AMH Tier 3 Delegated Care Management
Key Terminology and Definitions

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Accountable Care Organization (ACO)
A network of health care providers who deliver coordinated care across multiple settings, agree to be held accountable for improving quality of care and slowing the rate of spending growth.

Advanced Medical Home (AMH) Program
The primary mechanism for delivering care management as North Carolina transitions to Managed Care.

The AMH program requires PHP's 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 partner.

Attestation
The process of validating as true the AMH is able to meet the requirements laid out by DHHS for Tier 3 status via dated signature form.

Authority *(delegated to AMH/CIN & LHD (HRP/HRC))*
A health plan may give a delegate the authority to action its behalf, but the organization remains accountable.

Care (Case) Coordination
Deliberate organization of patient care activities between two or more participants (including the patient) to facilitate the appropriate delivery of health care services.

Care (Case) Management
Team-based, person-centered approach to effectively managing patients' medical, social, and behavioral conditions.

Clinically Integrated Network (CIN)
Entities with which provider practices can voluntarily choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH. CINs provide support to the AMH practices in such areas as handling data, performing analytics, and in the delivery of advance care coordination & care management functions.

Care Management for At-Risk Children (CMARC)
Care Management services for at-risk children age's zero-five. Responsibility for this population will be assumed by the PHPs with requirements that PHPs contract with LHDs for the provision of local care management services.

Care Management for High-Risk Pregnant Women (CMHRP)
All pregnant women enrolled in managed care through PHPs will receive a coordinated set of high-quality clinical maternity services through Pregnancy Medical Program (PMP). The program will be administered as a partnership between PHPs and local maternity care service providers.

Care Transitions
The activity involved when a member goes from one level of care to another level (e.g. hospital to home, SNF, hospice, etc.)

Community Based Organizations (CBOs)
Non-profit groups that work at a local level to improve life for residents.

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Complex Care (Case) Management
Set of activities designed to more effectively assist patients and their caregivers in managing medication conditions and co-occurring psychosocial factors. Goal is improve health status and prevent the need for hospitalization.

Delegated Care (Case) Management
A formal process by which the organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate authority to perform a function, it may not delegate the oversight responsibility that ensures that responsibility if performed appropriately.

Fee-for-Service
A payment model in which providers are paid for each service provided. The term FFS refers to the healthcare program delivered by Medicaid participating providers who are paid directly by the state at a rate set by the state within federal guidelines. The state pays each provider for services provided to a participant. In essence, there is a one-to-one match between payments and the quantity and type of service actually provided.

Healthy Opportunities Pilot (HOP)
The nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety and toxic stress to high-needs Medicaid enrollees.

Joint Operating Committee (JOC)
A clinical leadership of health systems and Clinically Integrated Networks (CINs) who meet with health plans as well as Provider Engagement/Provider Relations teams on a monthly or as-needed cadence. This is an opportunity to address and resolve operational issues and share updates between the parties.

Local Health Department (LHD)
An entity that has long standing in North Carolina in the provision of care management for high-risk pregnant women and at-risk children, in addition to primary care services and other critical public health functions.

Local Management Entity/Managed Care Organization (LME/MCO)
A public managed care organizations that provide a comprehensive behavioral health service plan under the North Carolina 1915(b) (c) waiver for people in need of mental health, developmental disability or substance use services.

Long Term Services and Supports (LTSS)
A variety of health, health-related, and social services that assist individual with functional limitations due to physical, cognitive, or mental conditions or disabilities.

Managed Care
Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

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In Sept. 2015, the General Assembly enacted law directing the transitions 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.

Medicaid
A health coverage to over 2 million North Carolinians, including low-income adults, children, pregnant women, elderly adults, and people with disabilities

The National Committee for Quality Assurance (NCQA)
An Independent 501C-3 nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

North Carolina Department of Health and Human Services (DHHS)
A state department managing 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).

North Carolina Integrated Care for Kids (InCK)
A new model that aims to improve the way children under age 21 and their families receive care and support services. NC InCK focuses on prevention, early identification and treatment of behavioral and physical health needs, and integrated care coordination and care management. NC InCK also uses Alternative Payment Models (APMs) that link payments to meaningful measures of child well-being.

Patient-Centered Medical Home (PCMH)
A widely used primary care medical home model developed and recognized by the National Committee for Quality Assurance (NCQA).

Pay for Performance (P4P)
in Healthcare, a payment model where hospitals, physicians and other healthcare workers are given financial incentives for meeting performance objectives. Pay for Performance is also known as value-based purchasing.

Practice
A broad range of healthcare facilities, clinics and providers that deliver medical care services to North Carolina Medicaid beneficiaries. These healthcare facilities, clinics and providers will participate in the AMH program at the NPI/location level.

Performance Improvement Plan (PIP)
A formal document stating any recurring performance issues along with goals that the AMH needs to achieve to meet the standards set out in their contract.

Prepaid Health Plan (PHP)
A managed care organization, to which DHHS will delegate the direct management of certain health services and financial risk. These organizations will receive a monthly capitated payment and will contract with providers to deliver health services to their members. They 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 successful Medicaid managed care program.

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Provider Led Entity (PLE)
An entity that meets all of the following criteria: 1. a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers. 2. A majority of the entity's governing body is composed of physicians, physician assistants, nurse practitioners, or psychologists. 3. Holds a PHP license issued by the Department of Insurance.

Risk Stratification
A method for identifying high-risk members who can benefit from care management.

Social Determinants of Health (SDOH)
Those conditions in which people are born, grown, live, work, and age. These circumstances are shaped by the distribution of money, power and resources at global, national, and local levels.

Standard Plan
NC DHHS has developed a model of Medicaid managed care for North Carolina that breaks Medicaid recipients into populations. The Standard Plan will be offered to Medicaid recipients with predominant physical health care needs and some mild-to-moderate mental health and substance use treatment needs.

Tailored Behavior Health Intellectual/Developmental Disability (BH/IDD) Plan
NC DHHS has developed a model of Medicaid Managed Care for North Carolina that breaks Medicaid recipients into populations. The BH/IDD Tailored Plan will be offered to Medicaid recipients and State-funded consumers with high intensity treatment and support needs for mental illness, intellectual/developmental disabilities and substance abuse disorders.

Transitions of Care (TOC)
The process of assisting a Member to transition between PHPs or to other payment delivery systems, including transitions that result in the disenrollment from managed care.

Upside-Only Risk
Means practices will be eligible to earn additional payments if they meet specified cost of care, quality and patient experience. Practices will not be at risk of losing money if they do not meet specified performance targets (they will not be exposed to down-side risk)

Value-Based Care (VBC)
A health care delivery model under which providers are paid based on the health outcomes of patients and the quality of services rendered.

Value-Based Payment (VBP)
VBP arrangements align financial incentives to pay for improved quality of care and health outcomes, rather than the quantity of care provided. They also offer greater flexibility for providers to focus on improving their patient's health, rather than on providing specific services paid for under fee-for-service arrangements. Prepaid Health Plans (PHPs) and providers are encouraged to develop and enter into VBP arrangements tailored to their specific populations and needs.