Advanced Medical Home (AMH)[3]

NC Medicaid

Frequently Asked Questions

GENERAL QUESTIONS

WHAT IS THE ADVANCED MEDICAL HOME PROGRAM?

The North Carolina Department of Health and Human Services (NCDHHS) developed the AMH program as the primary vehicle for delivering care management when the State transitioned its Medicaid program to managed care. AMHs are providers of primary care services who meet requirements for serving as a Medicaid member's medical home, provide a minimum set of care coordination services, and may elect to be delegated for broader care management services. AMH works to incentivize, over time, increased provider responsibility for population health and total cost of care. The AMH program requires Prepaid Health Plans (PHPs) to coordinate care management functions with enrolled providers, which may be performed directly by the practice, through an affiliated Clinically Integrated Network (CIN), or other partner.

WHAT POPULATIONS MAY RECEIVE MANAGED CARE?

NC Medicaid members receive the same Medicaid services through NC Medicaid Managed Care. Health care choices are specific to each person's needs and situation. Populations receiving managed care include:

Standard Plan:

- Most families and children
- Pregnant women
- People who are blind or disabled and do not get Medicare
- Federally recognized tribal members or others who qualify for services through Indian Health Service (IHS)

EBCI Tribal Option:

- Federally recognized tribal members or others who qualify for services through IHS who live in the following counties: Buncombe, Clay, Cherokee, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, Transylvania

Tailored Plan:

- People who get Innovations Waiver services
- People who get Traumatic Brain Injury (TBI) Waiver services
- People who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or TBI

For more information on NC Medicaid populations receiving managed care, please review the NCDHHS NC Medicaid Managed Care Populations.

HOW DOES THE AMH PROGRAM FIT INTO NORTH CAROLINA'S CARE MANAGEMENT INFRASTRUCTURE?

The AMH program replaced Carolina ACCESS in 2018 under the managed care environment. Previous care management programs for pregnant women and at-risk children, including Pregnant Medical Home (PMH), Obstetric Care Management (OBCM), and Care Coordination for Children (CC4C) continue to operate in managed care under new names: Pregnancy Management Program (PMP), Care Management for High-Risk Pregnancy (CMHRP), and Care Management for At-Risk Children (CMARC), respectively. Additional information can be found in the Program guide for Management of High-Risk Pregnancies and At-Risk Children in Managed Care.

HOW WILL BENEFICIARIES THAT ARE EXEMPT OR EXCLUDED RECEIVE MEDICAID COVERAGE?

Exempt beneficiaries will remain in NC Medicaid Direct unless they choose a health plan during open enrollment. Excluded beneficiaries will remain in NC Medicaid Direct. Auto-enrollment does not apply to exempt or excluded beneficiaries. For more information, please refer to the NC Medicaid Managed Care Fact Sheet.

ARE PRACTICES REQUIRED TO PARTICIPATE IN AMH IN ORDER TO ENROLL IN THE MEDICAID PROGRAM OR CONTINUE TO SEE MEDICAID PATIENTS?

No. Participation in the AMH program is voluntary. Practices may join one or more PHP provider networks as a non-AMH practice if they wish to participate in managed care but not the AMH program. Participation in the AMH program also has no bearing on a practice's ability to participate in NC Medicaid Direct fee-for-service.

WHERE CAN I FIND MORE INFORMATION ABOUT NORTH CAROLINA'S TRANSITION TO MANAGED CARE?

A policy paper Supporting Provider Transition to Medicaid Managed Care, describes the key programmatic features of the State's transition to managed care. NCDHHS has also created a Medicaid Transformation homepage, containing additional informational resources, 1115 waiver documents, and procurement materials. It can be found on the NC Section 1115 Demonstration Waiver webpage.

WHAT IS THE DIFFERENCE BETWEEN THE AMH "TIERS"?

AMH Tier 1 or 2: Practices choosing to participate in the AMH program meet minimum care coordination and beneficiary access requirements. The AMH Tier 1 and 2 practices that contract for services with multiple PHPs interface and coordinate with each of those PHPs care management programs for high need patients. AMH Tier 1 and 2 practices receive medical home fees. These are non-visit-based payments to AMH practices, providing stable funding for care coordination support and quality improvement at the practice level.

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

AMH Plus (AMH +): Primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Tailored Care Management (TCM) eligible population or can otherwise demonstrate strong competency to serve that population. AMH+ providers must demonstrate experience with Medicaid patients who have a Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), Severe Substance Use Disorder (SUD), Intellectual/Developmental Disability (I/DD) or Traumatic Brain Injury (TBI). AMH Tier 3 practices must go through a certification process with the Department to become a certified AMH+.

PRACTICE REQUIREMENTS

WHAT ARE THE PRACTICE REQUIREMENTS FOR AMH TIERS 1 AND 2?

Please refer to Section II: AMH Practice Requirements for a full list of current AMH Tiers 1 and 2 requirements in the AMH Provider Manual. These requirements are incorporated into the Department's contract with PHPs, and PHPs are required to include them in their contracts with all AMH practices.

WHAT ARE THE PRACTICE REQUIREMENTS FOR AMH TIER 3?

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 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. Additional details can be found in the AMH Provider Manual.

All AMH Tier 3 Practices must:

- Risk-stratify all empaneled patients
- Provide care management to high-need patients
- Develop a Care Plan for all patients receiving high-need care management
- Provide short-term, transitional care management along with medication management to all empaneled patients who are discharged from the Emergency Department (ED) or an inpatient setting
- Be able to receive claims data feeds and meet State-designated security standards for claims storage and use.

CAN RURAL HEALTH CLINICS PARTICIPATE AS AMH TIER 3 PRACTICES?

Yes. If rural health clinics attest to become Tier 3 practices, provide primary care services, and meet all of the Tier 3 requirements, they can participate as an AMH Tier 3 practice and receive additional payments. For a full list of permitted subspecialties, see Provider Permission Matrix.

WHAT HAPPENS TO TIER 3- CERTIFIED PRACTICES THAT ARE UNABLE TO REACH AGREEMENT ON TIER 3 CONTRACTING TERMS?

PHPs must accept Tier 3-certified practices into their provider networks at a minimum Tier 2 level if they cannot reach agreement on Tier 3 contracting terms.

WHAT ARE THE REQUIRED QUALIFICATIONS FOR STAFF TO LEAD THE DELIVERY OF CARE MANAGEMENT?

Each high-need patient and each patient in transition identified as high risk for admission or other poor outcome must be assigned a care manager with a minimum credential of a Registered Nurse (RN) or a Licensed Clinical Social Worker (LCSW). The individual leading the care management process should have the full credentials, not an individual in training such as Licensed Clinical Social Worker Associate (LCSW-A). Individuals in training and other non-licensed staff may appropriately participate in certain elements of care management but should not lead the care team or perform clinically focused assessments. 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. Staff with other qualifications may appropriately assist in this process.

WILL PATIENTS EMPANELED BY TIER 1 AND 2 PRACTICES RECEIVE THE SAME CARE MANAGEMENT SERVICES AS THOSE EMPANELED BY TIER 3 PRACTICES?

Yes. Patients empaneled by AMH Tier 1 and 2 practices (and non-AMH, managed care-enrolled practices) will receive the same level of care management services as those empaneled by Tier 3 practices. Patients empaneled by non-AMH/AMH Tier 1 and AMH Tier 2 practices will receive local care management services provided either directly by the PHP or through an entity contracted by the PHP. Patients empaneled by Tier 3 practices will receive the same level of care management but with services provided by the Tier 3 practice directly or by a CIN/other partner that has contracted with the Tier 3 practice.

WILL PRACTICES HAVE TO INTERFACE WITH MULTIPLE CARE MANAGERS (I.E., A CARE MANAGER FOR EACH PHP)?

Most likely, if in Tier 1 or 2. In Tiers 1 and 2, PHPs will be accountable for ensuring that beneficiaries receive required care management services. Since most practices are likely to contract with multiple PHPs, it is possible practices will have to interface with different care managers across multiple PHP contracts.

For Tier 3 practices, PHPs will delegate care management responsibility to the practice level. This will allow practices to establish a unified care management platform across all of its PHP contracts. Tier 3 AMHs will have the opportunity to conduct care management for all of their patients in-house but may also choose to work with a CIN or other partner to assist with aggregating care management functions.

DO AMHS NEED TO HAVE ALL THE REQUIRED CARE MANAGEMENT CAPABILITIES IN-HOUSE?

No. Practices may contract with a CIN or other partner to provide care management services and other operational support in order to satisfy AMH practice requirements. Only AMH Tier 3s accept responsibility for high need care management and population health for their Medicaid managed care patients. Participating practices are accountable for ensuring that patients are receiving required services, either directly from the practice or through a CIN or other partner. For more information on CINs and other partners, refer to the AMH Program Fact Sheet and Clinically Integrated Networks and Other Partners Support of Advanced Medical Homes Care Management Data Needs.

WILL A CARE MANAGER NEED TO BE PHYSICALLY EMBEDDED IN THE PRACTICE FOR ANY AMOUNT OF TIME?

Tier 3 practices must have a care manager that is assigned to the practice, and care managers should have dedicated face-to-face interactions with their assigned patients when appropriate. They may serve multiple AMH practices, and must be able to serve patients at other points of care including at hospitals, post-acute care facilities, in the patient's homes, etc. The care manager may be employed directly by the AMH practice or be employed by a CIN or other partner organization that supports the Tier 3 practice. See Standard Terms and Conditions of the AMH Provider Manual for more information.

WILL MEMBERS HAVE THE OPTION OF OPTING OUT OF CARE MANAGEMENT?

Members may decline to engage in care management. If a patient declines care management, the practice, CIN, or plan should still assign a care manager and review utilization and other available data in order to inform interactions between the members and his/her clinician during routine visits.

WHAT ARE THE TECHNOLOGY AND DATA-SHARING REQUIREMENTS FOR PARTICIPATION IN THE AMH PROGRAM?

There are no lists of certified technologies that providers must adopt for the AMH program. However, to be certified as an AMH Tier 3, providers must be able to receive claims and encounter data feeds, access Emergency Department (ED) and Hospital Admission, Transfer, and Discharge (ADT) information, and risk stratify their patient panels using Care Needs Screenings and PHP risk scores. These capabilities may be fulfilled by the AMH practice directly or through a CIN or other partner. Although there are no lists of certified technologies, the Department has set requirements for "downstream" AMH data sharing with the PHPs participating in the AMH program with standards for certain critical data flows. Additionally, the Department requires standardized "upstream" data

reporting between AMH practices, PHPs, and the Department.

For Tier 3 practices, PHPs must share member assignment files and pharmacy lock-in data using specific file layouts, established by the Department. See the recent concept paper entitled Data Strategy to Support the Advanced Medical Home Program in North Carolina and the Data Strategy in Support of Care Management paper for more information on this topic.

DOES THE CARE MANAGEMENT DOCUMENTATION SYSTEM NEED TO BE THE SAME AS ELECTRONIC HEALTH RECORD (EHR) SYSTEM?

No. The only requirement is for Tier 3 AMHs to document and store Care Plans in the clinical system of record. The clinical system of record does not necessarily need to be an EHR. While some EHRs may be able to meet the requirements of documenting and storing a Care Plan, practices may choose to use a separate care management documentation system to meet the requirement.

DO ALL AMHS HAVE TO CONNECT TO THE STATEWIDE HIE NETWORK, NC HEALTHCONNEX?

NC HealthConnex links disparate systems and existing HIE networks together to deliver a holistic view of patient records. The HIE network allow PHPs to access patients' comprehensive records across multiple providers, review labs, diagnostics, history, allergies, medications and more. Health care providers or other entities meet the law mandate when its clinical and demographic information are being sent to NC HealthConnex at least twice daily. While there is a mandate for those receiving State funds for care through Medicaid and the State Health Plan to connect to NC HealthConnex, all providers have the option to participate in NC HealthConnex. To learn more about the connection process, please review Frequently Asked Questions about NC HealthConnex Participation.

DO PRACTICES NEED TO RE-STRATIFY A PATIENT AFTER A CERTAIN PERIOD OF TIME?

No. Practices are not required to re-stratify patients over any set period of time, but practices must have a process or defined methodology to determine when it is necessary to re-stratify all of their attributed patients.

CAN PROVIDERS HAVE MEMBERS REMOVED FROM THEIR PANEL UPON REQUEST?

Member reassignment must align with Medicaid policies, prioritizing member choice and specific assignment criteria.

CAN PROVIDERS BE ASSIGNED MEMBERS THEY DO NOT HAVE AN EXISTING CARE RELATIONSHIP WITH?

Yes, all members are expected to have a PCP to ensure access to a primary care medical home, including previously unengaged members.

WHY DO I NEED TO UPDATE MY PANEL LIMITS WITH NC TRACKS AND EACH PLAN?

Providers may accept different numbers of members from each contracted plan, so this information must be updated directly with each plan.

WHAT'S THE DIFFERENCE BETWEEN ASSIGNMENT AND ATTRIBUTION?

- Assignment: The process of member selection or Department-initiated auto-assignment to an AMH for care delivery, with AMHs receiving PMPM payments for members during their assignment period.
- Attribution: The method used to determine which provider is included in quality metrics and performance evaluations. There is no Department-set attribution standard that PHPs must uniformly follow for the purposes of calculating quality metrics and performance.

HOW CLOSELY WILL THE AMH PROGRAM ALIGN WITH THE PATIENT-CENTERED MEDICAL HOME (PCMH) PROGRAM? WILL PCMH RECOGNITION QUALIFY PRACTICES FOR PARTICIPATION IN AMH?

The PCMH is categorized as a care delivery model which coordinates patient treatment through their primary care physician. PCMH creates a centralized setting to facilitate partnership between patients and physicians. The NCQA's PCMH recognition comes in three stages, with Level 1 being the most basic and Level 3 the most advanced. Similar to AMH, PCMH recognitions require organizations to utilize certain protocols intended to foster coordinated, patient-centered care.

PCMH-certified practices that wish to participate in the AMH program will need to follow the process for becoming AMH-certified, as described in the AMH 103 Webinar on Certification, Contracting, and Oversight.

PAYMENT

WHAT IS THE AMH PAYMENT STRUCTURE?

All AMHs will receive Medical Home Fees (see below for amounts by Tier). In exchange for taking on additional care management functions, Tier 3 AMHs will also be eligible for an additional, negotiated Care Management Fee from PHPs. All practices will be eligible to earn negotiated Performance Incentive Payments. These payments are optional for Tier 1 and 2 AMHs. PHPs are required to offer opportunities for such payments to Tier 3 AMHs.

Tier-specific Payments

AMH Tiers 1 and 2

- Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group, and all Tailored Plan members

AMH Tier 3

- Medical Home Fee: $2.50 PMPM – members who are not in the ABD eligibility group and not enrolled in Tailored Plans
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group, and all Tailored Plan members
- Care Management Fee: negotiated amount with PHP
- Performance Incentive Payments: conditions of payment negotiated with PHP

AMH+

- AMH+ practices will receive Medical Home Fees in the same way as other Tier 3 practices and will receive care management payment.

Healthy Opportunities Pilot (HOP) Fee Schedule

- NCDHHS has implemented updates to the pilot fee schedule services rates/caps to reflect the costs of delivering pilot services in 2024. For a full list of services and payment rates, please refer to the Healthy Opportunities Pilots Fee Schedule.

WHAT ARE THE AMH PERFORMANCE INCENTIVE PAYMENTS?

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

WILL THE AMH PROGRAM IMPACT MEDICAL SERVICES PAYMENTS IN MEDICAID?

No. The AMH program will only impact how PMPM payments for primary care case management services are delivered.

ARE THERE OPPORTUNITIES FOR PRACTICES TO RECEIVE COMPENSATION IN EXCESS OF MEDICAL HOME FEES?

Yes. In addition to PMPM Medical Home Fees, Tier 3 AMHs can receive Care Management Fees that are negotiated between the practice and the PHP. Tier 3 practices will also be eligible to earn upside-only Performance Incentive Payments from PHPs.

WHEN WILL PRACTICES BEGIN RECEIVING AMH MEDICAL HOME FEES AND CARE MANAGEMENT FEES?

The PHP shall pay Medical Home Fees for any month in which the Member is assigned to that AMH practice. Care Management Fees are negotiated between the PHP and Tier 3 practices to adequately compensate Tier 3 practices for the additional care management responsibility assumed.

ARE MEDICAL HOME FEES AND CARE MANAGEMENT FEES NEGOTIABLE?

Medical Home Fee amounts are intended to serve as payment floors and PHPs are required to pay no less than published Medical Home Fees. Practices in any AMH Tier are free to negotiate higher Medical Home Fees with PHPs. The State has not set minimum payment amounts for Care Management Fees or Performance Incentive Payments paid to Tier 3 practices by PHPs. However, the requirement that PHPs contract with all Tier 3-certified practices in their service areas will serve as a basis for practices to negotiate fees that are appropriate given the additional practice requirements associated with this Tier. See NC Managed Care Capitation Rates provider bulletin for additional information on the care management component of PHP capitation payments.

IF A PATIENT REFUSES CARE MANAGEMENT, WILL PRACTICES STILL RECEIVE MEDICAL HOME FEES AND/OR CARE MANAGEMENT FEES?

Yes. Medical Home Fees and Care Management Fees both will be made on a PMPM basis regardless of whether patients actually utilize care management services. Practices are free to negotiate separate arrangements with PHPs where they receive reimbursement contingent upon delivery of specific care management services. However, PHPs will not be permitted to pay less than the Medical Home Fee payment floors. For additional information on the Medical Home Fees component, please visit AMH Payment Model in the AMH Provider Manual.

CAN PRACTICES RECEIVE PMPM CARE MANAGEMENT PAYMENTS THROUGH OTHER PROGRAMS AT THE SAME TIME THEY ARE RECEIVING AMH MEDICAL HOME PAYMENTS?

Yes. Participation in AMH does not preclude participation in other care management programs through North Carolina Medicaid, (including care management programs for high-risk pregnant women or at-risk children) or any other payer.

WHAT ARE AMH QUALITY MEASURES?

AMH Tier 3 practices will be eligible for additional Performance Incentive Payments based on their performance on State-approved AMH quality measures (or other measures subject to Departmental approval). For additional information on the AMH quality measures, see page 32 of North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual.

IF A PRACTICE DECIDES TO CONTRACT WITH A CIN/OTHER PARTNER, CAN IT DESIGNATE FUNDS TO FLOW DIRECTLY TO THEM FROM THE PHP (I.E., BYPASSING THE PRACTICE)?

Yes. AMHs may designate CINs or other partners to receive AMH payments, including Medical Home Fees, Care Management Fees, and Performance Incentive Payments, directly from PHPs. DHHS will not establish funds flow parameters between AMHs, CINs/other partners, and PHPs, although AMHs must consent to the CIN/other partner being the recipient of any AMH payments. AMHs may arrange with CINs and other partners that their Care Management Fee funds from PHPs may be paid directly to the CIN and other partners.

IF A PATIENT IS SEEN BY PRACTICE A BUT IS ASSIGNED TO PRACTICE B, WILL PRACTICE A BE PAID FOR THE VISIT?

Yes. Assignment does not impact whether a practice will be paid for the visit. Rather, assignment determines the flow of AMH payments (Medical Home Fees, Care Management Fees, and Performance Incentive Payments).

ATTESTATION AND CERTIFICATION

WHAT TYPES OF PRACTICES ARE ELIGIBLE TO PARTICIPATE IN AMH? HOW DO PRACTICES BECOME AMH CERTIFIED?

In order to be eligible to participate in the AMH program, practices must provide primary care services and be enrolled in the North Carolina Medicaid program. Eligible practices are single- and multi-specialty groups led by allopathic and osteopathic physicians in the following specialties:

- General Practice
- Internal Medicine
- Pediatrics

- Family Medicine
- OB/GYN
- Psychiatry and Neurology

WHEN WILL PRACTICES BE ABLE TO BEGIN THE CERTIFICATION PROCESS? WHEN IS THE CERTIFICATION DEADLINE?

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

CAN ANY PRACTICE PARTICIPATE IN TIER 3?

Yes. All Medicaid-enrolled primary care practices in permitted specialties that attest to meeting Tier 3 practice requirements (described above in A1 above) may participate in Tier 3.

WILL PRACTICES BE REQUIRED TO CONTRACT WITH COMMUNITY CARE OF NORTH CAROLINA (CCNC) IN ORDER TO PARTICIPATE IN THE AMH PROGRAM?

No. CCNC is a primary care, case management entity for Medicaid beneficiaries who are enrolled in NC Medicaid Direct. Community Care Physician Network (CCPN) is a physician led CIN. Contracting with CCPN, CCNC, or any CIN or other partner is not a requirement of participation in the AMH program at any Tier level.

WILL DHHS PRODUCE A LIST OF APPROVED CINS AND OTHER PARTNERS?

No. Practices are responsible for ensuring that CINs/other partners can fulfill AMH requirements for enrolled patients they serve, regardless of whether care management services are delivered directly by the practice or through a CIN or other partner.

CAN LHDS PARTICIPATE IN THE AMH PROGRAM?

Yes. LHDs that provide primary care services and meet the requirements (described above in A1 above) are eligible to participate as AMH's.

WHAT IS THE UNIT OF ENROLLMENT FOR THE AMH PROGRAM?

Practices will enroll in the AMH program at the NPI/location level. For organizational NPIs, each service location must certify and enroll separately. Practices will not have the ability to "batch attest" for multiple service locations under a single NPI.

WILL GROUP NPIS BE REQUIRED TO PARTICIPATE IN THE AMH PROGRAM ACROSS ALL THEIR SERVICE LOCATIONS?

No. Practices will be required to be certified for the AMH program for each NPI/location combination and may choose to participate at only some of these locations. Practices may also have different Tier certifications for different locations within an organizational NPI.

ARE PRACTICES THAT HAVE ALREADY COMPLETED THE AMH ATTESTATION THROUGH NCTRACKS REQUIRED TO NOTIFY DHHS IF THEY:

(1) CHANGE THEIR CIN/OTHER PARTNER;
(2) BEGIN WORKING WITH A NEW CIN/OTHER PARTNER; OR

(3) TERMINATE THEIR RELATIONSHIP WITH A CIN/OTHER PARTNER?

Practices are not required to update their attestation information in NCTracks if existing arrangements with CINs/other partners change, as NCTracks currently lacks this functionality. Practices may choose to supply NCDHHS with this information by emailing Medicaid.AdvancedMedicalHome@dhhs.nc.gov, but this is not a requirement. As a reminder, NCDHHS will not directly oversee CINs/other partners, and practices are ultimately responsible for ensuring that contracted partners are equipped to fulfill all AMH responsibilities.

PHP CONTRACTING

WHO WILL OVERSEE AMHS TO ENSURE THAT THEY ARE MEETING ALL PROGRAM REQUIREMENTS?

PHPs oversee AMH practices and are required to include certain language in contracts that reflects AMH practices requirements. Additionally, PHPs must share with each AMH Tier 3 practice a description of the oversight process they will utilize to monitor practices' performance. PHPs may perform evaluations of the CIN or other partner instead of or in addition to the AMH if the AMH contracts with a third party to provide any of the Tier 3 care management required services. PHPs will have broad discretion in ongoing oversight and monitoring of AMH practices' performance against Tier-specific AMH requirements, as reflected in contracts with AMH practices. For additional information on standard contract terms, please see Appendices A and B of the AMH Provider Manual.

HOW WILL PRACTICES BE ASSIGNED MEMBERS UNDER THE AMH PROGRAM?

The PHP shall ensure that each Member has a choice of AMH. In instances in which a member does not select an AMH at the time of enrollment, the PHP will assign the Member to an AMHs within 24 hours of effectuation date of enrollment in PHP. The PHP's methodology for assigning Members to an AMH shall include the following components, in this order:

- Prior AMH or primary care practice assignment;
- Member claims history;
- Family member's AMH or primary care practice assignment;
- Family member's claims history;
- Geographic proximity;
- Special medical needs; and
- Language/cultural preference

WILL PHPS BE REQUIRED TO ACCEPT THE CERTIFIED TIER STATUS OF EACH AMH?

Yes. PHPs should offer contracts to practices at their NCTracks attested level unless the practice declines to contract with the PHP or chooses to contract at a lower tier. During initial contracting PHPs can contract at the AMHs attested tier level.

ARE PRACTICES LOCKED-IN TO PARTICIPATING AS AN AMH TIER 3 PRACTICE IF THEY ATTEST TO MEETING TIER 3 REQUIREMENTS?

No. Practices are free to decline Tier 3 responsibilities if they are not able to reach mutually agreeable contract terms with the PHP even if the practice has attested to meeting Tier 3 requirements. Before contracting at a Tier 3 level, practices should consider whether agreed upon Care Management Fees are adequate to cover the costs of additional care management responsibilities. For additional information on how practices can voluntarily revert to Tier 2, please see the overview of the AMH Tier Attestation.

CAN AMH PRACTICES BE DOWNGRADED TO A DIFFERENT TIER BY THE PHP?

If an AMH practice is not able to perform the activities associated with its AMH Tier, the PHP may downgrade the practice or move a practice out of the AMH program altogether. PHPs must have a defined process for downgrade actions. To see more information on AMH downgrades, please review the Advanced Medical Home website.

WHAT APPEAL RIGHTS DO AMH PRACTICES HAVE?

AMH practices will have the right to appeal any Tier certification downgrades to the PHP by going through their regular appeals process but will not be able to appeal directly to the State. However, the State will monitor PHPs' downgrade decisions as part of its overall monitoring of PHP activities and may consider PHPs' pattern of downgrading in its ongoing compliance activities and in subsequent contracting decisions.

IF A PRACTICE DETERMINES THE NEGOTIATED CARE MANAGEMENT FEES ARE NOT SUFFICIENT, CAN THE PRACTICE RENEGOTIATE WITH THE PHP?

Yes. Practices can negotiate AMH contracts with PHPs each year and re-determine Care Management Fees and Performance Incentive Payments. Practices have broad flexibility to use CINs/other partners to help negotiate AMH contracts with PHPs.

WHEN WILL DHHS PROVIDE SPECIFICATIONS FOR THE ENCOUNTER DATA THAT PHPS SEND TO AMHS?

PHPs are required to share timely claims and encounter data with Tier 3 practices using specific file layouts, formats and transmission protocols established by the Department. PHPs are required to complete testing with partner AMH Tier 3 practices/CINs/other partners. For more information, please see the Advanced Medical Home Data Specification Guidance webpage which AMH data specification guidance documents.