Fact Sheet
Advanced Medical Home (AMH) Program

What is the AMH Program and how does it work?

The North Carolina Department of Health and Human Services (DHHS) developed the Advanced Medical Home (AMH) program as the primary vehicle for delivering local care management as the state transitions to NC Medicaid Managed Care. Through AMHs, North Carolina seeks to build on the Carolina ACCESS primary care infrastructure for Medicaid and NC Health Choice enrollees and further strengthen the role of primary care in care management and quality improvement.

Health plans are required to delegate care management functions to certain AMHs (see below) and to establish value-based payment arrangements with AMHs for a defined set of quality measures. The AMH program is designed to, over time, support increased provider responsibility for overall population health and total cost of care.

WHAT IS AN AMH?

An AMH is a primary care practice which agrees to:

- Accept a patient panel
- Provide primary and preventative care according to program guidelines
- Have a certain amount of access and availability for Medicaid/CHIP patients
- Coordinate primary and specialty care for their patient panel
- Provide age - and condition-appropriate screenings, immunizations and interventions
- Provide team-based care management

More information and resources can be found on the Advanced Medical Home webpage.

ARE PRIMARY CARE PRACTICES REQUIRED TO PARTICIPATE IN THE AMH PROGRAM?

Participation in the AMH program is voluntary. Primary care practices may choose not to take responsibility for AMH requirements and can simply join health plan networks as primary care providers (PCPs). Participation as an AMH in Medicaid Managed Care has no bearing on a practice's ability to participate as a primary care practice or a Carolina ACCESS practice in NC Medicaid Direct.

WHAT TYPES OF PROVIDERS CAN BECOME AN AMH?

AMH eligibility is the same as Carolina ACCESS eligibility. Eligible practices are generally single and multispecialty groups led by allopathic and osteopathic physicians in the following specialties:

- General Practice
- Family Medicine
- Internal Medicine
- OB/GYN
- Pediatrics

AMH practices can also include physician assistants, advanced practice nursing providers, and certain ambulatory health care facilities. The Provider Permission Matrix in NCTracks identifies all taxonomies eligible for participation.

HOW CAN A PROVIDER BECOME AN AMH?

All practices must be enrolled in Medicaid and Carolina ACCESS before they can be certified to participate in the AMH Program.

Practices that were already participating in Carolina ACCESS in 2018 were grandfathered into the AMH program in 2018. Carolina Access I (CAI) and Carolina Access II (CAII) providers were grandfathered into AMH Tiers 1 and 2, respectively. Since that time, practices approved for participation in Carolina ACCESS have been automatically enrolled as an AMH Tier 2 provider. There is no longer a path for providers to enroll as AMH Tier 1.

Newly enrolling providers may apply for Carolina ACCESS as part of their initial Medicaid/NCHC provider enrollment application. Existing Medicaid providers may apply for Carolina ACCESS participation through the Manage Change Request process. More information is available here. Once approved and designated as an AMH Tier 2, the provider may use the AMH Tier Attestation Tool available on the Secure Provider Portal Status and Management page to attest to a higher tier.

For detailed directions on the AMH Tier Attestation process please see the AMH Tier Attestation Job Aid in NCTracks.

IF A PROVIDER HAS MULTIPLE LOCATIONS, HOW DOES THAT AFFECT THE APPLICATION / ATTESTATION PROCESS IN NCTRACKS?

Practices will enroll in the AMH program at the National Provider Identifier (NPI)/location (LOC) level. Each service location must enroll in Medicaid and Carolina ACCESS and attest (if applicable) as an Advanced Medical Home Tier 3. Practices may choose to participate as an AMH at only some of their locations. Practices may have different AMH Tier certifications for different locations within an organizational NPI. Practices will not have the ability to “batch attest” as an AMH for multiple service locations under a single NPI.

HOW DOES CARE MANAGEMENT WORK IF PATIENTS ARE ENROLLED WITH AN AMH TIER 1, 2 OR 3 PLUS PROVIDER?

Under AMH Tiers 1 and 2, Health Plans retain primary responsibility for ensuring that beneficiaries receive appropriate care management services.

AMH Tier 3 practices assume primary responsibility for care management, delivered either directly or through a Clinically Integrated Network (CIN) or another partner. The requirements for care management are in addition to the AMH Tier 1 and 2 primary care practice requirements. AMH Tier 3 practices receive an additional Care Management Fee to provide this service to their assigned patients.

AMH Tier 3 practices may apply to become AMH+ for the purpose of providing Tailored Care Management for beneficiaries in Tailored Plans. Information on how to become an AMH+ can be found on the Tailored Care Management web page.

HOW CAN A PROVIDER ATTEST TO A HIGHER TIER THAN THEY ARE CURRENTLY DESIGNATED?

Current Tier 1 practices can attest to become a Tier 2 or Tier 3 practice. Current Tier 2 practices can attest to become a Tier 3 practice. If a provider would like to attest to a higher tier, the assigned office administrator for the impacted provider record can complete the AMH Tier Attestation Tool available on the NCTracks Secure Provider Portal Status and Management page.

Upgrading to a higher tier requires additional information about the practice, which is provided through a series of questions on the tool. AMH Tier 1 providers can answer the question to become an AMH Tier 2 provider and continue during the same action to answer the Tier 3 questions if desired. AMH Tier 2 providers will be presented with only the question to become an AMH Tier 3 provider.

The provider’s responses to the questions on this page may not automatically result in a tier upgrade. Upon submission, the provider will receive a notification of their successful or unsuccessful attestation. To confirm, the provider may return to the main page of the tool and select the same NPI and location to see confirmation of their current state designated tier.

WHAT ARE THE REQUIREMENTS FOR THE AMH TIERS?

A full list of requirements can be found in the AMH Provider Manual located on the Advanced Medical Home webpage. Practice requirements for Tiers 1 and 2 are the same as requirements for Carolina ACCESS. All AMH practices must:

- Perform primary care services that include certain preventive and ancillary services (for more information on these services, refer to the AMH Provider Manual)
- Create and maintain a patient-clinician relationship
- Provide direct patient care a minimum of 30 office hours per week
- Provide access to medical advice and services 24 hours per day, seven days per week
- Refer to other providers when service cannot be provided by the PCP
- Provide oral interpretation for all non-English proficient beneficiaries at no cost to the beneficiary

Under Tier 3, practices assume primary care management responsibility. Practice Requirements for Tier 3 include all the requirements for Tier 2 and the following:

- Risk-stratify all empaneled patients
- Provide care management to high-need patients
- Develop a Care Plan for all patients receiving high-need care management
- Provide short-term, transitional care management along with medication management to all empaneled patients who are discharged from the emergency department (ED) or an inpatient setting
- Demonstrate that, at a minimum, they have active access to an Admission, Discharge, Transfer (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
- Receive claims data feeds (directly or via a CIN or other partner) and meet State-designated security standards for their storage and use.

More information on Tier 3 requirements can be found in the AMH Provider Manual located on the Advanced Medical Home webpage.

WHAT IS THE AMH PAYMENT STRUCTURE?

Medical Home Fees under the AMH program will initially be the same as those established under Carolina ACCESS. All AMHs will receive Medical Home Fees for assigned members (see below for amounts by tier).

In exchange for taking on additional care management functions, Tier 3 AMHs will also be eligible for an additional, negotiated Care Management Fee from health plans.

All practices will be eligible to earn negotiated Performance Incentive Payments. These payments are optional for Tier 1 and 2 AMHs. Health plans are required to offer opportunities for such payments to Tier 3 AMHs.

Tier-specific Payments

AMH Tier 1

- Medical Home Fee: $2.50 PMPM – non-Aged, Blind, Disabled (ABD) beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group
- *Optional: negotiated Performance Incentive Payment*

AMH Tier 2

- Medical Home Fee: $2.50 PMPM – non-Aged, Blind, Disabled (ABD) beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group
- *Optional: negotiated Performance Incentive Payment*

AMH Tier 3

- Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group
- Care Management Fee: negotiated amount with health plan
- Performance Incentive Payments: conditions of payment negotiated with health plan

Effective December 1, 2022 through June 30, 2023, AMH 1, 2, and 3 practices that are serving as the assigned primary care provider for beneficiaries eligible for Tailed Care Management will receive an enhanced medical home fee of $20 PMPM.

CAN AN AMH BE MOVED DOWN A TIER?

AMH Tier 3 providers can be downgraded by the health plans if the practice is out of compliance with the AMH program requirements. However, health plans must allow AMH Tier 3 providers and CINs/ Other Partners at least 30 days for remediation of non-compliance with Tier 3 standards before pursuing a tier downgrade. More information on this process can be found in the AMH Provider Manual located on the Advanced Medical Home webpage.

At any time, a provider may change their state-designated tier status using the guidance published in the NC Medicaid bulletin article, Modified NCTracks AMH Tier Attestation Tool Available.

AMH Practices should remember that changing their tier status at the State will impact the way they can contract with health plans. The state-designated tier represents the highest tier at which the AMH may contract with any health plan. However, providers are not required to contract at the state-designated tier level with every health plan.

WHAT IS A CIN AND HOW CAN THEY HELP?

In North Carolina, the Department is using the term “CINs and other partners” to mean organizations that provide support to AMH practices including: managing data, supporting analytics and delivering advanced care coordination and care management services, regardless of whether such organizations meet federal standards for clinical integration. CINs and other partners may include hospitals, health systems, integrated delivery networks, independent practice associations (IPAs), other provider-based networks and associations, care management organizations and technology vendors.

The Department expects CINs and other partners to offer a wide range of differing packages of administrative support to AMH practices, clinical staffing resources, care delivery wraparound services, and/or technology services. AMHs can ask CINs to support ANY part of AMH Tier 3 requirements.

WHAT IF I HAVE QUESTIONS?

More information on the AMH Program can be found on the Advanced Medical Home webpage.

Additional resources for providers on the transition to managed care can be found in the Provider Playbook and on the Medicaid Transformation website.

For questions about contracting, contact the health plan. Information can be found here.

For general inquiries and complaints regarding Health Plans, NC Medicaid has created a **Provider Ombudsman** to represent the interests of the provider community. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 866-304-7062. The Provider Ombudsman contact information is also published in each health plan’s provider manual.

For questions related to your NCTracks provider information, please contact the General Dynamics Information Technology (GDIT) Call Center at 800-688-6696. To update your information, please log into the NCTracks Provider Portal to verify your information and submit a Managed Change Request (MCR) or contact the GDIT Call Center.

Fact Sheets will be updated periodically with new information. Updated November 2022.For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation