recognition is not required for AMH Tier 3.

AMH Tier 3 practices must meet all of the following requirements.[8] Some or all of these requirements may bemet on the practice's behalf by a CIN/other partner.

Requirement 1: Risk-stratify all empaneled members.

The expectation for Tier 3 AMHs is that they can combine risk information generated at the health plan level with their own clinical understanding of members to produce a practice-wide view of risk and member need, allowing targeting of care management to the right members at the right time.

Table 1. Standard Terms and Conditions: Risk Stratification

AMH Tier 3 Practices Must …	Additional Information[9]
1.1 *Ensure that assignment lists transmitted to the practice by the health plan are reconciled with the practice's panel list and are 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.
1.2 *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

[8] Standard Plan Contract Section VII. Attachment M.2.

[9] For more information on risk stratification, see AMH training webinar on risk stratification and Programmatic Guidance on Risk Stratification for AMH Tier 3 Practices.

1.3 *Use a consistent method to combine risk scoring information received from the health plan with clinical information to score and stratify the patient panel.*	CIN/other partner or application of clinical judgment to risk scores received from the health plan or another source suffice as strategies, as long as the practice's clinical team members have a shared understanding of the methodology.
1.4 *To the greatest extent possible, ensure that the risk stratification method is consistent with the Department's program policy of identifying "priority populations"[10] for care management.*	Not all care team members need to be able to perform risk stratification, but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
1.5 *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.*	
1.6 *Define the process and frequency of risk score review and validation.*	There is no set required frequency, as long as there is a regular process.

Requirement 2: Provide care management to high-needs patients.

Care management is foundational to the success of North Carolina's Medicaid system of care, supporting high-quality delivery of the right care in the right place and at the right time. Patients with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team equipped to address the identified needs. The AMH Tier 3 requirements for high-need care management reflect the requirements that DHHS places on health plans when they perform care management directly.

Table 2. Standard Terms and Conditions: Care Management of High-Need Patients

AMH Tier 3 Practices Must …	Additional Information
2.1 *Use risk stratification methods to 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. Care management designations need not precisely mirror risk stratification levels.

[10] Priority populations, as defined in Section 6.a.iv.b.2 of the Standard Plan contract include individuals with LTSS needs; adults and children with Special Health Care Needs; individuals defined by the health plans as Rising Risk; individuals with high unmet health-related resource needs, defined at minimum to include members who are homeless, members experiencing or witnessing domestic violence or lack of personal safety, and members showing unmet health-related resource needs in three or more Healthy Opportunities Pilots (HOP) domains on the Care Needs Screening; at risk children ages 0-5; high risk pregnant women; and other priority populations as determined by the health plan.

AMH Tier 3 Practices Must …	Additional Information
2.2 *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:* • *Patient's immediate care needs and current services;* • *Other state or local services currently used;* • *Physical health conditions, including dental;* • *Current and past behavioral and mentalhealth and substance use status and/or disorders;* • *Physical, intellectual developmental disabilities;* • *Medications – prescribed and taken;* • *Priority domains of social determinants ofhealth (housing, food, transportation, andinterpersonal safety); and* • *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 health plan (if available). The clinician performing the assessment should confirm the information with the patient. 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 patient's claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. The 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 patient may be referred for formal diagnostic evaluation. The practice or CIN/other partners administering the Comprehensive Assessment should develop a protocol for situations when a patient 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 patient 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.
2.3 *Have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.*	Care managers must be assigned to the practice but need not be physically embedded at the practice location.

AMH Tier 3 Practices Must …	Additional Information
2.4 *For each high-need patient, 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.*	A patient may decline to engage in care management, but the practice or CIN/other partner should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during routine visits.

Requirement 3: Develop a care plan for all patients receiving care management.

A written care plan helps the care management team document the patient's needs and goals, identify appropriate services and track progress against goals over time. The care plan also promotes alignment across all members of a patient's care team to ensure the services a patient receives are coordinated and working together to advance progress toward the patient's health goals.

Table 3. Standard Terms and Conditions: Developing a Care Plan for All Patients Receiving Care Management

AMH Tier 3 Practices Must …	Additional Information
3.1 *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. Incorporate findings from the health plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the care plan.*	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.
3.2 *Include, at a minimum, the following elements in the care plan:* • *Measurable patient (or patient and caregiver) goals;* • *Medical needs, including any behavioral health and dental needs;* • *Interventions, including medication management and adherence;* • *Intended outcomes; and* • *Social, educational and other services needed by the patient.*	Practices should take an individualized, person-centered and collaborative approach to care plan development and should be able to describe how their care plan development approach demonstrates these attributes.
3.3 *Have a process to document and store each care plan in the clinical system of record.*	A clinical system of record can include the provider's electronic health record (EHR) system, care management data system, or other electronic system that collects and stores care plan information.

AMH Tier 3 Practices Must …	Additional Information
3.4 *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.
3.5 *Have a process to update each care plan as member needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.*	As member needs change, the AMH should update the care plan in a clinical system of record to reflect these changes.
3.6 *Track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local EDs and hospitals, throughactive access to an admission, discharge and transfer(ADT) data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to/from an ED 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 EHR or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s).
3.7 *Implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (below) 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):* • *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.*	Practices (directly or via CIN/other partners) are not required to respond to all ADT alertsin 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 thepractice 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 – to enable an external observer to easily determine whether the process is being followed.

Requirement 4: Provide short-term, transitional care management, along with medication management, to all empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are at high risk of readmission and other poor outcomes.

Patients who are transitioning from one care setting to another, such as from the hospital back to the community, can benefit from short-term support to prevent unplanned or unnecessary readmissions or other adverse outcomes. Care management teams can support these patients by facilitating clinical handoffs, conducting medication reconciliation, and ensuring they receive appropriate follow-up care.

Table 4. Standard Terms and Conditions: Transitional Care Management

AMH Tier 3 Practices Must …	Additional Information
4.1 *Have a methodology or system for identifying patients in transition who are at risk of readmission and other poor outcomes that considers all of the following:* • *Frequency, duration and acuity of inpatient, Skilled Nursing Facility (SNF) and Long-TermServices and Supports (LTSS) admissions or ED visits;* • *Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, or a medically supervised or alcohol/drug abuse treatment center;* • *Neonatal intensive care unit (NICU) discharges; and* *Clinical complexity, severity of condition, medications, and risk score.*	Practices or their CIN/other partner may use whichever methodology and information they see fit to identify patients in need of transitional care management.
4.2 *For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, 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 credential of RN or LCSW.*	A patient may decline to engage in care management, but the practice should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during the transition period.

AMH Tier 3 Practices Must …	Additional Information
4.3 *Include the following elements in transitional care management:* • *Ensuring that a care manager is assigned to manage the transition;* • *Facilitating clinical handoffs;* • *Obtaining a copy of the discharge plan/summary;* • *Conducting medication reconciliation;* • *Following up by the assigned care manager rapidly following discharge;* • *Ensuring that a follow-up outpatient, home visit or face-to-face encounter occurs; and* • *Developing a protocol for determining the appropriate timing and format of such outreach.*	The practice must have a process for determining a clinically appropriate follow-up interval for each patient that is specific enough – with regard to the interval within which follow-up should occur and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.

Requirement 5: Be able to receive claims data feeds and meet state-designated security standards for claims storage and use.

To provide appropriate care management services to empaneled patients and work toward improved care outcomes, Tier 3 practices will need to have timely access to relevant, patient-level data. To meet this requirement, Tier 3 practices (or their CIN/other partners) must receive claims data feeds and meet state-designated security standards for their storage and use.[11] See **Section V** for additional information on the standardized data flows that will support the AMH program.

Future Evolution of AMH Practice Requirements

The Department views the AMH program as the vehicle for promoting data-enabled primary care that can assume responsibility for the whole-person health of populations. This transition takes time, and the initial AMH Tier 3 set of requirements is a starting point that intentionally prioritizes the use of data for the management of population needs. The Department expects to evolve the AMH program requirements based on experience in managed care with the ultimate goals of maintaining strong primary care access and promoting high-quality, coordinated care for NC Medicaid members.

It is evident that primary care's role in addressing social determinants of health is critically important and evolving rapidly, both nationally and in North Carolina. North Carolina has worked on enhancing the capacity of the Medicaid delivery system to integrate healthcare with the addressing of social needs. This has been accomplished through the launch of HOP, the nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal violence and toxic stress to high-needs Medicaid

[11] Standard Plan Contract III.E.5.

enrollees. HOP referrals are facilitated through the utilization of the NCCARE360 platform, a statewide, closed loop referral platform that allows providers to electronically link members with identified health-related social needs to community resources.

HOP participation is opening to TCM-eligible Medicaid beneficiaries in the spring of 2024. Furthermore, the AMH program will extend into North Carolina's Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans which will launch in July 2024. AMH Tier 1, 2, and 3 practices will meet the same care coordination and member access requirements in Tailored Plans as AMH Tier 1 and 2 providers meet in Standard Plans. AMH practices are the foundation of primary and preventive care access across the NC Medicaid program, and NC Medicaid is committed to strengthening these practices' coordination of care for members.

Section III: AMH Payment Model

The AMH payment model provides a smooth transition from the payment model in place prior to Medicaid Transformation while also introducing payment linked to performance on care management expectations and the AMH measure set (see **Section IV**). In addition to Medicaid clinical services fees (fee for service), the health plan contract requires health plans to pay AMH practices three types of payments. These payments are described in Table 5 and the accompanying text.

Summary of Payment Model by Tier

Table 5. Summary of Payment Model by Tier

<table>
<tr><th>AMH Tier</th><th>Medical Home Fees[12]</th><th>HOP Referral Fee[13]</th><th>Care Management Fees</th><th>Performance Incentive Payments</th></tr>
<tr><td>Tier 1</td><td rowspan="3">$2.50
(Non-ABD)

or

$5.00
(Members in the Aged, Blind, and Disabled [ABD] eligibility group, and all Tailored Plan members)</td><td>None</td><td>None</td><td rowspan="2">None required, but Standard Plans and Tailored Plans are encouraged to offer performance incentive payments based on the AMH Measures.</td></tr>
<tr><td>Tier 2</td><td>None</td><td>None</td></tr>
<tr><td>Tier 3</td><td>$2.10</td><td>Standard Plans: Negotiated between practices (or CINs/other partners on behalf of practices) and health plan

Tailored Plans: None</td><td>Standard Plans and Tailored Plans must offer performance incentive payments to practices for measures within the AMH quality measure set.</td></tr>
</table>

- **Medical Home Fees:** Non-visit-based payments to AMH practices, providing stable funding for care coordination support and quality improvement at the practice level, as defined by the AMH Tier 1 and 2 requirements set out in **Section II** above.[14] All AMH practices will receive medical home fees for all their assigned patients. Members are assigned to AMHs at the NPI + location level. PMPM amounts for the medical home fees are set by the Department. Medical practices in AMH Tiers 1, 2, and 3 will receive $2.50 PMPM for most members and $5.00 PMPM for

[12] Fees are per member per month based on the number of assigned members.
[13] Applies to HOP-participating AMH Tier 3s within the HOP regions. Fees are per member per month based on the number of assigned beneficiaries. The Department may transition this PMPM to a per enrollee per month (PEPM) as the program matures.
[14] Standard Plan contract III.A.77.

members in the aged, blind, and disabled Medicaid eligibility group and for all Tailored Plan members.[15] AMH Plus (AMH+) practices will receive Medical Home Fees in the same way as other Tier 3 practices in recognition of their role as PCPs and will receive care management payments in addition under the TCM model.[16]

- **Care Management Fees:** Non-visit-based payments to AMH Tier 3 practices (or CINs/other partners on their behalf) providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.[17] Care management fees that Standard Plans pay to AMHs are set through negotiations between Standard Plans and Tier 3 practices (or CINs/other partners acting on their behalf). The Department has not established minimum care management fees to date, but the expectation underlying the AMH Tier 3 model is that Standard Plans and practices will arrive at mutually agreeable rates that are commensurate with the intensity and breadth of the care management being provided. The Department has issued information on care management rate assumptions detailing the Department's assumed costs for delivering care management. Standard Plans must pay the full negotiated care management fee amount. Payment of Tier 3 practices' care management fees, or any portion of their care management fees, may not be conditioned on, or otherwise put at risk.[18]

- **Performance Incentive Payments:** Payments additional to fee for service, care management fees and medical home fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics.[19] Standard Plans and Tailored Plans are *required* to offer Performance Incentive Payment opportunities to Tier 3 and AMH+ practices and are *encouraged* to offer them to practices in Tiers 1 and 2. While performance thresholds and payment rates are set by health plans, all performance incentive payments *must be based exclusively on the AMH measure set* and not on measures outside the set.[17] See **Section IV** for the AMH Measure List.

AMH Payment Model and Advanced Value-Based Payment Models

The Department recognizes that some practices and CINs/other partners may be interested in moving beyond the current AMH Tier 3 model toward more advanced value-based contracts that include increased accountability for total cost of care and/or shift payments to practices to a primary care capitated model (HCP-LAN level 3A or above). The Department strongly encourages these developments, which align with the Department's Value-Based Payment Strategy. AMH Tier 3 practices participating in the Integrated Care for Kids (InCK) model have the option to participate in the InCK Foundation Alternative Payment Model (APM). See Appendix D for additional detail on participation in the InCK model.

[15] During the PHE, which continues at the time of publication of this manual, Carolina ACCESS fees are temporarily increased. These changes will carry into Managed Care if the PHE is still in effect when Managed Care launches.
[16] NC Medicaid Managed Care Factsheet: Contracting with Tailored Plans
[17] Standard Plan Contract III.A.18
[18] The current care management rate assumption can be found posted on the AMH Website.
[19] Standard Plan Contract III.A.94

Section IV: Quality

To ensure delivery of high-quality care under the managed care delivery system, the Department has developed a Medicaid managed care and identified a set of quality metrics that it will use to assess health plans' performance across their entire populations. The Department has identified a subset of these measures for health plans to use to monitor AMH performance and calculate AMH performance incentive payments.

Figure 3. AMH Quality Metrics for Calendar Year 2024

Calendar Year 2024 AMH Measure Set
• Child and Adolescent Well-Care Visits • Childhood Immunization Status (Combination 10) • Immunizations for Adolescents (Combination 2) • Screening for Depression and Follow-Up Plan • Well-Child Visits in the First 30 Months of Life • Prenatal and Postpartum Care [20] • Cervical Cancer Screening • Chlamydia Screening in Women • Glycemic Status Assessment for Patients with Diabetes (GSD) Controlling High Blood Pressure • Plan All-Cause Readmission – Observed to Expected Ratio • Colorectal Cancer Screening (COL) • Total Cost of Care

All quality measures health plans incorporate into their contracts with AMH practices (all Tiers) must be taken from this measure set, although health plans are not required to use all AMH measures. For the AMH measure set, the Department prioritized measures that can be calculated using claims data (i.e., practices will not be required to submit any additional information to health plans for the majority of these measures). If health plans and AMHs choose to use measures for which hybrid reporting is appropriate (e.g., Glycemic Status Assessment for Patients with Diabetes), the Department encourages health plans to use consistent reporting approaches that will minimize burden on AMH practices.

Beginning in 2024, Standard Plans will be subject to withholds from their capitation based on plan-level performance. Withholds will be applied to payments made to health plans, **not providers**. However, providers may notice an increased emphasis by health plans on the performance measures included in the Withhold Program.[21]

Measurement for all Department-required quality incentive programs, including AMH, will be aligned with calendar years.

Standard Plans and Tailored Plans are required to offer incentive programs to Tier 3 practices based on the AMH measure set. AMH+ practices, which will serve members of the forthcoming Tailored Plans, are also Tier 3 practices and therefore are included in any AMH incentive program. These incentive programs are optional for Standard Plans and Tailored Plans to offer to Tier 1 and Tier 2 AMHs.

At Tailored Plan launch it will be optional for Tailored Plans to offer an incentive program specific to

[20] This measure is new for CY2024.

[21] More details on the withholds program is available on the Quality webpage.

TCM to AMH+ practices. However, following the release of an AMH+ or Care Management Agencies (CMA) measure set and further TCM incentive guidance (under development at the Department), these incentive programs will become required and must be based on the standard AMH+/CMA measure set.

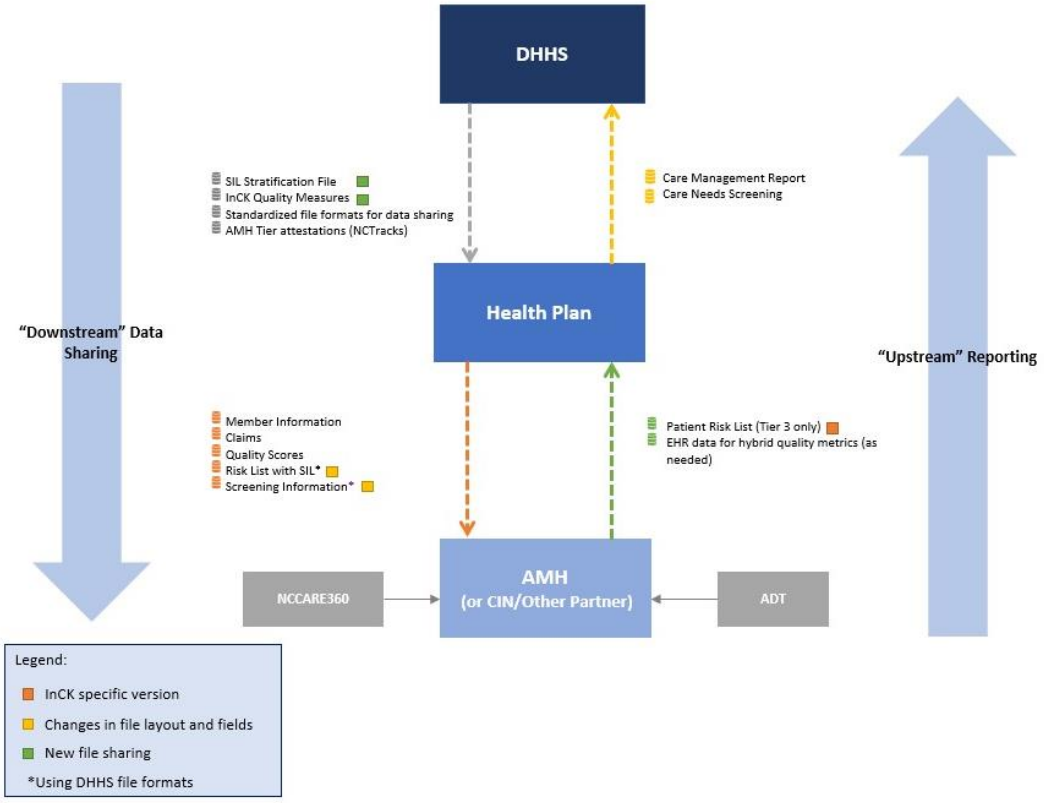
Section V: Data Exchange between Health Plans and AMH Practices

A key component of the Department's vision for AMH is that practices will be equipped with data to support their ability to manage the health of their populations. To achieve this vision and promote a population approach at the level of each practice, the Department has set requirements for "downstream" AMH data sharing within the health plan contract and has rolled out standards for certain critical data flows. At the same time, the Department has standardized "upstream" data reporting between AMH practices, health plans and the Department to reduce administrative burden and improve the quality of data flowing to health plans and the Department for oversight purposes.

"Downstream" Data Flows from Health Plans to AMHs and CINs/Other Partners

To support AMH practices in carrying out care management and related functions for their population, the Department requires health plans to share multiple data types with their contracted AMH practices (whether directly or through a designated CIN/other partner).[22] Prior to managed care launch,the Department partnered with health plans and AMH practices/CINs or other partners to standardize file formats for the most critical data for care management, as described below.

Figure 4. AMH Program Data Flows



[22] For more information on data that AMH practices will receive, refer to the PHP contract, "Advanced Medical Home Data and Information Sharing" Section 6.b.IV.c. See also the Department's 2018 white paper "Data Strategy to Support the Advanced Medical Home Program in North Carolina."

Health plans are required to share the following data types with AMH practices in their networks:

- **Member Assignment Files (all AMH Tiers):** health plans are required to deliver timely, accurate information to AMH practices about the members that have been assigned to them. The way that health plans are required to share this data differs by AMH Tier.
    - **For Tier 1 and 2 practices,** health plans must share, in a format of their choosing:
        - Point-in-time assignment, on at least a monthly basis;
        - Projected assignment information for the following month (to the extent the information is available);
        - Information about newly assigned members to the health plan, within *seven* business days of enrollment (more rapid notification may be required for assignment of newborns);
        - Notifications of any ad hoc changes in assignment as they occur, within *seven* business days of each change.
    - **For Tier 3 practices or CINs/other partners acting on their behalf,** health plans must share member assignment files and pharmacy lock-in data using specific file layouts, formats and transmission protocols established by the Department. The Department's file layout uses the 834 EDI Enrollment standard file format as the baseline. Health plans are required to complete testing with partner AMH Tier 3 practices/CINs/other partners. For more information, see the "Requirements for Sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support AMHs" reference document on the AMH Data Specification Guidance website.
- **Claims and encounter data (AMH Tier 3 only):** health plans must share timely claims and encounter data with Tier 3 practices using specific file layouts, formats and transmission protocols established by the Department. Health plans are required to complete testing with partner AMHTier 3 practices/CINs/other partners. For more information, see the "Requirements for Sharing Encounters and Historical Claims Data to Support AMHs" reference document on the AMH Data Specification Guidance website.
- **Health plan risk scoring and risk stratification results (all AMH Tiers):** health plans must share results of their risk scoring with all AMH practices, including (where possible and relevant) member-level information about cost and utilization. For Tier 3 only, the Department developed a standardized report, the Patient Risk List (PRL) template, that health plans must use to transmit risk stratification results on a monthly basis to Tier 3 practices (or CINs/other partners on their behalf). As described below (see "'Upstream' Reporting from AMHs to health plans"), Tier 3 practices must use the PRL report to transmit information "upstream" to the health plan. Health plans use information in the Tier 3 practices' PRL report to inform their development of the care management report that is transmitted to the Department encounters that actually took place for the members. For more information, see the "Requirements for Sharing Patient Risk List to Support Advanced Medical Homes (AMHs)" and "Patient Risk List Frequently Asked Questions" reference documents on the AMH Data Specification Guidance website.
- **Initial Care Needs Screening results (all AMH Tiers and non-AMH PCPs):** health plans are required to make at least three attempts to collect information via an "Initial Care Needs Screening" that assess member health and unmet resource need within 90 days of members' enrollment. Health plans are required to share the results of the Initial Care Needs Screening

with PCPs within *seven* days of screening or within seven days of assignment to a new PCP, whichever is earlier.

- **Quality measure performance information (all AMH Tiers):** As noted in **Section III,** health planswill use a set of quality metrics to assess AMH performance and calculate performance-based payments. Health plans will share with AMHs information on the quality measures included in AMH practices' contracts. Health plans will also be required to share total cost of care information with AMH practices.

"Upstream" Reporting from AMH Practices to Health Plans

AMH practices will report information back to health plans as follows:

- **Care Management Reporting (Tier 3 only):** health plans are responsible for reporting to the Department the care management activities delivered to their entire populations using the Care Management Interaction Report. The Care Management Interaction Report includes member-level care management encounter reporting that spans care management provided by the health plan itself, Local Health Departments and AMHs. The Department' uses information received from health plans' Care Management Reports to monitor the frequency and types of care management activities to inform future policy and rate development.

  To ensure that health plans have the full range of information to develop their Care Management Reports, the Department developed a standardized file format, the PRL, for Tier 3 practices to report care management encounter information to health plans. Detailed specifications for the PRL are available on the AMH Data Specification Guidance website.

  The PRL is both the vehicle for AMH Tier 3 practices (or their CINs/other partners) to receive member-level risk information from the health plans and to transmit care management encounter data to the health plan. The PRL includes, for each assigned patient:

  - The AMH risk score category (e.g., high, medium, low, or null);
  - The number of care management interactions;
  - The number of face-to-face care management encounters;
  - The date on which the comprehensive assessment was completed;
  - The date on which the care plan was created (when applicable);
  - The date on which the care plan was updated (when applicable); and
  - The date on which the care plan was closed (when applicable).
  - The date care manager assigned (InCK beneficiaries only)
  - The initial care manager outreach date (InCK beneficiaries only)
  - The name of care manager assigned (InCK only)
  - The phone number of care manager assigned (InCK beneficiaries only)
  - The date of the share action plan was created (InCK beneficiaries only)
  - The assigned care management entity care management code (InCK beneficiaries only)

  For the purposes of the PRL, Tier 3 AMHs (or their CINs/other partners) should report all levels

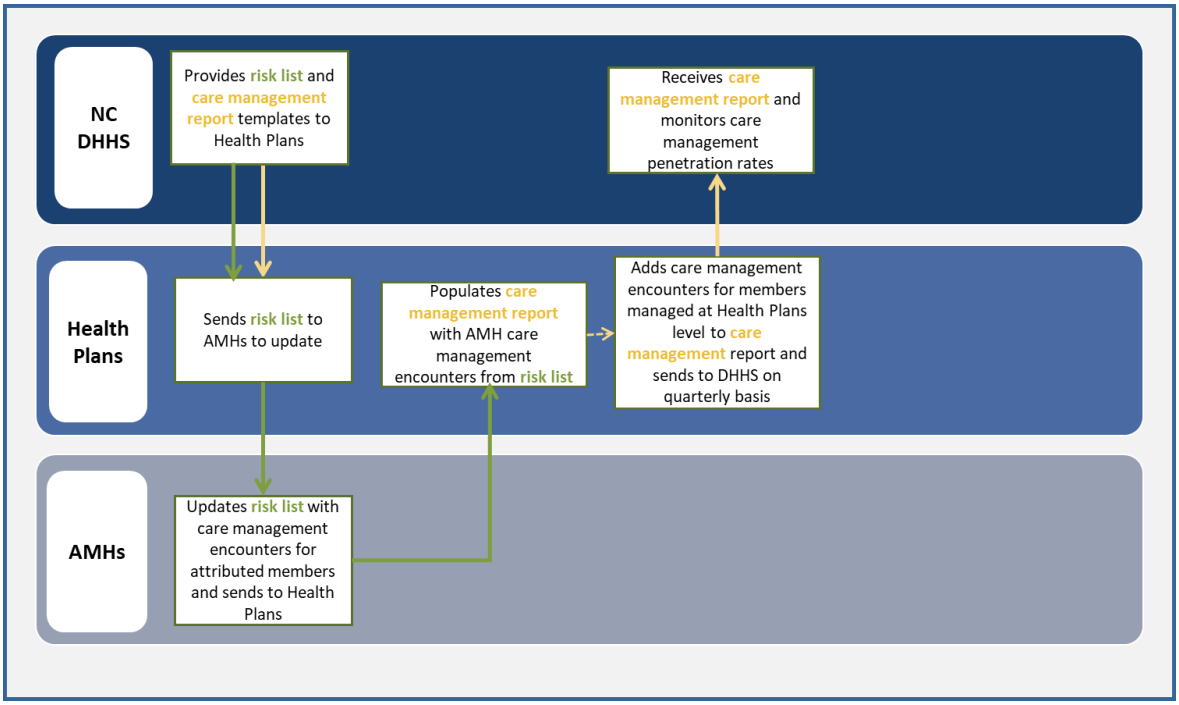
of care management, ranging from high intensity (e.g., care plan development and frequent face-to-face encounters) to low intensity (e.g., infrequent, telephonic contact). Forthe purposes of care management reporting, the Department considers the following to be care management encounters:

- In-person (including virtual) visit with care manager; could include delivery of Comprehensive Assessment, development of care plan or other discussion of patient's health-related needs.
- Phone call or active email/text exchange between member of care team and member (must include active participation by both parties; unreturned emails/text messages do NOT count). Examples of a qualifying encounter would include discussion of the member's care plan or other health-related needs.

The following should **not** be reported as care management encounters in the PRL:

- Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP) encounters.
- Care manager leaves a voicemail with member or sends unreturned email/text message.
- Health plan/care manager sends mailer to member.
- Phone calls between member and practice front desk staff for scheduling purposes.
- Scheduled in-person visit to which the member fails to show up.

Figure 5. Patient Risk and Care Management Interaction Data Flow



- ***"Upstream" quality reporting* (all AMH Tiers):** Separately from the PRL, health plans may require AMH practices to share EHR data for the purposesof quality measurement if the health plans select AMH measures with hybrid claims/clinical specifications.
- ***Additional "upstream" reporting*:** health plans may request that AMHs report additional data; however, any AMH reporting requirements not listed in this manual are unique to the health plans and not required by the Department. AMH practices may negotiate which additional data elements to share and how frequently they will share them when contracting with health plans.DHHS does not require AMH Tier 3 practices to share Comprehensive Assessments or care plans with health plans.

ADT Data, Clinical Information, and Health-related Resource Needs

Tier 3 AMH practices are required to access ADT data; while Tier 1 and 2 practices are not required to access ADT data, they are strongly encouraged to do so. AMHs also benefit from timely access to certain clinical information for care oversight and management, including information about members' test results, lab values and immunizations. Practices have several options for how and where to access clinical data, such as clinical data from affiliated health systems' EHR software, or NC HealthConnex. Practices may also work throughtheir CINs/other partners to obtain clinical data.

AMHs are encouraged to access NCCARE360 for information regarding available community resources to address members' health-related resource needs. NCCARE360 is North Carolina's statewide coordinated care network that electronically connects those with identified needs to community resources and supports a feedback loop on the outcome of that connection. As of June 2020, NCCARE360 is available in every county in North Carolina. Practices should refer to the NCCARE360 website for information about how to gain access.

Section VI: AMH Attestation and Certification

To participate in the AMH program, practices must attest to AMH Tier-specific practice requirements for participating in the corresponding Tier. After the Department reviews the AMH practice attestation and notifies it of its Tier status designation, the practice can then contract with health plans in its region at the Tier for which the practice is designated. The Tier for which a practice receives Departmental designation represents the highest Tier level at which that practice is able to contract with a health plan. Practices may choose to contract at different Tiers with each health plan, though they may not exceed their highest Tier designation with any health plan. Departmental AMH designation does not obligate practices to participate in the AMH program, and an AMH may choose not to contract as an AMH practice.

For more information on AMH Tier attestation to participate in the AMH program, see the AMH Tier Attestation Overview on NCTracks.

Checking or Changing AMH Status

Practices may confirm or change their AMH status on the NCTracks site. To change status, a Tier 3 practice should enter its NPI/Atypical ID and Service Location in NCTracks and select "Downgrade to AMH Tier Level 2." Similarly, if a practice that attested for a lower AMH determines it is ready to meet Tier 3 requirements, it may attest into Tier 3 on NCTracks to request Departmental designation as a Tier 3 practice. There is no limit to how often a practice can upgrade or downgrade its AMH Tier. However, because Tier changes will be effective on the first day of the following month, subsequent changes must occur after the practice's most recent Tier change goes into effect. See Protocol for Changing Advanced Medical Home Tier Status for additional information.

Section VII: Contracting and Oversight

AMH Contracting

For AMH Tiers 1 and 2, health plans are required to enter into contracts with practices that meet the requirements described in **Section II**. For AMH Tiers 1 and 2, health plans must accept the attestation "as is" without the ability to review during the initial contracting process. Health plans are requiredto include language that reflects the Tier 1 and 2 requirements (**Appendix A**).

For AMH Tier 3, health plans are required to enter into contracts with those practices that meet the requirements described in **Section II**. Health plans may assess the capabilities of Tier 3-designated practice as part of the initial contracting process. Health plans are required to include language that reflects both the Tier 1 and 2 requirements (**Appendix A**) and the Tier 3-specific requirements (**Appendix B**). Activities by health plans may include conducting an onsite review, telephone consultation, documentation review or other virtual/offsite reviews. Based on the extent to which AMH Tier 3 functions are undertaken by a CIN/other partner, the health plan may perform an evaluation of the CIN/other partner instead of or in addition to the AMH practice.

The Department will review and approve all health plan/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated. Contracts must:

- Be mutually agreed upon;
- Assign responsibilities (details of activities performed vs. retained) and specify responsibilities;
- Assign responsibilities that contain all required elements included in Appendix A (for all AMH practices) and Appendix B (for Tier 3 AMH practices);
- Specify reporting standards and performance monitoring (in alignment with the Department's standards);
- Specify consequences for underperformance, including appeals rights; and
- Include data sharing and provisions for privacy/security, in alignment with the Department's data sharing policies.

Health plans must share with each AMH Tier 3 practice a description of the oversight process they will use to monitor practices' performance against specific AMH requirements, including the processes they will use to monitor the CIN/other partner with which the practice is affiliated. In the event of a compliance action against a CIN/other partner, the health plan will provide notice to each AMH Tier 3 practice affiliated with that CIN/other partner within 60 calendar days that a corrective action was imposed.

AMH Oversight and "Downgrades"

After launch, if an AMH practice is not able to perform the activities associated with its AMH Tier, the health plan may "downgrade" the practice, or move a practice out of the AMH program altogether. For AMH Tier 3, the Department will permit health plans to stop paying the AMH Tier 3 payment components and lower the Tier status of the AMH practice if the practice is unable to perform Tier 3 functions.[23] health plans must have a defined process for "downgrade" actions that includes at least 30 days for remediation of noncompliance. In the event of a compliance action against a CIN/other

[23] Standard Plan Scope of Services, Section V.C.6.b.iv.d.4.

partner, the health plan must provide notice to each AMH Tier 3 associated with that CIN/other partner within 60 calendar days that a corrective action was imposed.[24]

AMH practices have the right to appeal any such downgrades to the health plan by going through the health plan's regular appeals process.[25] There will be no direct route of appeal to the Department.

The Department will monitor health plans' downgrade decisions as part of its overall monitoring of health plan activities and may consider health plans' pattern of downgrading in its ongoing compliance activities and in subsequent monitoring decisions.

Under their contracts with the Department, health plans are required to achieve NCQA Health Plan Accreditation by July 1, 2025. In order to minimize the impact of this process on delegated care management entities, including AMH Tier 3 practices, the Department is prohibiting health plans from requiring[26] that AMH Tier 3 practices and other DHHS-mandated delegates participate in audits or monitoring activities for the purpose of meeting requirements enumerated in the NCQA Population Health Management (PHM) 5 complex case management standards.[27] The Department is instituting this policy until Standard Plan NCQA health plan accreditation is complete in 2025, after which it may be extended or modified.

Standard Plans may continue to monitor delegated entities' care management activities against other care management or program requirements (e.g., AMH care management requirements) to advance their performance expectations. Health plans are also encouraged to work in collaboration with delegated care management entities to prepare for potential future NCQA delegation oversight as outlined in PHM 7 (e.g., PHM 7 Element B: Predelegation Evaluation) or otherwise to improve care management performance or build care management capacity.

[24] See "Advanced Medical Home Policy Changes," Nov. 16, 2020.
[25] Standard Plan Contract, Section VII. Attachment I.
[26] For example, as part of contract execution.
[27] Please refer to the NCQA Health Plan Accreditation Population Health Management Standards 5: Complex Care Management for further information on these requirements.

Section VIII: Practice Supports and Other Resources

The Department, in partnership with NC Area Health Education Centers (AHEC), provides education, engagement, outreach and practice-level technical assistance aligned with the AMH program. Starting in January 2021, AHEC coaches have been working with individual practices to accelerate the adoption of Tier 3 standards and support practices with continued provision of high-quality AMH Tier 3 services. Coaching is available to primary care practices that are in-network with at least one health plan. For more information on AHEC practice supports, visit the NC AHEC Advanced Medical Home webpage.

Health plans are also required to engage and support practices through a call center and online provider portal as well as provide training and education on the Medicaid program and providers' rights within the programs. Health plans should also meet with clinical leadership at the regional level at least quarterly to discuss implementation of quality improvement activities aligned with the Quality Strategy. AMHs should contact the health plans they have contracted with for information on any support services the health plans make available to their AMH contractors and how to access those services.

The Department also publishes AMH policy papers, programmatic guidance and FAQs for AMH providers on its Advanced Medical Home webpage.

The Department convenes a Technical Advisory Group (TAG) and TAG Data Subcommittee to inform the development and evolution of the AMH program. The role of the AMH TAG is to advise and inform the Department on keyaspects of AMH design and to provide feedback on proposed program changes. While TAG membership is by Departmental invitation only, all TAG meetings are open to the public, and AMH providers are encouraged to join meetings and share feedback during the public comment portion of each session. For more information on the AMH TAG, please see the NC Medicaid Advanced Medical Home Technical Advisory Group webpage.

Appendices

Appendix A. Standard Terms and Conditions for Health Plan Contracts with AMH Tier 1 and 2 Practices

Health plans are required to include the following language in all contracts with AMH practices. The Department will review all health plan/AMHpractice contract templates prior to use to ensure standard contract terms are incorporated:

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

Preventive Health Requirements:

			Required for providers that serve the following age ranges											
NCTracks Assigned Number	**Requirement**		**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary							Y		Y		Y	Y	Y
	Health Assessment													

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 and 9	Hemoglobin or Hematocrit		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
10	Hepatitis B Vaccine		Y	Y	Y	Y	Y	Y	Y						
11	Inactivated Polio Vaccine (IPV)		Y	Y	Y	Y	Y	Y	Y						
12	Influenza Vaccine		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Measles, Mumps, Rubella Vaccine (MMR)		Y	Y	Y	Y	Y	Y	Y						
14	Pneumococcal Vaccine		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	
15	Standardized Written Developmental		Y	Y	Y	Y	Y	Y	Y						
16	Tetanus				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
18	Urinalysis									Y		Y	Y	Y	
19	Varicella Vaccine		Y	Y	Y	Y	Y	Y	Y						
20	Vision Assessment			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		

Appendix B. Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices

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

a. Tier 3 AMH practices must be able to risk stratify all empaneled patients.
    i. The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the health plan are reconciled with the practice's panel list and up to date in the clinical system of record.
    ii. The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.
    iii. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from health plan with clinical information to score and stratifythe patient panel.
    iv. The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Department's program Policy of identifying "priority populations" for care management.
    v. The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.
b. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.
    i. The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.
    ii. The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:
        1. Patient's immediate care needs and current services;
        2. Other State or local services currently used;
        3. Physical health conditions;
        4. Current and past behavioral and mental health and substance use status and/or disorders;
        5. Physical, intellectual developmental disabilities;
        6. Medications;
        7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
        8. Available informal, caregiver, or social supports, including peer supports.
    iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with cliniciansin a team-based approach to care for high-need patients.
    iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

c. Tier 3 AMH practices must use a documented care plan for each high-need patient receivingcare management.
    i. The Tier 3 AMH practice must develop the care plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the care plan.
    ii. The Tier 3 AMH practice must develop the care plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.
    iii. The Tier 3 AMH practice must incorporate findings from the health plan care needs screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the care plan.
    iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the care plan:
        1. Measurable patient (or patient and caregiver) goals;
        2. Medical needs, including any behavioral health needs;
        3. Interventions;
        4. Intended outcomes; and
        5. Social, educational and other services needed by the patient.
    v. The Tier 3 AMH practice must have a process to update each care plan as member needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.
    vi. The Tier 3 AMH practice must have a process to document and store each care plan in the clinical system of record.
    vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients and refine the care management servicesas necessary.
    viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local EDs and hospitals, through active access toan admission, discharge and transfer ADT data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to/from an ED or hospital in real time or near real time.
    ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).
        1. Real time (minutes/hours) response to outreach from EDs relating to patientcare or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
        2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
        3. Within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been discharged from a hospital orED (e.g., to assist with scheduling appropriate follow-up visits or medicationreconciliations post discharge)
d. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an ED visit or hospital

admission / discharge / transfer and who are at risk of readmissions andother poor outcomes.

i. The Tier 3 AMH practice must have a methodology or system for identifying patientsin transition who are at risk of readmissions and other poor outcomes that considers all of the following:
    1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or EDvisits
    2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
    3. NICU discharges;
    4. Clinical complexity, severity of condition, medications, risk score.

ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentialsof RN or LCSW.

iii. The Tier 3 AMH practice must include the following elements in transitional care management:
    1. Ensuring that a care manager is assigned to manage the transition;
    2. Facilitating clinical handoffs;
    3. Obtaining a copy of the discharge plan/summary;
    4. Conducting medication reconciliation;
    5. Follow-up by the assigned care manager rapidly after discharge;
    6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs;
    7. Developing a protocol for determining the appropriate timing and format ofsuch outreach.

e. Tier 3 AMH practices must use electronic data to promote care management.

i. The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.

Appendix C. AMH Tier 3 Practice Attestation Questions

Section A: Requirements (contact information)		
#	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 (email and phone number)	
N/A	Organization National Provider Identifier (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		
Section B: Medical Home Certification Process: Tier 3 Required Attestations		
Please indicate whether your practice, contracted CIN/other partners, or system can perform the following functions. (See supplemental questions 1-4 to provide more information about CIN/partner participation.)		
#	Requirement	Rationale
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 health plan are reconciled with the practice's panel list and are 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 EHR 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
3	Can your practice use a consistent method to combine risk scoring information received from the health plan with clinical information to score and stratify the patient panel?	

	(See supplemental question 5 to provide more information.)	received from the health plan or another source will suffice.
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 the health plan.
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.
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): • Patient's immediate care needs and current services; • Other state or local services currently used; • Physical health conditions; • Current and past behavioral and mental health and substance use status and/or disorders; • Physical, intellectual developmental disabilities; • Medications; • Priority domains of social determinants of health	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 health plan (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

	(housing, food, transportation and interpersonal safety); and • Available informal, caregiver or social supports, including peer supports.	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.
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 credential 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 clinically appropriate.

	credential of RN or LCSW? (See supplemental question 6 to provide further information.)	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 health plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinicalknowledge of the patient into the care plan? 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 finger sticks 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
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 members by the practice to ensure that services are meeting the needs of empaneled members, 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 members' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local EDs and hospitals, through active access to an admissions, discharge, and transfer ADT data feed that correctly identifies when empaneled members are admitted, discharged, or transferred to/from an ED or hospital in real time or near real time?	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems, so this information is readily available to members of the care team on the next (and future) office visit(s).
18	Can your practice or CIN/partners 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 outpatientneeds or prevent future problems for high-risk members 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 member's complaint (suggesting the member 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 member 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 – to enable an external observer to 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 members who have an ED visitor hospital admission/discharge/transfer and who are at risk of readmission and other poor outcomes.		
19	Does your practice have a methodology or system for identifying members in transition who are at risk of readmission 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, or a medically supervised or alcohol/drug abuse treatment center • NICU discharges • Clinical complexity, severity of condition, medications and risk score	
20	For each member 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 credential of RN or LCSW? (Please see supplemental question 8 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data to inform interactions between the enrollee and the clinician during the transition period.
21	Does your practice include the following elements in transitional care management? • Ensuring that a care manager is assigned to manage the transition • Facilitating clinical handoffs • Obtaining a copy of the discharge plan/summary • Conducting medication reconciliation • Following up by the assigned care manager rapidly following discharge • Ensuring that a follow-up outpatient, home visit or face-to-face encounter occurs • 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 – to enable an external observer to 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?	

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

Supplemental Questions		
Please indicate whether your practice, or contracted CIN, can perform the following functions. (See supplemental questions 1-3 to provide more information about CIN participation.)		
S1	Will your practice work with a CIN or other partners?	This element must be completed, but responses will not affect certification.
S2	If yes, please list the names and regions of the CIN(s) or other partners you are working with.	This element must be completed, but responses will not affect certification. This list should include the full legal name of each CIN.
S3	Who will provide care management services for your AMH? (e.g., CIN or other CM vendor) ☐ 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 they 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 who 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.
S7	For patients who need LTSS, can your practice coordinate with the health plan 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 the same capabilities as the health plan for screening and management of LTSS populations.
S8	What are the credentials of the staff who will participate in the transitional care management team within the 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. North Carolina Integrated Care for Kids Model for AMH Tier 3 Practices

Section D1: NC NC InCK Overview

NC InCK is a state-funded payment and service delivery model of integrated care for children insured by Medicaid and CHIP. InCK is supported by CMS grant funding designed to improve outcomes for children. InCK aims to:

1. **Understand Needs:** More holistically understand the needs of children and youth;
2. **Support and Bridge Services:** Integrate services across sectors for children and youth who could benefit from additional support; and
3. **Focus Healthcare Investments:** Find ways to invest resources into what matters most for children, youth and families.

Implementation of InCK in North Carolina is led by a team that spans Duke University, the University of North Carolina and DHHS (jointly known as NC InCK).[28] NC InCK took effect on Jan. 1, 2022, and will run through Dec. 31, 2026.

Eligibility of Children and Youth for NC InCK

Medicaid and CHIP-insured children and youth ages 0-20 whose Medicaid administrative county is one of the following were automatically enrolled in InCK starting in January 2022: Alamance, Durham, Granville, Orange, and Vance and referred to as InCK members. DHHS will centrally maintain member-level data on children and youth participating in NC InCK, will update it monthly and will share the data with Standard Plans as described below.

NC InCK Eligible AMHs

AMH Tier 3 practices contracted with the Duke Connected Care, UNC Healthcare System and Community Care Physician Network (CCPN) CINs within the participating InCK counties are eligible to participate in the NC InCK model.

NC InCK Components

InCK will be focused on integrating care across ten core child services:

- Physical and Behavioral Health
- Early Care and Education
- Housing
- Food
- Schools
- Title V
- Child Welfare
- Mobile Crisis Response Services
- Juvenile Justice
- Legal Services

NC InCK incorporates the following design features:

[28] For more information, see the NC InCK website.

- **Service Integration Levels** (SILs): NC InCK will use cross-sector data to stratify children into three Service Integration levels. SILs use cross-sector data from state child welfare, juvenile justice, school attendance and suspensions, in addition to Medicaid data, to assign a SIL of 1, 2 or 3 to each assigned member. The SILs will then be shared with health plans and AMHs (as described below) to inform care management. InCK members in SIL 2 and SIL 3 will be "priority populations" for health plans and AMH Tier 3 practices. InCK members in SIL 3 will be assigned a High risk designation.

- **Family Navigator:** In NC InCK, InCK members in SIL 2 or 3 will be assigned a Family Navigator, who is part of the care management team. All InCK members assigned to a participating AMH Tier 3 practice will receive outreach for assignment of a Family Navigator. The Family Navigator will work directly with the InCK member and family to help the InCK member and family meet health, social and educational goals. Family Navigators are part of the care team and can be based at the AMH or the CIN, depending on the practice's relationship with a CIN. The Family Navigator role may be performed by an existing care manager on the care management team and may be an RN, MSW, BSW, CHW, LPN, Population Health Specialist or equivalent, but the person assigned the role should be consistent for each child enrolled in InCK. The Family Navigator will hold a specific set of InCK responsibilities for the InCK member outlined below.

- **Shared Action Plan (SAP) and Integrated Care Platform**: The Family Navigator will work with the InCK member and family to develop a SAP with the family, which is a brief, actionable plan in a standard format set by NC InCK for improved family-centered, whole-child service coordination. The SAP must be stored in the AMH practice's care management record but also should be shared with the InCK care teams if a Consent Agreement has been signed. For InCK, the SAP will be stored on the InCK Integrated Care Platform maintained by InCK. The InCK Integrated Care Platform is a standardized, internet-accessible care integration tool that InCK staff and other authorized personnel will use to create, store, view, update and share InCK member information, including but not limited to basic InCK member data and the SAP.

- **Integration Consultant:** To support implementation of NC InCK, health plans, CINs and other core child service sectors employ Integration Consultants, whose role is specifically to support Family Navigators and care teams in the InCK model. Each InCK member in SIL 2 and SIL 3 will be assigned an Integration Consultant who is available to support the Family Navigator working with the InCK member. Integration Consultants do not have direct contact with InCK members.

- **Integrated Care Team**: An integrated care team is a family-driven team of professional and natural supports that collaborate to support an InCK member and their family in meeting the health, education and social service needs identified by the family. In InCK, care teams are intentionally cross-sector, including both healthcare providers and those from schools, early childhood, and, if applicable, sectors like child welfare and juvenile justice.

- **Enhanced Data Exchange:** health plans will share additional information with AMH Tier 3 practices serving InCK members and AMH Tier 3 practices will complete additional reporting requirements, as described below.

- **Quality Measure Reporting and Tracking**: NC InCK will track specific measures in addition to the AMH Measure Set, as described below and reflected in greater detail in the InCK Performance

Measure Technical Specifications Manual. AMHs participating in NC InCK APM will receive reports on the InCK measure set (report information will vary based on APM participation).

- **Alternative Payment Model (APM):** The APM is an opportunity for increased resources for AMH practices to support innovative approaches to caring for children and families. Health plans must offer all AMH Tier 3 practices serving InCK members an opportunity to participate in the InCK APM. As with other AMH APMs, health plans can offer these InCK APMs for AMH Tier 1 and Tier 2 practices but are not required to do so. Participation in the APM is voluntary.

- **Pay-for-Reporting (Used in InCK Foundation)**: This mandate rewards practices that successfully report on specific applicable quality measures with an incentive bonus. There will not be any withholding of provider reimbursement, AMH fees or care management fees as part of the InCK APM.

- **Pay-for-Performance (Used in InCK Foundation):** Pay for Performance (P4P) ties reimbursement to metric-driven outcomes, best practices and member satisfaction. P4P in healthcare, also known as value-based payment, comprises payment models that attach financial incentives/disincentives to provider performance. P4P is part of the overall national strategy to transition healthcare to value-based medicine. While it still utilizes the fee-for-service system, it nudges providers toward value-based care because it ties reimbursement to metric-driven outcomes, proven best practices, and member satisfaction, thus aligning payment with value and quality.

- **Shared Savings or Losses (May be used in InCK Advanced)**: Shared savings is a payment strategy that offers incentives for provider entities to reduce health care spending for a defined member population by offering them a percentage of any net savings realized as a result of their efforts and accounting for their performance against quality measures. Shared losses are the monetary amount owed to a payer as determined by the provider's expenditures for enrollees against a benchmark and accounting for their performance against quality measures.

Role of AMH Tier 3 Practices and CINs/Other Partners in NC InCK

To integrate care across these core child services and test the effect on outcomes, NC InCK adds new components to the existing care management and data exchange requirements that exist within health plan contracts and AMH Tier 3 practices as described above.

For InCK members assigned to AMH Tier 1 and Tier 2 practices, the health plan will be responsible for the care management components described throughout Appendix D and later outlined in the standard terms & conditions.

The role of AMH Tier 3 practices in NC InCK follows the same logic and principles as the broader AMH program described in this manual. AMH Tier 3 practices have responsibility for care management that is based in the community for high and rising risk health plan members, whether that responsibility is organized at the practice level, at the CIN/other partner level or a combination. For children and youth who are identified by NC InCK as part of the NC InCK model and are assigned to AMH Tier 3 practices, those AMH Tier 3 practices (or CINs/other partners on their behalf) are responsible for the enhanced components of the care management, data exchange and quality measurement that are being tested in NC InCK. These requirements are set out in Section D2 below. AMH Tier 3 practices that serve NC InCK members and participate in the InCK program are required to follow the below requirements in

addition to the requirements for AMH Tier 3 practices described above in this manual. As described below, expectations for AMH Tier 3 practices are encapsulated in a set of standard terms and conditions to be integrated in contracts with health plans. No additional attestation is required from AMH Tier 3 practices.

Section D2: InCK AMH Tier 3 Practice Requirements

Requirement 1: Use the SIL to refine Risk Stratification for InCK Members.

NC InCK will centrally assign each InCK member into one of three SILs, based on clinical and non-clinical data. This process will use healthcare utilization, diagnoses, school-based data (attendance and suspensions), data from key social services like child welfare, juvenile justice, as well as direct feedback from families on social service needs in areas like food, housing and transportation to assign each InCK member a SIL. DHHS will transmit InCK member-level SILs to each health plan, and health plans will be responsible for transmitting InCK member SILs each month to AMH Tier 3 practices.

Table 6. Standard Terms and Conditions: Risk Stratification

AMH Tier 3 Practices Must …	Additional Information
1.1 Use the SIL assigned to each InCK member to outreach InCK members in SIL 2 and 3 for assessment and care management.	• AMH Tier 3 practices will receive the InCK SIL for each InCK member monthly on the PRL transmitted by health plans. • InCK members assigned to SIL 2 and SIL 3 should be considered priority populations for the InCK integrated care support model regardless of their health plan assigned stratification. • Both InCK members in SIL 2 and SIL 3 will receive outreach for InCK care management and engaged InCK members should be assigned a Family Navigator, regardless of the health plans Risk Score Category. • Health plans will ensure all InCK members assigned to SIL 3 are designated a Risk Score Category of high on the PRL sent downstream to AMH Tier 3 practices.
1.2 Ensure that the SIL assigned to the InCK member is reconciled each month in the clinical system of record.	• AMH Tier 3 practices should reconcile and update the SIL assigned to InCK members monthly with the transmission of the PRL from health plans. • AMH Tier 3 practices are required to maintain the InCK member's SIL in their care management system, and best practice is to also provide the SIL for the

	InCK member in the system of record for PCPs and other clinical teams.

Requirement 2: Provide Integrated Care Support to InCK Priority Populations.

InCK members assigned to SIL 2 and SIL 3 are considered priority populations likely to benefit from integrated care support (i.e., care management facilitated by the Family Navigator that spans the 10 InCK core child services). All InCK members in SIL 2 and SIL 3 should receive outreach for InCK's integrated care model and assignment of a Family Navigator. Outreach practices should mirror those used for enrolling other populations with high risk in care management. InCK's care management model is similar for InCK members in SIL 2 and 3 with two exceptions: requirements for comprehensive assessment (i.e., required for all InCK members in SIL 3) and requirements for SAP (i.e., required to be offered for all InCK members in SIL 3).

Table 7. Standard Terms and Conditions: Integrated Care Support in InCK

AMH Tier 3 Practices Must …	Additional Information
2.1 Coordinate with health plans to screen InCK members for food and housing needs for all InCK members assigned to SIL 1 and two at least annually, and to all InCK members in SIL 3 every six months.	To maximize screening or food and housing rates in InCK, NC Medicaid expects health plans and AMH Tier 3 practices or their CINs or other partners to work together. AMH Tier 3 practices (or CINs/other partners) can conduct screenings within routine visits or direct InCK member outreach. The intent is to facilitate and streamline health plan and AMH collection and reporting of complementary data on InCK members. Additional guidance on data collection for screenings from AMH Tier 3 practices (or CIN/other partner) will be released Quarter 2 of 2022.
2.2 AMH Tier 3 practices should perform a Comprehensive Assessment on each InCK member assigned to SIL 3 within 30 calendar days of the InCK member (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for InCK members should also include assessing these additional InCK domains: educational needs, child welfare needs, and juvenile justice needs.	• InCK members assigned to SIL 3 are those currently in an out of home placement or at high-risk of entry or re-entry. AMH Tier 3 practices are encouraged and have flexibility to use a pediatric-focused comprehensive assessment tool and use information collected to support pre-population of some components of the InCK SAP and InCK consent. Family Navigators administering the Comprehensive Assessment can also use information collected to start establishing an InCK

	member's integrated care team. • AMH Tier 3 practices or their CINs or other partners can also complete a Comprehensive Assessment on InCK members assigned to SIL2 to better understand their holistic needs, but it is not required at this time.
2.3 Assign a Family Navigator to all SIL 2 and SIL 3 InCK members who agree to participate in care management as part of the integrated care management team. At a minimum, the InCK Family Navigator will: 1) Serve as the InCK member's single point of contact; 2) Communicate with the InCK member's guardian at least quarterly for a period of a year on their integrated care needs and make referrals; 3) Identify and convene the integrated care team as defined together with the InCK member's guardian; 4) Support service referrals across InCK's 10 core child service areas; and *5)* Ensure that an InCK SAP is completed for at least 30% of SIL 3 InCK members and at least 10% of SIL 2 InCK members. *6)* Attend at least 60% of all Family Navigator capacity building events organized by NC InCK each year.	• Family Navigators are part of the care management team and can be existing staff within the AMH Tier 3 practice (or CIN) with responsibilities for care management and components of InCK's pediatric integrated care model. • InCK requirements for length and frequency of care management are minimum requirements. AMH Tier 3 practices, their CINs or partners can engage with higher frequency or longer duration based on the needs of the InCK member. • Please reference InCK's website for in-depth guidance on integrated care team formation, the SAP and navigating the InCK 10 core child service areas. • Family Navigator capacity building events will be held monthly for a period of 1.5 hours.
2.4 For each InCK member in SIL 2 and SIL 3, use the InCK standardized consent form to support care team collaboration, access to the InCK integrated care platform and the SAP, all of which facilitate integrated care for the InCK member across InCK's 10 core child service areas. Any completed consent form should be shared with the InCK member's Integration Consultant for records maintenance.	The intent of InCK's consent form is to promote two-way information sharing between care team members in healthcare and any other service providers desired by the InCK member (e.g., behavioral health, schools, early childhood, child welfare, juvenile justice). Signing the consent form also gives integrated care team members access to the InCK member's profile on the InCK Integrated Care Platform (Virtual Health). The InCK consent form, Family Navigator training on consent, and InCK's Guide to an Integrated Care team are available on the NC InCK website.
2.5 For each InCK member in SIL 2 and SIL 3 actively engaged in integrated care management, convene the InCK member's integrated care team	• An integrated care team is a family-driven team of professional and natural supports that collaborate to support an

and family to align on cross-sector goals and methods of communicating to meet the InCK member's integrated care needs.	InCK member and their family in meeting the health, education and social service needs identified by the family. • Not all integrated care team members are required to attend a care team meeting, but Family Navigators should provide avenues for each care team member to contribute to the coordination for the InCK member either prior to or after the meeting and should be included on correspondence and action steps after the meeting. • Meetings convened to create the SAP or other existing care team meetings (e.g., care management meeting with school or child welfare) may be used to meet this integrated care team convening requirement if a meeting structure is already working well for the family.
2.6 For InCK members in SIL 2 and 3, provide assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, which should also include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Free and Reduced Lunch (FRL), and school-based services for InCK members with exceptional needs.	This requirement adds three service areas -- WIC, FRL and school-based services -- to the previous list of benefits care management teams are outlined to support in the care management model.

Requirement 3: Develop a Shared Action Plan for 30% of InCK members assigned to SIL 3 and at least 10% of InCK members assigned to SIL 2

Membership in InCK does not change any of the existing AMH Tier 3 practice requirements for creation of a care plan for members as outlined in Table 3 "Standard Terms and Conditions: Developing a Care Plan for All Patients Receiving Care Management." AMH Tier 3 practices will also be responsible for working with families of InCK members to complete a brief, strengths focused InCK SAP for InCK members assigned to SIL 2 and SIL 3.

The SAP is a shareable, living document created in collaboration between the Family Navigator, family and the InCK member's integrated care team to encourage coordination among care team members and natural supports. The SAP is an important tool designed to support a conversation with families and their integrated care team on the cross-sector goals and needs for the InCK member and provide an easy-to-navigate roster of services and contact information for all members of the care team. An InCK consent form will also be provided for completion to support in the sharing of the SAP after completion. InCK has set specific minimum targets detailed below for completion of this new integrated care document, but encourages broad use of the SAP.

NC InCK created a SAP guide to support Family Navigators in completing the document, available on the NC InCK website.

Table 8. Standard Terms and Conditions: Shared Action Plan Development

AMH Tier 3 Practices Must …	Additional Information
3.1 For at least 30% of InCK members assigned to SIL 3 and at least 10% of InCK members assigned to SIL 2, complete an InCK SAP with the family and integrated care team within 30 days of the Comprehensive Assessment being completed. The SAP should be completed with input and participation from the majority of the integrated care team members. The ideal is that the majority of the care team convene at a time when they can discuss the plan together and with the family.	• For a subset of members with high needs for integrated care, the Family Navigator listed in requirement 2 must also work collaboratively with the family and care team to complete a 3-page SAP template. Scripts, templates and best practices for facilitation are available on the NC InCK website and through the Integration Consultants. 30 days is the maximum interval for developing a SAP. If there are clinical benefits to developing a SAP more quickly, practices should do so whenever feasible. • Not all integrated care team members are required to attend the SAP creation meeting, but Family Navigators should provide avenues for each care team member to contribute to the plan either prior to, during, or after the SAP meeting before the final SAP is distributed to the full integrated care team listed on the InCK consent. Most importantly, the SAP is not a tool to be created in a 1:1 meeting between the family and Family Navigator; instead, the SAP should be created with the inclusion of a care team. • CINs and AMH Tier 3 practices can use their comprehensive assessment process to initiate some components of the SAP with members ahead of the SAP meeting; including contact information, needs and strengths. Information collected in the comprehensive assessment should be reviewed with the full care team in the meeting. • AMHs or their CIN/other partner are strongly encouraged to use the SAP

	template created by InCK because it was designed with families to be family- friendly and facilitate integrated care team participation. However, if AMH Tier 3 practices or their CIN/other partner would like to use an alternative template (e.g., an existing form in their system of record to store and create the SAP) they must seek approval from NC Medicaid (via Kimberly.gibson@dhhs.nc.gov) on both the format and method of distributing the SAP to the child's integrated care team. All alternative SAP formats must include a care team roster.
3.2 For members offered a SAP, support the member in completing the InCK consent process to support sharing of the SAP and ongoing care team collaboration via the InCK Consent Form. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance.	NC InCK has designed a consent form to support Family Navigators in sharing the SAP after completion and to facilitate ongoing care team collaboration on behalf of the member. This is the same consent form listed in 2.6.

Requirement 4: Receive and send claims data feeds and other specified data elements in accordance with state-designated security standards.

To help support InCK participants' risk and needs, AMH Tier 3 practices will receive additional data elements in the current reports from health plans in a standardized format. AMH Tier 3 practices will be required to provide additional information on InCK members to the health plans based on the guidance in Table 9 below.

Table 9. Standard Terms and Conditions: InCK Data Requirements

AMH Tier 3 Practices Must …	Additional Information
4.1. Receive and use data from health plans on InCK-specific data elements such as InCK members and SILs in the following reports and as specified in the AMH Provider Manual and **InCK Performance Measure Technical Specifications Manual**: • PRL (with SIL level); • Quality Measure results for practices in the InCK APM.	PRL will include SIL stratification for InCK members as indicated in the 'Priority Population' field within the PRL. AMH Tier 3 practices will use the SIL information in the PRL to provide assessment and care management services to these priority populations as outlined in Table 7.

4.2 Send data to the health plan on InCK-specific data elements and as specified in the AMH Provider Manual and **InCK Performance Measure Technical Specifications Manual**, including: • PRL Release 2.0;	AMH Tier 3 practices and their CIN/other partners will provide information on the PRL about • Family Navigator assignment • Dates related to outreach • SAP creation • Phone and email contact information for the assigned Family Navigator

Section D3. Quality Measures for InCK

All measures, including those used for the InCK APM (see Table 10) and those sent to CMS for all InCK members (see Table 11) will be calculated by the Department on behalf of the AMH. The technical specifications for all NC InCK measures are available in the NC InCK Performance Measure Technical Specifications Manual.

Section D4. NC InCK Alternative Payment Model (APM)

InCK APM Overview

The NC InCK APM is a 4-year, targeted incentive program that will be available to practices that provide care for InCK members (Medicaid and CHIP-insured children and youth ages 0-20 whose Medicaid administrative county[29] is one of the following: Alamance, Orange, Durham, Granville and Vance counties. The NC InCK APM launched in January of 2023 and will run through December of 2026. January through December of 2022 served as the benchmark year for InCK APM measures. The first measurement year for the InCK APM was calendar year 2023. Beginning in 2023, performance was determined against benchmark rates with incentive payments allocated based on targets outlined in the NC InCK Performance Measure Technical Specifications Manual.

NC InCK's APM includes incentives for reporting and achieving goals in the areas of:

- Kindergarten Readiness
- Housing instability
- Food insecurity
- Completion of a SAP for children with higher needs
- Screening for clinical depression and documenting a follow-up plan
- ED utilization
- Disparities by race and ethnicity in well child visit completion in the first 30 months of life

[29] Administrative county refers to the DSS county that administers the Medicaid benefits, eligibility and enrollment of the member.

Health plans are required to offer the NC InCK APM to all InCK participating AMH Tier 3 practices with InCK members. The Department encourages health plans to offer the InCK APM to all other InCK participating AMHs. Participation in the InCK APM is voluntary. InCK participating AMH practices can elect to participate in the InCK APM with none, one or multiple health plans. Enrollment in one health plans' InCK APM does not require enrollment in another health plans' InCK APM. Electing to not participate in the InCK APM has no impact on other established agreements with a health plan.

InCK APM Structure and Design

The NC InCK APM includes AMH incentive payments, through health plan contracts, linked to reporting and performance against benchmark targets defined further in the NC InCK Performance Measure Technical Specifications Manual. All AMH practices that choose to contract with one or more health plans for InCK are eligible to earn negotiated performance incentive payments in the InCK APM based on the set of performance measures in Table 10. Health plans are required to offer meaningful performance incentive payments for all incentive-related NC InCK APM measures, excluding the measures with reports included for awareness. Each health plan may choose to determine their own weighting strategy.

The Department requires health plans to use a tiered performance benchmark structure for the InCK APM. Health plans will use Department-determined benchmarks developed using (1) historical rates where comparable historical data are available at the regional, state, or national levels (with a preference for statewide or regional standards) or (2) program goals where requirements have been set forth by CMS, particularly for the novel measures in the NC InCK APM measures.

All AMH Tier 3 practices participating in the InCK APM are required to report data and screening for calculation of the performance measures in Table 10 for all InCK members per the NC InCK Performance Measure Technical Specifications Manual.

NC InCK members are assigned to AMHs at the NPI + location level. For the purposes of measure production, InCK beneficiaries are assigned to the AMH to which they were assigned on the last day of the measurement period. No risk adjustment will be used in InCK Foundation, though the Department may provide performance measure risk scores to AMHs participating in the APM for informational purposes only.

AMHs contracting with health plans utilizing InCK Foundation will receive financial incentives for activities that promote child well-being, such as promoting Kindergarten Readiness, and screening for food insecurity and housing instability. In addition, providers are offered the opportunity to participate in NC InCK integrated care case rounds and will receive resource guides and recommendations for how to best meet InCK members' integrated care needs.

AMH practices participating in the APM will also receive more information about the children assigned to their practice. NC InCK, in partnership with NC Medicaid, will provide regular reports to practices with actionable data on novel child-centered measures, such as rates of kindergarten readiness, chronic absenteeism from school, food insecurity and housing instability. This model leverages multi-sector state data to compile and calculate many of the quality measures for this program. The technical specifications for all NC InCK measures are available in the NC InCK Performance Measure Technical Specifications Manual.

Table 10. InCK Foundation Performance Measures

InCK Performance Measure	InCK Foundation
SAP for children in SIL-2 and SIL-3	**Pay-for-Reporting** *For Documenting the Completion of a SAP*
Primary Care Kindergarten Readiness Bundle	**Pay-for-Reporting** *For documenting Kindergarten Readiness Bundle*
Kindergarten Readiness Rate	No incentive: Report shared for awareness
Food Insecurity & Housing Instability Screening	**Pay-for-Reporting** *For Documenting Screenings Performed*
Food Insecurity Rate	No incentive: Report shared for awareness
Housing Instability Rate	No incentive: Report shared for awareness
Screening for Clinical Depression & Follow-Up Plan	**Pay-for-Reporting** *For documenting Clinical Depression Screening & Follow-up Plan*
Ambulatory Care: ED Visits	**Pay-for-Performance** *For Stabilizing/Reducing Rate*
Disparity Measure: Well-Child Visits for Age 0 – 15 Months*	**Pay-for-Performance** *For Increasing Black/African American Rate*
Well-Child Visits for Age 15 – 30 Months*	No incentive: Report shared for awareness
Total Cost of Care (TCOC)	Not available in Year 1 (2023); **Year 2 (2024) - No Incentive: Report shared for awareness** ***TCOC measure will not be used for evaluation in InCK Foundation, but the Department may provide TCOC data to AMHs participating in the APM for informational purposes only.*

*These two rates collectively are referred to as "Well-Child Visits in the First 30 Months of Life (W30)"

Required Data Collection Activities for AMH Practices Participating in the InCK APM

Data collected between January 2022 and December 2022 were used as an observation period for NC InCK quality measures, with a focus on refining data quality and measure production for the novel NC InCK performance measures that are distinct from the Standard Plan measures. Calendar year 2023 was the first full year of performance measurement with accountability for all NC InCK APM measures. The first comprehensive reports of performance across all NC InCK APM measures will be available Summer 2024.

Performance Measure Reports for Health Plans & Providers

NC InCK will employ **pooled performance measures** by provider for the NC InCK APM measures that evaluate an AMH practice's performance on NC InCK APM measures across all InCK members in Standard Plans with which they are contracted for the InCK APM.

NC Medicaid will generate a series of reports at least annually that will be shared with health plans and providers for quality improvement and administration of the InCK APM. For details, please refer to the NC InCK Performance Measure Technical Specifications Manual.

Table 11. NC InCK APM Measures

NC InCK APM Measures *Except where indicated with an *, these measures will be used only for AMH Practices in which the AMH is contracted for the InCK APM.*	
Health Care	• Ambulatory Care: ED visits • Screening for Clinical Depression and Follow-Up Plan • SAP for children in SIL 2 and SIL 3* • Well-Child Visits in the First 30 Months of Life (Disparity Measure) • Total cost of care **Creation of a SAP is required for all InCK Participating AMH Practices, regardless of participation in the InCK APM.*
Cross Sector	• Kindergarten Readiness Rate • Primary Care Kindergarten Readiness Bundle • Screening for Food Insecurity and Housing Instability • Housing Instability Rate • Food Insecurity Rate

Full measure technical specifications are available in the NC InCK Performance Measure Technical Specifications Manual.

Section D5: InCK Practice and Care Management Supports and Other Resources

InCK Webpages and Guides: For additional guidance, program-related resources and program information visit:

- DHHS's InCK webpage
- NC InCK's webpage

The webpages will also house a range of materials to support Family Navigators in fulfilling their responsibilities under the model, including:

- Family Navigator Handbook
- Health Care Provider Playbook
- InCK Guide to the SAP and Integrated Care Teams
- InCK Consent Form and Training
- Talking points and FAQs for member communication
- Core Child Service guides for Child Welfare, Housing, Food, Early Childhood, Schools, Behavioral Health, Public Health, Juvenile Justice and Legal Aid

Monthly Webinars on Pediatric Integrated Care: NC InCK hosts a monthly capacity building on pediatric care management topics via webinar for AMH care management teams to support the InCK model. Each month will focus on a component of the InCK model or different core child service areas (i.e., early childhood, housing) and will bring together experts in the field to support care managers in meeting these sector-specific needs of beneficiaries.

Appendix E: InCK Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice or by a CIN with which the practice has a contractual agreement that contains equivalent contract requirements. The InCK Standard Terms and Conditions are in addition to the existing AMH standard terms and conditions in Appendix B.

The Tier 3 AMH practice must:

1. Use the SIL to refine Risk Stratification for InCK members.

1.1. Use the SIL assigned to each InCK member to outreach InCK members in SIL 2 and 3 for assessment and care management.

1.2. Ensure that the SIL assigned to the InCK member is reconciled each month in the clinical system of record.

2. Provide Integrated Care Support to InCK Priority Populations.

2.1. Coordinate with health plans to screen InCK members for food and housing needs for all InCK members assigned to SIL 1 and 2 at least annually, and to all InCK members in SIL 3 every 6 months.

2.2. AMH Tier 3 practices should perform a Comprehensive Assessment on each Member assigned to SIL 3 within 30 calendar days of member (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for InCK members should also include the educational needs, child welfare needs and juvenile justice needs of the InCK member in addition to all current required domains.

2.3. Assign a Family Navigator to all SIL 2 and SIL 3 InCK members who agree to participate in care management as part of the integrated care management team. At a minimum, the InCK Family Navigator will:

- Serve as the InCK member's single point of contact;
- Communicate with the InCK member's guardian at least quarterly for a period of a year on their integrated care needs and make referrals;
- Identify and convene the integrated care team as defined together with the InCK member's guardian;
- Support service referrals across InCK's 10 core child service areas;
- Ensure that an InCK SAP is completed for at least 30% of SIL 3 InCK members and at least 10% of SIL 2 InCK members; and
- Attend at least 60% of all monthly Family Navigator capacity building events organized by NC InCK each year.

2.4. For each InCK member in SIL 2 and SIL 3, use the InCK standardized Consent Form to support care team collaboration, access to the InCK integrated care platform, and the SAP, all of which facilitates integrated care for the InCK member across InCK's 10 core child service areas. Any completed consent form should be shared with the InCK members Integration Consultant for records maintenance.

2.5. For each InCK member in SIL 2 and SIL 3 actively engaged in integrated care management, convene the InCK member's integrated care team and family to align on cross-sector goals and methods of communicating to meet the member's integrated care needs.

2.6. For InCK members in SIL 2 and SIL 3, provide assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting

applications, which should also include WIC, FRL and school-based services for patients with exceptional needs.

3. Develop a SAP for at least 30% of InCK members assigned to SIL 3 and at least 10% of InCK members assigned to SIL 2.

3.1. For at least 30% of InCK members assigned to SIL 3 and at least 10% of InCK members assigned to SIL 2, complete a InCK SAP with the family and integrated care team within 30 days of the Comprehensive Assessment being completed. The SAP should be completed with input and participation from the majority of the integrated care team members. The ideal is that the majority of the care team convene at a time when they can discuss the plan together and with the family. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance.

3.2. For InCK members offered a SAP, support the InCK member in completing the InCK consent process to support sharing of the SAP and ongoing care team collaboration via the InCK consent form. Any completed consent form should be shared with the member's InCK Integration Consultant for records maintenance.

4. Receive and send claims data feeds and other specified data elements in accordance with state-designated security standards.

4.1. Receive and use data from health plans on InCK-specific data elements such as InCK members and SIL levels, in the following reports and as specified in the AMH Provider Manual and InCK Technical Specifications:

- PRL;
- Care Needs Screening Results;
- Quality Measure results.

4.2. Send data to the health plan on InCK-specific data elements as specified in the AMH Provider Manual and InCK Technical Specifications, including:

4.2.1. PRL Release 2.0.

Appendix F. Healthy Opportunities Pilot Guidance for AMH Tier 3 Practices

Part I: Overview of HOP

While access to high-quality medical care is critical, research shows that up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.[30] A substantial body of research has established that having an unmet resource need – including experiencing housing instability,[31] food insecurity,[32] unmet transportation needs,[33] and interpersonal violence or toxic stress[34,35] – can significantly and negatively impact health and well-being, as well as increase health care utilization and costs.[36,37] HOP is an unprecedented opportunity for NC Medicaid to test the impact of providing evidence-based, non-medical interventions, priced and defined in a standardized Fee Schedule, to high-need Medicaid enrollees. In October 2018, CMS authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing 29 services that address health-related social needs in four priority domains: housing, food, transportation and interpersonal violence or toxic stress.

HOP developed the infrastructure for NC Medicaid health plans (Standard Plans, Tailored Plans and Local Management Entity/Managed Care Organization (LME/MCOs)), providers, and community-based organizations to integrate non-medical services that are linked to health outcomes, such as medically tailored home delivered meals or short-term post hospitalization housing, into the delivery of care. The Department has developed the HOP Fee Schedule[38] to define and price these non-medical interventions. The Pilot tests whether HOP services, which are delivered by local community-based organizations and social services agencies, called Human Service Organizations (HSOs), can improve health outcomes and/or reduce health care costs for Medicaid managed care enrollees experiencing certain health needs and social risk factors.

Most HSOs that deliver HOP services are participating in the health care system for the first time

[30] Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010

[31] A. Simon, et al. "HUD Housing Assistance Associated with Lower Uninsurance Rates and Unmet Medical Need." Health Affairs, June 2017

[32] A.Coleman-Jensen, et al., Household Food Security in the United States in 2012, Economic Research Report No. 155 (Sept. 2013); Food Res. & Action Ctr., Food Hardship in America 2012 (Feb. 2013).

[33] S. Syed, B. Gerber, L. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." Journal of Community Health. October, 2013.

[34] H. Resnick, R. Acierno, D. Kilpatrick. "Health Impact of Interpersonal Violence: Medical and Mental Health Outcomes." Journal of Behavioral Medicine, 1997.

[35] V. Felitti, et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults—The Adverse Childhood Experiences Study." American Journal of Preventive Medicine. May 1998.

[36] B. C. Booske, J. K. Athens, D. A. Kindig et al., Different Perspectives for Assigning Weights to Determinants of Health (University of Wisconsin Population Health Institute, Feb. 2010).

[37] L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., "States' Influences on Medicaid Investments to Address Patients' Social Needs," American Journal of Preventive Medicine, Jan. 2017 52(1):31–37.

[38] HOP Fee Schedule and Service Definitions: https://www.ncdhhs.gov/healthy-opportunities-pilot-fee-schedule-and-service-definitions/open

through HOP. While many HSOs traditionally rely on grant funding, in HOP they operate as Medicaid providers by invoicing for delivered services based on a fee schedule. To operationalize the fundamental shift in business processes for these organizations, additional technical assistance and training is made available via the Network Lead (NL) entities which support the HSO networks' infrastructure development. The Department further provided capacity building funds to NLs and HSOs to allow for additional infrastructure to be created and developed including technology solutions and operational processes to assist HSOs in invoicing (rather than submitting claims) and paying for HOP services. These processes seek to build HSO capacity while minimizing burden and ensuring that HSOs are able to effectively participate in HOP.

Recognizing that North Carolina is breaking new ground with HOP, DHHS is rigorously evaluating HOP to assess its effectiveness and identify key elements, including successful services, that could be continued on an ongoing basis and extended statewide in the Medicaid program.

HOP operates in three regions of the state – two in eastern North Carolina and one in western North Carolina. See Appendix G for a map of the HOP regions. A "care hub" organization in each region – called the "HOPs NL" –builds and oversees networks of HSOs that deliver HOP services and acts as the bridge between the HSO network and the MCOs.

The purpose of this document is to provide guidance to AMH Tier 3 practices on how they can participate in HOP including through partnerships with CINs/other partners. Unless otherwise specified, any required element may be performed either by the AMH Tier 3 practice itself or by a CIN or other partner with which the practice has a contractual agreement that contains equivalent contract requirements.

The sections below detail the specific roles and responsibilities for AMH Tier 3 practices as it relates to HOP care management. AMH Tier 3 Practices serving as a Designated HOP Care Management Entity[39] must contract with health plans for the provision of HOP-related care management to HOP enrollees. As this is a pilot program, the Department will continually review, and update entity requirements based on the on-the-ground experience of Designated HOP Care Management Entities.

Part II: Summary of Roles and Responsibilities for HOP

Foundational to NC Medicaid Managed Care, which includes both Standard Plans and Tailored Plans, is local care management integrated with primary care where personal interaction is possible. North Carolina's Standard Plans, which launched on July 1, 2021, are required to contract with local care management entities including AMH Tier 3 practices that provide care management for physical health, behavioral health and social needs. AMH Tier 3 practices may fulfill their care management responsibilities with their own staff or by working with a CIN/other partner. If a qualifying enrollee does not receive care management from an AMH Tier 3 or CIN/other partner, Standard Plans must

[39] A Designated Pilot Care Management Entity refers to the entity that is assuming care management responsibilities specifically related to the HOP.

directly provide care management services.[40]

Mirroring the Department's approach to care management for all Medicaid managed care enrollees, it is also critical to HOP that care management associated with addressing member's social determinants of health (SDOH), which is currently offered in addition to the broader care management responsibilities under North Carolina's Medicaid managed care program[41], is delivered by designated local care management entities (or by health plans if enrollees do not receive care management from a Designated Local Care Management Entity). HOP care management services, which build on existing care management requirements, include assessing patients' HOP eligibility and specific non-medical needs, and connecting them to appropriate HOP services. Recognizing the added responsibilities that come with HOP participation, AMH Tier 3 Practices serving as a Designated HOP Care Management Entity or their delegated CIN/other partner will receive an additional, DHHS-standardized, HOP Care Management PMPM payment, on top of existing care management and medical home payments, for each Medicaid enrollee assigned to a HOP-participating Tier 3 AMH regardless of HOP enrollment at HOP launch (discussed more in Part V: AMH Tier 3 Payment for HOP Responsibilities).

A critical component of implementing HOP is how health plans and local care management entities will work together to identify and enroll patients who are eligible for HOP services, connect those individuals to such services, and ensure ongoing whole person care management. The Department has developed the following overarching goals for these processes:

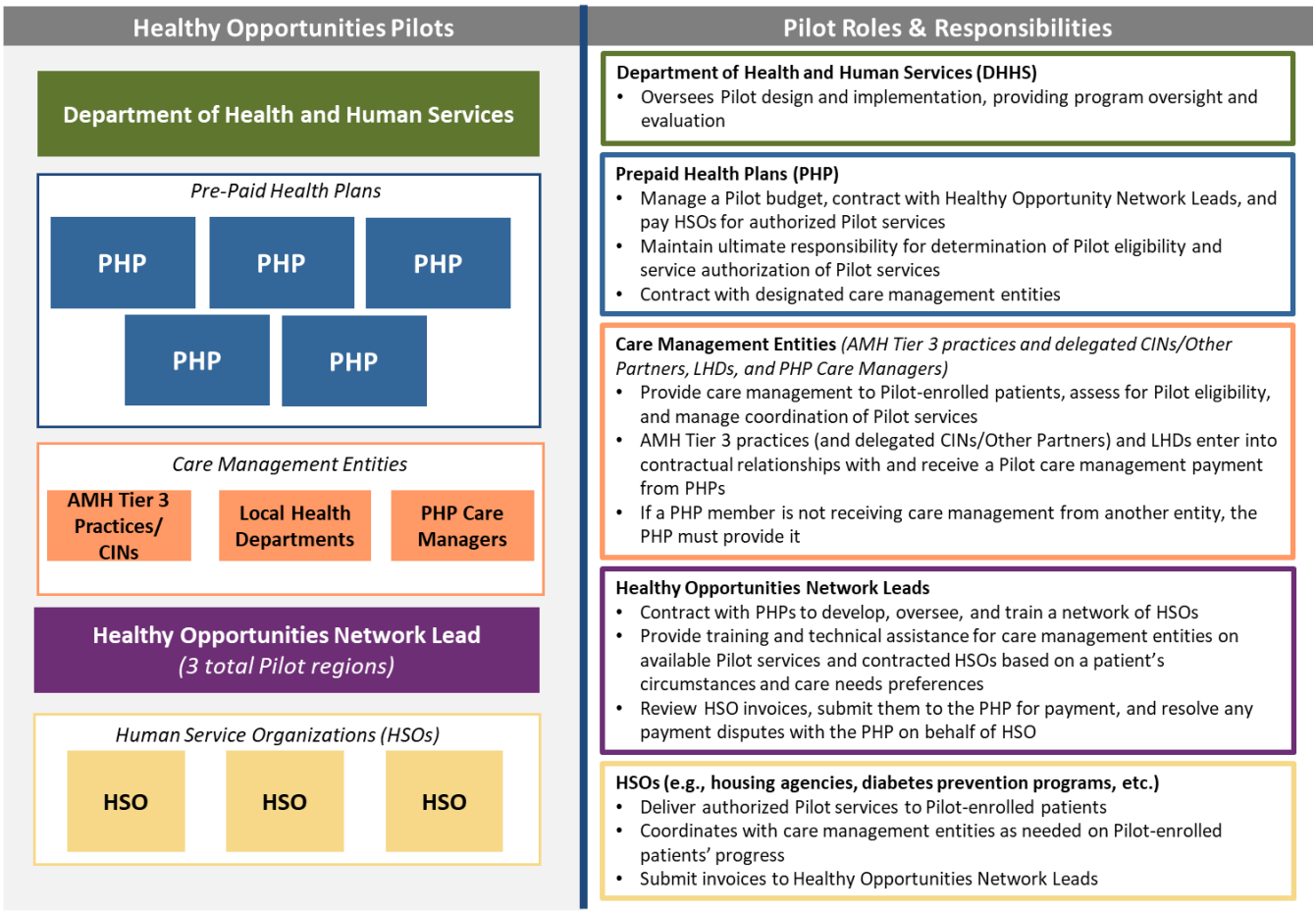
- Place Medicaid patients at the center of the HOP program, prioritizing the patient's seamless and timely experience;
- Utilize a "no wrong door" policy to streamline enrollment into the HOP program regardless of where a member initially seeks care;
- Encourage that care management for the HOP program occurs at the local community level;
- Standardize information collected regarding patients' HOP eligibility and recommended HOP services using a standard documentation tool called the Pilot Eligibility and Service Assessment (PESA);
- Seek to ensure services are allocated across all HOP-eligible member populations;
- Minimize the number of member handoffs between health plans and care management entities;
- Standardize the processes and systems as much as possible across health plans to eliminate Designated HOP Care Management Entity and HSO burden; and
- Maintain accountability and integrity for the HOP program.

Figure 6 describes the key roles and responsibilities for each HOP entity and provides an overview of how the entities interact with one another.

[40] Behavioral Health I/DD Tailored Plans are planning to launch in July 2024. While Behavioral Health I/DD Tailored Plans are not the focus for this guidance, it is anticipated that many of the requirements in this document will apply.

[41] For a complete list of AMH Tier 3 care management responsibilities, refer to the AMH Provider Manual 2.0.

Figure 6: Key Roles and Responsibilities for HOP Entities



This document provides specific guidance for how AMH Tier 3 practices, CINs/other partners (including Local Health Departments that are also certified as AMH Tier 3 practices) can participate in HOP as Designated HOP Care Management Entities.

Health plans will be required to provide the same core HOP functions as Designated HOP Care Management Entities and will be compensated through health plans' HOP administrative payments.

Part III, below, further defines HOP care management responsibilities.

Part III: HOP Care Management Responsibilities for AMH Tier 3 Practices Serving as a Designated HOP Care Management Entity

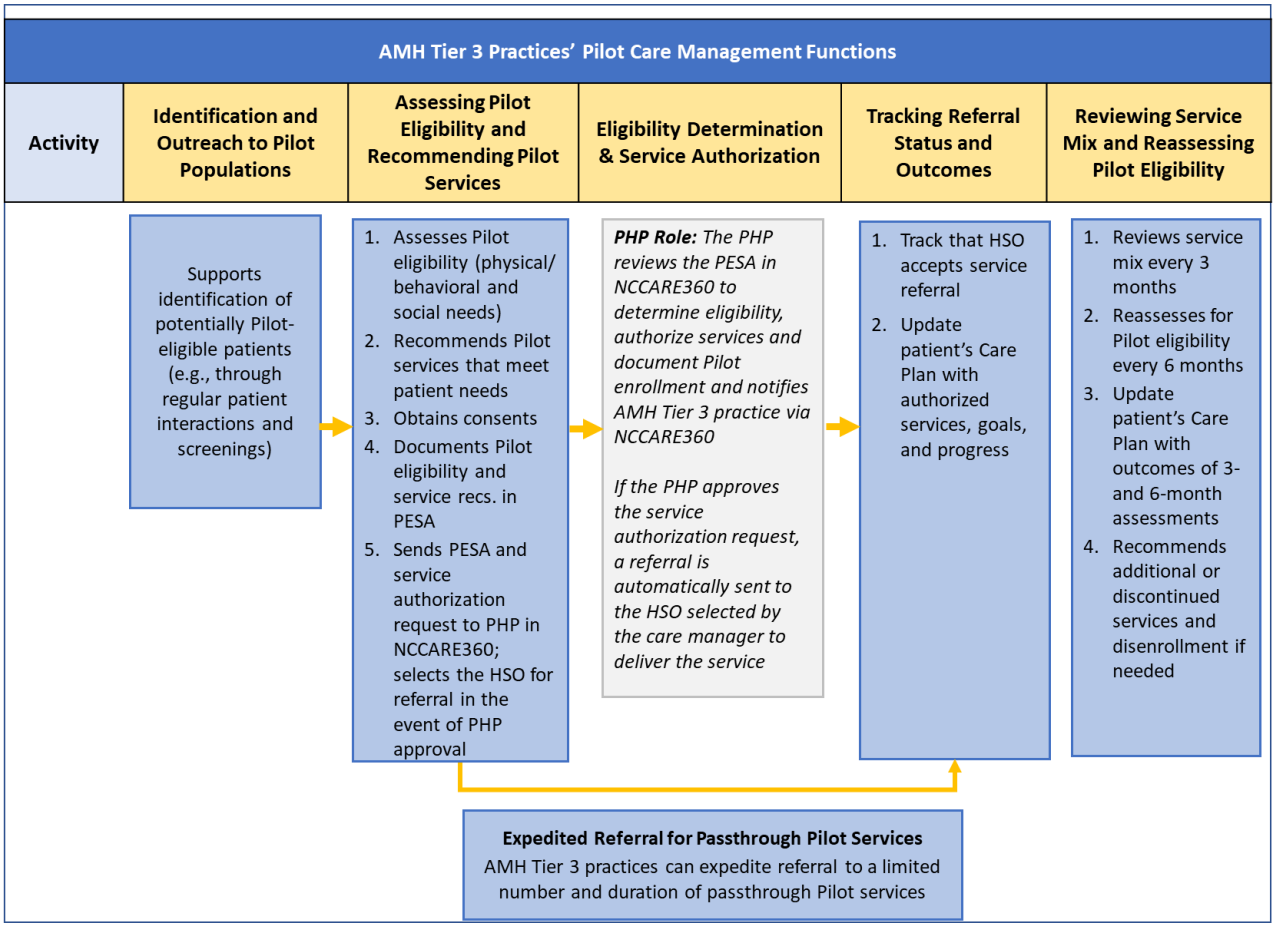
Participating in HOP gives AMH Tier 3 practices the opportunity to be part of an innovative and nationally recognized initiative. Participating in AMH Tier 3 practices will integrate their HOP responsibilities into clinical care, further supporting beneficiaries' whole-person health. Further, AMHs will have access to HOP participating HSOs that are reimbursed for the provision of supports that address health-related social needs. The cornerstone of the AMH Tier 3 program is that care management is delivered to patients locally, and the same is true for HOP. While the Department

strongly encourages AMH Tier 3 practices to participate in HOP, participation is not required. AMH Tier 3 practices that choose to participate in HOP are responsible for ensuring HOP care management is provided to their patients; they may fulfill this responsibility with their own staff or by working with a CIN/other partner.

In alignment with current AMH contracting for care management with health plans, each AMH Tier 3 must have a contract with the health plan for HOP-related care management activities using the Department-standardized contracting terms and conditions. Contracting should follow current arrangements (e.g., if a health plan contracts directly with a CIN/other partner for care management, rather than through an AMH Tier 3 practice).

Figure 7 outlines the critical HOP care management functions that AMH Tier 3 practices will perform to participate in HOP and receive HOP care management payments.

Figure 7: AMH Tier 3 Practices' Pilot Care Management Functions



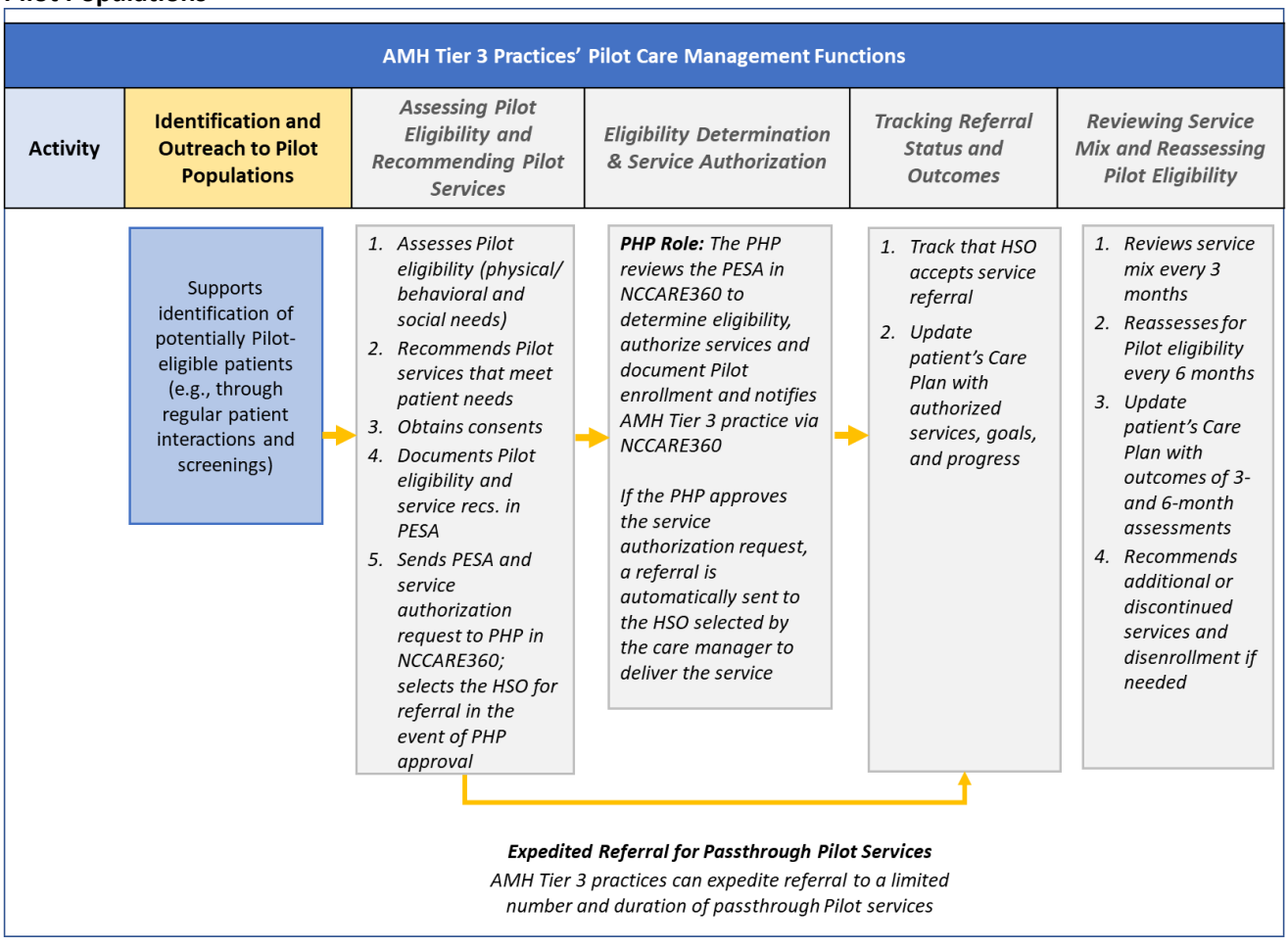
Getting patients initially enrolled in HOP and connected to HOP services will require a higher level of effort. Once patients are enrolled in HOP, AMH Tier 3 practices will have a minimum requirement of engaging with their HOP-enrolled patients every three months to review their HOP services (*see Part E. Reviewing Pilot Service Mix and Reassessing Pilot Eligibility below*); some HOP-enrolled patients will require more frequent and intensive engagement and coordination.

In addition, AMH Tier 3 practices should be aware that patients participating in HOP or that may benefit from HOP services may have certain highly sensitive needs, such as those related to interpersonal violence (IPV). To protect the safety and security of patients who may be eligible for or may receive (or who are receiving) IPV-related services, and to safeguard the privacy and security IPV-related data, AMH Tier 3 practices participating in the HOP must comply with the terms of *Interpersonal Violence-Related HOP (IPV)-Related Services: Conditions, Requirements, and Standards* attachment in the DHHS-Standard Plan contract.

The below sub-sections provide details on each care management activity shown above in Figure 7 Figure 8 outlines the HOP care management functions that AMH Tier 3 practices will perform to identify and outreach Pilot populations.

A. Identification and Outreach to HOP Populations

Figure 8: AMH Tier 3 Practices' Pilot Care Management Functions: Identification and Outreach to Pilot Populations



AMH Tier 3 practices should build in opportunities to identify potentially HOP-eligible patients during existing touchpoints with members who have been identified for care management and/or referred by the health plan or are currently receiving comprehensive care management. These touchpoints may occur during regular care visits, care manager check-ins, throughout pregnancy and the

postpartum period, at transitions of care, and when a patient's circumstances or needs change significantly (e.g., a member has been diagnosed with a chronic condition).

During these existing touchpoints, AMH Tier 3 practices can utilize the DHHS standardized HOP screening questions or other SDOH screening tools approved by the Department, annual Comprehensive Assessments, and any data analytics used by the practice for existing care management to help identify patients that may potentially be eligible for HOP. Eligibility criteria for HOP is outlined in the next section.

AMH Tier 3 practices must also conduct outreach to any of their patients that health plans, providers, or HSOs flag as being potentially HOP eligible. At least quarterly, health plans will identify patients they think may be eligible for HOP based on health plan data. Once identified, the health plans will notify each patient's AMH Tier 3 practice/CIN other partner as part of the PRL transfer if the member already has an assigned AMH Tier 3 practice. If the health plan identifies a potentially eligible member who is not currently assigned to an AMH Tier 3 practice, the health plan will assign the member to an AMH Tier 3 practice or Local Health Department (as appropriate) within 10 business days. If the member is already assigned to an AMH Tier 1 or Tier 2 practice, the health plan will assume HOP-related care management.

Upon being notified by the health plan of HOP eligible members, AMH Tier 3 practices should conduct outreach – including at least two documented follow-up attempts if the first is unsuccessful - to the patient within three business days to assess for HOP eligibility. Providers and HSOs may also flag patients they think may be eligible for HOP, and patients (or their family members) may identify themselves as possibly HOP eligible. If the provider, HSO, or patient knows who the patient's assigned AMH Tier 3 practice is, they may notify the AMH Tier 3 practice, and upon being notified, the AMH Tier 3 practice should conduct outreach, including at least two documented follow-up attempts if the first is unsuccessful, to the patient within three business days to assess for HOP eligibility. If the patient's assigned AMH Tier 3 practice is not known to the provider, HSO, or patient, they may notify the member's health plan in order to flag a potentially HOP eligible patient has been identified and should be assessed for HOP eligibility and recommended services.

The health plan will notify the AMH Tier 3 practice, if applicable, to conduct an assessment of HOP eligibility and recommend appropriate services. Once an AMH Tier 3 practice has conducted outreach to a patient, the AMH Tier 3 practice should document this outreach in the patient's care plan or in the patient record, as appropriate based on whether the member has an existing care plan, and inform the health plan, provider, or HSO of the outcome of the outreach through existing communication channels.

To protect the safety and confidentiality of members who may be experiencing IPV, AMH Tier 3 practices are required to record during the initial HOP enrollment, and adhere to in subsequent outreach, instructions from members about how and when to contact them. These instructions should be informed by and specific to each member, and include information about the following:

- Safe methods to contact (phone, text, email, letter),
- Whether it is safe to leave a voicemail,
- Safe days of the week and times to contact,
- Whose contact information is recorded, if not the Member's (i.e., a parent/guardian for minors, a relative or another individual helping to coordinate services), and

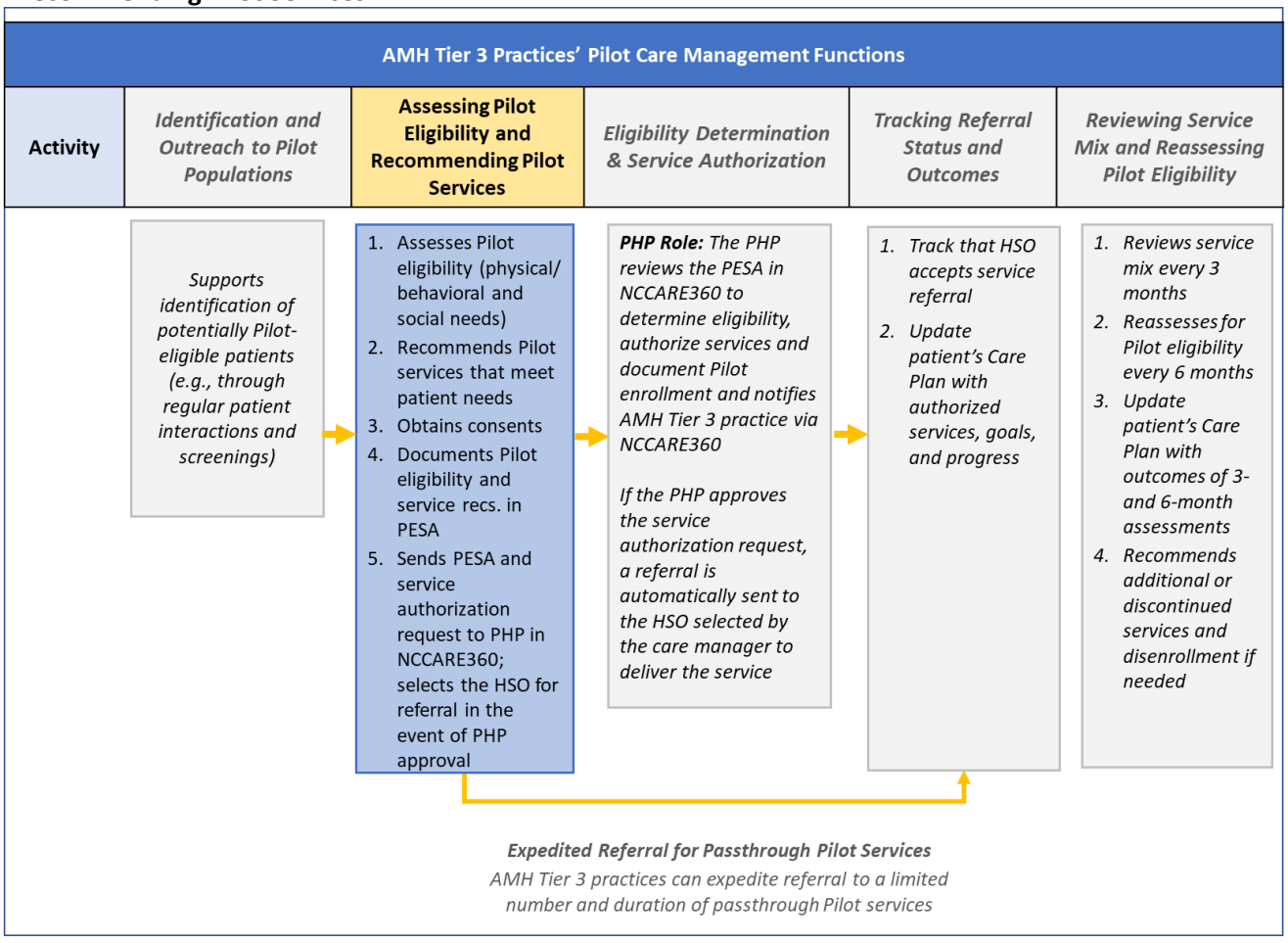
- Additional information on how outreach to the Member can be safely conducted (e.g., "when calling, please say you are from the library," or "Client requested to receive all HOP communications from their HSO case manager, Mr. Bob Smith. Please contact the HSO case manager at XXX-XXX-XXXX to coordinate communications with the client.")

Since it is not always possible to know if a member is experiencing IPV, AMH Tier 3 practices are required to record and apply these contact instructions for all members. This requirement applies regardless of whether a member is referred to IPV-related services or not.

B. Assessing HOP Eligibility and Recommending HOP Services

Care managers with AMH Tier 3 practices will need to determine whether patients are eligible for HOP, and depending on patients' identified social needs, will recommend specific HOP service(s). Figure 9 outlines the HOP care management functions associated with HOP assessment and service recommendations.

Figure 9: AMH Tier 3 Practices' Pilot Care Management Functions: Assessing Pilot Eligibility and Recommending Pilot Services



B1. Assessing HOP Eligibility: To assess a patient's eligibility for HOP, AMH Tier 3 practices need to confirm and document in the PESA in NCCARE360 whether the patient:

- Lives in a HOP region;
- Is enrolled in Medicaid managed care;
- Meets at least one qualified physical/behavioral health criterion; and
- Has at least one qualified social risk factor.

HOP eligibility is determined based on whether the member lives in a HOP region, not on the location of the AMH Tier 3 practice where a member receives care. Table 12 outlines the detailed physical/behavioral qualifying conditions for the HOP program, and Table 13 outlines qualifying social risk factors for the HOP program.

Table 12: HOP Physical/Behavioral Health-Based Criteria

Population	Age	Physical/Behavioral Health-Based Criteria (must meet at least one criteria)
Adults	21+	• Two or more chronic conditions. Chronic conditions that qualify anindividual for HOP enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease, chronic infectious disease, cancer, autoimmune disorders, chronic liver disease and chronic renal failure, I/DD, and traumatic brain injury (TBI). • Meets the clinical eligibility criteria for TCM, North Carolina's Health Home benefit (SPA 22-0024)[42] • Repeated incidents of ED use (defined as more than four visits per year) or hospital admissions. • Former placement in North Carolina's foster care or kinship placement system. • Previously experienced three or more categories of ACEs.

[42] Individuals are eligible for TCM if they have one serious and persistent mental health condition, I/DD, TBI, or severe substance use disorder, as defined further in North Carolina's approved SPA.

Pregnant Women	N/A	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death • Former or current placement in NC's foster care or kinship placement system • Previously experienced or currently experiencing three or more categories of ACEs • I/DD • TBI
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2,500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-20	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of $<5^{th}$ or $>85^{th}$ percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention-deficit/hyperactivity disorder, cancer, autoimmune diseases, learning disorders, I/DD, and TBI • Meets the clinical eligibility criteria for TCM Experiencing or previously experienced three or more categories of adverse childhood experiences (e.g., Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled or formerly enrolled in North Carolina's foster care or kinship placement system

Table 13: HOP Social Risk Factors

Risk Factor	Definition
Homelessness or housing insecurity	Homelessness, as defined in 42 C.F.R. § 254b(h)(5)(A), or housing insecurity, as defined based on the principles in the questions used to establish housing insecurity in the Accountable Health Communities Health Related Screening Tool or based on responses to the North Carolina SDOH screening tool.[43,44]
Food insecurity	As defined by the US Department of Agriculture commissioned report on Food Insecurity in America:[45] • Low Food Security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. • Very low food security: Reports of multiple indications of disrupted eating patterns and reduced food intake Or food insecure as defined based on the principles in the questions used to establish food insecurity in the North Carolina SDOH screening tool.[46]
Transportation insecurity	Defined based on the principles in the questions used to establish transportation insecurities in the Accountable Health Communities Health Related Screening Tool or based on responses to the North Carolina SDOH screening tool.[47]
At risk of, witnessing, or experiencing interpersonal violence	Defined based on the principles in the questions used to establish interpersonal violence in the Accountable Health Communities Health Related Screening Tool or the North Carolina SDOH screening tool.[6]

To assess whether a patient meets the HOP eligibility criteria, AMH Tier 3 practices should ask the

[43] The Accountable Health Communities Health-Related Social Needs Screening Tool. Available https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

[44] North Carolina's SDOH Screening Questions. Available: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions.

[45] USDA Economic Research Service [Internet]. Washington: USDA Economic Research Service; [updated 2017 Nov 27]. Definitions of Food Insecurity; [updated 2017 Oct 4; cited 2017 Nov 27]. Available from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/

[46] North Carolina SDOH Screening Tool. Available: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

[47] *Ibid*

[6] *Ibid*.

patient questions and review available data/information (e.g., information provided by a health plan on a patient's clinical conditions and/or the patient's results of the DHHS standardized set of HOP screening questions). Health plans have primary responsibility to screen members for unmet health-related resource needs as part of the Care Needs Screening. If a health plan has not already completed the DHHS standardized set of HOP screening questions for the patient, AMH Tier 3 practices should conduct this screening as part of the HOP eligibility assessment.

B2. Recommending HOP Services: After assessing a patient's eligibility for HOP, AMH Tier 3 practices should recommend which specific HOP service(s) would best address the patient's physical/behavioral health and social needs from a list of federally-approved services outlined in Table 14. HOP services fall into one of four priority domains: housing, food, transportation and interpersonal safety/toxic stress. In some cases, a patient may require more than one service—either in one domain (e.g., a patient requires two housing services) or spanning multiple domains (e.g., a patient who requires a food and transportation service).

Table 14: HOP Services

HOP Services
Housing
Housing Navigation, Support and Sustaining Services
Inspection for Housing Safety and Quality
Housing Move-In Support
Essential Utility Set-Up
Home Remediation Services
Home Accessibility and Safety Modifications
Healthy Home Goods
One-Time Payment for Security Deposit and First Month's Rent
Short-Term Post Hospitalization Housing
Interpersonal Violence / Toxic Stress
IPV Case Management Services
Violence Intervention Services
Evidence-Based Parenting Curriculum
Home Visiting Services
Dyadic Therapy
Food
Food and Nutrition Access Case Management Services
Evidence-Based Group Nutrition Class
Diabetes Prevention Program
Fruit and Vegetable Prescription
Healthy Food Box (For Pick-Up)
Healthy Food Box (Delivered)
Healthy Meal (For Pick-Up)
Healthy Meal (Home Delivered)

HOP Services
Medically Tailored Home Delivered Meal
Transportation
Reimbursement for Health-Related Public Transportation
Reimbursement for Health-Related Private Transportation
Transportation PMPM Add-On for Case Management Services
Cross-Domain
Holistic High Intensity Enhanced Case Management
Medical Respite
Linkages to Health-Related Legal Supports

As outlined in the federally-approved HOP Service Fee Schedule , each HOP service has a specific unit of service, service rate, service description, anticipated frequency, duration, setting of service delivery, and minimum eligibility criteria for receiving the specific service.

AMH Tier 3 practices will be able to access the eligibility criteria for HOP and specific HOP services in the state-standardized tool PESA (described in more detail below), available on the NCCARE360 platform.

Some services have additional service-specific eligibility criteria. For example, in order to be considered eligible to receive the Diabetes Prevention Program HOP service, patients must meet the following additional service-specific eligibility criteria:

- Be 18 years of age or older,
- Have a BMI ≥ 25,
- Not be pregnant at the time of enrollment
- Not have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment
- Have one of the following:
  - A blood test result in the prediabetes range within the past year, or
  - A previous clinical diagnosis of gestational diabetes, or,
  - A screening result of high risk for type 2 diabetes through the "Prediabetes Risk Test"[48]

To determine if a patient meets the service-specific eligibility criteria for the particular HOP service the care management team is recommending for the patient, AMH Tier 3 practices will need to ask the patient questions and gather and review available data/information to evaluate whether the patient is qualified to receive the service, and document that service in the PESA.

AMH Tier 3 practices should also talk to the patient about where and how they would like to receive a HOP service. For example, the patient might already have a relationship with an HSO that offers the service or only be able to use an HSO that offers evening hours. AMH Tier 3 practices will be able to see all HOP-participating HSOs in the NCCARE360 platform.

Care managers may encounter patients who require multiple Pilot services to adequately meet their needs. If an enrollee needs to access multiple HOP services, it is best practice for care managers to

[48] Available at: https://www.cdc.gov/prediabetes/takethetest/

refer the enrollee to an HSO that can provide the multiple HOP services, when such an HSO is available. For example, if a care manager is considering referring an enrollee to Holistic High Intensity Enhanced Care Management and another IPV/housing service, the care manager might refer the enrollee to an HSO that actively offers both services, if available.

B3. Obtaining HOP Consents: Members must give consent to participate in HOP. **AMH Tier 3 practices will be responsible for obtaining patient consent** using the DHHS-standardized 'Consent Form for NC Medicaid Coverage of HOP Services' for the following activities:

- **Participation in HOP and receipt of HOP services,** including an understanding that HOP services are not an entitlement and may be revoked at any time;
- **Sharing of personal data, including personal health information**, that will be used to **evaluate HOP** as part of North Carolina's 1115 waiver evaluation; and
- **Sharing of personal data, including personal health information, with organizations in the NCCARE360 network, including health plans, NLs, and HSOs,** that will be stored and exchanged on NCCARE360**.**

As described on the Consent Form Job Aid, member consent should be recorded in NCCARE360. AMH Tier 3 practices are permitted to accept electronic or written consent from a patient. Written consents should be stored by attaching them to the patient's PESA in NCCARE360 (described in more detail below). Care managers should communicate to patients that they can request a copy of the consent form from their health plan, if desired. Consent must be obtained before a health plan authorizes HOP services or referrals are made to HSOs.

If a patient does not give consent, AMH Tier 3 practices should explain to the patient that he or she will not have HOP services reimbursed by Medicaid. However, the patient will continue to receive non-HOP care management to find other non-medical services that meet the member's need. If a patient revokes consent, consent is revoked going forward, and the patient must be disenrolled from HOP services (see Part F2. Disenrollment from HOP).

B4. Documentation Requirements: AMH Tier 3 practices must document the results of the HOP eligibility assessment, the specific HOP service recommendations, the results of the HOP service-specific eligibility assessment, and the patient's HOP consents in NCCARE360 for the patient's health plan. Ultimately, it is the health plan – rather than the AMH Tier 3 practice – that determines whether a patient is eligible for HOP and authorized to receive specific HOP services. A member will be considered enrolled in HOP if they have been authorized for at least one HOP service.

AMH Tier 3 practices will document this information for the health plan in the PESA on the NCCARE360 platform. All HOP-enrolled patients receiving services must have a completed and up-to-date PESA documenting their HOP eligibility criteria as well as eligibility criteria for each HOP service being requested.

AMH Tier 3 practices will utilize NCCARE360 to transmit the completed PESA including the enrollment and authorization request to the patient's health plan that documents the following for service authorization**:**

- Patient contact information (including address to ensure they live in a HOP region);
- Care manager of record;
- Physical and social risk factors supporting HOP eligibility;
- Recommended HOP services;

- Service-specific eligibility criteria for recommended services;
- Indication of consent for 1) HOP participation, 2) HOP evaluation and 3) validation of consent to share personal information using NCCARE360; and
- Additional rationale or documentation for specific services (as needed).

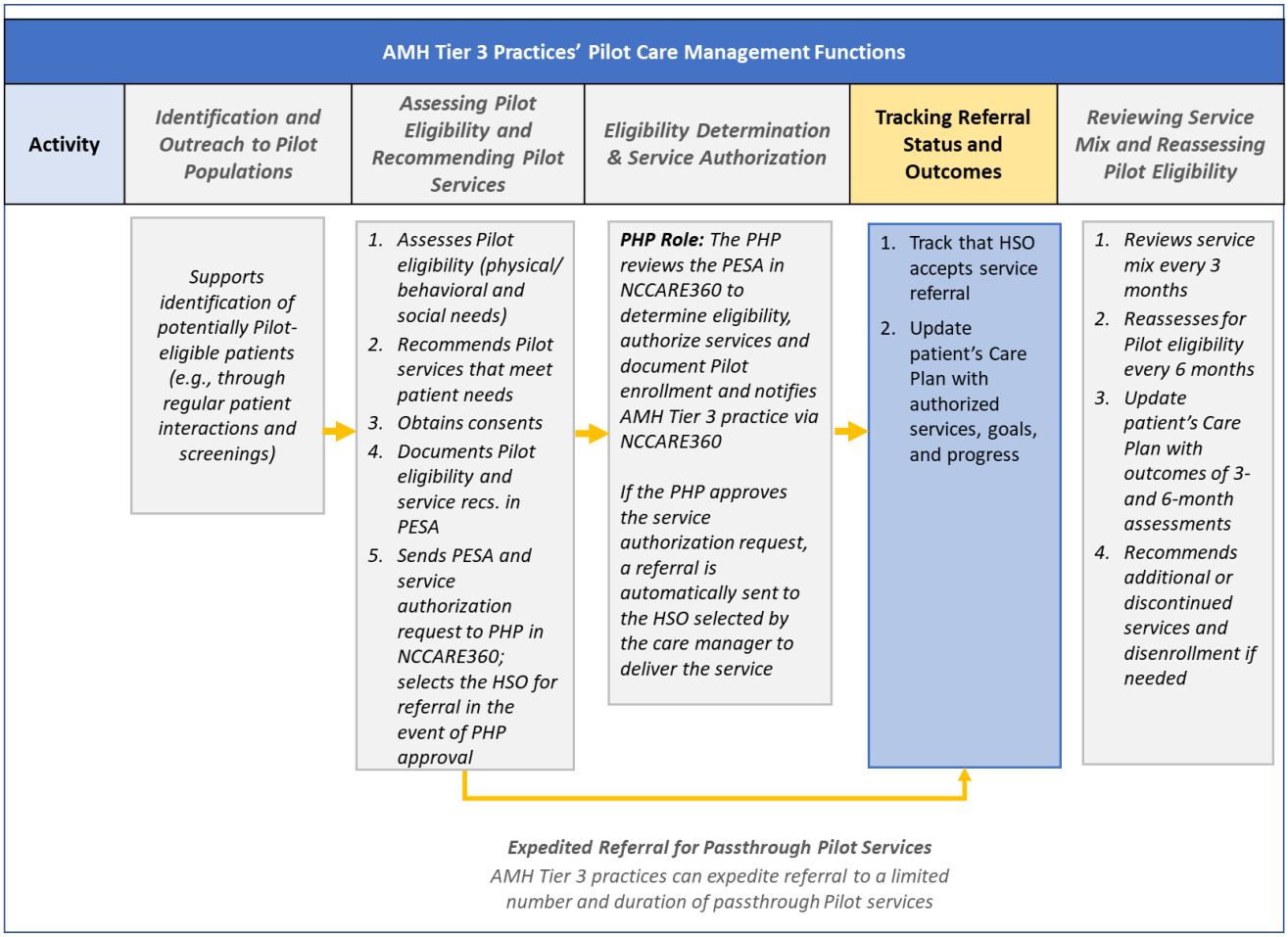
AMH Tier 3 practices are responsible for completing the PESA during the initial HOP assessment and updating it any time there is a change to a patient's service needs or HOP eligibility. If the health plan requires additional eligibility information (e.g., if information in the PESA is missing or incomplete), the health plan may contact the AMH Tier 3 practice to obtain it. AMH Tier 3 practices should work collaboratively with health plans to fill out any incomplete information. Health plans will not be permitted to require AMH Tier 3 practices to submit anything beyond what is required to determine HOP eligibility and authorize appropriate services, and only health plans and AMH Tier 3 practices will be able to view and make changes to a patient's PESA.

Health plans will be subject to standardized turnaround times for authorizing HOP services (which vary by service). Health plans will document their decision and rationale on HOP eligibility by reviewing the patient's PESA and choosing to accept or reject the patient's Social Care Coverage Enrollment Request in NCCARE360, which indicates HOP enrollment. The AMH Tier 3 will be notified of the health plan's decision on the Enrollment Request by an automated email generated by NCCARE360 and will be able to view the patient's Social Care Coverage status on their NCCARE360 profile. For a limited number of low-cost, high-value services, AMH Tier 3 practices will be permitted to refer patients to 30 days' worth of HOP services without prior approval from health plans (see Part D: Referrals for Passthrough HOP Services). When making a referral for Passthrough HOP services, AMH Tier 3 practices must make a corresponding referral for an authorized service that would extend beyond 30 days. For all other Pilot services, AMH Tier 3 practices will have to submit an Authorization Request to the patient's health plan for review. The AMH Tier 3 will be notified of the health plan's decision to either accept or reject the Authorization Request by an automated email generated by NCCARE360. If the health plan accepts the Authorization Request, a referral is automatically sent to the HSO selected by the AMH Tier 3 to deliver the service to the patient.

C. Tracking Referral to Authorized HOP Services

AMH Tier 3 practices are responsible for identifying appropriate Pilot services for eligible patients and submitting Authorization Requests to the patient's health plan through the NCCARE360 platform. Figure 10 outlines the HOP care management functions that AMH Tier 3 practices will perform to track referrals to authorized HOP services and outcomes.

Figure 10: AMH Tier 3 Practices Pilot Care Management Functions: Tracking Referral Status and Outcomes



C1. Making Referrals to HOP Services: When submitting the Authorization Request, the AMH Tier 3 selects the HSO to deliver the service in the event the authorization is approved. Once a health plan has approved an Authorization Request, a referral is automatically sent to the HSO selected by the AMH Tier 3. Health plans will monitor receipt of invoices from HSOs to ensure that referrals are occurring, and services are being delivered in a timely manner. NCCARE360 will clearly indicate which HSOs are participating in HOP. Upon health plan notification of service authorization, the AMH Tier 3 practice must communicate to the patient the authorized HOP services and that an HSO will soon be reaching out to them.

AMH Tier 3 practices may target a referral to a particular HSO (for example, if a patient has an existing relationship with that HSO) or send the referral to all relevant HSOs that are available to provide HOP service. NCCARE360 will have a profile of the HSO including but not limited to: contact information, hours of operation, services offered, and languages spoken. AMH Tier 3 practices may also consult with the HOP Network Lead as needed to assist in identifying appropriate HSOs.

Referrals for services that require simultaneous case management will be noted in the PESA, in NCCARE360 (e.g., in order to receive the one-time payment for security deposit and first month's rent

service, a patient must also receive ongoing housing case management) and will include a separate referral to an HSO case management service if the patient does not already have an established HSO case management service. For a list of HOP services that require simultaneous case management, see the HOP Fee Schedule and Service Definitions.

C2. Tracking Referral Status and Outcomes: Once an authorization is approved by the health plan and a referral is automatically sent to the HSO as a result, AMH Tier 3 practices should follow-up with the HSO if the HSO does not respond to the referral within two business days. Further, AMH Tier 3 practices should elevate the issue to the appropriate Network Lead as necessary to ensure the individual can access services.

AMH Tier 3 practices should reasonably expect HSOs to accept all appropriate service referrals. In limited circumstances, HSOs may reach capacity for how many individuals they can serve. In such circumstances, HSOs are responsible for proactively notifying their HOP Network Lead of limited capacity and indicating that they are not currently accepting referrals in NCCARE360 in order to prevent further referrals that cannot be acted upon. While AMH Tier 3 practices must ensure HSOs accept individual referrals submitted for their patients in a timely manner, Network Leads will hold primary responsibility for monitoring referral acceptance from HSOs across their network.

If a referral was sent to a particular HSO and is not accepted within two business days, the AMH Tier 3 practice should contact the HSO to confirm whether it can provide the service. If the HSO does not respond or indicates it does not have capacity, AMH Tier 3 practices should escalate the issue to both the health plan and the NL, as appropriate, and send the referral to another HSO.

Similarly, if a referral was sent to all relevant HSOs and is not accepted within two business days, AMH Tier 3 practices should escalate the issue to both the health plan and the NL, as appropriate. AMH Tier 3 practices then need to monitor and track HOP services delivered and coordinate with the HSO to help assess to what extent the HOP service(s) are meeting their needs.

C3. Documenting HOP Enrollment Status and Authorized HOP Services in Patient's Care Plan: Upon HOP enrollment, AMH Tier 3 practices must initiate care management to the member, if the member is not already receiving care management and continue providing care management if the member is already receiving it**.**

For HOP-enrolled patients, AMH Tier 3 practices must include in the patient's care plan information on the patient's HOP-related goals, HOP enrollment status, authorized HOP services and HOP-related needs. AMH Tier 3 practices will regularly update patient's care plan when an HSO accepts a referral for an authorized HOP service, throughout the time the patient is receiving HOP services, and after a patient's three-month HOP service mix review and six-month HOP eligibility reassessment (discussed more below).

D. Referrals for Passthrough HOP Services

In order to expedite service delivery and reduce touchpoints with the patient, health plans are required to permit AMH Tier 3 practices to refer patients to passthrough services, a select number of high-value, low-cost HOP services for a 30-day passthrough period without prior health plan approval. Health plans are required to treat these select HOP services as pre-approved for up to 30 days. Passthrough HOP services will be standardized across all health plans and include:

- Fruit and Vegetable Prescription
- Healthy Food Box (For Pick-Up)
- Healthy Food Box (Delivered)
- Healthy Meal (For Pick-Up)
- Healthy Meal (Home Delivered)
- Reimbursement for Health-Related Public Transportation
- Reimbursement for Health-Related Private Transportation

The Department may expand this list over time.

After an AMH Tier 3 practice identifies a potentially HOP-eligible patient that is currently in care management or who has been referred to the AMH for a HOP assessment, and who would benefit from one of the passthrough services, the AMH Tier 3 practice obtains required consents, and validates HOP eligibility and service-specific eligibility by completing a PESA form in NCCARE360. Once HOP eligibility is validated through the completed PESA, the AMH Tier 3 must then navigate to the Face-sheet and add Provisional Social Care Coverage for the patient.

Once the patient's profile includes Provisional Social Care Coverage, the AMH Tier 3 practice may then refer the patient to an HSO that delivers the specific passthrough HOP service using NCCARE360 for a period of up to 30 days. The AMH Tier 3 practice monitors via NCCARE360 that the referral is accepted by an HSO within two business days and then creates or updates the patient's care plan with the passthrough HOP service. The AMH Tier 3 practice tracks the passthrough HOP service delivered to the patient and coordinates with the HSO to track patient progress.

The patient's health plan will be able to review the patient's completed PESA and monitor the progress of the patient's passthrough service referral through NCCARE360.

If the AMH Tier 3 practice would like to refer the patient for additional services beyond the 30-day passthrough period, the AMH Tier 3 practice should send an Enrollment Request to the patient's health plan through NCCARE360, which is initiated by adding non-Provisional Social Care Coverage on the patient's profile. If the patient's health plan approves the Enrollment Request, the patient is now fully enrolled in the Pilot and eligible to receive services beyond the 30-day passthrough period.

To ensure the member continues to receive services beyond the initial 30-day period, the AMH Tier 3 should send new referrals to the same HSO with extended service delivery dates. The AMH Tier 3 practice must then communicate to the patient that they are authorized to receive the full duration of the HOP service and monitors that the HSO accepts the new referral within two business days. The AMH Tier 3 practice will also update the patient's care plan, track the additional HOP services delivered to the patient, and coordinate with the HSO regarding patient progress.

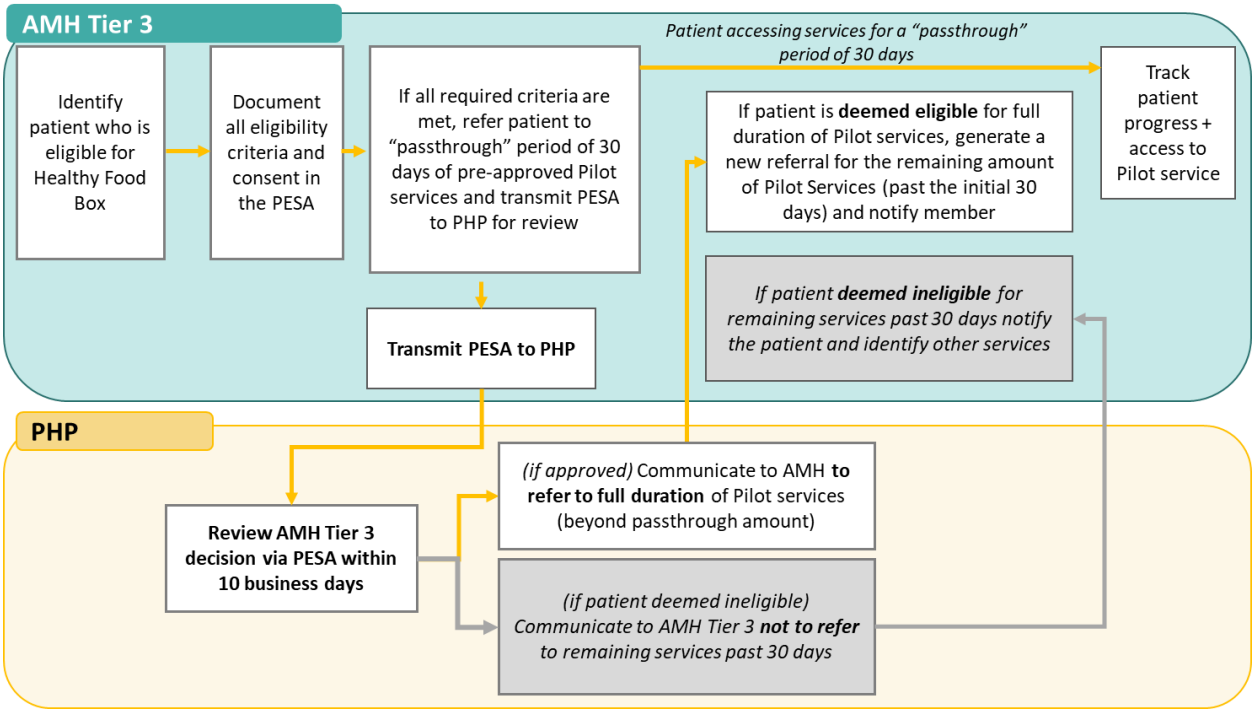
If the health plan deems the patient ineligible for HOP or to receive additional services beyond the 30-

day passthrough period, the health plan will alert the AMH Tier 3 practice of its decision by rejecting the Enrollment Request, as shown in Figure 11 below. The AMH Tier 3 practice then may not issue another referral for the patient for the recommended HOP service. The AMH Tier 3 practice must communicate to the patient of the health plan's decision and direct the patient to other HOP or non-HOP services or HSOs to meet their needs.

Health plans have the ability to discontinue an individual AMH Tier 3 practice's ability to refer patients to passthrough services if that practice is found to have a pattern of making referrals for patients that are subsequently found to be ineligible for HOP or if the health plan runs out of HOP funds.

Note: the practice should receive prior notification that they are outliers in referring ineligible members to the passthrough program and given a time period to demonstrate improvement.

Figure 11: Referrals for Passthrough HOP Services (Example)

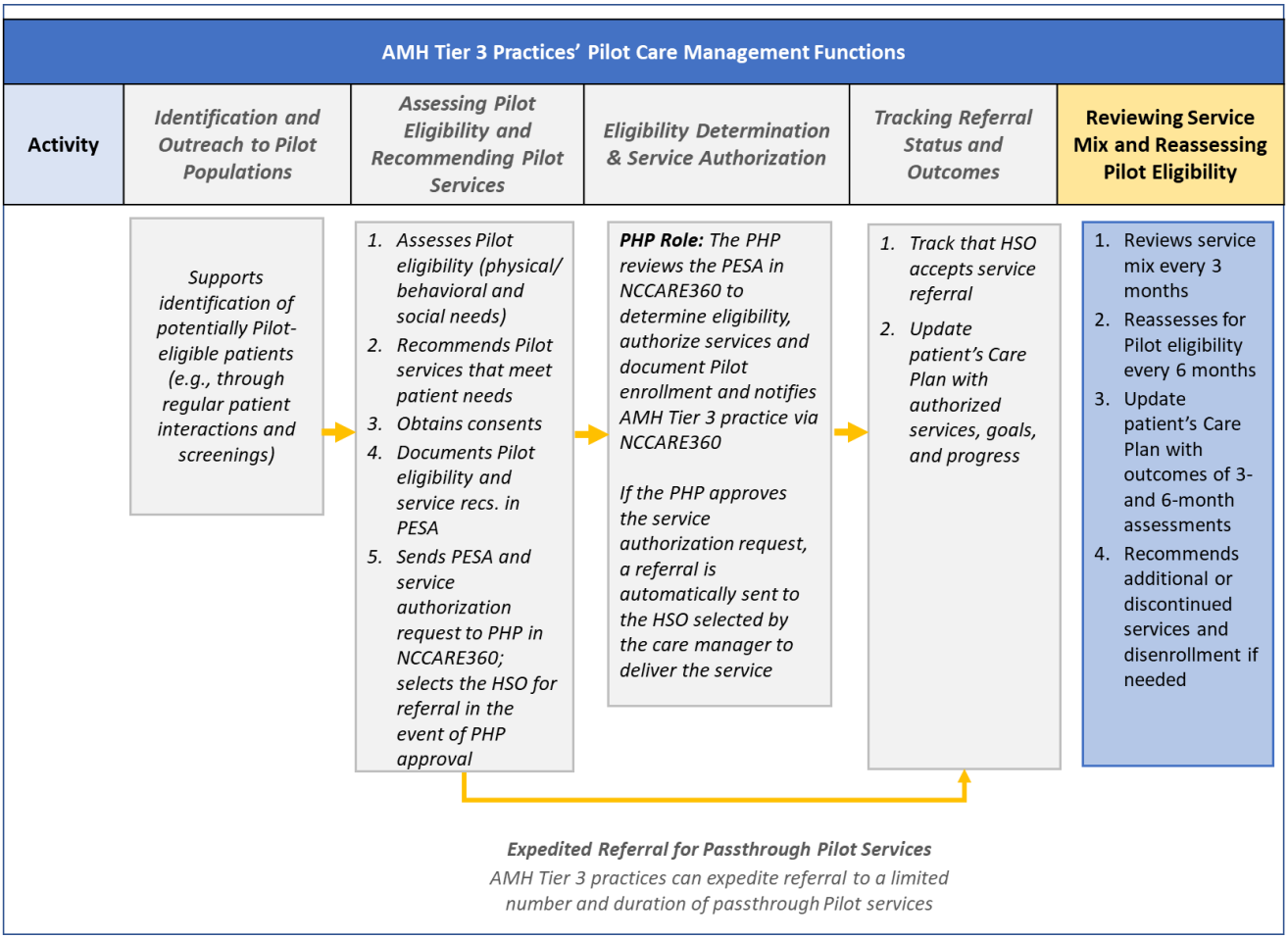


E. Reviewing HOP Service Mix and Reassessing HOP Eligibility

The HOP program requires AMH Tier 3 practices to conduct a three-month assessment of a patient's HOP service mix to determine if the authorized HOP services are meeting a patient's needs. If existing services are not meeting a patient's needs, the AMH Tier 3 practice should recommend to the health plan adding new services and/or discontinuing one or more services. AMH Tier 3 practices must also conduct a six-month assessment to reassess patients for HOP eligibility (eligibility reassessment) in addition to the service mix review. Reassessment at the three- and six-month intervals after enrollment are the minimum requirements for patient contact but should not replace regular care team check-ins with patients to understand how HOP services are meeting the patient's needs.

If an AMH Tier 3 practice identifies that a HOP-enrolled patient has met their HOP-related care plan goals in fewer than three months and no longer requires HOP services, the AMH Tier 3 practice may recommend discontinuing HOP services (see Part F1. Discontinuation of HOP Services). Figure 12 outlines the HOP care management functions that AMH Tier 3 practices will perform to review service mix and reassess pilot eligibility.

Figure 12: AMH Tier 3 Practices Pilot Care Management Functions: Review Service Mix and Reassess Pilot Eligibility



AMH Tier 3 practices must identify patients that are due for a three- or six-month assessment based on

their date of enrollment (i.e., not from when the patient accessed the HOP service to which they were referred). AMH Tier 3 practices will schedule an in-person, telephonic, or video reassessment with the patient (depending on the enrollee preference).

AMH Tier 3 practices should schedule a reassessment meeting with HOP-enrolled patients within 30 days of the date that patients are due for their three- or six-month assessment. If the first attempt to conduct a reassessment is unsuccessful, AMH Tier 3 practices should make reassessment attempts at least monthly following the original due date of a three- or six-month assessment. If the patient does not respond by the next six-month interval, AMH Tier 3 practices must recommend to the health plan that the patient be disenrolled from HOP (described in detail below).

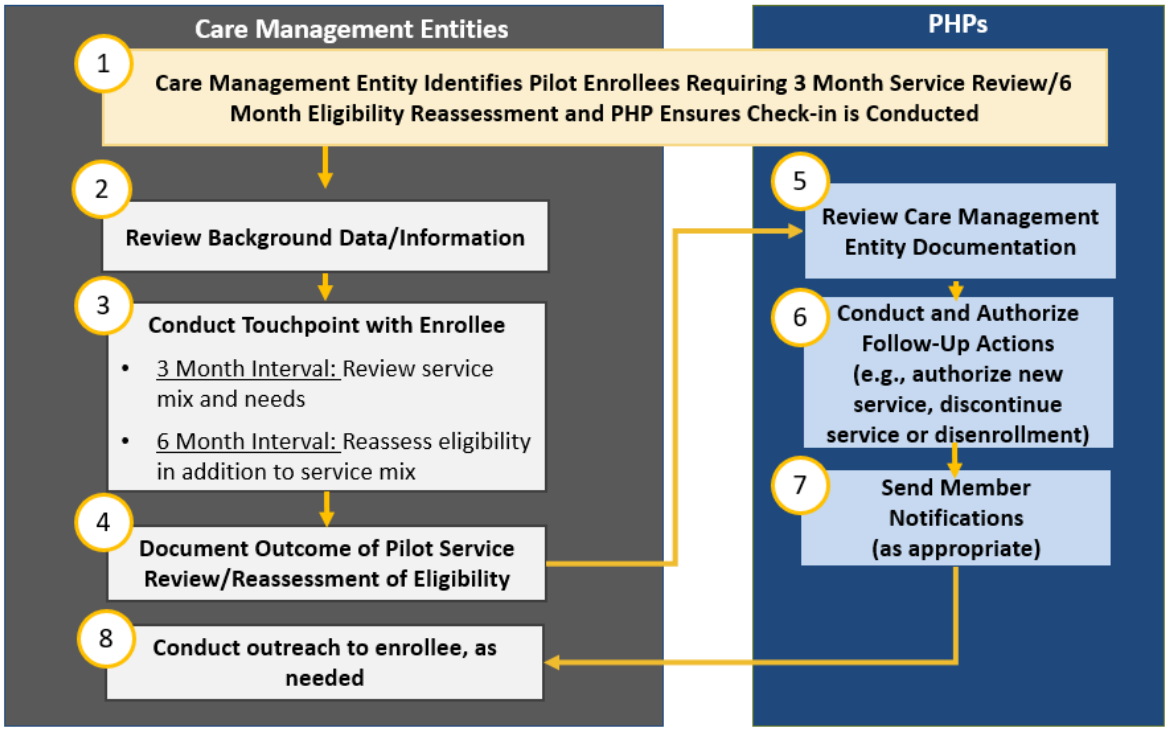
Prior to conducting the three- or six-month assessment, AMH Tier 3 practices should review all available data on the patient in preparation for the assessment, including, for example:

- The patient's care plan, including current and previously authorized HOP services, status updates and overarching goals;
- Care team notes from prior assessments;
- Outcomes of referred HOP services in NCCARE360 and any subsequent information provided by HSO staff to the care team; and
- Data provided by the health plan related to health care activities.

Health plans will monitor requirements for HOP service mix reviews and eligibility reassessment through spot audits of member PESAs, but will not require additional reporting of AMH Tier 3 practices related to reassessments.

Figure 13 provides a summary of the process AMH Tier 3 Practices will use to conduct three-and six-month assessments.

Figure 13: Reviewing HOP Service Mix and Reassessing Eligibility: High-Level Process Flow



E1. Three-Month Service Mix Review: For each HOP-enrolled patient, AMH Tier 3 practices must conduct an assessment every three months to discuss the patient's current service mix and assess if it is meeting the patient's needs. AMH Tier 3 practices should use the Department's standardized HOP screening questions and/or other assessments, including those used to originally recommend HOP services, to evaluate if the patient needs different HOP services. If a patient has no new or changed needs and requires HOP services to continue, AMH Tier 3 practices will document this in the patient's care plan and add a comment in the patient's PESA in NCCARE360. Once the PESA has been updated, the new version is immediately available for review by the patient's health plan.

If new or modified services are required due to new or changed needs, AMH Tier 3 practices should use the PESA in NCCARE360 to make recommendations for new or modified services and submit the PESA to the health plan for review and authorization. If AMH Tier 3 practices decide that a service is no longer needed, they are permitted to discontinue that particular service (see next Part III.F1. Discontinuation of HOP Services for additional details). AMH Tier 3 practices should document the outcome of the three-month assessment in the patient's PESA, including any health plan action or decision, and update the patient's care plan. The service mix review may occur concurrently with a HOP eligibility reassessment if it is being conducted at the six-month interval (described in *Part III.E2. Six-Month HOP Eligibility Reassessment* below).

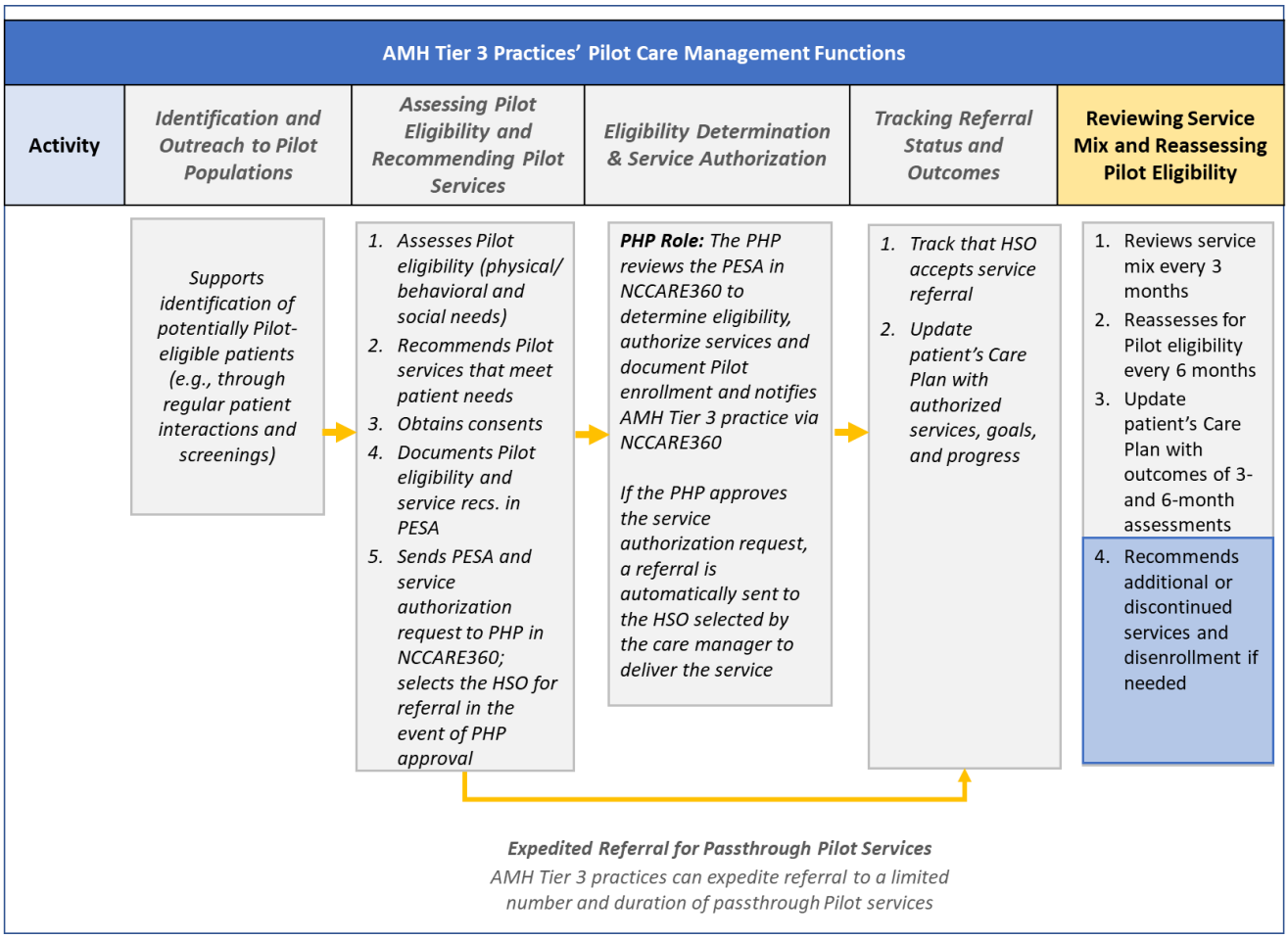
***E2. Six-Month HOP Eligibility Reassessment*:** In addition to conducting a HOP service mix review every three months, AMH Tier 3 practices must reassess each HOP-enrolled patient for their ongoing HOP eligibility every six months. To do so, AMH Tier 3 practices should ensure that a HOP-enrolled patient is still Medicaid eligible, lives in a Pilot county, has a qualifying social factor in one of the priority HOP domains and meets physical/behavioral health criteria (or new criteria) that makes the patient eligible for HOP (e.g., the patient requires ongoing HOP services to address the needs that make them eligible for HOP in the first place).

When conducting a HOP eligibility reassessment, the AMH Tier 3 practice may also conduct a three-month service mix review. Any completed assessment should be documented in the PESA, regardless of whether the patient has no new or changed needs. AMH Tier 3 practices should document the outcome of the six-month HOP eligibility reassessment in the patient's PESA in NCCARE360, including any health plan action or decision, and update the patient's care plan. Changes to HOP eligibility status will automatically impact the patient's ability to receive HOP services. If the health plan finds the patient ineligible for HOP, the patient's HOP services will be discontinued, and the AMH Tier 3 practice should find new, non-HOP services that meet that patient's needs.

F. Discontinuation of HOP Services and Disenrollment from HOPs

Patients' needs and circumstances will change over the course of their HOP participation. For this reason, there are some circumstances in which a patient's HOP service(s) should be discontinued, and other circumstances where the patient should be disenrolled from the HOP program.

Figure 14: AMH Tier 3 Practices Pilot Care Management Functions: Discontinuation of Pilot Services and Disenrollment from HOP



F1. Discontinuation of HOP Services: Discontinuation of HOP services refers to instances when an authorized HOP service should be stopped. Discontinuation of a service does not necessarily mean that an individual is ineligible to receive other or modified amounts/intensity of existing HOP services. Examples of potential scenarios for discontinuation of HOP services include:

- Current HOP service(s) are not meeting the needs of the patient (e.g., the patient no longer requires support with their housing needs, but indicates that they have not been able to purchase enough food in the past month and may require a Healthy Food Box).
- Patient has met their HOP-related care plan goals and no longer requires the HOP service (e.g., patient has been stably housed for 12 months and no longer requires Housing Navigation, Support and Sustaining Services).
  Patient no longer meets HOP service-specific qualifying criteria (e.g., the patient no longer has pre-diabetes and is ineligible for the diabetes prevention program service).

If AMH Tier 3 practices identify that a HOP service should be discontinued during a three-month assessment, six-month HOP reassessment, or other regular check-in with a patient, AMH Tier 3 practices should document that the service is to be discontinued and the rationale (e.g., if the service is

no longer meeting the member's need) for doing so in a patient's PESA and notify the health plan via NCCARE360. AMH Tier 3 practices must then close out any open referrals for the discontinued service(s) in NCCARE360, communicate directly with the HSO(s) regarding the change in status, and update the patient's care plan.

After a HOP service has been discontinued, AMH Tier 3 practices need to communicate the decision to the patient and provide transition support by identifying other HOP or non-HOP services and programs to meet the patient's ongoing needs. If the patient requires new or modified HOP services in lieu of the discontinued service, AMH Tier 3 practices must submit a HOP service authorization request for the new HOP service to the health plan as part of the PESA.

F2. Disenrollment from HOP: HOP disenrollment refers to instances where a patient is no longer eligible to participate in HOP and should no longer receive HOP services. Examples of potential scenarios for disenrollment from HOP include:

- Patient is no longer enrolled in Managed Care (see Part I. Supporting HOP-Enrolled Patients Transitioning between Designated HOP Care Management Entities and/or health plans below).
- Patient no longer lives in a HOP region (regardless of the location of the AMH Tier 3 practice where they receive care).
- Patient is receiving duplicative services or programs that disqualify them from HOP (e.g., certain Innovations Waiver services).
- Patient wishes to opt out of HOP.
- Patient is unreachable after consistent, monthly outreach efforts by the AMH Tier 3 practice for a period of six months.
- The enrollee transitions to another delivery system that has yet to launch HOP (i.e., transitions to the Tribal Option).

Upon identifying a trigger for HOP disenrollment, AMH Tier 3 practices must document information and rationale for HOP disenrollment in a patient's PESA and transmit to the health plan for verification. If the health plan agrees with the AMH Tier 3 practice recommendation, the health plan disenrolls the patient from HOP; AMH Tier 3 practices must then close out any open referrals for HOP services in NCCARE360, communicate directly with the HSO(s) regarding the change in status and ensure they do not submit invoices for further HOP services, and update the patient's care plan.

In the event a member has HOP services that were authorized and started at the time of HOP enrollment (e.g., home modifications) or passthrough services, the AMH Tier 3 practice must coordinate with the HSO to ensure the HSO only invoices for services provided up until the point of disenrollment After a patient has been disenrolled from HOP, the AMH Tier 3 practice needs to communicate the decision to the patient and provide transition support by identifying non-HOP services, programs and HSOs to meet the needs of the patient.

G. Use of NCCARE360 for HOP Responsibilities

To participate in HOP, AMH Tier 3 practices—in addition to delegated CINs/other partners performing care management—must be registered and trained on NCCARE360 for core HOP responsibilities including:

- Developing the member's record and profile in NCCARE360 if it does not already exist.
- Obtaining consent for sharing patients' personal data, including personal health information, with organizations in the NCCARE360 network.

- Completing the PESA documentation, transmitting it to the health plan for review, and reviewing health plan decisions on eligibility and service authorization.
- Generating referrals to HSOs for authorized HOP services.
- Monitoring referrals to HSOs for authorized HOP services to ensure they are accepted by the HSO and communicating with the HSO on patient progress as needed.
- Using the PESA to conduct the 3-month and 6-month assessment.
- Instructing HSOs to close out referrals for services that are no longer needed/authorized
- Prompting disenrollment from HOP if the patient is no longer eligible to participate.

Whichever entity is contracted by the health plan to provide care management must be registered, trained, and actively use NCCARE360 to promote whole-person care.

H. Participation in HOP Convenings/Trainings

HOP-Related Convenings

There will be regular telephonic or web-based convenings with HOP-participating entities, including AMH Tier 3 practices serving as a Designated HOP Care Management Entity, to share learnings and best practices as well as at least two in-person convenings per year that include all HOP participating entities (HSOs, NLs, health plans, etc.). Specifically, the HOP convenings may:

- Solicit information about implementation barriers and best practices and identify areas where training and/or technical assistance would support effective HOP implementation;
- Review HOP-related policies and procedures; and
- Strengthen relationships between HOP-participating entities.

The Department will also hold learning collaboratives designed to share best practices across HOP regions.

HOP-participating AMH Tier 3 practices must participate in HOP-related convenings; where applicable, the convening entity will specify the intended audiences for each convening so AMH Tier 3 practices can determine who from the practice is best suited to attend.

Training and Technical Assistance

The Department provides HOP-related technical assistance for frontline care managers via its partnership with the Mountain Area Health Education Centers (MAHEC). Training materials and forums may include webinars, written materials, and targeted, one-on-one training. Trainings will cover topics including, for example:

- Assessing eligibility for HOP services
- The HOP for the Care Manager: Food Services; Housing Services; Transportation Services; Interpersonal Violence Services 1 and Interpersonal Violence Services 2; and How Care Managers Can Choose Appropriate Toxic Stress Services; Tracking Enrollee Progress, Reviewing Service Mix, and Reassessing Pilot Eligibility; and How Care Managers Can Obtain Pilot Consent

In addition, prior to making referrals for IPV-related services or handling sensitive data, all AMH Tier 3 practices must complete Department-identified IPV training related to topics such as: provision of IPV-related services, working with IPV survivors, trauma informed care delivery, IPV-related data and privacy and security of sensitive data. These trainings are outlined in the HOP Interpersonal Violence (IPV) Protocol.

In addition, the HOP NLs also provide technical assistance for care management entities, including AMH Tier 3 practices, on available HOP services and appropriate contracted HSOs based on a patient's circumstances and care needs preferences.

The HOP NLs will also provide ongoing technical assistance for AMH Tier 3 practices, to:

- Address issues related to HOP services and HSO availability/accessibility;
- Support AMH Tier 3 practices ability to refer patients to contracted HSOs and adhere to HOP responsibilities; and
- Support AMH Tier 3 practices' understanding of and familiarity with contracted HSOs and Plot services.

AMH Tier 3 practices must participate in both the HOP NLs and the Department-led trainings as well as the HOP Networks Leads technical assistance; where applicable, the HOP NLs and the Department will specify the intended audiences for each training and technical assistance session so AMH Tier 3 practices can determine who from the practice is best suited to attend.

I. Supporting HOP-Enrolled Patients Transitioning between Designated HOP Care Management Entities and/or Health Plans

A patient's transition between service delivery systems, including between health plans and care management entities can pose unique challenges to ensuring service continuity and coordination for patients. AMH Tier 3 practices have robust existing requirements for supporting transitions of care for patients that are moving between health plans and/or care management entities.

Building off the existing requirements for supporting transitions of care, AMH Tier 3 practices will be required to assist HOP-enrolled patients by:

- **Coordinating a timely warm handoff, or a transfer of care between AMH Tier 3 practices and/or health plans** for effective knowledge transfer or to ensure patient continuity of care with regards to HOP services;
- **Promoting proactive communication** regarding the patient's HOP participation/services with the receiving entity (e.g., the health plan, a new AMH Tier 3 practice, etc.) prior to transition to coordinate the transfer of care;
- **Establishing a follow-up protocol** to communicate with the receiving entity (e.g., the health plan, a new AMH Tier 3 practice, etc.) after the patient's transition to confirm receipt of the transferred information and to troubleshoot dynamics related to HOP that may have resulted from the transition;
- **Working with the HSO and former health plan** to ensure the continued delivery of any current HOP services authorized while the member was still enrolled with the former health plan;
- **Using the NCCARE360 functionality** to send the new Designated HOP Care Management Entity or health plan a summary of services using a Transition of Care Referral Request [See Transition of Care Policy for more detail].
- **For AMH Tier 3 practices acting as the receiving entity in a transition of care, ensuring that members are reassessed** for ongoing HOP eligibility and service mix within 90-days of transfer following a transition of care.
- **In the case that a referral for services has not yet been accepted by the HSO**, the AMH Tier 3 must close the case.

- **For services that were accepted by the HSO and not yet started**, the AMH Tier 3 must contact the HSO to close the case for the HOP service.

In a transition of care scenario where a member is no longer Pilot-eligible, the AMH Tier 3 practice must disenroll the member from HOP, work with the HSO to close the case for the service(s), and coordinate with the HSO to ensure any pending HOP services that were authorized and started at the time of HOP enrollment are delivered (see Part III.F2. Disenrollment from HOP).

J. HOP-Related Member and Provider Grievances

HOP services have been approved as part of the State's 1115 waiver and are separate from North Carolina's Medicaid Managed Care benefit package available statewide to Medicaid members. For this reason, Medicaid members are not entitled to receive HOP services, and traditional Medicaid managed care appeals processes do not apply to adverse determinations made about HOP services/eligibility. However, to keep the member at the center of the HOP experience, AMH Tier 3 practices will support the tracking and resolution of HOP-related grievances submitted by members. AMH Tier 3 practices must submit any HOP-related member grievances to the health plan. Further, for any member grievances that involve the AMH Tier 3 practice, AMHs will be required to resolve those issues in a timely manner.

In addition, AMH Tier 3 practices will be permitted to submit HOP-related provider grievances directly to the health plan.

Part IV: AMH Practice Eligibility Criteria to Participate in HOP

AMH Practice Eligibility Criteria to Participate in HOP

To participate in HOP, AMH practices must:

- Be certified with the Department as an AMH Tier 3 practice,
- Be contracted with at least one health plan as a Tier 3 AMH, either directly or through their delegated CIN/other partner,
- Provide care management to Medicaid managed care-enrolled patients in a HOP region, either directly or through their delegated CIN/other partner (note—AMH practices may only provide HOP-related care management for enrollees of health plans for which it is contracted as a Tier 3), and
- Contract with the health plan to assume HOP-related responsibilities using Department-standardized contracting terms and conditions.

If an AMH Tier 3 practice does not participate in HOP, there is no effect on their AMH Tier 3 status.

Part V: AMH Tier 3 Payment for HOP Responsibilities

Since HOP launched in March 2022, AMH Tier 3 practices that are contracted with one or more health plans to provide HOP care management services will receive HOP care management payments from the health plans. HOP care management payments are not negotiated. Instead, DHHS will require health plans to pay AMH Tier 3 practices serving as a Designated HOP Care Management Entity (or their

delegated CIN/other partner, if applicable based on chosen contracting arrangements) an additional, DHHS-standardized, HOP Care Management PMPM payment, on top of existing care management and medical home payments. The health plan must pay AMH Tier 3 practices a HOP Care Management PMPM payment for each Medicaid member assigned to a HOP-participating AMH Tier 3 practice regardless of HOP enrollment, on top of existing care management and medical home payments.

HOP design seeks to maintain (and not disrupt) current contracting and payment practices. Given that each relationship between health plans, AMH Tier 3 practices, and CINs is unique, entities are encouraged to continue their existing processes for HOP care management payments. Health plans must use the care management rates and payment approach outlined in the HOP Payment Protocol to pay AMH Tier 3 practices for HOP-related care management and are not permitted to further negotiate rates. The Department reserves the right to modify this payment approach in the future, including to require that health plans pay contracted AMH Tier 3 practices based on actual HOP enrollment, rather than assigned population.

In addition to receiving HOP care management payments, HOP-participating AMHs/CINs will be eligible to participate in the HOP VBP program described further in the Department's HOP VBP protocols and guidance.

Part VI: Health Plan Oversight of AMH Tier 3 Practices for HOP Responsibilities

Health plan will be responsible for overseeing and monitoring AMH Tier 3 compliance with HOP responsibilities but may not put additional requirements on Designated HOP Care Management Entities above and beyond what the Department requires.

Under the existing AMH program, health plans are responsible for overseeing and monitoring compliance of each contracted AMH Tier 3. Health plans are not permitted to hold AMH Tier 3 practices accountable for requirements that go above and beyond the AMH Tier 3 program requirements. Health plans are permitted to downgrade AMH Tier 3 practices if they determine that those practices are out of compliance with the AMH program requirements (discussed further below in Part VII: Changes in AMH Status and HOP Participation), but health plans must use a defined process for their "downgrade" actions.

Health plans also have the ability to put an individual AMH Tier 3 practice on a corrective action plan if the practice is found to have a pattern of making referrals to Pilot passthrough services for patients that are subsequently found to be ineligible for HOP. The health plan will also have the ability to discontinue an individual AMH Tier 3 practice's ability to refer patients to passthrough services if that practice continues to have a pattern of making referrals for patients that are subsequently found to be ineligible for HOP. Health plans should give prior notification to AMH Tier 3 practices if they are outliers in referring ineligible members to the program and given a time period to demonstrate improvement.

Part VII: Changes to HOP Participation and Contract Terminations

The health plan may terminate a HOP-related contract with an AMH Tier 3 practice, with cause related to HOP performance. In addition, to participate in the AMH program, practices must be certified as an AMH Tier 3 by the Department. Practices may confirm or change their AMH status on the NCTracks provider portal. If a practice certified as an AMH Tier 3 determines that it needs additional time to meet Tier 3 requirements, it may change its Tier status without penalty.

In addition, for AMH Tier 3 practices that are out of compliance with the activities associated with Tier 3 participation, a health plan may "downgrade" the practice, or move a practice out of the AMH program altogether. Health plans must allow AMH Tier 3 practices and CINs/other partners at least 30 days for remediation of non-compliance with Tier 3 standards before pursuing a tier downgrade.

If an AMH Tier 3 changes or loses its Tier 3 status with any health plan, it will also lose its HOP certification and HOP care management payment with the same health plan. If that AMH is contracted with other health plans at the Tier 3 level, it can continue to participate in HOP with those health plans unless they also downgrade the practice's Tier 3 status.

As discussed above in Part VI: health plan Oversight of AMH Tier 3 Practices for HOP Responsibilities, **if a health plan determines that an AMH Tier 3 is not adequately meeting HOP requirements, it may lose its HOP certification and corresponding HOP care management payment.** Prior to HOP contract terminations, the health plan must notify the AMH Tier 3 of the underperformance issues and give the AMH Tier 3 practice 90 business days to remedy any HOP-related underperformance.

Prior to HOP contract termination with cause related to HOP performance, the health plan must notify the AMH Tier 3 practice of the underperformance issues and give the AMH Tier 3 practice 90 business days to remedy any HOP-related underperformance. These contract provisions are not applicable in cases where the AMH Tier 3 has been downgraded to Tier 2 status or is otherwise no longer contracted with a health plan for non-HOP reasons.

Once notified, the AMH Tier 3 must acknowledge receipt of the notice within three business days and develop and submit a corrective action plan (CAP) to the health plan within 15 business days of receiving notice of underperformance. The AMH Tier 3 must include in their CAP a performance improvement plan that clearly states the steps being taken to rectify underperformance. Health plans are required to notify the Department of any HOP-related underperformance and/or CAPs.

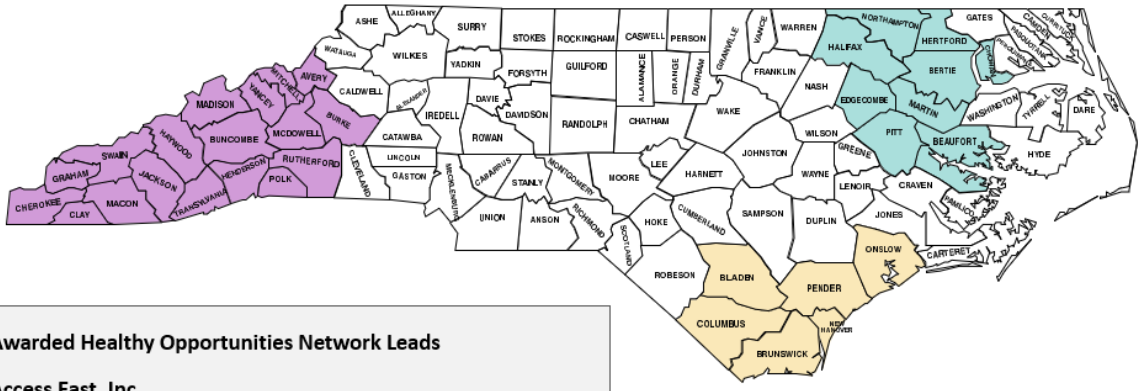
If the health plan moves forward with the termination of a HOP contract because the AMH Tier 3 practice does not remedy its underperformance after 90 business days, the health plan will provide written notice to the AMH Tier 3 practice. Upon receiving notice of termination, the health plan must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform (unless contracts with other health plans for HOP care management are still active).

In addition, AMH Tier 3 practices are permitted to discontinue HOP-related contracts with health plans at any time. AMH Tier 3 practices must notify the Department and the health plan of its intent to terminate the HOP-related contract, 45 business days before doing so.

In addition, AMH Tier 3 practices must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform, unless contracts with other health plans for HOP care management are still active. AMH Tier 3 practices must notify the health plan of the end date of the HOP-portion of its contract and meet the data storage requirements outlined in the NC Provider Participation Agreement (Paragraph 7.a).

Appendix G: Awarded Health Opportunities Network Leads

HOP operates in three geographical regions of the state led by NLs.



Awarded Healthy Opportunities Network Leads

Access East, Inc.

Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Dogwood Health Trust

Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Appendix H: Healthy Opportunities Pilot Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices Serving as a Designated HOP Care Management Entity

1. Background

The AMH program refers to an initiative under which the health plan delegates care management responsibilities and functions to State-designated AMH practices either directly or through the practice's CIN or other partner to provide local care management services. Refer to Part III.C.6. Care Management of the Prepaid Health Plan Services Contract for additional detail regarding the AMH Program. An AMH practice will be defined by an NPI and service location.

2. Scope

The scope of this Policy covers the agreement between the health plan, the CIN (if applicable) and PCPs participating in the AMH program outlined below and in the Contract.

The scope of the terms below covers the agreement between the health plan and AMH Tier 3 Practices or their contracted CIN serving as a Designated Pilot Care Management Entity.[49] As this is a pilot program, the Department will continually review, and update entity requirements based on the on-the-ground experience of Designated Pilot Care Management Entities.

Unless otherwise specified, any required element may be performed either by the AMH Tier 3 practice itself or by a CIN or other partner with which the practice has a contractual agreement that contains equivalent contract requirements. Health plans should align with contracting for current AMH care management for standard plan members. Contracting can follow current arrangements in situations where AMH providers use their CIN to negotiate or contract on their behalf.

Standard terms and conditions for health plan contracts with AMH Tier 3 Providers or CINs participating in HOP. The AMH Tier 3 practice or their contracted CIN must:

General

- Conduct all HOP-related responsibilities detailed in the HOP Participation section of the AMH Tier 3 Provider Manual.
- Be onboarded onto and utilize NCCARE360 for all HOP-related functionalities. The Department will cover the cost of NCCARE360 use for Medicaid members for functionality required by the Department.
- Follow any future DHHS-developed guidance documents or protocols related to the provision of HOP-related care management.
- Adhere to requirements regarding the collection, storage, and exchange of information related to HOP sensitive services (including but not limited to IPV-related services), as described in the *Interpersonal Violence-Related HOP (IPV)-Related Services: Conditions, Requirements, and Standards* attachment of the DHHS-Standard Plan contract. These include requirements to:
    - Provide training for staff with access to any HOP data on handling IPV-related data;

[49] A Designated Pilot Care Management Entity that is assuming care management responsibilities specifically related to the HOP. CINs or other partners may contract with health plans directly for Pilot-related responsibilities or AMH Tier 3 practices may contract with health plans for Pilot responsibilities directly. These standard terms and conditions use the term "AMH Tier 3 Practice" as an umbrella term any PHP-Designated Pilot Care Management entity relationship.

    - Limit access to IPV-related data to those who have received IPV-related data training and require access to IPV-related data; and
    - Require collection, documentation, review, and use of a member's contact requirements *[see Refer to and Confirm Delivery of HOP Services sub-section below for more detail].*
- The health plan is not permitted to add any additional oversight, monitoring or reporting requirements above and beyond what is enumerated in these terms and conditions.

Identify Potentially HOP-Eligible Members

- Assess potentially HOP-eligible members currently receiving care management for baseline HOP program eligibility, including qualifying physical/behavioral qualifying criteria and social risk factor(s).
- Undertake best efforts to conduct outreach attempts to the member in a timely manner, and in accordance with the AMH Provider Manual upon receipt of a referral of a potentially HOP-eligible member.
- Utilize the DHHS-standardized SDOH Screening Questions, other SDOH screenings, Comprehensive Assessments, other evidence-based assessment tools, and findings from regular care management check-ins with members to identify HOP-eligible individuals.
- Build in opportunities for assessing members' HOP eligibility at additional checkpoints with the member at existing check-ins (e.g., transitions of care).

Assess HOP Eligibility and Recommend HOP Services

- Assess potentially HOP-eligible members referred to the AMH Tier 3 for HOP eligibility assessment from external sources (e.g., the health plan) and members assigned to the AMH Tier 3 that are currently receiving care management, for qualifying criteria and recommend specific HOP services.
- Use the PESA to document standardized information regarding HOP eligibility and recommended services (see AMH Provider Manual Section on HOP Participation).
- Complete the PESA for the initial HOP eligibility assessment/service recommendations and anytime there is a change to a member's HOP service needs or eligibility.
- Utilize NCCARE360 to transmit the enrollment and authorization request to the member's health plan for service authorization.

Obtain HOP Consent

- Obtain or verify all required consents from the member using the DHHS-standardized 'Consent Form for NC Medicaid Coverage of HOP Services' prior to the member being enrolled in HOP and receiving HOP services and record consent in NCCARE360.

Refer to and Confirm Delivery of HOP Services

- Conduct outreach to the member about authorized HOP services.
- Obtain and record Pilot members' contact requirements prior to conducting any HOP-related outreach to members about HOP services, and review and adhere to HOP members' contact requirements when conducting any future HOP outreach. Members' contact requirements include:
    - Whether the patient opts-in or opts-out of non-essential HOP-specific communications (as recorded during their initial HOP eligibility assessment and as amended from time to time thereafter at the member's sole discretion),

    - Preferred dates or days of the week for being contacted, time of day at which to be contacted, and modality of contact (e.g., calls vs. texts, use of voicemail, email, postal mail, etc.),
    - Whether any other days of the week, times of day, or modalities for contact must not be used, and
    - Whether it is acceptable to leave a message for the member using their preferred modality of contact.
- Include in the member's care plan information on HOP enrollment status, authorized HOP services and HOP-related needs.
- Upon HOP enrollment, initiate care management to the member if the member is not already receiving care management. Continue providing care management if the member is already receiving it.
    - Ensure that care management is delivered in accordance with AMH Program requirements, as detailed in the AMH Provider Manual.
- Make referrals for authorized HOP services using NCCARE360 upon receiving health plan authorization.
    - Health plans will monitor receipt of invoices from Human Service Organizations (HSOs) to ensure that referrals are occurring, and services are being delivered in a timely manner.
- Follow-up with the HSO (if the referral is not accepted) and elevate the issue to the appropriate NL as required.
    - NLs will oversee HSO network performance across their HOP region.
- Health plans are not required to monitor HSO referral acceptance as HSO performance is predominately a NL function.
- Once an HSO begins providing a HOP service to a HOP enrollee:
    - Track the status of a referral to an HSO to ensure that HOP service delivery is initiated.
    - Coordinate with the HSO that accepted the referral in order to track the outcomes of authorized HOP service(s) and to ensure HOP service(s) are meeting the enrollee's needs, as needed.
    - Update the HOP service delivery outcome(s) in the HOP section of a member's care plan.
- In the event an HSO is terminated from the HOP network or cannot fulfill HOP services, the AMH Tier 3 practice will be notified of the HSO's termination by the NL. Following notice of an HSO's termination, The AMH Tier 3 must:
    - Close the existing case with the suspended or terminated HSO and send a new referral for the remainder of the authorized or passthrough service period to another HSO to fulfill for HOP enrollees currently receiving services through the HSO (i.e., HSO has accepted the referral and enrollee has an 'open case' in NCCARE360), or
- Redirect the outstanding referral or generate a new referral to another HSO to fulfill for HOP enrollees who have been referred to the HSO but have not yet received services (i.e., HSO has not accepted the referral).
- HOP services are generally duplicative of services provided by congregate care and institutional settings (e.g., housing and food). Members residing or receiving care in a congregate or institutional setting do not meet HOP eligibility criteria based on their access to services within the congregate or institutional setting.

- Upon five days of being notified that a HOP-enrolled member has entered a stay in a congregate care or institutional setting, the AMH Tier 3 practice must assess the need to continue, suspend, or terminate HOP services.
  - If the stay is projected to be longer than 30 days, the AMH Tier 3 practice should terminate HOP services, and prior to discharge, reassess the member for HOP eligibility and service needs.
  - For stays projected to be shorter than 30 days, the AMH Tier 3 practice should determine which referrals should be closed out in NCCARE360 for the length of the stay. The AMH Tier 3 practice should send new referrals using NCCARE360 to restart the services post-discharge (e.g., delivery of a healthy food box would no longer be needed and should be closed out for the duration of the stay, whereas telephonic-based housing case management may continue to benefit enrollee health, depending on the member's circumstances).
- For those currently residing in congregate care or institutional settings, the AMH Tier 3 practice may assess HOP eligibility and service needs prior to discharge/transition so long as service delivery starts upon the return to the community.
- Congregate/Institutional settings include:
  - Residential Treatment Facility Services (including ASAM 3.3 and above and services under Clinical Coverage Policy 8D-2)
  - Psychiatric Residential Treatment Facilities (PRTFs)
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
  - Inpatient Psychiatric Hospitals
  - Inpatient/Acute Care Hospitals
  - Nursing Facilities
  - Long-term Care Hospitals
  - Group Homes
  - Halfway House
  - Adult Care Homes
  - Family Care Homes
  - Alternative Family Living Arrangements

Referral to Passthrough Services

- Identify potentially-HOP eligible members that are currently in care management or who have been referred to the AMH for a HOP assessment, who would benefit from one of the passthrough services [See AMH Provider Manual *Appendix F. Healthy Opportunities Pilot Guidance for AMH Tier 3 Practices, Part D: Referrals for Passthrough HOP Services*.
- Upon identification of a member that would benefit from a passthrough service, and once required consents are obtained, send the PESA to health plan recommending an additional duration of the service beyond the 30-day passthrough period, indicating that the member is provisionally enrolled in HOP and pre-authorized to receive a HOP service for passthrough period of 30-days.
- Upon identification of a member that would benefit from a passthrough service, refer the member to an HSO that delivers HOP service for a passthrough period of 30-days, simultaneously with the transmittal of the PESA to the health plan.

- If the member is deemed eligible by the health plan for additional HOP services beyond the 30-day passthrough period:
    - Generate a referral to the same HSO to deliver the remaining HOP services past the initial 30-days.
    - Engage with the member to inform them that they are authorized to receive the full duration of the HOP service.
- If the member is deemed ineligible by the health plan for additional HOP services beyond the 30-day passthrough period:
    - Do not issue another referral for the remaining HOP services past the initial 30 days.
    - Engage with the member to inform and direct them to non-HOP services to meet their needs.

Reassess HOP Service Mix Review and Eligibility

- Conduct a HOP service mix review every three months and reassess HOP eligibility every six months and update the status of the assessment within the member's PESA in NCCARE360 using the notes field.
- Identify HOP enrollees requiring three-month and six6-month reassessments and schedule and conduct the service mix review and/or eligibility reassessment in a manner that is aligned with the guidance provided in the AMH Provider Manual on HOP responsibilities.
- Health plans will review data collected in NCCARE360 to monitor requirements for HOP service mix reviews and eligibility reassessment through spot audits of member PESAs but will not require additional reporting of AMH Tier 3 practices. In the future, the Department expects that NCCARE360 will have a monitoring dashboard that can be utilized for this functionality.

Transitions to Another Health Plan or Designated HOP Care Management Entity

- If a member moves to another health plan while enrolled in HOP, the AMH Tier 3 practice must:
    - Use the NCCARE360 functionality to send the health plan a summary of services using a Transition of Care Referral Request [See HOP Transition of Care Protocol for more detail.]
    - In the case that a referral for services has not yet been accepted by the HSO, the AMH Tier 3 must close the case.
    - For services that were accepted by the HSO and not yet started, the AMH Tier 3 must contact the HSO to close the case for the HOP service.
- If a member moves to another Designated HOP Care Management Entity, the AMH Tier 3 practice must:
    - Coordinate a timely warm handoff, or a transfer of care between AMH Tier 3 practices for effective knowledge transfer or to ensure patient continuity of care with regards to HOP services
    - Use the NCCARE360 functionality to send the new Designated Care Management Entity a summary of services using a Transition of Care Referral Request. See HOP Transition of Care Protocol for more details.

Discontinuation of HOP Services

- If an AMH Tier 3 practice identifies a HOP service to be discontinued, it must:
    - Document the service(s) to be discontinued and rationale (e.g., if the service is no longer meeting the member's need) and notify the health plan via NCCARE360.
    - Close out any open referrals for the discontinued service(s) in NCCARE360 and communicate with HSO regarding enrollee status.
    - Document discontinued service(s) and rationale for discontinuation in the member's PESA within NCCARE360 and the member's care plan.
    - Communicate with the member and provide transition support by identifying other HOP and non-HOP services and programs to meet ongoing needs.

Disenrollment from HOP

- Identify the following circumstances that result in HOP-disenrollment:
    - The enrollee is no longer enrolled in NC Medicaid Managed Care (e.g., congregate/institutional settings);
    - The enrollee has moved out of a HOP region;
    - The enrollee is receiving duplicative services/programs that disqualify them from HOP; or
    - The enrollee has not been responsive for more than six months and has not responded to requests for the three-month service mix review and the six-month eligibility assessment.
- Document information and rationale for HOP disenrollment in the PESA and transmit it to the health plan for verification.
- Upon receipt of the disenrollment decision:
    - Communicate with the member regarding the change(s) to HOP services.
    - Close out any open referrals for the discontinued service(s) in NCCARE360 and communicate with HSO(s).
    - In the event a HOP enrollee is transitioning to Medicaid Direct or has been retroactively disenrolled from managed care, AMH Tier 3 practices must inform the HSO of the date of disenrollment within 10 days of receiving this notification. Coordinate with the HSO to ensure any HOP services that were authorized and started at the time of HOP enrollment or pending passthrough services are delivered to the member.
    - Document health plan decision on HOP disenrollment in the member's care plan.
    - Provide transition support by identifying non-HOP services and programs to meet the needs of the member.

Member and Provider Grievances

- If an AMH Tier 3 has any grievances related to HOP, it may transmit those issues directly to the health plan.
- If the AMH Tier 3 is made aware of any HOP-related member grievances, it will transmit them directly to the health plan.
- Address member-related grievances routed by the health plan in a timely manner, and document the action taken using standard member grievance documentation policies for non-HOP issues.

HOP Payments

- The health plan s shall receive funds from the Department and make the following HOP payments to AMH Tier 3 practices:
    - **HOP Care Management Payments**:
        1. The health plan shall pay AMH Tier 3 practices or their contracted entity serving as a Designated HOP Care Management Entity (e.g., a CIN) an additional, DHHS-standardized, HOP Care Management PMPM payment for each Medicaid member assigned to a HOP-participating AMH Tier 3 regardless of HOP enrollment, on top of existing care management and medical home payments, initially, at HOP launch on Feb. 1, 2022.
        2. The health plan shall use the care management rates and payment approach outlined in the HOP Payment Protocol to pay AMH Tier 3 practices for HOP-related care management and are not permitted to further negotiate rates. The Department reserves the right to modify this payment approach in the future, including to require that health plans pay contracted AMH Tier 3 practices based on actual HOP enrollment, rather than assigned population.
    - **Value-Based Payments**:
        1. The health plan shall share earned incentive payments with high-performing HOP-participating AMH Tier 3 practices that contribute to meeting Department standardized milestones. Milestones are defined in the Department's HOP VBP guides.
        2. The health plan shall distribute earned incentive payments to eligible AMH Tier 3 practices in the manner outlined in HOP VBP guides.

Health Plan-Initiated HOP Contract Termination

- The health plan may terminate a HOP-related contract with a AMH Tier 3 with cause associated with HOP-related performance.
    - The health plan may also terminate a HOP-related contract if that AMH Tier 3 has been downgraded to Tier 2 status or is otherwise no longer contracted with a health plan for other non-HOP reasons.
- Prior to HOP contract termination with cause related to HOP performance, the health plan must notify the AMH Tier 3 practice of the underperformance issues and give the AMH Tier 3 90 business days to remedy any HOP-related underperformance. These contract provisions are not applicable in cases where the AMH Tier 3 has been downgraded to Tier 2 status or is otherwise no longer contracted with a health plan for non-HOP reasons.
    - The AMH Tier 3 must acknowledge receipt of the notice within three business days.
    - The AMH Tier 3 must develop and submit a corrective action plan (CAP) to the health plan within 15 business days of receiving notice of underperformance.
    - The AMH Tier 3 must include in their CAP a performance improvement plan that clearly states the steps being taken to rectify underperformance.
- The health plan must notify the Department of any HOP underperformance within 45 business days of notifying the AMH Tier 3.
- If the health plan moves forward with the termination of a HOP contract because the AMH Tier 3 does not remedy its underperformance issues after the 90 business days, the health plan must provide written notice to the AMH Tier 3 of the decision to terminate. The notice, at a minimum, must include:
    - The reason for the health plan's decision; and
    - The effective date of termination.

- The health plan must also provide written notice to the Department regarding the termination of any HOP-related contracts with an AMH Tier 3 within 15 business days of notifying the AMH Tier 3. The notice must include, at a minimum:
    - The reason for the health plan's decision;
    - Outcomes of any actions to address underperformance; and
    - The effective date of termination.
- The health plan must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform.
- For any terminated contracts, the health plan must follow all requirements in the HOP Transition of Care Protocol to ensure continuity of care for members.

AMH Tier 3-Initiated HOP Contract Termination

- AMH Tier 3 may terminate a HOP-related contract with a health plan at any time.
    - AMH Tier 3 must notify the Department and the health plan of its intent to terminate the HOP-related contract 45 business days before doing so.
- AMH Tier 3 must notify Unite Us of the terminated contract in order to be removed from the HOP-related components of the NCCARE360 platform.
- AMH Tier 3 must notify the health plan of the end date of the HOP-portion of its contract.
- AMH Tier 3 must meet the data storage requirements outlined in the NC Provider Participation Agreement (Paragraph 7.a).