NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advanced Medical Home Provider Manual July 2026

This document was updated in July 2026. This Provider Manual supersedes previous versions.
Questions about the Advanced Medical Home program should be submitted to:
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Contents

Section I: Introduction

The North Carolina Department of Health and Human Services (the Department) is focused on building robust and effective models for managing Medicaid members' comprehensive needs through care management. The Advanced Medical Home (AMH) model provides an infrastructure for primary care medical homes with integrated local care management, which supports the Department's managed care vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community. Over 2.5 million Members are covered through NC Medicaid Managed Care in North Carolina as of June 2025.[1]

AMH practices are providers of primary care services that meet requirements for serving as a Medicaid member's medical home and meet care coordination and access for members enrolled in Medicaid managed care requirements. In addition, AMH practices that meet additional criteria may elect to provide care management services for high-need members enrolled in Standard Plans, one type of Medicaid managed care prepaid health plan.[2] These AMH practices are designated as Tier 3 AMHs. AMH practices that meet the other requirements of the AMH program but do not meet the criteria for delegated care management are designated as Tier 1 or Tier 2 (see Section II, AMH Practice Eligibility).

To promote provider-based, local care management, the Department requires Standard Plans to delegate care management functions to AMH practices that meet the criteria for AMH Tier 3. To provide these care management functions, eligible AMH practices may work with an affiliated health care system or partner with entities called Clinically Integrated Network (CIN), care management vendors or other population health entities.

The AMH program is integrated with the Department's broader Quality Strategy under which health plans must meet population health targets.

This document outlines AMH program requirements and is a resource for AMH practices, primary care providers (PCPs) and Clinically Integrated Networks and/or other partners working with Advanced Medical Homes. NCDHHS reserves the right to update the manual or guidance at any time. Practices should regularly check NC Medicaid bulletins and the AMH website for additional guidance, updates and information.

[1] Enrollment Dashboard | NC Medicaid

[2] Additional requirements and provider structures are in place for care management for Medicaid members enrolled in other managed care plan types (i.e., Tailored Plans and the Children and Families Specialty Plan). Requirements specific to care management for Tailored Plan members can be found in the Tailored Care Management Manual.

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, the following specialties, including certain subspecialties[3]:

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

AMH practices can also include physician assistants and advanced practice nursing providers, such as advanced practice midwives and nurse practitioners. 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 and Carolina Access program. All practices must provide primary care services, although they may provide other services as well. There are no minimum panel size requirements to become an AMH practice. However, practices serving only a small number of Medicaid beneficiaries may wish to consider how AMH participation can complement their practice transformation efforts with other payers to ensure sustainability.

Practices that wish to become AMH practices should refer to the **Section VI** for details on AMH attestation, including information on how to check the NCDHHS assigned tier status and how to change tier, if needed, see **Section VI.**

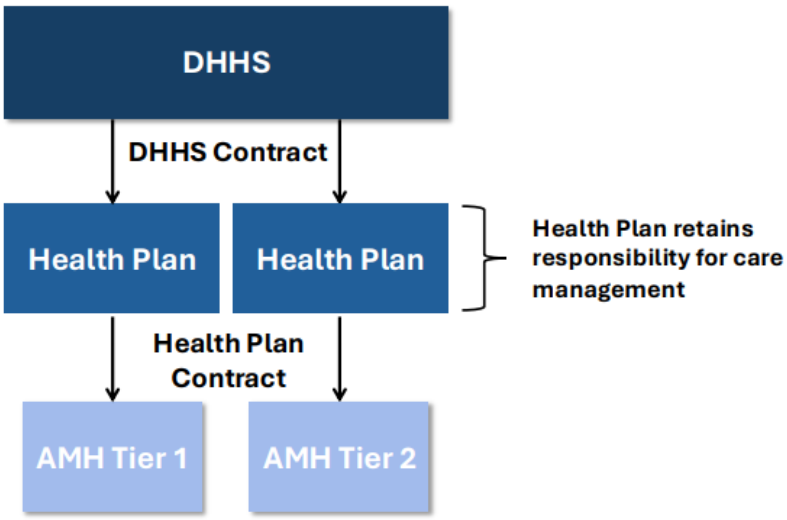
Overview of AMH Tiers

PCPs choosing to participate in the AMH program must meet minimum care coordination and member access requirements. Each Standard Plan is responsible for care management for any high-need Medicaid patients assigned to AMH Tier 1 and 2 practices. AMH Tier 1 and 2 practices receive medical home fees as described in Section III and interface and coordinate with each of those health plan's care management programs for high-need patients.

[3] For a full list of permitted subspecialties, please refer to Provider Permission Matrix in 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. Carolina Access is the gateway to the AMH program. A provider cannot be an AMH without first enrolling in Carolina Access. In addition to single/multi-specialty organization, these organizations can participate: Community Health, FQHC, RHC, Public Health primary care clinics.

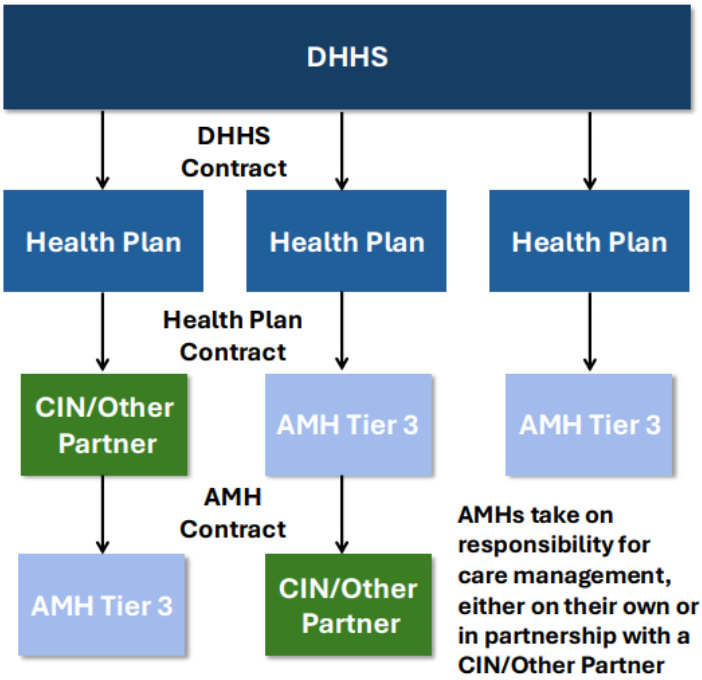
AMH Tier 1 and 2: AMH Tier 2 is automatically assigned when a provider is approved for Carolina Access participation. AMH Tier 1 is no longer an enrollment option, although some providers maintain this historical designation. AMH Tier 1 and 2 program requirements are the same. Practices serve as the medical home for their assigned Medicaid beneficiary but do not perform care management. They receive a per member per month (PMPM) medical home fee for each assigned Medicaid beneficiary (see Section III).

Figure 1: AMH Tier 1 or 2



AMH Tier 3: Practices choosing to become AMH Tier 3 must meet the same minimum requirements as AMH Tier 2 practices and, additionally, accept responsibility for high-need care management and population health for their NC Medicaid Managed Care members. In addition to medical home fees, health plans must pay PMPM fees to AMH Tier 3 practices to reflect the delegated care management function. To be designated as an AMH Tier 3, a practice must attest to meeting Tier 3 requirements.[4]

Figure 2: AMH Tier 3



[4] The only AMH Tier that providers may **choose** is AMH Tier 3, which providers enroll with by affirmatively answering the questions on the AMH Tier Attestation Form; or if a provider is already AMH Tier 3, they may **choose** to downgrade to AMH Tier 2. More details are available in the AMH Tier Attestation Job Aid.

Clinically Integrated Networks/Other Partners: In support of their care management and population health efforts, AMH Tier 3 practices may choose to work with Clinically Integrated Networks (CINs) and other partners. CINs and other partners may provide AMH practices with administrative support, clinical staffing resources, advanced care coordination and care management services, and/or technology services. CINs and other partners may include hospitals, health systems, integrated delivery networks, independent practice associations (IPAs) or other provider-based networks and associations. CINs will collect, compile, analyze and exchange data to fulfill their care management obligations to support AMH practices that may not have the capacity to provide care management and information technology services. For more information, please review the Clinically Integrated Networks and Other Partners Support of Advanced Medical Homes Care Management Data Needs.

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.**

Non-AMH Primary Care Practice : Primary care practices serving managed care members must be contracted with health plans as AMH practices to receive AMH payments applicable by AMH Tier. Primary care 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.

AMH Assignment Protocols

In NC Medicaid Managed Care, members are encouraged to actively select a primary care provider; if they do not, they are assigned to an AMH by their health plans using state-determined criteria. This approach ensures that all beneficiaries, including those previously unengaged with a primary care practice, have access to ongoing primary and preventive services. An AMH's assigned members form the basis for several elements of the AMH program, including member data exchange, care management, risk stratification, payment of per-member medical home and care management fees, quality measurement and performance incentives.

Primary care provider assignment also facilitates population health management by enabling providers to proactively address patient needs, manage risk and align care delivery with broader Medicaid goals. Because each member must have a designated PCP, AMHs may have individuals assigned to their panel whom they have not previously served.[5] For more information on assignment, refer to the Member Enrollment PCP/AMH Auto-Assignment Guidance.

AMH Tier 1 and 2 Practice Requirements

The AMH Tier 1 and 2 requirements build on NC Medicaid's pre-managed care primary care programs and are incorporated into the Department's contract with all prepaid health plans (Standard Plans,

[5] The Department continues to work with health plans to monitor, prevent and resolve errors in applying the assignment algorithm and to ensure assignment change requests are processed appropriately. To assist in maintaining accurate member assignments, AMHs should regularly review and update panel limits in NCTracks, including capacity, age, and gender restrictions. Additionally, providers may also set panel limits with each contracted health plan to reflect the specific number of members they are willing to serve from each plan. The Panel Management for PCPs fact sheet offers additional guidance for modifying panel limits.

Tailored Plans and Children and Families Specialty Plan). PHPs are required to include them in their contracts with all AMH practices.

The requirements for AMH Tier 1 and 2 are:[6]

- Accept members and be listed as a PCP in the health plan's beneficiary--facing materials for the purpose of providing care to beneficiaries and managing their health care needs.
- Provide primary care and patient care coordination services to each beneficiary, 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 beneficiary 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 beneficiary's medical record to the receiving provider upon the change of PCP at the request of the new PCP or health plan (if applicable) and as authorized by the beneficiary within 30 days of the date of the request, free of charge.
- Authorize care for the beneficiary or provide care for the beneficiary 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 beneficiary, based on the Department's guidelines and health plan standards.
- Review and use beneficiary 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 AMH requirements above. AMH Tier 1 and 2 practices may interface with multiple health plan-based care management programs and staff if they contract with multiple health plans.

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 all prepaid

[6] Standard Plan Contract Section VII. Attachment M.2; Tailored Plan Contract Section VII. Attachment M.2; see also **Appendix A** of this manual. 30-2024-001 CFSP Amendment 1 EXECUTED Section VII. Attachment L.2. CFSP Advanced Medical Home Program Policy

health plans (PHPs). PHPs 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.**[7]

AMH Tier 3 practices must meet all the following requirements. A CIN/other partner may perform these functions to meet some or all these requirements on the practice's behalf.

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 beneficiaries to produce a practice-wide view of risk and beneficiary need, allowing targeting of care management to the right beneficiaries at the right time. For more information on risk stratification, see AMH 105: Introduction to Advanced Medical Home and Programmatic Guidance on Risk Stratification for Tier 3 AMH Practices.

Table 1. Standard Terms and Conditions: Risk Stratification

AMH Tier 3 Practices Must …	Additional Information[8]
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 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.
1.3 *Use a consistent method to combine risk scoring information received from the health plan with clinical information to score and stratify the patient panel.*	
1.4 *To the greatest extent possible, ensure that the risk stratification method is consistent with the Department's program policy of identifying "priority*	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

[7] While Tier 3 standards contain significant overlap with National Committee for Quality Assurance guidance, AMH practices are not currently expected to gain NCQA recognition 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.

[8] For more information on risk stratification, see AMH training webinar on risk stratification, AMH 105: Introduction to Advanced Medical Home, DHHS Guidance: PHP Risk Stratification Communication Standardization (2024), and Programmatic Guidance on Risk Stratification for Tier 3 AMH Practices (2019).

populations"[9] for care management.	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 NC Medicaid's 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 NCDHHS 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.

[9] 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 PHP 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 mental health and substance use status and/or disorders;* • *Physical, intellectual/developmental disabilities;* • *Medications – prescribed and taken";* • *Priority domains of social determinants of health (health, food, transportation and interpersonal 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 theinformation with the patient. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond areview 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 partnersadministering the Comprehensive Assessmentshould 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 caremanagement 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. Develop the care plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible. 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.*	While dental benefits are not included in the State Term Contracts for AMH Tier 3 practices, 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 beneficiary needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.*	As beneficiary 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, through active 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 needsadmitted 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 the practice should reach out to the patient to understand why they were 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. Care manager or member of the care team member should attempt to visit the patient during hospital or facility-stay and be present on the day of discharge (attempts include contact with beneficiary, hospital social worker or other facility staff working with the member).

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 must have timely access to relevant, patient-level data[10]. See **Section V** for additional informationon the standardized data flows that support the AMH program.

Future Evolution of AMH Practice Requirements

Primary care is the cornerstone of an effective and efficient health care system and therefore central to NC Medicaid's strategy to achieve better care delivery, healthier people and communities, and smarter spending.[11] 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, promoting high-quality, coordinated care and improving outcomes for NC Medicaid beneficiaries. Continuing to evolve the Advanced Medical Home program will fortify NC Medicaid's care management programs and support providers and health plans in implementing new initiatives that are tailored to unique populations.

Requirements for AMH Practices Serving Youth Involved with Child Welfare System

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

[11] National Academics of Sciences, Engineering and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. 2021.

In December 2025, the Children and Families Specialty Plan launched. AMH practices play a critical coordinating role, working closely with members' assigned care managers and/or County Child Welfare workers. As the Department grows its capacity to provide care management services, it remains committed to harmonizing practice requirements across programs and improving the consistency with which care management is delivered. These alignment efforts aim to reduce administrative burden for providers, avoid duplication of services, improve oversight and evaluation of care management programs, and ensure members are receiving care that best meets their needs.

Practices serving youth in Foster Care must complete additional functions:

a) Review all available clinical documentation prior to each visit.
b) Coordinate with the member's assigned care manager and/or County Child Welfare Worker, as appropriate, and make best efforts to ensure the following occur:

1. Initial physical examination within seven days of entering County DSS custody; and
2. Comprehensive physical examination within 30 days of entering County DSS custody.

c) Complete DSS Child Health Summary forms during required physical examinations and return forms to the assigned County DSS. RFP #30-2024-001-DHB CFSP Section VII. Attachment L.2. CFSP Advanced Medical Home CFSP Ops Copy thru A2 Program Policy Page 110 of 154

1. For the initial seven-day physical examination, complete and return Form DSS-5206; and
2. For the comprehensive 30-day physical examination, complete and return Form DSS5208.

d) Make best efforts to schedule and conduct follow-up well visits in accordance with the AAP Health Care Standards for Members in Foster Care:

1. Members ages 0 to 6 months: every month;
2. Members ages 6 to 24 months: every three months; and
3. Members ages 2 to 21: every six months.

e) Conduct required health screenings in accordance with required timeframes (as appropriate, based on age and the member's clinical condition):

1. Screening for evidence of ACEs and trauma: within 30 days of entry into Foster Care and as determined necessary after that;
2. General developmental and behavioral screening (e.g., ASQ-3, PEDS, PEDS DM): within 30 days of entry into Foster Care and at ages6, 12, 18 and 24 months, and 3, 4 and 5 years;
3. Psychosocial assessment (e.g., ASQ-SE, PSC, PSC-Y, SDQ, PSQ-A, Beck's, CRAFFT, Vanderbilt, Conners, Bright Futures Adolescent Questionnaire, GAPS, HEADSSS): within 30 days of entry into Foster Care and every well visit thereafter as Medically Necessary;
4. Autism Spectrum Disorder screening (e.g., MCHAT R/F, STAT): at 18 and 24 months; and
5. Oral health screening and risk assessment (e.g., NC Priority Oral Risk and Referral Tool, Bright Futures Oral Health Risk Tool): within 30 days of entry into Foster Care all subsequent well visits up to age 3 ½.

f) As appropriate, coordinate with care manager to refer Member to a dental home.
g) As appropriate, utilize best practices described in "Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System" from the American Academy of Child and Adolescent Psychiatry (AACAP) when treating members served by the child welfare system.

Health Information Exchange Medicaid Services

In parallel with its transition to managed care, the Department continues to modernize its Medicaid data systems to support oversight of managed care plan performance and generate accurate, actionable information for program operations as well as performance measurement. As part of this

process, the Department is partnering with NC Health Information Exchange Authority (NC HIEA) to leverage the state's designated health information exchange, NC HealthConnex, to improve exchange of clinical, screening, and care management data between NC Medicaid health plans and providers.

NC HIEA has worked closely with NC Medicaid since 2020, providing support for COVID surveillance and warm hand-offs for high-risk patients during NC Medicaid Managed Care launch. Recognizing the success of this work, NC Medicaid submitted an Advanced Planning Document (APD) to Centers for Medicare & Medicaid Services (CMS) to request enhanced federal financial participation to support three additional use cases.

1. Digital Quality Measures: The Department is working with NC HealthConnex to develop the capabilities to calculate a selected set of Medicaid's high-priority quality measures combining both administrative data (claims and encounters) with clinical information from providers' EHRs to produce Digital Quality Measures (dQMs) timely. To ensure all clinical data submitted are appropriate, complete and accurate for use in quality measurement, provider organizations will participate in the National Committee for Quality Assurance (NCQA) Data Aggregator Validation program. The Data Aggregator Validation program is a process by which the provider's approach to data management and exchange is approved by NCQA. The goal is to improve accuracy, timeliness and ease of collecting, calculating and sharing quality measure performance information across sources.
2. Health-Related Social Needs (HRSN) Screening: Understanding and addressing HRSN is a key focus for the Department. Complete and up-to-date data on a member's HRSN can help patients get connected to the resources they need to thrive and help providers improve clinical decision-making. The HRSN use case will focus on the use of NC HealthConnex in transmitting HRSN screening data for six of NCDHHS' 11 standardized screening questions covering food, housing/utilities and transportation, and make the information available to providers via the NC HealthConnex Clinical portal. This will improve the availability, accuracy and timeliness of NC Medicaid beneficiaries' HRSN screening information to various stakeholders.
3. Care Management Data Exchange: The goal of the care management use case is to improve the ability to exchange claims/encounter data and care management interaction details between health plans and care management entities to facilitate seamless transitions of care and support the provision of care management services. This will minimize the number of interfaces managed to support data exchanges, serve as a single data source of truth available to all stakeholders and minimize custom enhancements of data interfaces. Initial focus will be on essential population health data including transition of care, claims and encounter, beneficiary assignment, care plans, clinical assessments and care management interactions.

NC Medicaid and NC HIEA have partnered to launch the HIE Medicaid Services (HMS) Early Adopters Program to provide financial incentives and hands-on support to Medicaid-serving provider organizations willing to lead the way in advancing these efforts. To learn more about the Early Adopters Program, including eligibility, key activities and available funding review the HMS Early Adopters Program overview.

For the most up-to-date information on the HMS initiative and its use cases, visit:

1. HIE Medicaid Services webpage
2. HIE Use Cases Presentation at the AMH Technical Advisory Group (TAG) Data Subcommittee March 2025 Meeting
3. Use Case flyers:
    1. HMS dQM Use Case

2. HMS HRSN Screening Use Case

Section III: AMH Payment Model

In addition to Medicaid clinical services fees (fee-for-service), the health plan contract requires health plans to make additional payments to AMH practices. 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

AMH Tier	Medical Home Fees[12]	Care Management Fees	Performance Incentive Payments
Tier 1	**$2.50** (Standard Plan Non-ABD) or **$5.00** (Members in the Aged, Blind, and Disabled [ABD] eligibility group, and all Tailored Plan and CFSP members)	**None**	None required, but Standard Plans and Tailored Plans are encouraged to offer performance incentive payments based on the AMH Measures.
Tier 2		**None**	
Tier 3		Standard Plans: Negotiated between practices (or CINs/other partners on behalf of practices) and health plan Tailored Plans: None[13]	Standard Plans and Tailored Plans must offer performance incentive payments to practices for measures within the AMH quality measure set.

- **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 AMHTier 1 and 2 requirements set out in **Section II** above.[14] All AMH practices will receive medical home fees for all their assigned members. Members are assigned to AMHs at the National Provider Identifier (NPI) location level. PMPM amounts for the medical home fees are set by the Department and based on the number of assigned members. Medical practices in AMH Tiers 1, 2 and 3 will receive $2.50 PMPM for Standard Plan non-ABD members and $5.00 PMPM for members in the aged, blind and disabled Medicaid eligibility group and for all Tailored Plan and CFSP members.
- **Care Management Fees:** Non-visit-based payments to AMH Tier 3 practices (or CINs/other partners

[12] Fees are per member per month based on the number of assigned members.
[13] Information on Tailored Plan payments to AMHs can be found in the Tailored Plan contract. AMH+ practices receive care management payments for TCM; more information on these payments can be found in the Tailored Care Management Provider Manual.
[14] Standard Plan contract III.A.77

on their behalf) by Standard Plans providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.[15] 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.[16]

- **Performance Incentive Payments**[17]**:** 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.[17] 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. All performance incentive payments must be based exclusively on the AMH measure set and not on measures outside the set. See **Section IV** for the AMH Measure List[18].

AMH Participation in Value-Based Payment Models

Standard Plans and Tailored Plans are required to offer AMH performance incentive programs to Tier 3 practices, inclusive of AMH+ practices, based on the AMH measure set. Standard Plans and Tailored Plans have the option to offer incentive programs to AMH Tier 1 and Tier 2 AMHs. The Department continues to explore ways to reduce the administrative burden on AMH practices to participate in value-based models.

The Department encourages practices and CINs/other partners 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).

[15] Standard Plan Contract III.A.18

[16] The current care management rate assumption can be found posted on the AMH Website.

[17] Standard Plan Contract III.A.94

[18] To learn more about NC Medicaid's quality measures, please refer to NC Medicaid's Quality Measurement Technical Specifications.

Figure 3. AMH Quality Metrics for Calendar Year 2027

Calendar Year 2027 AMH Measure Set
• Adults Access to Preventative and Ambulatory Health Services (AAP)[19] • Child and Adolescent Well-Care Visits (WCV) • Childhood Immunization Status (CIS-E) (Combination 7)[20] • Immunizations for Adolescents (IMA-E)(Combination 2) • Well-Child Visits in the First 30 Months of Life (W30) • Prenatal and Postpartum Care (PPC) [21] • Cervical Cancer Screening (CCS-E) • Chlamydia Screening (CHL) • Glycemic Status Assessment for Patients with Diabetes (GSD) • Colorectal Cancer Screening (COL-E)[22] • Controlling High Blood Pressure (CBP)

Figure 4 AMH Quality Measure Set:

Measure Acronym	MY2022	M2023	MY2024	MY2025	MY2026	MY2027
AAP					X	X
CCS/CCS-E	X	X	X	X	X	X
CIS/CIS-E	X	X	X	X	X	X*
CDF	X	X	X	X		
CHL	X	X	X	X	X	X
COL/COL-E				X	X	X
CBP	X	X	X	X	X	X

[19] AAP was added to the AMH Measure Set in the 2025 Tech Specs. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2026 through December 2026.

[20] This measure was added to the AMH set in in North Carolina's 2026 Medicaid Quality Measurement Technical Specifications Manual. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2027 through December 2027.

[21] This measure was added to the AMH set in North Carolina's 2023 Medicaid Quality Measurement Technical Specifications Manual. As such, the first measurement year in which this measure could be incentivized as an AMH measure was the claims-year running from January 2024 through December 2024.

[22] This measure was added to the AMH set in in North Carolina's 2024 Medicaid Quality Measurement Technical Specifications Manual. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2025 through December 2025.

HBD/GSD		X	X	X	X	X
HPC	X					
IMA/IMA-E	X	X	X	X	X	X
PCR	X	X	X	X		
PPC			X	X	X	X
TCOC	X	X	X	X		
WCV	X	X	X	X	X	X
W30	X	X	X	X	X	X

**CIS-E combination 10 was switched to combination 7 for MY2027 AMH set*

The AMH Quality Measure Set is reviewed annually. For the most current measure set, see the NC Medicaid Quality Measurement Technical Specifications available at the NC Medicaid Quality Management and Improvement webpage.

All quality measures health plans incorporate into their contracts with AMH Tier 1, 2, and 3 practices must be taken from the AMH Measure Set, although health plans are not required to use all AMH measures. NC Medicaid does not set targets for AMHs. An AMH practice (NPI + location code) will have its own rate that may be above or below the baseline statewide rate and/or the Standard Plan rate. AMHs should negotiate target performance rates directly with Health Plans.

For the AMH Measure Set, the Department originally prioritized measures plan-reported measures that can be reported using the administrative methodology (including claims and encounters data). However, as NCQA Healthcare Effectiveness Data and Information Set (HEDIS) moves towards Electronic Clinical Data Systems (ECDS) reporting methodology, the Department will follow and transition measures over to ECDS. ECDS methodology gives health plans a method for collecting and reporting standard electronic clinical data for HEDIS quality measurement and improvement while still including claims and encounters data as needed.

The Department is simultaneously supporting the development of a digital quality measurement which will leverage clinical data from NC HealthConnex, North Carolina's health information exchange; this project will initially focus on Glycemic Status Assessment, Screening for Depression and Follow-Up Plan and Controlling High Blood Pressure. AMHs are encouraged to engage with supports that will be offered under this project to participate in the transition to digital quality reporting.

Beginning in 2024, Standard Plans were 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. [23]

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

[23] More details on the Withhold Program is available on the Quality webpage.

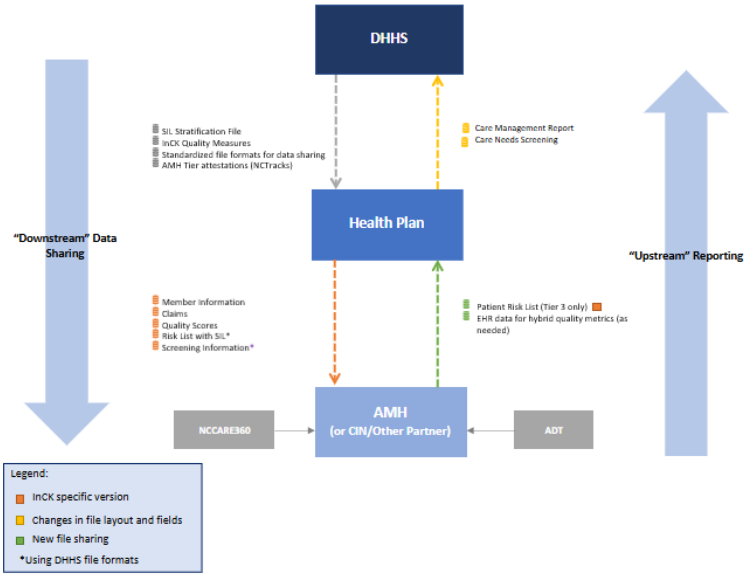
Section V: Data Exchange between Health Plans and AMH Practice

A key component of the AMH program is that practices are 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 burdenand 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).[24] Prior to the NC Medicaid 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 5. AMH Program Data Flows



[24] 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 AMH Tier 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) beneficiary-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. Per the Department's PHP Risk Stratification Communication Standardization Guidance, health plans must describe and share their risk stratification approaches with applicable AMH Tier 3 practices and CINs according to the required content, format and distribution method specified in the guidance. Health plans must transmit a description of their risk stratification approach to applicable AMH Tier 3 practices and CINs by March 1, 2025, and annually thereafter.
- **Initial Care Needs Screening results:** Health plans are required to make at least three attempts to

collect information via an "Initial Care Needs Screening" that assess beneficiary health and unmet resource need within 90 days of beneficiary 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.

"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 beneficiary-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. The PRL is both the vehicle for AMH Tier 3 practices (or their CINs/other partners) to receive beneficiary-level risk information from the health plans and to transmit care management encounter data to the health plan. Detailed specifications for the PRL are available on the AMH Data Specification Guidance website.

  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 following PRL elements apply only to beneficiaries enrolled in the NC Integrated Care for Kids (NC InCK) program. This program is explained in further detail in Section D1.

- The date care manager assigned (NC InCK beneficiaries only)
- The initial care manager outreach date (NC InCK beneficiaries only)
- The name of care manager assigned (NC InCK only)
- The phone number of care manager assigned (NC InCK beneficiaries only)
- The date of the share action plan was created (NC InCK beneficiaries only)
- The assigned care management entity care management code (NC InCK beneficiaries only)

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

management activities, such as care plan development, face-to-face encounters and telephonic contact. For the purposes of care management reporting, the Department considers the following to be care management encounters:

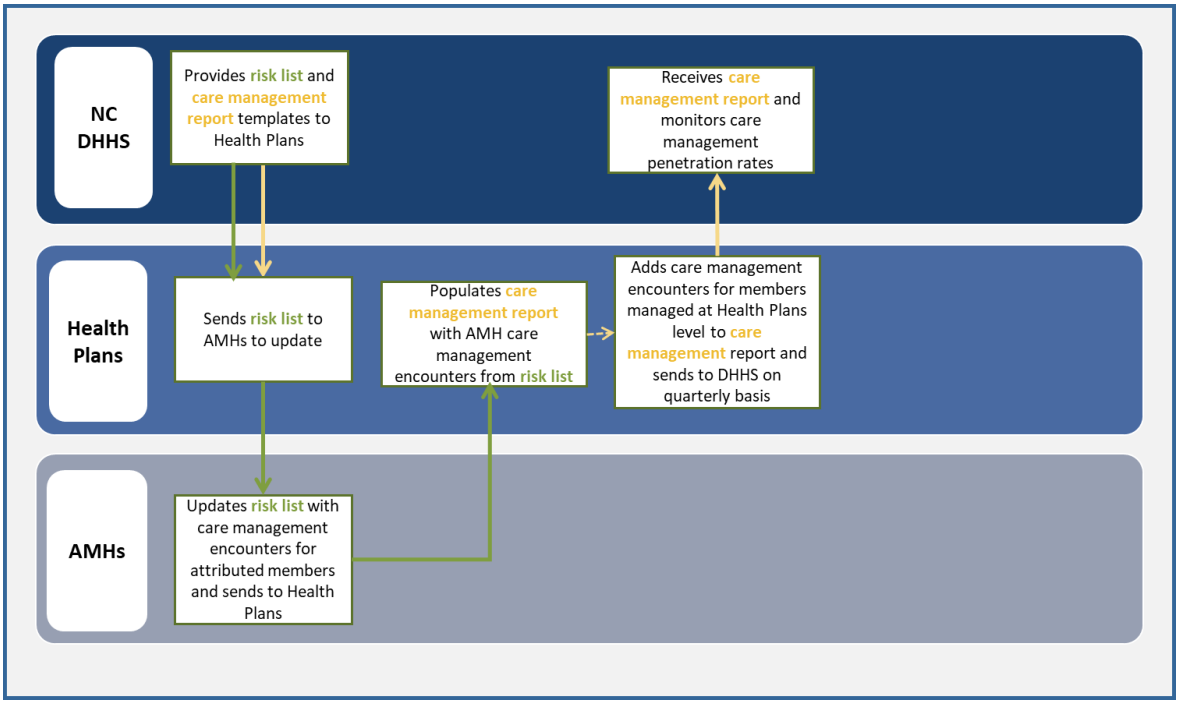
- In-person (including virtual) visit with care manager; could include delivery of Comprehensive Assessment, development of care plan or other discussion of patient'shealth-related needs.
- Phone call or active email/text exchange between member of care team and beneficiary (must include active participation by both parties; unreturned emails/text messages do NOT count). Examples of a qualifying encounter would include discussion of the beneficiary'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, through Dec. 31, 2026.
- Care manager leaves a voicemail with beneficiary or sends unreturned email/text message.
- Health plan/care manager sends mailer to beneficiary.
- Phone calls between member and practice front desk staff for scheduling purposes.
- Scheduled in-person visit to which the member fails to show up.

Per the Department's PHP Risk Stratification Communication Standardization Guidance, the Department encourages AMH Tier 3 and/or their CINs to share their risk stratification approaches with their contracted health plans in the Department's risk stratification template.

Figure 6. 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 purposes of 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.NCDHHS 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 beneficiary 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 through their CINs/other partners to obtain clinical data.

AMHs are encouraged to access NCCARE360 or other community resource platforms for information regarding available community resources to address members' health-related resource needs. NCCARE360 is North Carolina's statewide coordinated carenetwork that electronically connects those with identified needs to community resources and supports a feedback loop on the outcome of that connection. NCCARE360 is available in every county in North Carolina and 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 first be approved for participation with the Carolina Access program, which also approves them for AMH Tier 2. The provider may then upgrade their AMH Tier by affirmatively attesting to AMH Tier 3-specific practice requirements. After the Department notification of the provider's assigned Tier status designation, the practice can then contract with health plans in its catchment area. 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 NCDHHS 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 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 practices 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 useto ensure that standard contract terms are incorporated. Contracts must:

- Be mutually agreed upon;
- Assign responsibilities, including details of activities performed vs. retained, and specify who will fulfill these responsibilities;
- Assign responsibilities that contain all required elements included in Appendix A for all AMHpractices, 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'sdata 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 Measures: Evaluating Care Management

The Department assumes a certain percentage of beneficiaries to receive care management, and the need level will vary by population. To review the percentage of beneficiaries assumed to receive care management, please see the NC Standard Plan Capitation Rates –Care Management Assumptions State Fiscal Year 2025 which is updated annually. Please review the overall care management numerator and denominator measures:

Measure	Health Plans Care Management Penetration Rate
Numerator	1. "Number of Beneficiary Interactions" ≥ One for at least one month during the 12-month period, the member is counted ONCE.
Denominator	1. Appeared in ANY BCM051 report over the 12-month period

AMH Oversight and "Downgrades"

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.[25] 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 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.[26]

AMH practices have the right to appeal any such downgrades to the health plan by going through the health plan's regular appeals process.[27] 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, Standard Plans were 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 restricting health plans from requiring[28] that AMH Tier 3 practices and other NCDHHS-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.[29] 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: Pre-delegation Evaluation) or otherwise to improve care management performance or build care management capacity.

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[25] Standard Plan Scope of Services, Section V.C.6.b.iv.d.4.
[26] See "Advanced Medical Home Policy Changes," Nov. 16, 2020.
[27] Standard Plan Contract, Section VII. Attachment I.
[28] For example, as part of contract execution.
[29] 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. Examples of AHEC support for AMH Tier 3 practices include Quality Improvement, Practice Management, EHR Optimization, HIE Training and Integration and NC Medicaid Managed Care issue resolution and training. 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 practices on its Advanced Medical Home webpage.

The Department has previously convened a TAG Data Subcommittee to address specific data and reporting topics. The subcommittee is not currently meeting, but it may be reconvened as needed. For more information on the AMH TAG, please see the AMH TAG website.

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 members and be listed as a PCP in the health plan's member 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.
- Provide or arrange 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 for a minimum of 30 office hours per week.
- Provide preventive services. (See Preventive Health Requirements table below.)
- 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 provideddirectly 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 30 days of the date of the request.
- Authorize care for the member or provide care for the enrollee based on the standards of appointment availability as defined by the health plan's network adequacy standards.
- Refer to a second opinion as requested by the patient, based on Department guidelines andhealth 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.

Preventative Health Requirements:

Required for providers who serve the following age ranges				
Reference Number	**AMH Preventative Health Requirements**	**0 to 5**	**6 to 21**	**22 to 121**
1	Adult Preventative and Ancillary Health Assessment			Y
2	Blood Lead Level Screening	Y	Y	

3	Cervical Cancer Screening (applicable to Females only)		As Needed	Y
4	Vaccines per ACIP recommendations https://www.cdc.gov/vaccines/hcp/acip-recs/index.html	Y	Y	Y
5	Reserved			
6	Health Check Screening Assessment	*	*	
7	Hearing	*	*	
8 & 9	Hemoglobin or Hematocrit	*	*	As Needed
10	Reserved			
11	Reserved			
12	Reserved			
13	Reserved			
14	Reserved			
15	Standardized Written Developmental	*		
16	Reserved			
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	*	*	Y
18	Urinalysis		*	Y
19	Reserved			
20	Vision Assessment	*	*	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 todate in the clinical system of record.
    ii. The Tier 3 AMH practice must use a consistent method to assign and adjust riskstatus 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 "prioritypopulations" 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 clinicianjudgment 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 clinicianvisit, 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 statusand/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 support.
    iii. The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.
    iv. For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office- based clinical diagnosis and treatment and who has the minimum credentials of RNor LCSW.
c. Tier 3 AMH practices must use a documented care plan for each high-need patient receiving care management.
    i. The Tier 3 AMH practice must develop the care plan within 30 days of Comprehensive

Assessment, or sooner if feasible, while ensuring that neededtreatment 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 andperson-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 thecare 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 planin their 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 the empaneled patients and refine the care management services as necessary.

viii. The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local 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 appropriatecare 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 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 healthcare 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 and other poor outcomes.

i. The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;
2. Discharges from inpatient behavioral health services, facility-based crisisservices, 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 who is in transition and identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

iii. The Tier 3 AMH practice must include the following elements in transitional care management:
1. Ensuring that a care manager is assigned to manage the transition;
2. Facilitating clinical handoffs;
3. Obtaining a copy of the discharge plan/summary;
4. Conducting medication 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 encounteroccurs;
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) andmeet 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 theForm	The form should be completed bythe individual who has the electronic PIN required to submitdata to NCTracks on behalf of the practice.
N/A	Completing Contact Information of Office Administrator the Form (email and phone number)	
N/A	Organization National Provider Identifier (NPI) or Individual NPI, for practitioners who do not bill throughan organizational NPI	
N/A	Phone Number	This should be the general number and address used to reach the practice, as opposed tothe specific contact information requested for the office administrator (above).
N/A	Email Address	
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 aboutCIN/partner participation.)		
#	Requirement	Rationale
1	Does your practice use a consistent method to assign andadjust risk status for each assigned patient?	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/partneror system would meet this requirement, or application of clinical judgment to risk scores received from the health plan or another source will suffice.
2	Can your practice use a consistent method to combine risk scoring information received from the PHPs with clinical information to score and stratify the patient panel? (See supplemental question 5 to provide more information.)	
3	To the greatest extent possible, can your practice ensurethat the method is consistent with the Department's program policy of identifying "priority populations" for	Not all care team members need to be able to perform risk stratification (for example, risk stratification will most likely be

	care management?	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.
4	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 judgmentat the practice level) and that the methodology is applied consistently?	
5	Can your practice define the process and frequency of riskscore 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:		
6	Using the practice's risk stratification method, can yourpractice 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.
7	Can your practice ensure that assignment lists transmitted to the practice by each PHP are reconciled with the practice's panel list and up to date in the clinical system of record?	
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 healthand substance use status and/or disorders; Physical, intellectual developmental disabilities; Medications; Priority domains of social determinants of health (housing, food, transportation and interpersonal safety); and	In preparation for the assessment, care team membersmay consolidate information from a variety of sources and must review the Initial Care Needs Screening performed by the health plan (if available). Theclinician 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 assessmentshould go beyond a review of diagnoses listed in the enrollee's claims history and include a discussion of current symptoms and needs, including those that may not

	Available informal, caregiver or social supports, including peer supports.	have been documented previously. This section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2or 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/partnerlevel 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 caremanager 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.)	A member may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data in order to inform interactions between

		the member 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 ofComprehensive 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 intervalfor 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 collaborativeapproach including patient and family participation where possible?	Practice may identify their own definitions of 'individualized', 'person-centered' and 'collaborative', but should be ableto describe how their care planning process demonstrates these attributes.
13	Can your practice incorporate findings from PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinicalknowledge of the patient into the care plan? o Can your practice include, at a minimum, the following elements in the care plan o Measurable patient (or patient and caregiver) goals o Medical needs including any behavioral health needs; o Interventions; o Intended outcomes; and o Social, educational, and other services needed by thepatient.	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 levelof glycemic control at which the enrollee could attempt a trial of oral hypoglycemics, and a second intended clinical outcome that represents the level of control on oral hypoglycemics that would allow the enrollee to continue with the regimen.

14	Does your practice have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment?	The clinical system of record may include an electronic health record.
15	Does your practice have a process to document and storeeach care plan in the clinical system of 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.
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.		

17	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 outto 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.
18	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 andwho has the minimum credential of RN or LCSW? (Pleasesee 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 enrolleeand the clinician during the transition period.

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 ofthe 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	Does your practice include the following elements intransitional 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 members' needs may vary. However, the practice must have a process for determining a clinically appropriate follow-up interval foreach 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.
21	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 tomembers of the care team on the next (and future) office visit(s).
Tier 3 AMH practices must use electronic data to promote care management.		

22	Can your practice receive claims data feeds (directly or viaa 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 theCIN(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 foryour 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 aCIN ☐ 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 yourassigned 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	For patients who need LTSS, can your practice coordinate with the health plan to develop thecare 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.
S7	What are the credentials of the staff who will participate in the complex care managementteam 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.
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 thatapply.) ☐ 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 InCK Overview

Practices will no longer be required to adhere to the additional NC InCK requirements outlined in this section after the program ends Dec. 31, 2026.

NC InCK is an alternative payment and service delivery model of integrated care for children insured by Medicaid and enrolled in Standard Plans and NC Medicaid Direct. AMH Tier 3 practices contracted with the Duke Connected Care, UNC Healthcare System and Community Care Physician Network (CCPN) CINs within the participating NC InCK counties are eligible to participate in the NC InCK model. NC InCK is supported by CMS grant funding designed to improve outcomes for children. NC 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 NCDHHS (jointly known as NC InCK).[30] NC InCK took effect Jan. 1, 2022, and will run through Dec. 31, 2026. No new practices can be added to the NC InCK APM program after March 30, 2025. Any practices contracted in calendar year 2025 were ineligible for calendar year 2024 NC InCK APM payments.

Eligibility of Children and Youth for NC InCK

Medicaid-insured children and youth ages 0 through 20 whose Medicaid administrative county is one of the following were automatically enrolled in NC InCK starting in January 2022: Alamance, Durham, Granville, Orange and Vance and referred to as NC InCK beneficiaries. NCDHHS will centrally maintain beneficiary-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 Components

NC InCK will be focused on integrating care across 10 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

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

NC InCK incorporates the following design features:

- **Service Integration Levels**: NC InCK will use cross-sector data to stratify children into three Service Integration Levels (SILs). 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. NC InCK Members in SIL 2 and SIL 3 will be "priority populations" for health plans and AMH Tier 3 practices. NC InCK beneficiaries in SIL 3 will be assigned a high-risk designation.

- **Family Navigator:** In NC InCK, NC InCK beneficiaries in SIL 2 or 3 will be assigned a Family Navigator, who is part of the care management team. All NC InCK beneficiaries 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 NC InCK beneficiary and family to help the NC InCK beneficiary 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 NC InCK. The Family Navigator will hold a specific set of NC InCK responsibilities for the NC InCK beneficiary outlined below.

- **Shared Action Plan and Integrated Care Platform**: The Family Navigator will work with the NC InCK beneficiary and family to develop a Shared Action Plan (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 NC InCK care teams if a Consent Agreement has been signed. For NC InCK, the SAP will be stored on the NC InCK Integrated Care Platform maintained by NC InCK. The NC InCK Integrated Care Platform is a standardized, internet-accessible care integration tool that NC InCK staff and other authorized personnel will use to create, store, view, update and share NC InCK beneficiary information, including but not limited to basic NC InCK beneficiary 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 NC InCK model. Each NC InCK beneficiary in SIL 2 and SIL 3 will be assigned an Integration Consultant who is available to support the Family Navigator working with the NC InCK Member. Integration Consultants do not have direct contact with NC InCK beneficiaries.

- **Integrated Care Team**: An integrated care team is a family-driven team of professional and natural supports that collaborate to support an NC InCK beneficiary and their family in meeting the health, education and social service needs identified by the family. In NC 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 NC InCK beneficiaries 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 NC InCK Performance Measure

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

- **Alternative Payment Model:** The Alternative Payment Model (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 NC InCK beneficiaries an opportunity to participate in the NC InCK APM. As with other AMH APMs, health plans can offer these NC InCK APMs for AMH Tier 1 and Tier 2 practices but are not required to do so. Participation in the APM is voluntary. There will not be any withholding of provider reimbursement, AMH fees or care management fees as part of the NC InCK APM.

- **Pay-for-Reporting**: Rewards practices that successfully report on specific applicable quality measures with an incentive bonus.

- **Pay-for-Performance:** Pay-for-Performance (P4P) rewards provider performance on a set of predetermined 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 NC 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 and 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 beneficiaries, 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 beneficaries and participate in the NC 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: NC InCK AMH Tier 3 Practice Requirements

Requirement 1: Use the SIL to refine Risk Stratification for NC InCK Beneficiaries

NC InCK will centrally assign each NC InCK beneficiary 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 NC InCK beneficiary a SIL. NCDHHS will transmit NC InCK beneficiary-level SILs to each health plan, and health plans will be responsible for transmitting NC InCK beneficiary 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 NC InCK beneficiary to outreach NC InCK beneficiaries in SIL 2 and 3 for assessment and care management.	• AMH Tier 3 practices will receive the NC InCK SIL for each NC InCK beneficiary monthly on the PRL transmitted by health plans. • NC InCK beneficiaries assigned to SIL 2 and SIL 3 should be considered priority populations for the NC InCK integrated care support model regardless of their health plan assigned stratification. • Both NC InCK beneficiaries in SIL 2 and SIL 3 will receive outreach for NC InCK care management and engaged NC InCK beneficiaries should be assigned a Family Navigator, regardless of the health plans Risk Score Category. • Health plans will ensure all NC InCK beneficiaries 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 NC InCK beneficiaries is reconciled each month in the clinical system of record.	• AMH Tier 3 practices should reconcile and update the SIL assigned to NC InCK beneficiaries monthly with the transmission of the PRL from health plans. • AMH Tier 3 practices are required to maintain the NC InCK beneficiary's SIL in their care management system, and best practice is to also provide the SIL for the NC InCK beneficiary in the system of record for PCPs and other clinical teams.

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

NC InCK beneficiaries 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 NC InCK core child services). All NC InCK beneficiaries in SIL 2 and SIL 3 should receive outreach for NC 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. NC InCK's care

management model is similar for NC InCK beneficiaries in SIL 2 and 3 with two exceptions: requirements for comprehensive assessment (i.e., required for all NC InCK beneficiaries in SIL 3) and requirements for SAP (i.e., required to be offered for all NC InCK beneficiaries in SIL 3).

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

AMH Tier 3 Practices Must …	Additional Information
2.1 Coordinate with health plans to screen NC InCK Members for food and housing needs for all NC InCK beneficiaries assigned to SIL 1 and 2 at least annually, and to all NC InCK Members in SIL 3 every six months.	To maximize screening or food and housing rates in NC 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 NC InCK beneficiary outreach. The intent is to facilitate and streamline health plan and AMH collection and reporting of complementary data on NC InCK beneficiaries. Additional guidance on data collection for screenings from AMH Tier 3 practices (or CIN/other partner) will be released Quarter 2 2022.
2.2 AMH Tier 3 practices should perform a Comprehensive Assessment on each NC InCK Member assigned to SIL 3 within 30 calendar days of the NC InCK beneficiary (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for NC InCK Members should also include assessing these additional NC InCK domains: educational needs, child welfare needs and juvenile justice needs.	• NC InCK beneficiaries 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 NC InCK SAP and NC InCK consent. Family Navigators administering the Comprehensive Assessment can also use information collected to start establishing an NC InCK beneficiary's integrated care team. • AMH Tier 3 practices or their CINs or other partners can also complete a Comprehensive Assessment on NC InCK beneficiaries 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 NC InCK beneficiaries who agree to participate in care management as part of the integrated care management team. At a minimum, the NC InCK Family Navigator will: 1) Serve as the NC InCK Member's single point of contact; 2) Communicate with the NC 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 NC InCK beneficiary's guardian; 4) Support service referrals across NC InCK's 10 core child service areas; and *5)* Ensure that an NC InCK SAP is completed for at least 30% of SIL 3 NC InCK beneficiaries and at least 10% of SIL 2 NC InCK beneficiaries. *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 NC InCK's pediatric integrated care model. • NC 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 NC InCK beneficiary. • Please reference NC InCK's website for in-depth guidance on integrated care team formation, the SAP and navigating the NC InCK 10 core child service areas. • Family Navigator capacity building events will be held monthly for 90 minutes.
2.4 For each NC InCK beneficiary in SIL 2 and SIL 3, use the NC InCK standardized consent form to support care team collaboration, access to the NC InCK integrated care platform and the SAP, all of which facilitate integrated care for the NC InCK beneficiary across NC InCK's 10 core child service areas. Any completed consent form should be shared with the NC InCK beneficiary's Integration Consultant for records maintenance.	The intent of NC 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 NC InCK beneficiary (e.g., behavioral health, schools, early childhood, child welfare, juvenile justice). Signing the consent form also gives integrated care team members access to the NC InCK beneficiary's profile on the NC InCK Integrated Care Platform (Virtual Health). The NC InCK consent form, Family Navigator training on consent, and NC InCK's Guide to an Integrated Care team are available on the NC InCK website.
2.5 For each NC InCK beneficiary in SIL 2 and SIL 3 actively engaged in integrated care management, convene the NC InCK beneficiary's integrated care team and family to align on cross-sector goals and methods of communicating to meet the NC InCK beneficiary's integrated care needs.	• An integrated care team is a family-driven team of professional and natural supports that collaborate to support an NC InCK beneficiary 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 NC InCK beneficiary 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 NC InCK beneficiaries 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 NC InCK beneficiaries 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 NC InCK beneficiaries assigned to SIL 3 and at least 10% of NC InCK beneficiaries assigned to SIL 2

Membership in NC 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 NC InCK beneficaries to complete a brief, strengths focused NC InCK SAP for NC InCK beneficaries assigned to SIL 2 and SIL 3.

The SAP is a shareable, living document created in collaboration between the Family Navigator, family and the NC InCK beneficiary'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 NC InCK beneficiary and provide an easy-to-navigate roster of services and contact information for all members of the care team. An NC InCK consent form will also be provided for completion to support in the sharing of the SAP after completion. NC 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 an 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 NC InCK beneficiaries assigned to SIL 3 and at least 10% of NC InCK beneficiaries assigned to SIL 2, complete an NC 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 beneficiaries 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 three-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 an SAP. If there are clinical benefits to developing an 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 NC 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 beneficiaries 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 NC 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 Medicaid.AdvancedMedicalHome@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 beneficiaries offered an SAP, support the beneficiary in completing the NC InCK consent process to support sharing of the SAP and ongoing care team collaboration via the NC InCK Consent Form. Any completed consent form should be shared with the beneficiary's NC 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 beneficiary. 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 NC 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 NC InCK beneficiaries to the health plans based on the guidance in Table 9 below.

Table 9. Standard Terms and Conditions: NC InCK Data Requirements

AMH Tier 3 Practices Must …	Additional Information
4.1. Receive and use data from health plans on NC InCK-specific data elements such as NC InCK beneficiaries and SILs in the following reports and as specified in the AMH Provider Manual and **NC InCK Performance Measure Technical Specifications Manual**: • PRL (with SIL level); • Quality Measure results for practices in the NC InCK APM.	PRL will include SIL stratification for NC InCK beneficiaries 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 NC InCK-specific data elements and as specified in the AMH Provider Manual and **NC 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 NC InCK

All measures, including those used for the NC InCK APM (see Table 10) and those sent to CMS for all NC InCK beneficiaries (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

NC InCK Alternative Payment Model Overview

The NC InCK Alternative Payment Model (APM) is a four-year, targeted incentive program available to practices that provide care for NC InCK beneficiaries January through December 2022 served as the benchmark year for NC InCK APM measures. The first measurement year for the NC 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 an 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

Health plans are required to offer the NC InCK APM to all NC InCK–participating AMH Tier 3 practices serving NC InCK beneficiaries and are encouraged to make the APM available to other participating AMH Tier 1 and 2 practices. AMH practices may choose to participate with none, one or multiple health plans; participation with one plan does not obligate participation with any others, and choosing not to participate does not affect any existing agreements with a plan.

NC 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. AMHs contracting with health plans for the NC InCK APM will receive financial incentives for activities that promote child well-being, such as promoting kindergarten readiness, and screening for food insecurity and housing instability. All AMH practices that choose to contract with one or more health plans for NC InCK are eligible to earn negotiated performance incentive payments in the NC 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 and measures that

the plan incentivizes through other programs. 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 NC 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 NC InCK APM are required to report data and screening for calculation of the performance measures in Table 10 for all NC 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, NC 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 the NC InCK APM.

AMH practices with NC InCK Members 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. NC InCK APM Performance Measures

NC InCK Performance Measure	Performance Measure Type (Incentive or Awareness Only)
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)^	No Incentive: Report shared for awareness ***TCOC measure is not tied to incentives in the NC InCK APM. The Department provided TCOC data for the InCK population to AMHs for informational purposes only through the TCOC Dashboard until September 2025.**

*These two rates collectively are referred to as "Well-Child Visits in the First 30 Months of Life (W30)"
+These measures will not be tied to incentive payments in calendar year 2026.
^The TCOC dashboard was retired in September 2025 and is no longer available as a resource to AMHs participating in NC InCK.

Performance Measure Reports for Health Plans & Providers

The NC InCK APM performance measurement period is aligned with the calendar year, January through December. 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 NC InCK APM. For details, please refer to the NC InCK Performance Measure Technical Specifications Manual.

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 NC InCK Members in Standard Plans with which they are contracted for the NC InCK APM. If an AMH's performance on a measure meets a designated APM payment tier, the AMH is eligible for incentive payment from all Standard Plans with which they are contracted for NC InCK.

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

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

- NCDHHS NC 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
- NC InCK Guide to the SAP and Integrated Care Teams
- NC 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

Appendix E: NC 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 NC 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 NC InCK beneficiaries.**
   - 1.1. Use the SIL assigned to each NC InCK member to outreach NC InCK beneficiaries in SIL 2 and 3 for assessment and care management.
   - 1.2. Ensure that the SIL assigned to the NC InCK beneficiary is reconciled each month in the clinical system of record.

2. **Provide Integrated Care Support to NC InCK Priority Populations.**
   - 2.1. Coordinate with health plans to screen NC InCK beneficiaries for food and housing needs for all NC InCK beneficiaries assigned to SIL 1 and 2 at least annually, and to all NC InCK Members in SIL 3 every six months.
   - 2.2. AMH Tier 3 practices should perform a Comprehensive Assessment on each beneficiary assigned to SIL 3 within 30 calendar days of beneficiary (guardian/caregiver/parent) agreeing to integrated care management services (engagement). The Comprehensive Assessment for NC InCK Members should also include the educational needs, child welfare needs and juvenile justice needs of the NC InCK beneficiaries in addition to all current required domains.
   - 2.3. Assign a Family Navigator to all SIL 2 and SIL 3 NC InCK beneficiaries who agree to participate in care management as part of the integrated care management team. At a minimum, the NC InCK Family Navigator will:
     - Serve as the NC InCK beneficiary's single point of contact;
     - Communicate with the NC InCK beneficiary'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 NC InCK beneficiary's guardian;
     - Support service referrals across NC InCK's 10 core child service areas;
     - Ensure that an NC InCK SAP is completed for at least 30% of SIL 3 NC InCK beneficiaries and at least 10% of SIL 2 NC InCK beneficiaries; and
     - Attend at least 60% of all monthly Family Navigator capacity building events organized by NC InCK each year.
   - 2.4. For each NC InCK beneficiary in SIL 2 and SIL 3, use the NC InCK standardized Consent Form to support care team collaboration, access to the NC InCK integrated care platform, and the SAP, all of which facilitates integrated care for the NC InCK beneficiary across NC InCK's 10 core child service areas. Any completed consent form should be shared with the NC InCK beneficiary's Integration Consultant for records maintenance.
   - 2.5. For each NC InCK beneficiary in SIL 2 and SIL 3 actively engaged in integrated care management, convene the NC InCK beneficiary's integrated care team and family to align on cross-sector goals and methods of communicating to meet the beneficiary's integrated care needs.

2.6. For NC InCK beneficiaries 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 an SAP for at least 30% of NC InCK beneficiaries assigned to SIL 3 and at least 10% of NC InCK beneficiaries assigned to SIL 2.**
   3.1. For at least 30% of NC InCK beneficiaries assigned to SIL 3 and at least 10% of NC InCK beneficiaries assigned to SIL 2, complete a NC 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 benefciary's NC InCK Integration Consultant for records maintenance.
   3.2. For NC InCK beneficiaries offered an SAP, support the NC InCK beneficiary in completing the NC InCK consent process to support sharing of the SAP and ongoing care team collaboration via the NC InCK consent form. Any completed consent form should be shared with the beneficiary's NC 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 NC InCK-specific data elements such as NC InCK beneficiaries and SIL levels, in the following reports and as specified in the AMH Provider Manual and NC InCK Technical Specifications:
      - PRL;
      - Care Needs Screening Results;
      - Quality Measure results.
   4.2. Send data to the health plan on NC InCK-specific data elements as specified in the AMH Provider Manual and NC InCK Technical Specifications, including:
   4.2.1. PRL Release 2.0.

Appendix F: Reserved

Appendix G: Reserved

Appendix H: Reserved

Appendix I: Total Cost of Care Dashboard

The Department has retired the Total Cost of Care (TCOC) dashboard due to Medicaid budget constraints. This decision pertains only to the analytics tool and does not signal a change in the Department's support for TCOC-related value-based arrangements. The dashboard was an optional, informational initiative that offered a standardized view of TCOC for AMHs and Standard Plans; Prepaid Health Plans (PHPs) were not required to use its algorithm and may continue—at their discretion—to implement or expand shared-savings and other TCOC-linked incentives independent of the dashboard. TCOC is not a quality measure and, based on attribution challenges at the AMH level and stakeholder feedback, has been removed from the AMH and broader plan-level measure sets for 2026. The Department welcomes feedback from plans and providers on features that were most valuable and, contingent on future funding, may reassess options to support a shared cost-and-performance view.