NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Advanced Medical Home Manual 2.1
April 2021

Section I: Introduction

This Advanced Medical Home Manual 2.0 is a resource for Primary Care Providers (PCPs) as well as Clinically Integrated Networks (CINs) and Other Partners working with practices as they prepare for the go-live date of the Advanced Medical Home (AMH) program. The AMH program will go live with Medicaid Managed Care launch. This document updates and replaces the original Advanced Medical Home Manual published on December 12, 2018. It consolidates existing guidance into one document, including guidance released since the original Manual, but does not establish new policy or guidance.

The North Carolina Department of Health and Human Services ("the Department") developed the AMH model as the primary vehicle for care management as the state transitions to Medicaid Managed Care. High-quality primary care with the capacity to manage population health is foundational to the success of North Carolina's Medicaid Transformation, supporting the delivery of timely care in the appropriate setting to meet each Member's needs. The AMH model supports the Department's transformation vision by maintaining the strengths of North Carolina's legacy care management structure and promoting delivery of care management in the community.

On July 1, 2021, approximately 1.6 million Medicaid enrollees will move into Managed Care.[1] The Department's contract with Standard Plan Health Plans[2] establishes the AMH program as the vehicle for local care management integrated with primary care. The Standard Plan contract establishes the requirements on Health Plans associated with the AMH program and also establishes the mechanisms by which the Department will oversee the program.[3]

1 This manual applies to the AMH program under year 1 of Medicaid Managed Care in Standard Plans. For Care Management under BH/IDD Tailored Plans, please refer to the Department's Behavioral Health I/DD Tailored Plan website.

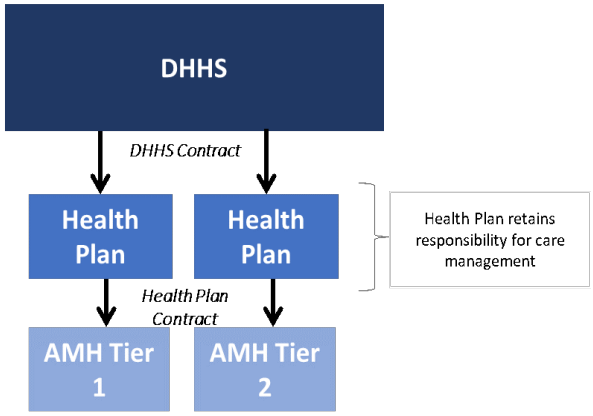
2 The information in this manual applies to practices participating in Medicaid Standard Plans. Practice requirements and other information for practices providing care management to Behavioral Health and Intellectual/Developmental Disability Tailored Plan members can be found in the Tailored Care Management Manual.

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

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

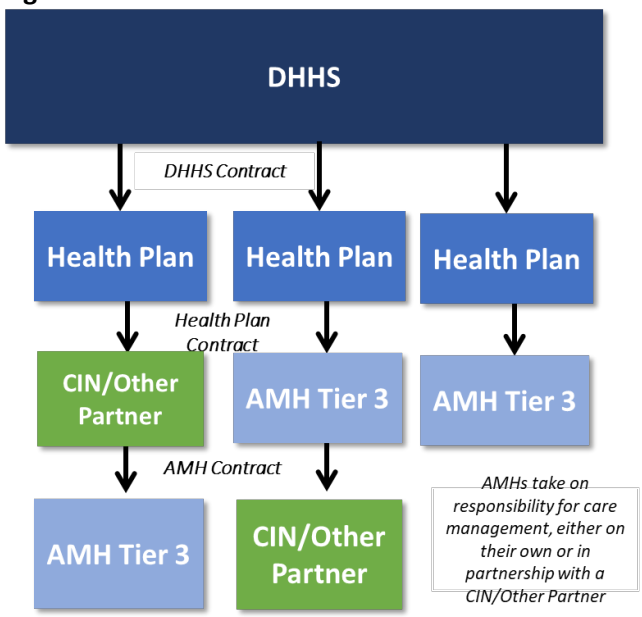
AMH Tier 1 or 2: Practices may choose to participate in the AMH program without practice-based responsibility for care management for high-need patients, or coordination of care across providers and settings for their patients. These practices, if they contract for services with multiple Health Plans, will interface and coordinate with those Health Plans' care management programs. AMH Tier 1 and 2 practices will receive medical home fees equivalent to Carolina ACCESS fees.

Figure 1: AMH Tier 1 or 2



AMH Tier 3: Practices opting into AMH Tier 3 take responsibility for care management and population health for their Medicaid managed care patients, allowing them to have a uniform platform of care management across the different Health Plans with which they contract. Clinically Integrated Networks (CINs) and Other Partners often play a role in organizing the work across Tier 3 practices and helping practices carry out the required responsibilities. Examples of functions typically assumed by the CIN or Other Partner are risk stratification, data aggregation and care management staffing. Health Plans must pay additional per-member-per-month (PMPM) fees to AMH Tier 3 practices, or the CIN/Other Partner on the practices' behalf, to reflect the care management function.

Figure 2: AMH Tier 3



Non-AMH Network PCP: Practices can choose to be in-network with one or more Health Plans but not participate in the AMH program, just as some practices did not participate in Carolina ACCESS prior to Medicaid Transformation. These practices will receive only fee-for-service payments for services without the additional per-member-per-month payments associated with the AMH program.

When Medicaid managed care launch occurs, primary care practices serving managed care Members will need to be contracted with Health Plans as AMH practices in order to receive AMH payments applicable by AMH Tier.

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

The AMH model was designed to spur 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 in specific ways. AMH Tier 3 practices must also report data back to Health Plans in a standardized format. These data flows are described in **Section V.**

The AMH model will evolve over time as practices gain data-driven capabilities and the market gains experience in managed care. The content of the manual applies to the first year of managed care implementation. DHHS reserves the right to update the manual or guidance at any time. Practices should regularly check DHHS' Medicaid bulletins and AMH website for additional guidance, updates and information.

Section II: AMH Practice Requirements

AMH Eligibility

Practices providing primary care as defined by the requirements for participation in the Carolina ACCESS program are eligible for the AMH program. Single and multispecialty groups led by allopathic and osteopathic physicians[4] in the following specialties, including certain subspecialties,[5] are eligible for participation:

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

Federally Qualified Health Centers, Local Health Departments, Public Health Clinics and Rural Health Clinics can also become AMHs.

All providers participating in an AMH practice must be enrolled in the state's Medicaid program. All practices must provide primary care services, although they may provide other services as well. There are no minimum panel size requirements, although practices serving only a small number of Medicaid enrollees may wish to consider how AMH participation can complement their practice transformation efforts with other payers to ensure sustainability. Practices do not need to have gained National Committee for Quality Assurance (NCQA) (or other external accreditor's) patient-centered medical home certification, or equivalent, in order to participate in the AMH program.

4 AMH providers can also include Physician Assistants and Advanced Practice Nursing Providers, such as Advanced Practice Midwives and Nurse Practitioners.

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

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

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

No practices were automatically recorded as AMH Tier 3s; Tier 3 status always requires affirmative attestation. Health Plans have had the complete roster of AMH practices by tier since Health Plan awards were made, and they receive continuous feeds from NCTracks conveying any updates to attestations.

Practices that were not previously enrolled in Carolina ACCESS and wish to become AMH practices should refer to **Section VI** for details on AMH attestation. For information on how to check the tier status that is logged with DHHS, how DHHS will keep track of practices' tier status and how to change tier, if needed, see **Section VII.**

AMH Tier 1 and 2 Practice Requirements

AMH Tier 1 and 2 are designed to provide continuity with the current state prior to managed care launch. In AMH Tier 1 and 2, practices must continue to meet the same requirements that they met for Carolina ACCESS prior to Medicaid Transformation. These requirements are incorporated into the Department's contract with Health Plans, and Health Plans are required to include them in their contracts with AMH Tier 1 and 2 practices. Tier 1 and 2 practices will receive PMPM payments equivalent to what they received prior to managed care launch (see **Section IV** below).

These requirements are as follows:[6]

- Accept Members and be listed as a primary care provider in the Health Plan's Member-facing materials for the purpose of providing care to Members and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each Member, in accordance with Health Plan policies.
- Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of thirty (30) office hours per week.
- Provide preventive services (see **Appendix A**).
- Maintain a unified patient medical record for each Member following the Health Plan's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the Member's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or Health Plan (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge.

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

- Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the Health Plan's network adequacy standards.
- Refer for a second opinion as requested by the Member, based on the Department's guidelines and Health Plan standards.
- Review and use Member utilization and cost reports provided by the Health Plan for the purpose of AMH-level utilization management, and advise the Health Plan of errors, omissions or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by the Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities.

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

The only difference between AMH Tier 1 and 2 is each practice's status prior to managed care launch and whether the practice completed an attestation in NCTracks. AMH Tier 1 is for practices that were grandfathered in from Carolina ACCESS I and is no longer an option for other practices. AMH Tier 2 is for practices that were grandfathered in from Carolina ACCESS II. Practices that were previously in Carolina ACCESS I or were not in the Carolina ACCESS program can choose to enroll in AMH Tier 2 via NCTracks. AMH Tier 1 will be discontinued two years after managed care launch.

AMH Tier 3 Practice Requirements

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

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

Tier 3 practices must meet all of the following requirements.[7] Some or all of these requirements may be met on the practice's behalf by a CIN/Other Partner.

Requirement 1: Risk-stratify all empaneled members.

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

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

Table 1. Standard Terms and Conditions: Risk Stratification

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 populations"[9] for care management.*	Not all care team members need to be able to perform risk stratification, but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
1.5 *Ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice level) and that the methodology is applied consistently.*	
1.6 *Define the process and frequency of risk score review and validation.*	There is no set required frequency, as long as there is a regular process.

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

[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 domains on the Care Needs Screening; at risk children ages 0-5; high risk pregnant women; and other priority populations as determined by the PHP.

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

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

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

Practices Must …	**Additional Information**
2.1 *Use risk stratification methods to identify patients who may benefit from care management.*	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management. Care management designations need not precisely mirror risk stratification levels.
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 (housing, 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 the information with the patient. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the patient's claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. The section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The patient may be referred for formal diagnostic evaluation. The practice or CIN/Other Partners administering the Comprehensive Assessment should develop a protocol for situations when a patient discloses information during the

Practices Must …	Additional Information
	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.
2.4 *For each high-need patient, assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.*	A patient may decline to engage in care management, but the practice or CIN/Other Partner should still assign a care manager and review utilization and other available data in order to inform interactions between the patient and his/her clinician during routine visits.

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

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

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

Practices Must …	Additional Information
3.1 *Develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan. Incorporate*	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management

Practices Must …	**Additional Information**
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.	designations need not precisely mirror risk stratification levels.
3.2 *Include, at a minimum, the following elements in the Care Plan:* • *Measurable patient (or patient and caregiver) goals;* • *Medical needs, including any behavioral health and dental needs;* • *Interventions, including medication management and adherence;* • *Intended outcomes; and* • *Social, educational and other services needed by the patient.*	Practices should take an individualized, person-centered and collaborative approach to Care Plan development and should be able to describe how their Care Plan development approach demonstrates these attributes.
3.3 *Have a process to document and store each Care Plan in the clinical system of record.*	The clinical system of record may be the electronic health record.
3.4 *Periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.*	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate.
3.5 *Have a process to update each Care Plan as Member needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.*	As Member needs change, the AMH should update the care plan 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 emergency departments (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 emergency department or hospital in real time or near real time.*	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s).
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*	Practices (directly or via CIN/Other 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

Practices Must …	Additional Information
discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge): • *Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions – for example, arranging rapid follow-up after an ED visit to avoid an admission.* • *Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital.*	that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough – with regard to the designation of ADT alerts as requiring or not requiring follow-up, the interval within which follow-up should occur, and the documentation that follow-up took place – 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

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 Term Services and Supports (LTSS) admissions or ED visits;* • *Discharges from inpatient behavioral health services, facility-based crisis services, non-*	Practices or their CIN/Other Partner may use whichever methodology and information they see fit to identify patients in need of transitional care management.

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

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

To provide appropriate care management services to empaneled patients and work toward improved care outcomes, Tier 3 practices will need to have timely access to relevant, patient-level data. To meet this requirement, Tier 3 practices (or their CIN/Other Partners) must receive claims data feeds and meet

state-designated security standards for their storage and use.[10] See **Section V** for additional information on the standardized data flows that will support the AMH program.

Future Evolution of AMH Practice Requirements

The Department views the AMH program as the vehicle for promoting data-enabled primary care that is able to 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 after 1-2 years of experience in managed care.

One particularly fast-moving area both nationally and in North Carolina is primary care's increasing role in addressing healthy opportunities, or social needs that impact individuals' health. In the planning for Medicaid Transformation, North Carolina is building capacity for the Medicaid delivery system to better integrate health care with addressing social needs, including preparation for North Carolina's Healthy Opportunities initiative and the deployment of the NCCARE360 platform, a statewide, coordinated care network to electronically connect those with identified needs with community resources. In year 1 of managed care, AMH practices are encouraged (but not formally required) to screen patients for unmet resource needs and use the information from the screening to refer patients to community-based resources to address their unmet needs. The Department is considering adding more explicit healthy opportunities requirements after the first year of managed care experience.

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

Section III: AMH Payment Model

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

Summary of Payment Model by Tier

Table 5. Summary of Payment Model by Tier

AMH Tier	Medical Home Fees[11]	Care Management Fees	Performance Incentive Payments
Tier 1	$1.00 (for all assigned Members)	None	None required, but Health Plans are encouraged to begin offering performance incentive payments based on AMH measures
Tier 2	$2.50 (most Members) or $5.00 (Members in the aged, blind and disabled [ABD] eligibility group)	None	
Tier 3	$2.50 (most Members) or $5.00 (Members in the ABD eligibility group)	Negotiated between practices (or CINs/Other Partners on behalf of practices) and Health Plan	Health Plans must pay performance incentive payments to practices if practices meet performance thresholds on AMH measures

- **Medical Home Fees:** Non-visit-based payments to AMH practices, providing stable funding for care coordination support and quality improvement at the practice level, as defined by the AMH Tier 1 and 2 requirements set out in **Section II** above.[12] All AMH practices will receive medical home fees for all their attributed patients. PMPM amounts for the medical home fees are set by the Department and continue the Carolina ACCESS fees in place prior to managed care launch. Medical practices in AMH Tier 1 will receive $1.00 PMPM; practices in AMH Tiers 2 and 3 will receive $2.50 PMPM for most Members and $5.00 PMPM for Members in the aged, blind and disabled Medicaid eligibility group.[13]

[11] During the COVID-19 Public Health Emergency (PHE), which continues at the time of publication of this manual, Carolina ACCESS fees are temporarily increased. These changes will carry into Managed Care if the PHE is still in effect when Managed Care launches.

[12] Standard Plan contract, p. 26.

[13] During the PHE, which continues at the time of publication of this manual, Carolina ACCESS fees are temporarily increased. These changes will carry into Managed Care if the PHE is still in effect when Managed Care launches.

- **Care Management Fees:** Non-visit-based payments to AMH Tier 3 practices (or CINs/Other Partners on their behalf), providing stable funding for the assumption of primary responsibility for care management and population health activities at the practice level.[14] Care management fees that Health Plans pay to AMHs are set through negotiations between Health Plans and Tier 3 practices (or CINs/Other Partners acting on their behalf). The Department is not imposing a rate floor on these care management fees. However, in 2019 the Department issued guidance on the capitation rate assumptions that explains the Department's assumed costs for delivering care management. This guidance remains in effect for the first year of managed care. Health 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 performance or otherwise put at risk.[15]

- **Performance Incentive Payments:** Payments additional to fee for service, care management fees and medical home fees that are contingent upon practices' reporting of and/or performance against the AMH Performance Metrics.[16] Health Plans are required to offer Performance Incentive Payment opportunities to Tier 3 practices and are encouraged to offer them to practices in Tiers 1 and 2. While performance thresholds and payment rates are set by Health Plans, all performance incentive payments must be based exclusively on the AMH measure set and not on measures outside the set.[17] See **Section IV** for the AMH Measure List. Due to differences in the Health Plan contract year and the quality measurement reporting time period, the performance period for AMH quality measurement will start six months after managed care launch (see **Section IV** below).

AMH Payment Model and Advanced Value-Based Payment Models

The Department recognizes that some practices and CINs/Other Partners may be interested in moving beyond the current AMH Tier 3 model toward more advanced value-based contracts that include increased accountability for total cost of care and/or shift payments to practices to a primary care capitated model (HCP-LAN level 3A or above). The Department strongly encourages these developments, which align with the Department's Value-Based Payment Strategy. Health Plans and practices that wish to enter into payment arrangements beyond Tier 3 in the HCP-LAN taxonomy may elect to do so at any time, with prior approval of the Department.

[14] PHP contract, p. 21.
[15] "Notice of Advanced Medical Home Policy Changes Memo" (11/20/2020), https://medicaid.ncdhhs.gov/blog/2020/11/20/notice-advanced-medical-home-amh-policy-changes-memo.
[16] PHP contract, p. 27.
[17] "Notice of Advanced Medical Home Policy Changes Memo" (11/20/2020), ibid.

Section IV: Quality

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

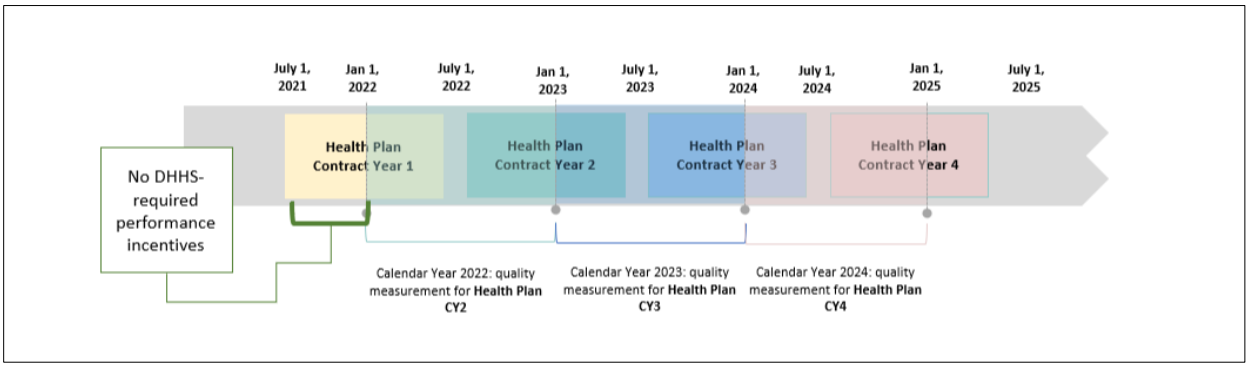
Figure 3. AMH Quality Metrics for Calendar Year 2022

Calendar Year 2022 AMH Measure Set
• Child and Adolescent Well-Care Visit • Childhood Immunization Status (Combination 10) • Immunization for Adolescents (Combination 2) • Screening for Depression and Follow-up Plan • Well-Child Visits in the First 30 Months of Life[18] • Cervical Cancer Screening • Chlamydia Screening in Women • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) • Controlling High Blood Pressure • Plan All-Cause Readmission – Observed to Expected Ratio

All quality measures that each Health Plan incorporates into its contracts with AMH practices (all Tiers) must be taken from this measure set, although Health Plans are not required to use all AMH measures. For the Year 1 AMH measure set, the Department prioritized measures that can be calculated using claims data (i.e., practices will not be required to submit any additional information to Health Plans for the majority of these measures). If Health Plans and AMHs choose to use measures for which hybrid reporting is appropriate (e.g., Comprehensive Diabetes Care: HbA1c Poor Control), the Department encourages Health Plans to use consistent reporting approaches that will minimize burden on AMH practices.

Measurement for all Department-required quality incentive programs, including AMH, will be aligned with calendar years. Therefore, the first quality performance period for AMH will not begin until approximately six months after the launch of managed care. See Figure 4.

Figure 4. AMH Performance Incentive Payment Timeline



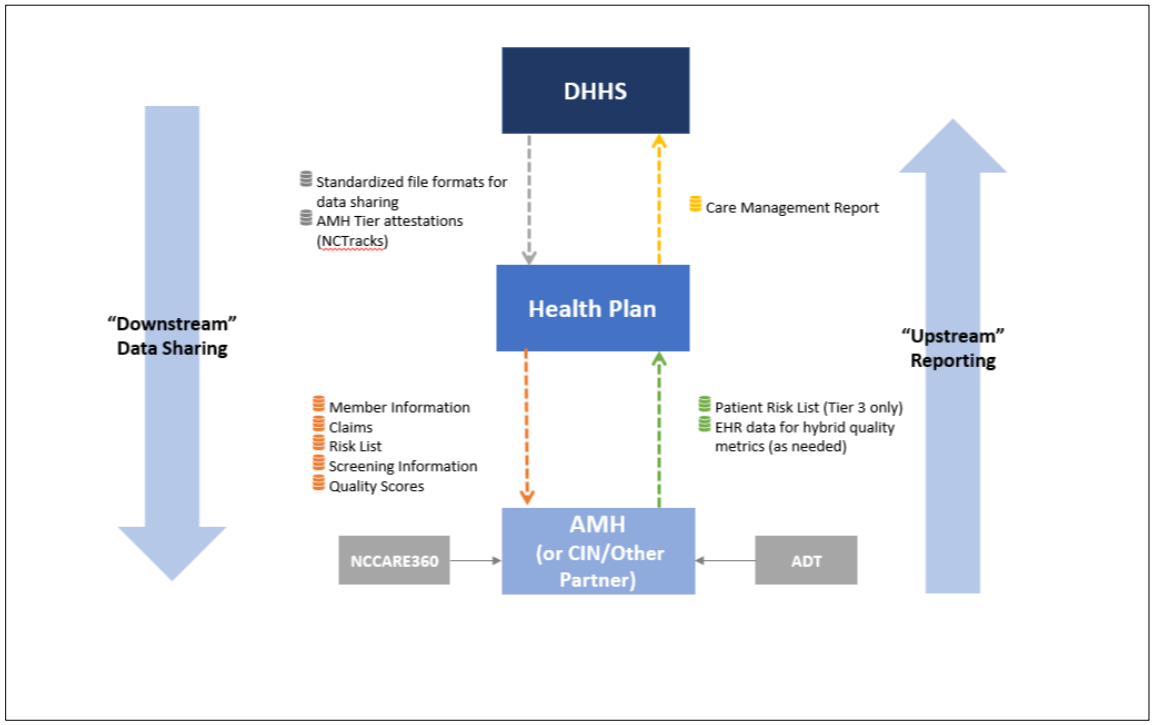
[18] This measure replaces the now retired "Well-Child Visits in the First 15 Months of Life" measure.

After managed care launch, the Department will work with the AMH Technical Advisory Group (TAG) to collect and align reporting approaches and to align to the greatest extent possible the feedback reports that Health Plans will share back with AMH practices to show their performance on the measure set.

Section V: Data Exchange between Health Plans and AMH Practices

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

Figure 5. AMH Program Data Flows



"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).[19] In the ramp-up to managed care launch, the Department has been working intensively 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.

[19] 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 (7) 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 (7) 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 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 to complete testing with partner AMH Tier 3 practices/CINs/Other Partners prior to Managed Care launch.[20]

- **Claims and encounter data (AMH Tier 3 only):** Health Plans must share timely claims and encounter data with Tier 3 practices using a file format as specified on the AMH Data Specification Guidance website. Health Plans are required to complete testing with partner AMH Tier 3 practices/CINs/Other Partners prior to managed care launch.[21]

- **Health Plan risk scoring and risk stratification results (all AMH Tiers):** Health Plans must share results of their risk scoring with all AMH practices, including (where possible and relevant) Member-level information about cost and utilization. For Tier 3 only, the Department is standardizing this process by providing Health Plans with a Patient Risk List Template that Health Plans will use to share risk information with Tier 3 AMH practices (or CINs/Other Partners on their behalf), pre-populated with assigned Members and their respective risk profiles, on a monthly basis. As described below (see "'Upstream' Reporting from AMHs to Health Plans"), this report links to practices' "upstream" reporting to the Health Plan on the care management encounters that actually took place for the Members, via the Patient Risk List.

- **Initial Care Needs Screening results (all AMH Tiers and non-AMH PCPs):** Health Plans are required to conduct an "Initial Care Needs Screening" to assess Member health and unmet resource need within 90 days of Members' enrollment. Health Plans are required to share the results of the Initial Care Needs Screening with PCPs within seven (7) days of screening or within seven days of assignment to a new PCP, whichever is earlier.

[20] The full specifications and protocol are available on the DHHS website; see "Requirements for Sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support AMHs, CMARC and CMHRP."
[21] For more information on claims and encounter data sharing, see "Requirements for Sharing Encounters and Historical Claim Data to Support AMHs, CMARC and CMHRP" on the AMH Data Specification Guidance website.

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

"Upstream" Reporting from AMHs 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. The vehicle for this report is called the Care Management Report. The Care Management Report includes member-level care management encounter reporting that spans care management provided by the Health Plan itself, Local Health Departments and AMHs. From the Department's perspective, the purpose of the Care Management Report is to monitor the total level and types of activity in the market to inform future policy and rate development.

  To ensure that Health Plans have complete information for the Care Management Report, the Department has standardized how Tier 3 AMHs are required to report care management encounter information to each Health Plan for inclusion in the Care Management Report. After hearing requests from AMH Tier 3s that care management reporting be streamlined across Health Plans to the greatest extent possible, the Department developed a standardized tool called the **Patient Risk List** for risk reporting, which is available on the AMH Data Specification Guidance website. This template is both the vehicle for AMH Tier 3 practices (or their CINs/Other Partners) to receive member-level risk information and to transmit care management encounter data to the Health Plan. AMH Tier 1 and 2 practices are not required to complete the Patient Risk List Template.

  The Patient Risk List Template includes, for each assigned patient:

  - The AMH risk score;
  - 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).

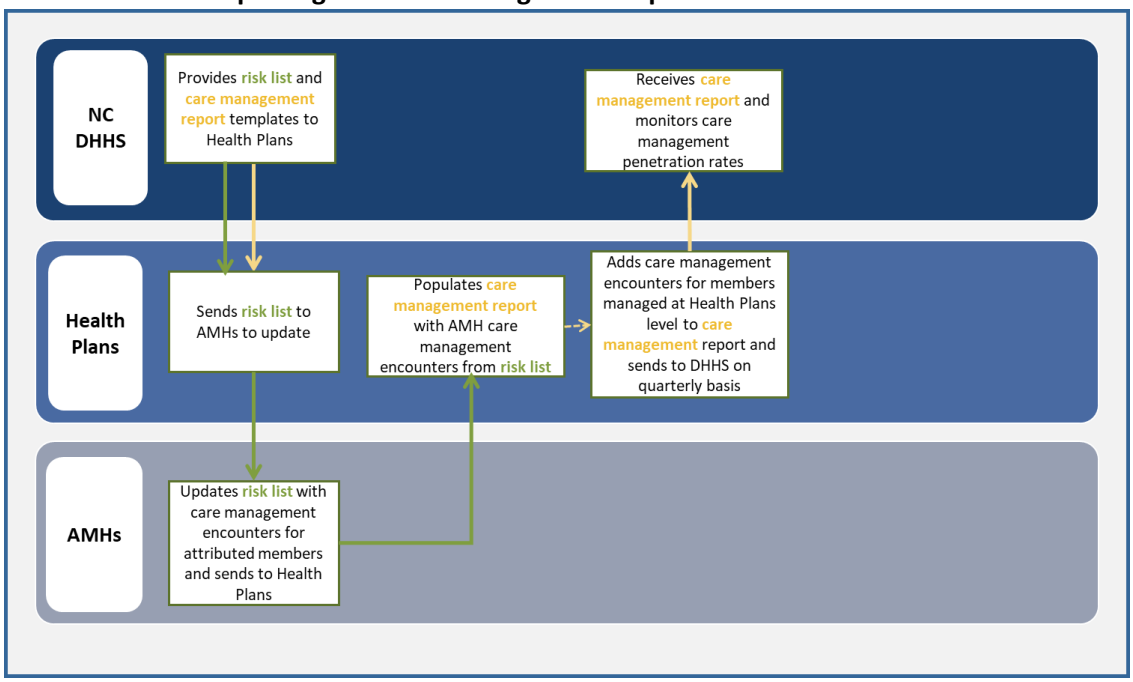
  For the purposes of the Patient Risk List, Tier 3 AMHs (or their CINs/Other Partners) should report all levels of care management, ranging from high intensity (e.g., Care Plan development and frequent face-to-face encounters) to low intensity (e.g., infrequent, telephonic contact). For the purposes of 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's health-related needs.
- Phone call or active email/text exchange between member of care team and Member (must include active participation by both parties; unreturned emails/text messages do NOT count).
- Phone call or active email/text exchange between member of care team and Member discussing Care Plan or other health-related needs.

The following should **not** be reported as care management encounters in the risk reporting template:

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

Figure 6. Patient Risk Reporting and Care Management Report Flow



- ***"Upstream" quality reporting* (all AMH Tiers):** Separately from the Patient Risk List, Health Plans may require AMH practices to share electronic health record (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. DHHS does not require AMH Tier 3 practices to share Comprehensive Assessments or Care Plans back with Health Plans.

ADT Data Flows and NCCARE360

In addition to receiving data from Health Plans, Tier 3 AMH practices are required to access admission, discharge and transfer (ADT) data; while Tier 1 and 2 practices are not required to access ADT data, they are strongly encouraged to do so. AMHs will also need timely access to certain clinical information for care oversight and management, including information about members' test results, lab values and immunizations. Practices have several options for how and where to access clinical data, such as clinical data from affiliated health systems' EHR software, or NC HealthConnex. Practices may also work through their CINs/Other Partners to obtain this data.

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

Section VI: AMH Attestation and Certification

To participate in the AMH program, practices must be certified as AMHs by the Department. AMH certification is a noncompetitive process whereby practices that complete a series of steps and attest to AMH Tier-specific practice requirements are certified by the Department as eligible for participating in the corresponding Tier. After the Department certifies an AMH practice and notifies it of its Tier status, the practice can then contract with Health Plans in its region at the Tier for which the practice is certified. The Tier for which a practice receives Departmental certification represents the highest Tier level at which that practice is able to contract with a Health Plan. Practices may choose to contract at different Tiers with each Health Plan, though they may not exceed their highest Tier certification with any Health Plan. Certification does not obligate practices to participate in the AMH program, and a certified AMH may choose not to contract as an AMH practice.

Practices' path to entry into the AMH program will depend on their level of participation in the Carolina ACCESS (CA) program. CAI and CAII providers will be grandfathered into AMH Tiers 1 and 2, respectively. CAI providers that wish to join a higher Tier may attest into Tier 2 or 3 in NCTracks. CAII providers that wish to join AMH Tier 3 may likewise attest into Tier 3 in NCTracks. Only current CAI practices will be permitted to join AMH Tier 1; therefore, practices grandfathered into AMH Tier 2 will not be permitted to lower their status to AMH Tier 1.

Practices that are not currently participating in Carolina ACCESS at any level, including newly formed practices and practices that are new to North Carolina, must join Carolina ACCESS in order to participate in the AMH program. Carolina ACCESS participation can be added to a provider record during initial enrollment or via a Manage Change Request (MCR). Once the Department determines the practice meets Carolina ACCESS requirements and approves provider record updates, the provider will

automatically be assigned an AMH Tier 2 status. Practices will then have the opportunity to enter AMH Tier 3 by attesting to AMH Tier 3 practice requirements in NCTracks. As previously noted, only current CAI providers will be allowed to join AMH Tier 1. Therefore, new Carolina ACCESS practices joining AMH Tier 2 will not be permitted to lower their status to AMH Tier 1.

For more information on AMH Tier attestation and joining Carolina ACCESS 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. If a practice certified as an AMH Tier 3 determines that it needs additional time to meet Tier 3 requirements, it may change its Tier status without penalty. To change status, the Tier 3 practice should enter its NP/Atypical ID and Service Location in NCTracks and select "Downgrade to AMH Tier Level 2." Similarly, if a practice certified for a lower AMH determines it is ready to meet Tier 3 requirements, it may attest into Tier 3 on NCTracks to request Departmental certification as a Tier 3 practice. There is no limit to how often a practice can upgrade or downgrade its AMH Tier. However, because Tier changes will be effective on the first day of the following month, subsequent changes must occur after the practice's most recent Tier change goes into effect. See Protocol for Changing Advanced Medical Home Tier Status for additional information.

Section VII: Contracting and Oversight

AMH Contracting

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

For AMH Tier 3, Health Plans will be 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-certified practices as part of the initial contracting process and prior to managed care launch. 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. Health Plans may not condition year 1 AMH Tier 3 contracts on audits/monitoring activities that go beyond what is necessary for practices to meet Tier 3 requirements, including requirements imposed as part of NCQA pre-delegation auditing. AMHs and Health Plans may, however, by mutual agreement prepare for NCQA pre-delegation or otherwise build care management capacity during year 1.

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

- Be mutually agreed upon;
- Assign responsibilities (details of activities performed vs. retained) and specify responsibilities;

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

Health Plans must share with each AMH Tier 3 practice a description of the oversight process it will use to monitor practices' performance against specific AMH requirements, including the processes it 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 days.

AMH Oversight and "Downgrades"

After launch, if an AMH practice is not able to perform the activities associated with its AMH tier, the Health Plan may "downgrade" the practice, or move a practice out of the AMH program altogether. For AMH Tier 3, the Department will permit Health Plans to stop paying the AMH Tier 3 payment components and lower the Tier status of the AMH practice if the practice is unable to perform Tier 3 functions.[22] Health Plans must have a defined process for "downgrade" actions that includes at least thirty (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 sixty (60) days.[23]

AMH practices have the right to appeal any such downgrades to the Health Plan by going through the Health Plan's regular appeals process.[24] 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.

Section VIII: Practice Supports and Other Resources

NC Medicaid, in partnership with NC Area Health Education Centers (AHEC), is providing education, engagement, outreach and practice-level technical assistance aligned with the AMH program. As of January 2021, AHEC coaches have been working with individual practices to accelerate the adoption of Tier 3 standards and facilitate transition to AMH Tier 3, starting with use of a standardized assessment tool. Coaching will be available to primary care practices that are in network with at least one Standard Plan. For more information on AHEC practice supports, visit https://www.ncahec.net/practice-support/advanced-medical-home/.

The Department also publishes AMH policy papers, programmatic guidance and FAQs for AMH providers on its AMH webpage. AMHs should contact the Health Plans with which they have contracted for

[22] Standard Plan Scope of Services, Section V.C.6.b.iv.d.4.
[23] See "Advanced Medical Home Policy Changes," Nov. 16, 2020.
[24] Standard Plan Contract, Section VII. Attachment I.

information on any support services the Health Plans make available to their AMH contractors and how to access those services.

The Department has convened a Technical Advisory Group (TAG) to inform the development and evolution of the AMH program. The role of the AMH TAG is to advise and inform the Department on key aspects of AMH design and to provide feedback on proposed program changes. While TAG membership is by Departmental invitation only, all TAG meetings are open to the public, and AMH providers are encouraged to join meetings and share feedback during the public comment portion of each session. For more information on the AMH TAG, please see the AMH TAG page on the Department's Medicaid Transformation site.

Appendices

Appendix A. Standard Terms and Conditions for AMH Tier 1 and 2 Contracts

Health Plan will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices' agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all Health Plan/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated:

- Accept enrollees and be listed as a PCP in the Health Plan's enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each enrollee.
- Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services. (See Preventive Health Requirements table below.)
- Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees.
- Maintain a unified patient medical record for each enrollee following the Health Plan's medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.
- Transfer the enrollee's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Health Plan (if applicable) and as authorized by the enrollee within 30 days of the date of the request.
- Authorize care for the enrollee or provide care for the enrollee based on the standards of appointment availability as defined by the Health Plan's network adequacy standards.
- Refer for a second opinion as requested by the patient, based on Department guidelines and Health Plan standards.
- Review and use enrollee utilization and cost reports provided by the Health Plan for the 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.

Preventive Health Requirements:

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

	Health Assessment													
2	Blood Lead Level Screening		Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)							Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)		Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Vaccine Hib		Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing			Y	Y	Y	Y	Y	Y	Y	Y	Y		
8 and 9	Hemoglobin or Hematocrit		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine		Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)		Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)		Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental		Y	Y	Y	Y	Y	Y	Y					
16	Tetanus				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis									Y		Y	Y	Y
19	Varicella Vaccine		Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

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

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

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

responsibilities encompass care management and who work closely with 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 RN or 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 needed treatment is not delayed by the development of the Care Plan.

ii. The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.

iii. The Tier 3 AMH practice must incorporate findings from the Health Plan Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

iv. The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:

1. Measurable patient (or patient and caregiver) goals;
2. Medical needs, including any behavioral health needs;
3. Interventions;
4. Intended outcomes; and
5. Social, educational and other services needed by the patient.

v. The Tier 3 AMH practice must have a process to update each Care Plan as beneficiary needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.

vi. The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

vii. The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management 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 emergency departments (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 emergency department or hospital in real time or near real time.

ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations 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 emergency department (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 crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
      3. NICU discharges;
      4. Clinical complexity, severity of condition, medications, risk score.
   ii. For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum 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. Following-up by the assigned care manager rapidly following discharge;
      6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs
      7. Developing a protocol for determining the appropriate timing and format of such outreach.

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

Appendix C. AMH Tier 3 Attestation Questions

Section A: Requirements (contact information)		
#	Requirement	Rationale/Description
N/A	Organization Name	The organization's legal name should be entered exactly as it appears in NCTracks, to facilitate matching.
N/A	Name and Title of Office Administrator Completing the Form	The form should be completed by the individual who has the electronic PIN required to submit data to NCTracks on behalf of the practice.
N/A	Contact Information of Office Administrator Completing the Form (email and phone number)	
N/A	Organization National Provider Identifier (NPI) or Individual NPI, for practitioners who do not bill through an organizational NPI	
N/A	Phone Number	This should be the general number and address used to reach the practice, as opposed to the specific contact information requested for the office administrator (above).
N/A	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 about CIN/partner participation.)		
#	Requirement	Rationale
Tier 3 AMH practices must be able to risk-stratify all empaneled patients. To meet this requirement, the practice must attest to doing the following:		
1	Can your practice ensure that assignment lists transmitted to the practice by each Health Plan are reconciled with the practice's panel list and are up to date in the clinical system of record?	There is no set minimum interval at which practices should perform this review, but practices should develop a process to ensure that it is done when clinically appropriate. The clinical system of record is an electronic health record or equivalent.
2	Does your practice use a consistent method to assign and adjust risk status for each assigned patient?	Practices are not required to purchase a risk stratification tool; risk stratification by a CIN/partner or system would meet this requirement, or application of
3	Can your practice use a consistent method to combine risk scoring information received from the Health Plan with	

	clinical information to score and stratify the patient panel? (See supplemental question 5 to provide more information.)	clinical judgment to risk scores received from the Health Plan or another source will suffice.
4	To the greatest extent possible, can your practice ensure that the method is consistent with the Department's program policy of identifying "priority populations" for care management?	Not all care team members need to be able to perform risk stratification (for example, risk stratification will most likely be done at the CIN/partner level, or may be performed exclusively by physicians if done independently at the practice level), but all team members should follow stratification-based protocols (as appropriate) once a risk level has been assigned.
5	Can your practice ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice level) and that the methodology is applied consistently?	
6	Can your practice define the process and frequency of risk score review and validation?	Practices should be prepared to describe these elements for the Health Plan.
Tier 3 AMHs must provide care management to high-need patients. To meet this requirement, the practice must attest to being able to do all of the following:		
7	Using the practice's risk stratification method, can your practice identify patients who may benefit from care management?	Practices should use their risk stratification method to inform decisions about which patients would benefit from care management, but care management designations need not precisely mirror risk stratification levels.
8	Can your practice perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs? The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum (see supplemental question 5 to provide further information): • Patient's immediate care needs and current services; • Other state or local services currently used; • Physical health conditions; • Current and past behavioral and mental health and substance use status and/or disorders; • Physical, intellectual developmental disabilities;	In preparation for the assessment, care team members may consolidate information from a variety of sources and must review the Initial Care Needs Screening performed by the Health Plan (if available). The clinician performing the assessment should confirm the information with the enrollee. After its completion, the Comprehensive Assessment should be reviewed by the care team members. The assessment should go beyond a review of diagnoses listed in the enrollee's

	• Medications; • Priority domains of social determinants of health (housing, food, transportation and interpersonal safety); and • Available informal, caregiver or social supports, including peer supports.	claims history and include a discussion of current symptoms and needs, including those that may not have been documented previously. This section of the assessment reviewing behavioral and mental health may include brief screening tools such as the PHQ-2 or GAD-7 scale, but these are not required. The enrollee may be referred for formal diagnostic evaluation. The practice or CIN/partners administering the Comprehensive Assessment should develop a protocol for situations when an enrollee discloses information during the Assessment indicating an immediate risk to self or others. The review of medications should include a medication reconciliation on the first Comprehensive Assessment, as well as on subsequent Assessments if the enrollee has not had a recent medication reconciliation related to a care transition or for another reason. The medication reconciliation should be performed by an individual with appropriate clinical training.
9	Does your practice have North Carolina licensed, trained staff organized at the practice level (or at the CIN/partner level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients?	Care managers must be assigned to the practice but need not be physically embedded at the practice location.
10	For each high-need patient, can your practice assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager

	credential of RN or LCSW? (See supplemental question 6 to provide further information.)	and review utilization and other available data in order to inform interactions between the enrollee and their clinician during routine visits.
For each high-need patient receiving care management, Tier 3 AMHs must use a documented Care Plan.		
11	Can your practice develop the Care Plan within 30 days of Comprehensive Assessment or sooner if feasible while ensuring that needed treatment is not delayed by the development of the Care Plan?	30 days is the maximum interval for developing a Care Plan. If there are clinical benefits to developing a Care Plan more quickly, practices should do so whenever feasible
12	Can your practice develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible?	Practice may identify their own definitions of 'individualized', 'person-centered' and 'collaborative', but should be able to describe how their care planning process demonstrates these attributes
13	Can your practice incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan? Can your practice include, at a minimum, the following elements in the Care Plan o Measurable patient (or patient and caregiver) goals o Medical needs including any behavioral health needs; o Interventions; o Intended outcomes; and o Social, educational, and other services needed by the patient.	Intended outcomes can be understood as clinical steps identified by the care team that will lead to the enrollee/caregiver-defined goal. For example, the enrollee may set a goal of no longer needing frequent fingersticks and injected insulin. The care team may develop an intended clinical outcome that represents the level of glycemic control at which the enrollee could attempt a trial of oral hypoglycemics, and a second intended clinical outcome that represents the level of control on oral hypoglycemics that would allow the enrollee to continue with the regimen
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	There is no set minimum interval at which practices should perform this review but practices should develop a process to

	reassessment? (See supplemental question 7 to provide more information.)	ensure that it is done when clinically appropriate
15	Does your practice have a process to document and store each Care Plan in the clinical system of record?	The clinical system of record may include an electronic health record.
16	Can your practice periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary?	There is no set minimum interval at which practices should perform this review but practices should develop a process to ensure that it is done when clinically appropriate
17	Can your practice track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time?	While not required, practices are also encouraged to develop systems to ingest ADT information into their electronic health records or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s)
18	Can your practice or CIN/partners implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below)? • Real-time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions – for example, arranging rapid follow-up after an ED visit to avoid an admission • Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital • Within a several-day period to address outpatient needs or prevent future problems for high-risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge)	Practices (directly or via CIN/partners) are not required to respond to all ADT alerts in these categories, but they are required to have a process in place to determine which notifications merit a response and to ensure that the response occurs. For example, such a process could designate certain ED visits as meriting follow-up based on the concerning nature of the patient's complaint (suggesting the patient may require further medical intervention) or the timing of the ED visit during regular clinic hours (suggesting that the practice should reach out to the patient to understand why he or she was not seen at the primary care site). The process should be specific enough – with regard to the designation of ADT alerts as requiring or not

		requiring follow-up, the interval within which follow-up should occur, and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.
Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are at risk of readmission and other poor outcomes.		
19	Does your practice have a methodology or system for identifying 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; SNF and LTSS admissions or ED visits • Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, or a medically supervised or alcohol/drug abuse treatment center • NICU discharges • Clinical complexity, severity of condition, medications and risk score	
20	For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, can your practice assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credential of RN or LCSW? (Please see supplemental question 8 to provide further information.)	An enrollee may decline to engage in care management, but the practice or CIN/partners should still assign a care manager and review utilization and other available data in order to inform interactions between the enrollee and the clinician during the transition period.
21	Does your practice include the following elements in transitional care management? • Ensuring that a care manager is assigned to manage the transition • Facilitating clinical handoffs • Obtaining a copy of the discharge plan/summary • Conducting medication reconciliation • Following up by the assigned care manager rapidly following discharge	The AMH practice is not required to ensure that follow-up visits occur within a specific time window because enrollees' needs may vary. However, the practice must have a process for determining a clinically appropriate follow-up interval for each enrollee that is specific enough – with regard to the

	• 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	interval within which follow-up should occur and the documentation that follow-up took place – to enable an external observer to easily determine whether the process is being followed.
Tier 3 AMH practices must use electronic data to promote care management.		
22	Can your practice receive claims data feeds (directly or via a CIN/partner) and meet Department-designated security standards for their storage and use?	

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

Supplemental Questions		
Please indicate whether your practice, or contracted CIN, can perform the following functions. (See supplemental questions 1-3 to provide more information about CIN participation.)		
S1	Will your practice work with a CIN or Other Partners?	This element must be completed, but responses will not affect certification.
S2	If yes, please list the names and regions of the CIN(s) or Other Partners you are working with.	This element must be completed, but responses will not affect certification. This list should include the full legal name of each CIN.
S3	Who will provide care management services for your AMH? (e.g., CIN or other CM vendor) ☐ Employed practice staff ☐ Staff of the CIN ☐ Staff of a care management or population health vendor that is not part of a CIN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.
S4	If you are working with more than one CIN/partner, please describe how CINs/partners will share accountability for your assigned population.	This element must be completed, but responses will not affect certification. When practices elect to work with multiple CINs/partners, they can divide their population among CINs/partners based on regional or other categorizations, but they

		should ensure that they can readily identify which CINs/partners have primary accountability for which patients.
S5	Practices/CINs/partners will have the option to assess adverse childhood experiences (ACEs). Can your practice/CIN/partner assess adults for ACEs?	This element must be completed, but responses will not affect certification.
S6	What are the credentials of the staff who will participate in the complex care management team within practice/CIN/partner? (Please indicate all that apply.) ☐ MD ☐ RN ☐ LCSW ☐ Medical Assistant/LPN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.
S7	For patients who need LTSS, can your practice coordinate with the Health Plan to develop the Care Plan?	This element must be completed, but responses will not affect certification. Practices and CINs/partners are not required to have the same capabilities as the Health Plan for screening and management of LTSS populations.
S8	What are the credentials of the staff who will participate in the transitional care management team within the practice/CIN/partner? (Please indicate all that apply.) ☐ MD ☐ RN ☐ LCSW ☐ Medical Assistant/LPN ☐ Other (Please specify:_____)	This element must be completed, but responses will not affect certification.