North Carolina Advanced Medical Home (AMH) Program
Frequently Asked Questions
12.19.2020

Please refer to the glossary at the end of this document for a list of terms, definitions, and acronyms described in these FAQs. Category List Key- PHP Contracting (C), General (G), Payment (P), and Practice Requirements (R)

No.	Category	Question	Answer
R1	Practice Requirements (R)	If we previously enrolled as a Tier 2, do we have to re-enroll?	No, you do not. Your Tier attestation for 2019 remains current until you update or change it.
G1	General (G)	If possible, I would love information on how community health workers will be reimbursed through this transformation?	Community Health Workers are able to be a part of the care management team. The Care Management payment rate pays for all analytics and care team services for the member-- including any CHWs on the team.
G2	General (G)	Last webinar, Feb was said to be the cutoff date for PHP contracts to be completed so that providers can be included in the Provider Directory. The previous slide tonight said "April." Which is correct?	The cut-off to be in the Provider Directory is February, while the cut-off for PHP auto enrollment is April.

No.	Category	Question	Answer

G3	General (G)	What constitutes successful testing?	Successful testing is when Practices must attest to meeting data exchange readiness milestones as part of their Tier 3 glidepath attestation. The AMH Tier 3 practice or its contracted Clinically Integrated Network (CIN)/other partner must have:
			
			    o Completed necessary technology work required to ingest all required/mandatory AMH data interfaces per the published state technical specifications.
			
			    o Completed at least one full round of testing with at least two (2) of its contracted health plans for all required AMH interfaces. One full round of testing includes demonstration of the ability to systematically ingest test AMH files for all required/mandatory interfaces and submission of test results to health plans.
			
			    o Completed defect resolution from the full round of testing and be on target to complete additional testing as needed to operationalize required/mandatory AMH interfaces aligned with the Medicaid production schedule.
			
			Please see the link below for additional details on the glidepath payment:
			https://medicaid.ncdhhs.gov/blog/2021/02/01/advanced-medical-home-tier-3-%E2%80%9Cglidepath%E2%80%9D-payments

G4	PHP Contracting (C)	Define "data exchange"- email spreadsheet? HL7? 835s?	Please see the link below for current AMH data requirements and file formats. https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance
G5	General (G)	If practice using a "CIN" will each need to attest or can the "CIN" attest on their behalf?	While AMH Tier 3 practices will be responsible for attesting to completion of data exchange requirements, CINs/other partners may complete these data exchange testing requirements on behalf of contracted practices if the AMH and CIN have an active association and if that CIN will be performing data exchange on behalf of the AMH practice after managed care launch.
P1	Payment (P)	Does the Glide Path payment come directly from DHB or does it go through the PHPs?	Glidepath payments are paid directly from DHB to providers.

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G6	General (G)	How do we access the fireside chat?	The fireside chat can be accessed at https://www.ncahec.net/medicaid-managed-care/
A1	Attestation & Certification	Will the AMH Tier 3 attestation questions change again? If so, will you be releasing the current questions on the website?	No--the attestation question for Tier 3 have not changed. We will have a NEW attestation for the glide path payment. That will be an attestation that you have met glide path requirements.
P2	Payments (P)	Is the glide path payments based on the # of members assigned to those practices during April/May/June or by the expected member population at go live?	Glide path based on the # of CURRENT members.
R2	Practice Requirements (R)	Do PCP's have to be NCQA year 3 for Tier 3?	No, the PHPs are required to be NCQA accredited by year 3

G7	General (G)	Are there any plans in Medicaid Managed Care for practices to have PCMH accreditation?	There are no current plans for PCMH accreditation.
G8	General (G)	What is CIN?	Clinically Integrated Network – Please see the glossary for a full definition of a CIN.
R3	Practice Requirements (R)	Where can we access the AMH Tier 3 standards?	Here is the link for the AMH Provider Manual that includes the Tier 3 standards. It will be updated with new policy guidance in January 2021. [Advanced Medical Home (AMH) Provider Manual 2.0](#)
G9	General (G)	Is the coaching just for practices not aligned with a CIN?	Coaching is prioritized for practices not in a CIN but if a practice is in a CIN and would like assistance, AHEC is able to help in collaboration with the CIN.

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G10	General (G)	How do I figure out who the CIN in my area is?	An AHEC practice support coach can help you. If you will email AHEC at practicesupport@ncahec.net. A practice support coach follow up with you.
G11	General (G)	Can the AHEC assistance help with those technical components of AMH III?	Yes, it can.
R4	Practice Requirements (R)	For Tier 3's, if not requiring Case Plans, etc. how are the PHP NCQA CM Accreditation requirements met?	NCQA HPA is required by Contract year 3. The PHP can specify in a delegation arrangement the activities performed by the delegate or retained by the organization. If the Tier 3 isn't performing all functions of an AMH Tier 3, the PHP can reevaluate their Tier 3 status until they can meet the requirements.
R5	Practice Requirements (R)	May we vary our AMH tier level by individual PHP? In other words, we may want to be a tier 2 with PHP A vs. tier 3 with PHP B?	The Department encourages practices to contract with PHPs at the Tier Level that they attested to within NC Tracks. However, the Department recognizes that some practices might choose to contract with certain PHPs at different levels.

No.	Category	Question	Answer
R6	Practice Requirements (R)	We are par with all PHP's in our region, contracted with a CIN/ACO, starting to test claims with PHP's. We are a tier 2 as we are OBGYN. Is there anything else we need to do now? We are a private practice, how would the reporting happen?	Tier 2s do not have any additional reporting requirements. Refer to website for additional information and connect with CIN for more information. If they are an AMH Tier 2 they don't need to do any special reporting to us. Only Tier 3s require data sharing from PHPs and only Tier 3s are eligible for GlidePath payments. The data and glidepath payments are for care management which only Tier 3s (not 1s or 2s) provide.
R7	Practice Requirements (R)	If we have already contracted with the PHP in 2019, do we need to get a new contract with new standards and changes?	No, it is not necessary to get a new contract unless any of the new requirements are absent from initial contract
G12	General (G)	Should we check in with our coach to make sure we are still up to date?	Absolutely. You can reach your coach directly or contact AHEC at practicesupport@ncahec.net.
G13	General (G)	Centene bought out WellCare effective Jan 1- does contracting with Centene and WellCare count as 2 PHPs or 1 ?	The 5 PHPs for contracting are WellCare, AmeriHealth Caritas, Healthy Blue, United Healthcare, and Carolina Complete Health.

R8	Practice Requirements (R)	Do payments go directly to the AMH tier 2 practice if working with a CIN or do they go to the CIN?	Payment goes to the AMH practice.
R11	Payment (P)	If we are contracted for lives but we aren't seeing patients yet, can we still get the glidepath dollars for hiring and startup costs?	Requirements for glidepath attesting as a AMH Tier 3, contracting at Tier 3 level with at least two health plans and completing data exchange and testing with at least two health plans. Please refer to https://medicaid.ncdhhs.gov/blog/2021/02/01/advanced-medical-home-tier-3-%E2%80%9Cglidepath%E2%80%9D-payments and https://medicaid.ncdhhs.gov/transformation/advanced-medical-home
P3	Payment (P)	Can the new 2021 CM fees be negotiated at a new rate due to low rates last contract	CM fees can always be negotiated at any time.
G14	General (G)	Where do we find information on the data exchange testing requirement for the glide path payments	PHPs should be working with all Tier 3s to inform them of the testing process that is required for glide path payments. The Department has published a guidance document that can also be used. https://medicaid.ncdhhs.gov/blog/2021/02/01/advanced-medical-home-tier-3-%E2%80%9Cglidepath%E2%80%9D-payments

AMH Glossary

- **1115 Demonstration Waiver:** Provides states with additional flexibility to design and improve their Medicaid programs by demonstrating and evaluating state-specific policy approaches to better serve Medicaid populations. North Carolina's amended 1115 demonstration waiver application focuses on the specific items of the Medicaid Managed Care transformation that require approval from the federal government.
- **Admission, discharge, transfer (ADT) feed:** Data feed notifying practices when members have been admitted, transferred or discharged from a hospital or ED. Tier 3 AMHs must attest that, at a minimum, they have active access to an ADT data source that correctly identifies specific empaneled Medicaid managed care members' admissions, discharges or transfers to/from an ED or hospital in real time or near real time. At the outset of the AMH program, Tier 1 and Tier 2 AMHs are also strongly encouraged (but not required) to make use of ADT feeds.
- **Advanced Medical Home (AMH) program:** The primary vehicle for delivering care management as North Carolina transitions to managed care. The AMH program requires PHPs to coordinate care management functions with enrolled practices, which may in some cases be performed directly by the practice or through an affiliated CIN or other partner.
- **Aged, Blind, Disabled (ABD):** Medicaid eligibility group for individuals who are categorically eligible for Medicaid on the basis of being aged, blind, or disabled.
- **Care Coordination for Children (CC4C):** Care management program provided by LHDs for at-risk children ages zero to five. The program provides coordination between healthcare providers, linkages and referrals to other community programs and supports, and family supports.
- **Care management:** Team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions. PHPs will maintain ultimate accountability for care management but will have the ability to delegate responsibility for these functions to the practice level through the AMH program. Key functions of care management include: risk stratifying all empaneled patients; providing care management to high-need patients; developing a Care Plan for all patients receiving care management; providing short-term, transitional care management along with medication management to all empaneled patients who have an ED visit or hospital ADT event and who are high-risk of readmissions and other poor outcomes; and receiving claims data feeds (directly or via a CIN/other partner) and meeting State-designated security standards for their storage and use.
- **Care Management Fee:** Tier 3-certified practices will have the opportunity to negotiate Care Management Fees *in addition* to regular AMH Medical Home Fees. Care Management Fees are required to be a per member per month payment that is a minimum guaranteed revenue to the practice and may not be placed at risk based on measures of utilization, cost, or quality. PHPs must account for and report on Care Management Fees separately from Medical Home Fees and Performance Incentive Payments. While PHPs will not be *required* to offer Tier 3 practices a minimum Care Management Fee, PHPs are required to contract with all Tier 3-certified AMHs in each region. This will provide practices with leverage to negotiate fees that are appropriate given the additional care management functions that Tier 3 AMHs are required to take on.
- **Care Plan:** AMH Tier 3 practices are required to develop Care Plans for each high-need patient receiving care management. Care Plans must be individualized and person-centered, using a collaborative approach including patient and family participation where possible. Care Plans must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge and must include, at a minimum, the following elements:
  - Measurable patient (or patient and caregiver) goals;
  - Medical needs including any behavioral health needs;
  - Interventions;
  - Intended outcomes; and

- o Social, educational, and other services needed by the patient.
- **Carolina ACCESS:** North Carolina's PCCM program since the early 1990s. Under Carolina ACCESS, practices certified as meeting certain standards for clinical access and care management receive a monthly PMPM fee; the standards and payments are tiered into two levels (CAI and CAII). Since the late 1990s, DHHS has contracted with Community Care of North Carolina (CCNC) to provide care management and enhanced services for practices and beneficiaries through a regionally-based care management model.
  - o **Carolina ACCESS I (CAI):** Practices that enroll in Carolina ACCESS through NCTracks but do not enter into a contract with their local CCNC network are enrolled in CAI. CAI practices must meet all necessary practice requirements as determined by DHHS, including after-hours availability, panel size, the availability of interpretation services, hours of operation, and the availability of certain preventive and ancillary services that vary by age. In addition to fee-for-service payments, CAI practices receive $1.00 PMPM for beneficiaries enrolled with their practice.
  - o **Carolina ACCESS II (CAII/CCNC):** Practices that enroll in Carolina ACCESS through NCTracks and sign a separate contract with their local CCNC network are enrolled in CAII. This track is often referred to simply as "CCNC". The practice requirements for CAII are identical to those in CAI with the only difference being the agreement with CCNC, which entails engagement in quality improvement and care management activities. In addition to fee-for-service payments, CAII practices receive $2.50 PMPM for non-ABD beneficiaries and $5.00 PMPM for ABD beneficiaries.
- **Clinically integrated network (CIN) or other partner:** Organization that provides support to AMH practices in areas such as handling data, performing analytics, and in the delivery of advanced care coordination and care management functions. DHHS does not intend for independent practices' gaps in data/analytics, care management and related capabilities to serve as barriers for participation in more advanced AMH tiers. Rather, DHHS seeks to ensure that such practices can team with other practices and third-party partners that demonstrate high levels of competency and expertise in several areas to fulfill the responsibilities of the AMH program. AMH practices may choose to partner with CCNC (or any other partner) to fulfill these functions but are not required to do so for any level of participation in AMH. Other Tier 3 practices are free to serve as a CIN/ other partner for other Tier 3 practices.
- **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) Waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs.
- **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) Waiver program that allows seniors and disabled adults ages 18 and older to receive support services in their own home, as an alternative to nursing home placement.
- **Dual-eligible beneficiaries:** Beneficiaries who are eligible for both Medicare and Medicaid, including those enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing.
- **Emergency department (ED):** Treatment facility specializing in emergency medicine and treating patients with acute needs.
- **Federally Recognized Tribes:** Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. In North Carolina, this includes the Eastern Band of Cherokee Indians.
- **Fee-for-service:** A payment model in which providers are paid for each service provided.
- **Grandfathering:** Process by which practices that are currently enrolled in Carolina ACCESS will be automatically moved into AMH. CAI practices will be moved into AMH Tier 1, and CAII/CCNC practices will be moved into Tier 2.
- **Health Information Exchange (HIE):** A secure electronic service that gives authorized health care providers the ability to access and share patient information across a statewide information network. Created by the North Carolina General Assembly (NCGS 90-414.7), NC HealthConnex is the state-designated HIE in North Carolina.

- **Health Insurance Premium Payment (HIPP) program:** In some cases, DHHS will pay private health insurance premiums for certain individuals who are eligible for Medicaid, have private health insurance through their employer, have a high-risk illness, and are at risk of losing private coverage.
- **Intellectual/Developmental Disability (I/DD):** Category of disorders that negatively affect the trajectory of an individual's physical, intellectual, and/or emotional development. These are usually present at birth and often affect multiple body parts or systems.
- **Local Health Departments (LHDs):** LHDs have long played a critical role in North Carolina in the provision of care management services for high-risk pregnant women and at-risk children, in addition to primary care services and other critical public health functions. LHDs that provide primary care services are permitted to participate in Carolina ACCESS and AMH.
- **Managed Care:** In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure in order to advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs. Beginning in February 2020, DHHS will delegate the direct management of certain health services and financial risks to PHPs. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members.
- **Medicaid:** Provides health coverage to over 2 million North Carolinians, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. References to "Medicaid" in this document also encompass NC Health Choice, the State's comprehensive health coverage program for low-income children.
- **Medical Home Fees:** PMPM payment to Carolina ACCESS and AMH practices that meet certain standards for clinical access and care management. Fees vary between CAI and CAII/CCNC. Additionally, CAII/CCNC and AMH practices receive increased Medical Home Fees for ABD beneficiaries.
- **Medically needy:** Medicaid eligibility pathway for families, children, aged, blind, or disabled individuals, and pregnant women with income that is too high to qualify for Medicaid but who have significant medical expenses and limited assets.
- **National Provider Identifier (NPI):** Standard unique health identifier for health care providers adopted by the Secretary of US Department of Health and Human Services. NPIs are established at the individual provider-level or at the organization-level.
- **North Carolina Department of Health and Human Services (DHHS):** DHHS manages the delivery of health- and human-related services for all North Carolinians, including the State's most vulnerable citizens – children, elderly, disabled and low-income families. It administers the State's Medicaid and NC Health Choice programs as well as a number of other programs and initiatives aimed at improving the health, safety and well-being of residents.
- **North Carolina Health Choice (NC Health Choice):** North Carolina's CHIP program. NC Health Choice provides comprehensive health coverage program for low-income children.
- **North Carolina Health Information Exchange Authority (NC HIEA):** The North Carolina General Assembly created the NC HIEA to oversee and administer the state-designated HIE (NCGS 90-414.7). NC HIEA receives input and advice from its Advisory Board, which consists of patients, hospital personnel, physicians, technology experts, public health officials and other key stakeholders to continuously improve NC HealthConnex.
- **Obstetric Care Management (OBCM):** Care management program provided by LHDs for pregnant Medicaid beneficiaries identified as being at high risk of a poor birth outcome. The care management model consists of education, support, linkages to other services and management of high-risk behavior that may have an impact on birth outcomes. Women identified as having a high-risk pregnancy are assigned a pregnancy care manager to coordinate their care and services through the end of the post-partum period.
- **Obstetrics and Gynecology (OB/GYN):** A medical specialty that deals primarily with maternal and infant health, although many OB/GYN providers in North Carolina provide primary care services. OB/GYNs that provide primary care services are permitted to participate in Carolina ACCESS and AMH.
- **Patient-Centered Medical Home (PCMH)**: PCMH is a widely used primary care medical home model developed and recognized by the National Committee for Quality Assurance (NCQA). PCMH contains similar requirements those used in AMH but recognition has no bearing on AMH certification.

- **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. Any measures or other metrics on which Performance Incentive Payments to AMH practices are based must be approved by the Department. Performance Incentive Payments must be accounted for and reported to the Department separately from Medical Home Fees and Care Management Fees.
- **Practice:** Term is intended to encompass a broad range of healthcare facilities, clinics, and providers that deliver medical care services to North Carolina Medicaid beneficiaries. Practices will participate in the AMH program at the NPI/location level. For practices that enroll through organizational NPIs, individual AMH practices may include multiple providers.
- **Pregnancy Medical Home (PMH) Program:** Launched in 2011, the PMH program provides comprehensive, coordinated maternity care to pregnant women, with a special focus on preterm birth prevention. Today, the PMH program operates through CCNC, who provides regionally-based support to enrolled practices and convenes clinicians on a routine basis and in conjunction with Department leadership to review programmatic requirements, performance and other items. To qualify for participation as a PMH, the provider must agree to meet certain requirements, such as: ensuring that no elective deliveries are performed before 39 weeks of gestation; decreasing the cesarean section rate among nulliparous women; completing a Department-specified high-risk screening on each pregnant Medicaid enrollee in the program and integrating the plan of care with local care management; and cooperating with open chart audits. The PMH program pays providers incentive payments for 1) completing a standardized risk-screening tool at initial visit ($50), and (2) conducting a postpartum visit ($150). All providers who bill for perinatal services are eligible to enroll in the program. Currently, more than 90% of all perinatal care provided to pregnant Medicaid patients in North Carolina is through a PMH.
- **Prepaid Health Plan (PHP):** A PHP is managed care organization to which DHHS will delegate the direct management of certain health services and financial risk. PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members. PHPs will be subject to rigorous monitoring and oversight by DHHS across many metrics to ensure adequate provider networks, high program quality, and other important aspects of a successful Medicaid managed care program.
- **Presumptive eligibility:** Permits qualified entities to immediately extend temporary Medicaid coverage to uninsured individuals if they appear to be eligible based on income.
- **Primary care case management (PCCM):** Model of managed care in which the State pays population-based, PMPM payments to practices that agree to meet certain standards for clinical access and care management.
- **Primary care provider (PCP):** Physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by the beneficiary or assigned by the PHP to provide and coordinate all the beneficiary's health care needs and to initiate and monitor referrals for specialized services, when required.
- **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age 55 and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.
- **Risk stratification:** Method for identifying high-risk patients who would benefit from care management. Tier 3 practices (or their designated CIN/other partner) are required to use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel. Practices are not required to purchase a risk stratification tool. Applying clinical judgment to risk scores received from the PHP will suffice.
- **Serious mental illness (SMI):** Characterized by persons 18 years and older who, at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Diagnoses commonly associated with SMI include major depression, schizophrenia, and bipolar disorder.
- **Short-term, transitional care management:** Management of beneficiary needs during transitions of care (e.g., from hospital to home).

- **Substance use disorder (SUD):** Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- **Traumatic Brain Injury (TBI) Waiver:** A North Carolina Medicaid 1915(c) Waiver program that established pilot project in Cumberland, Durham, Johnston and Wake counties to offer rehabilitation services for adults who have suffered TBI on or after their 22nd birthday.
- **Upside-only risk:** Tier 3 practices will be eligible for Performance Incentive Payments from PHPs based on performance on State-approved AMH quality measures (more information on measures will be provided in the fall of 2018). For at least the first two years of the AMH program, these incentives will be on an "upside-only" basis, meaning that practices will be eligible to earn additional payments if they meet specified cost of care, quality and patient experience measure benchmarks. Practices will NOT be at risk of losing money if they do not meet specified performance targets (i.e., they will not be exposed to "downside risk"). In other words, PHPs will not be permitted to require practices to pay back PMPM Medical Home Fees, Care Management Fees or any other payments for medical services. Practices are permitted to negotiate arrangements that include downside risk, but PHPs may not mandate that practices accept these terms.