North Carolina Advanced Medical Home (AMH) Program Data Strategy in Support of Care Management
Frequently Asked Questions
Oct. 4, 2018

Please refer to the glossary at the end of this document for a list of terms, definitions and acronyms.

No.	Category	Question	Answer
1	PHP transmission of quality measure data to AMHs	Will there be a standard for the content, format and transmission method of quality reporting data from the PHPs to the AMHs?	Consistent with the Department's principles identified in the Data Strategy to Support the Advanced Medical Home Program in North Carolina Policy Paper released on July 20, 2018, the Department seeks "to strike a balance between setting standards that promote system-wide consistency and efficiencies, and providing sufficient flexibility to allow PHPs and AMHs to innovate." As stated in the PHP RFP, in cases for which the Department "establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department." For quality measures identified in the PHP RFP Attachment E. *Required PHP Quality Metrics*, PHPs will be expected to adhere to the nationally recognized specifications for the applicable measures in their transmission of data to the Department and the AMHs, Clinically Integrated Networks and other authorized partners. The Department will provide additional guidance on content, data fields and reporting methodology prior to the award of PHP contracts. Guidance on format standards will be provided after contract award, and the Department expects that the AMHs and PHPs will work through the AMH Technical Advisory Group to discuss opportunities to further streamline the transmission of quality measures.

No.	Category	Question	Answer
2	PHP and AMH Tier 3 access to ADT feeds	Will PHPs and Tier 3 AMHs be a required to use a specific data source or HIE service for Admission, Discharge, and Transfer (ADT)-based alerts?	The Department does not seek to impose restrictions on where practices obtain their HIE services. State law requires providers and PHPs to connect to HealthConnex, a statewide health information exchange that is overseen by the North Carolina Health Authority (NC HIEA) housed within the North Carolina Department of Information Technology. As specified in NC HIE's onboarding and technical specifications, providers connectivity to HealthConnex includes the transmission of ADT feeds. In addition, state law requires PHPs to submit encounter and claims data to HealthConnex by the commencement of their contracts with the Department. While HealthConnex serves as a centralized, statewide resource that does not charge a fee for access, providers have alternative options for HIE services. The Department recognizes the benefit of allowing providers flexibility to choose the vendors of HIE services that best meet their needs. In addition, AMHs could contract with Clinically Integrated Networks or other partners to receive ADT feeds and compile them to produce actionable information that integrates into the AMHs' workflows. The Department also expects that PHPs and AMHs will work with the entities that provide ADT feeds through the AMH Technical Advisory Group to discuss the most effective and efficient approaches for data content, methodologies and transmission timeliness.
3	Providers' costs for accessing data	Will practices have to pay for additional connections or systems to receive data to conduct care management?	As one of its guiding principles, the Department seeks to minimize costs for all stakeholders: "Administrative and cost burdens on AMH practices and PHPs should be minimized to the extent possible, for example, by using common data standards and formats." While the Department cannot dictate EHR vendors' pricing strategies, the requirement of common data standards and formats for certain data types should reduce variability, which, in turn, should reduce costs for EHR vendors to make customized solutions.
4	PHP transmission of data to practices	Can the Department specify that PHPs provide AMHs access to data in the shortest timeframes possible?	The Department agrees that timely access to data will be a critical element of efficient and effective care management. As stated in the Data Strategy Paper, PHPs' timely transmission of adjudicated claims and encounter data is a priority that is balanced against the goal of minimizing administrative reporting burdens. At a minimum, as directed in the PHP RFP, PHPs are required to "provide encounter, provider and Member data at least monthly, or more frequently as requested by the Department… and deliver pharmacy data at least weekly, or more frequently as requested by the Department." To strike the appropriate balance in which trade-offs between speed and accuracy exist, the Department will gather feedback through the AMH Technical Advisory Group. This group will convene in March of 2019 to discuss data and other topics pertaining to AMH.

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5	Roles of HealthConnex and North Carolina Resource Platform	How will HealthConnex and the North Carolina Resource Platform interact and provide data to practices' Electronic Health Record (EHR) and care management platforms?	The Foundation for Health Leadership & Innovation (FHLI) oversees the development and deployment of the North Carolina Resource Platform, a statewide resource that will help providers, health plans and community-based organizations to connect with community resources needed to be healthy. The Resource Platform's capabilities are expected to roll out over time. On August 21, 2018, FHLI announced the selection of NCCARE360 to build the North Carolina Resource Platform. As stipulated in the Resource Platform RFP, NCCARE360 is expected to share data with other entities: "the vendor shall create a secure FTP site to transfer a batch of identifiable data in pre-specified formats to NC HealthConnex, containing an agreed-upon patient identifier (e.g., Medicaid identification number) and other specifications that will be developed in concert with the vendor post-award." The ability to integrate with EHRs and other data systems was also a key feature of the North Carolina Resource Platform. According to the RFP, this is expected to be a "flexible technology that can be integrated into EHRs and care management platforms with easy workflow integration."
6	Risk adjustment and stratification data	Can the Department clarify the use of the CDPS+Rx for risk adjustment and/or risk stratification?	The Department is not proposing that the CDPS+Rx model be used for risk stratification as it relates to care management, value-based purchasing, or quality incentive programs. The CDPS+Rx model will be used for risk adjusting the payment rates to the PHPs which shifts dollars across plans and is cost-neutral in aggregate across a given region. The risk adjustment process is designed to better align payments for expected healthcare costs by PHP and region. While the Department encourages sharing beneficiary risk scores from the CDPS+Rx models with AMHs, this is not intended to limit the consideration or use of other models for risk stratification. Other models may be more appropriate for risk stratification as it relates to care management. The Department encourages continued discussion about other models with PHPs and AMHs.

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7	Risk stratification data	While PHPs are expected to have their own data systems and risk-stratifying approaches, will there be standardization for the determination of high-risk or high-needs patients?	PHPs are required to use risk scoring and stratification to identify Members who are part of priority populations for care management and should receive a Comprehensive Assessment to determine their care management needs. As identified in the PHP RFP, "priority populations" likely to have care management needs and benefit from care management include: • individuals with long term services and supports needs; • adults and children with special health care needs; • individuals identified by the PHPs as at rising risk; • individuals with high unmet health-related resource needs; • at-risk children (age 0-5); • high-risk pregnant women; and • other priority populations as determined by the PHP. While each PHP will utilize its own risk scoring and stratification methodology and classification approach, their models and processes must take into account, at a minimum, a common set of information that includes: care needs screening results; claims history; claims analysis; pharmacy data; immunizations; lab results; ADT feed information; provider referrals; referrals from social services; member's zip code; member's race and ethnicity; and member or caretaker self-referral. While there will be varying risk stratification approaches in the marketplace, AMH Tier 3 and 4 providers have the flexibility to choose the models that work best for them. AMHs can utilize the PHPs' risk scoring and stratification results, apply their own risk stratification models, or integrate the PHPs' risk scoring results with their own. The Department expects that PHPs and AMHs will work together through the AMH Technical Advisory Group to determine the appropriate format and frequency for the sharing of this information and to discuss if further standardization would be beneficial.
8	Care processes	Can the Department encourage plans to reduce administrative complexity and work with practices to minimize different care management infrastructures?	While PHPs will have primary responsibility for care management functions, they are required to ensure that the majority of care management is delivered locally. The Department requires PHPs to collaborate and reduce administrative burden with Tier 1 and 2 practices. Practices that have the capabilities to take the lead in organizing and delivering care management services for their Medicaid Managed Care members across all Medicaid PHPs with whom they contract have the option to certify as Tier 3 AMHs.

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9	Payments	How will care management incentives reach providers so they can invest in care processes and systems?	Under Medicaid Managed Care, PHPs will be required to pay minimum "Medical Home Fees" to AMH practices in all tiers. The "Medical Home Fees" are equal to Carolina ACCESS program payments. The AMH program also introduces new funding to practices in the form of Care Management Fees, which allows practices to invest in care processes and systems. PHPs are also required to offer performance incentives payments to practices, which will work to align payment with positive quality and cost outcomes. PHPs will be required to pay practices based on the terms of the contract between the PHP and that AMH practice. AMH practices working with other partners are urged to work together to develop an internal funds flow model that ensures front line clinicians benefit through improvements in cost and quality outcomes. For any provider issues, including those that arise regarding PHP payments to practices, PHPs must have processes for clinicians to bring issues to the PHP, including a formal process for clinicians to challenge specific PHP decisions. An Ombudsman Program will be available to assist clinicians throughout this process.
10	Quality measures	Will there be a uniform set of quality measures across plans to evaluate AMHs?	PHPs are required to report a set of quality measures specified by the Department and must draw from a subset of these measures in developing their value-based purchasing and provider incentive programs- including programs for AMHs. Within this subset, the Department has given PHPs and providers the opportunity to choose measures as part of their internal contracting process. The Department will continue to engage PHPs and providers regarding the number and organization of quality measure reporting and accountability requirements.
11	Electronic patient engagement approaches	Are providers' existing and planned electronic patient portals examples of the type of Medicaid beneficiary engagement envisioned by the Department?	The Department's vision for data sharing in managed care includes the principle of engaging members in their own health and health care decisions by encouraging the secure and more widespread sharing of health information with members. As a means of meeting the patient engagement principle, the Department supports providers' use of patient portals. The Department also encourages PHPs and AMHs to implement innovative strategies for secure information sharing with members to provide beneficiaries with authorization control over how their data can be used by third-party, credentialed applications, services and research programs they trust. The Department's Data Strategy to Support the Advanced Medical Home Program in North Carolina paper offers examples including the Medicare Blue Button 2.0 Initiative.

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 emergency department (ED). Tier 3 (and eventually Tier 4) 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, through an affiliated CIN, or other partner.
- **Aged, Blind, Disabled (ABD):** A 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):** A 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:** A 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. While PHPs will not be *required* to offer Tier 3 practices a minimum Care Management Fee, PHPs are required to contract with 80 percent of Tier 3-certified AMHs in the service areas. 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
  - 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:** An 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/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): A** 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:** The 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)**: The HIE provides the capability to electronically move clinical information among disparate healthcare information systems and maintain the meaning of the information being exchanged.
- **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): A** 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 NC 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 November 2019, 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 more than 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:** A 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:** A 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):** A 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 Information Exchange Authority (NC HIEA):** In 2015 the General Assembly of North Carolina established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network (NCGS 90-414.7). The NC HIEA is housed within the NC Department of Information Technology's (DIT) Government Data Analytics Center (GDAC). The NC HIEA operates North Carolina's state-designated health information exchange, NC HealthConnex, a secure, standardized electronic system in which providers can share important patient health information. The use of this system promotes the access, exchange and analysis of health information. The law also requires that health care providers who receive State funds (e.g. Medicaid, State Health Plan) to connect to NC HealthConnex by certain dates in 2018 and 2019 to continue to receive payments for services provided. (NCGS 90-414.4).
- **North Carolina Health Choice (NC Health Choice):** North Carolina's Children's Health Insurance Program (CHIP). NC Health Choice provides comprehensive health coverage program for low-income children.
- **North Carolina HealthConnex:** North Carolina's state-designated health information exchange, NC HealthConnex, is a secure, standardized electronic system in which providers can share important patient health information. The use of this system promotes the access, exchange and analysis of health information. North Carolina HealthConnex is overseen by the North Carolina Health Authority (NC HIEA) housed within the North Carolina Department of Information Technology.
- **Obstetric Care Management (OBCM):** A 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)**: A 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.
- **Practice:** The 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.
- **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):** A 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):** A 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:** A 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 a 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 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. Beginning in year three of managed care, the State plans to launch AMH Tier 4, which will require that practices take on downside risk.