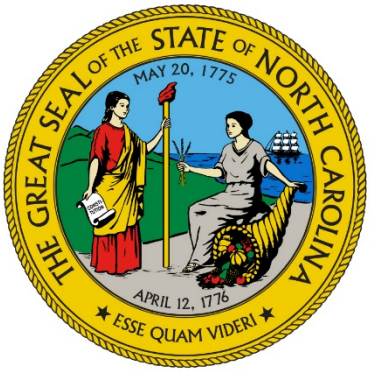


Clinically Integrated Networks and Other Partners Support of Advanced Medical Homes Care Management Data Needs

North Carolina Department of Health and Human Services

February 26, 2019

Content

Background Resources

In the previously published resources listed below, the North Carolina Department of Health and Human Services (the Department) outlined the data strategy and specific care management roles, relationships, and requirements for Prepaid Health Plans (PHPs), Advanced Medical Homes (AMH), Clinically Integrated Networks (CINs), and other partners.

- North Carolina's Care Management Strategy Under Managed Care (Released March 9, 2018), describes the AMH program, including the tier structure, payment model, and eligibility requirements for AMH practices. This document also provides a broad overview of AMH care management and data sharing responsibilities, and introduces the concept of CINs, which can support AMHs in meeting these responsibilities.

- Data Strategy to Support the Advanced Medical Home Program in North Carolina (Released July 20, 2018) expands on the requirements in the "Data Sharing" section of the Care Management Strategy to provide further information on the data AMH practices will likely need (and the entities responsible for providing it) to perform care coordination and management, population health improvement, and quality management functions for the beneficiaries they serve.

- Pre-paid Health Plan (PHP) Request for Proposals: Scope of Services (Released August 9, 2018), identifies specific requirements for PHPs and AMH practices in coordinating care and delivering local care management (see section C.6.), including expectations for data sharing between PHPs and AMHs.

- Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers (Released August 27, 2018), expands on the eligibility requirements and care management responsibilities of AMH practices described in the Care Management Strategy, with a focus on requirements for AMH practices (some of which may be performed by CINs and other partners).

- *Roles and Responsibilities of Clinically Integrated Networks and Other Partners* Webinar (Held November 1, 2018), provides an in-depth look at the roles and responsibilities of CINs and other partners. The webinar reviews areas in which CINs and other partners may be able to support AMHs, and includes several CIN "use cases" detailing some of the ways that AMH practices may work with or delegate responsibilities to CINs and other partners.

- *AMH IT and Data Sharing* Webinar (Held January 10, 2019), provides an in-depth review of the IT and data sharing infrastructure that AMHs will need to participate in the AMH program.

This issue brief builds upon the resources above by providing further information on how CINs can help AMHs meet the care coordination and management requirements listed in the PHP RFP and AMH Provider Manual and support data access, sharing and analysis functions as described in the AMH Data Strategy. The issue brief also outlines methods for increasing administrative efficiencies in these activities. Finally, the issue brief elaborates on the CIN and other partner capabilities described in the "Roles and Responsibilities of Clinically Integrated Networks and Other Partners" webinar, and identifies additional ways in which CINs and other partners may support AMH data management and analytics needs.

I. Introduction

North Carolina is preparing to transition its Medicaid and NC Health Choice programs from predominantly fee-for-service to managed care. Community-based care management through Advanced Medical Homes (AMHs) is foundational to the success of this transition, supporting high-quality service delivery and alternative payment arrangements in a partnership between providers and prepaid health plans (PHPs). To perform their delegated management roles and other responsibilities to manage population outcomes, AMHs will need to establish and maintain a wide range of connections to multiple data systems and sources, ensuring timely access to complete, accurate, individual-level and population-level data.

In support of their care management and population health efforts, AMHs may choose to work with clinically integrated networks (CINs) and other partners to help collect, compile, analyze, and exchange data. CINs may include hospitals, health systems, integrated delivery networks, independent practice associations (IPAs), other provider-based networks and associations.

Other partners that could support AMHs' care management and data needs include care management organizations and technology vendors. CINs and other partners are expected to play valuable roles helping AMHs collect, compile, analyze, and exchange data to fulfill their care management obligations. AMHs will be free to choose and contract with any individual CIN or multiple CINs and/or other partners that best meet their needs.

Building upon previous AMH policy papers, webinars, and materials identified in the Background Resource section on the previous page, this issue brief further describes the potential roles, relationships, and data flows between PHPs, AMH, CINs, and other partners as they perform their respective care management responsibilities and manage the health and outcomes of populations.

This issue brief also provides updated information on specific data formats, timing, transmission methods, and testing approaches in the following areas: beneficiary assignment, transmission of encounter data, care needs screening, risk stratification, comprehensive assessments, care planning, and coordinating beneficiary care.

II. Overview of AMHs' Role in North Carolina's Medicaid Transformation

In March 2018, the North Carolina Department of Health and Human Services (the Department) released its strategy for care management in Medicaid Managed Care that introduced the Advanced Medical Home (AMH) model.[1] In July 2018, the Department released a policy paper, "Data Strategy to Support the Advanced Medical Home Program in North Carolina,"[2] which outlined approaches to guide data sharing; recommendations on roles and relationships between PHPs, AMHs, CINs, and other partners; requirements and expectations for data exchange; and a roadmap for the types, content, format, and transmission methods for the exchange of data to support the Department's care management strategy.

> **What are CINs and other partners?**
> 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

[1] "North Carolina's Care Management Strategy under Managed Care" released by the Department March 9, 2018.
[2] "Data Strategy to Support the Advanced Medical Home Program in North Carolina" released by the Department July 20, 2018.

of whether such organizations meet federal standards for clinical integration.[3] 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. Provided below are examples of how different types of practices could work with CINs and other partners.

- **Health system-affiliated practices**. The Department expects practices owned by a hospital or health system that seek to be designated as an AMH Tier 3 practice may receive data, analytics, care coordination and management support at a system level from their hospital or health system. AMHs affiliated with a hospital or health system will specify in their AMH attestation that the health system will act as their CIN for the purposes of data sharing, care coordination and management support.

- **Independent practices**. The Department specifically aims to support independent primary care practices' participation in Tier 3 of the AMH program without requiring or necessarily incentivizing such practices to be formally affiliated with or owned by a hospital or health system. Some AMH practices may opt to work with other partners that help independent practices meet the AMH program requirements. The other partner in this case will deliver certain shared services to Tier 3 practices, such as data, analytics/risk stratification, care coordination and care management functions.

What are the benefits for a practice working with a CIN or other partners?
Many AMHs will choose to participate in multiple PHPs' provider networks. Accordingly, these AMHs will manage multiple care management relationships across the PHPs with whom they contract. Rather than having to conduct separate and distinct care management and data sharing processes with each PHP and multiple third-party data sources, an AMH may choose to work with CINs and other partners to coordinate across all of the AMH's PHPs or address areas where they have gaps in their technology infrastructure. Practices may find that by working with one or more CINs or other partners they can provide a cost effective, unified system of care management for all Medicaid enrollees across the AMHs' different PHP populations.

CINs and other partners may offer care management and information technology capabilities that AMHs may not have in-house or would otherwise be difficult to build. CIN and other partner data offerings could include data integration, warehousing and analytic services, care management documentation platforms, population health tools, and quality performance services.

[3] "Clinical integration" is a term used by the Federal Trade Commission (FTC) to describe certain types of collaborations among otherwise independent health care providers that work together to improve quality and reduce costs. When the FTC's requirements for clinical integration are met, the federal government provides a safe harbor from antitrust provisions that would normally apply. The FTC's standards are found in the 1996 joint FTC/Department of Justice Statements of Antitrust Enforcement Policy in Health Care.

Are AMHs required to contract with CINs and other partners?
The Department does not require AMHs to contract with CINs and other partners and does not advise AMHs regarding which CINs or other partners are best for AMHs to partner with. Practices participating as AMHs will have full discretion in their choice of a CIN or other partner as long as they meet the applicable requirements. Some provider practices, by virtue of being owned by or affiliated with a hospital or health system, may receive data/analytics and care coordination and management support at a system level from their hospital or health system. As noted in previous policy documents, the Department envisions AMH relationships with CINs and other partners as optional and a mechanism by which independent primary care practices participate in the AMH program without having to be formally affiliated with or owned by a hospital or health system. If AMHs decide to contract with CINs and other partners, they are free to choose the array of services that best meet the needs of their Medicaid beneficiaries. Practices that elect to work with a CIN or other partners should conduct the necessary due diligence to ensure that their CIN or other partners can perform the delegated functions.

When should AMHs consider working with CINs and other partners?
Provider practices that require assistance in meeting the requirements of Tier 3 AMHs should begin the process of identifying a CIN or other partner that can fulfill its needs as soon as possible. While the launch of managed care will not begin until November 2019, PHPs, AMHs, CINs, and other partners will need sufficient time to formalize arrangements, test capabilities, and ensure the appropriate systems are fully functional prior to the managed care launch.

How will AMHs designate their relationships with CINs and other partners?
As specified in the AMH Provider Manual[4], practices attesting to AMH Tier 3 status in NCTracks must identify the CIN or other partners that are or will be contracted to perform any of the required care management functions. The Department will provide additional details in future guidance regarding the method and timing for AMH Tier 3's conveyance to PHPs of their designation of CINs and other partners designations. The Department will also receive routine reports on from PHPs on contracted AMH practices and, as applicable, their CINs or other partners.

How are CINs and other partners funded?
PHPs will be required to pay AMH practices in accordance with certain criteria established by the Department, including Medical Home Fees, Care Management Fees and Performance Incentive Payments, depending on AMH Tier.[5] The Department will not establish contractual arrangements or oversee the arrangements that AMHs establish with CIN and other partners: AMHs are free to develop contractual arrangements that best meet their needs. For example, AMHs may arrange with CINs and other partners that their Care Management Fee funds from PHPs may be paid directly to the CIN and other partners.[6]

[4] "Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers released by the Department August 27, 2018.
[5] "North Carolina's Care Management Strategy under Managed Care" released by the Department March 9, 2018, describes in depth the AMH payment model.
[6] Subject to applicable laws, CINs and other partners may negotiate Care Management Fees on behalf of practices and pool those funds to apply to capacity that is shared across member practices.

How will oversight of CINs and other partners occur?
Unlike the certification of practices seeking to participate in the AMH program, the Department will not directly certify or validate the capabilities of CINs or other partners. Moreover, the Department will not endorse, promote, or approve specific CINs and other partners. Regardless of the relationship or arrangement between the AMH and CINs or other partners, Tier 3 AMHs will be accountable to the Department and PHPs for fulfilling their AMH responsibilities. AMH Tier 3 practices must oversee contracted CINs and other partners to ensure that patients are receiving required care management services. While the Department won't oversee contractual arrangements between AMHs and CINs and other partners, the Department will monitor how Care Management Fee funds are spent and how care management is being delivered throughout the state, including care management that is provided by CINs and other partners.

In August 2018, the Department released the requirements for practices interested in becoming AMHs in the form of an "AMH Provider Manual."[7] A summary of the Department's guidance to date is as follows:

- North Carolina's vision for locally-based, high quality Medicaid care management builds on Carolina ACCESS, preserves broad access to local primary care services for Medicaid enrollees, and strengthens the role of primary care in care management, care coordination, and quality improvement.

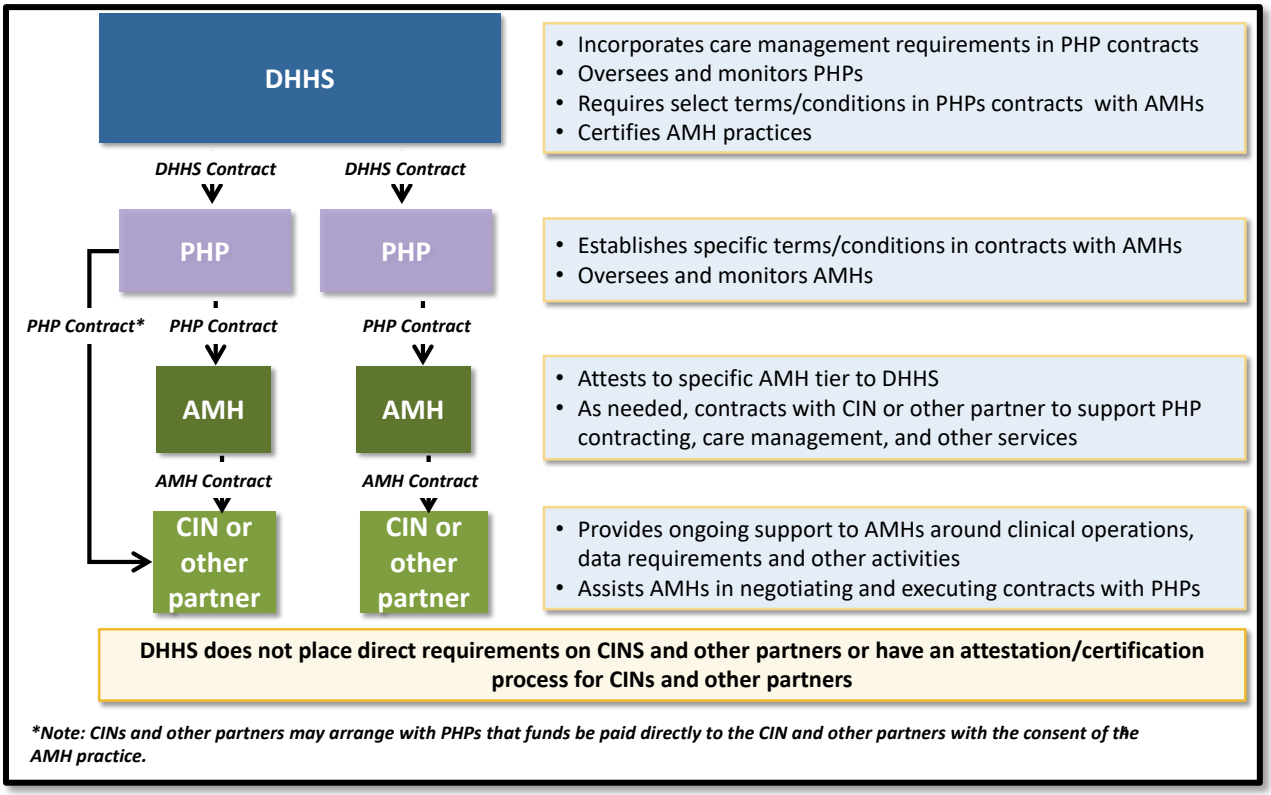
- In the new managed care environment, primary care practices can opt to provide services with few changes, interfacing with each PHP in the provision of care management as Tier 1 or Tier 2 AMHs. For practices serving as Tier 1 and Tier 2 AMHs, PHPs will have primary responsibility for care management functions. Alternatively, practices can take on more advanced care management functions (AMH Tier 3) and enter into other innovative payment arrangements with PHPs.[8] AMH Tier 3 practices will take the lead in organizing and delivering care management services for their Medicaid Managed Care beneficiaries across all Medicaid PHPs with whom they contract, with care management oversight and support provided by PHPs. PHPs will be expected to delegate primary responsibility for delivering care management to Tier 3 AMHs. The expectations for performing key care management functions (e.g., initial care needs screening, risk stratification, comprehensive assessment, and creation and curation of beneficiary care plans) by PHPs and AMHs will be shared as depicted in Figure 1 below. Practices may alternatively remain in Medicaid networks while opting out of the AMH program altogether.

- Practices that intend to serve as Tier 3 AMHs must complete an attestation directly with the Department. To meet the AMH Tier 3 requirements, providers must attest to providing a range of care management capabilities, including the ability to receive, compile, and exchange information. Tier 3 AMHs may choose to work with CINs and other partners to meet the required Tier 3 capabilities, but are not required to do so.

[7] "Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers" released by the Department August 27, 2018.
[8] After year two of Managed Care, the Department plans to launch a fourth AMH Tier. The Department anticipates that topics addressed in this Issue Brief regarding AMH Tier 3 data sharing will apply to Tier 4.

- Under managed care, responsibility for provider contracting and payment will shift from the Department to the qualified PHPs selected through a competitive procurement process by the Department. To advance the Department's goal of supporting care management that is performed at the site of care, in the home or in the community whenever possible, the Department will hold PHPs accountable for contracting with at least 80% of certified Tier 3 AMHs in each region in which they operate. The oversight and contractual relationships are illustrated in Figure 1.

Figure 1. Department, PHP, AMH, CIN and Other Partner Roles and Illustrative Contractual Relationships

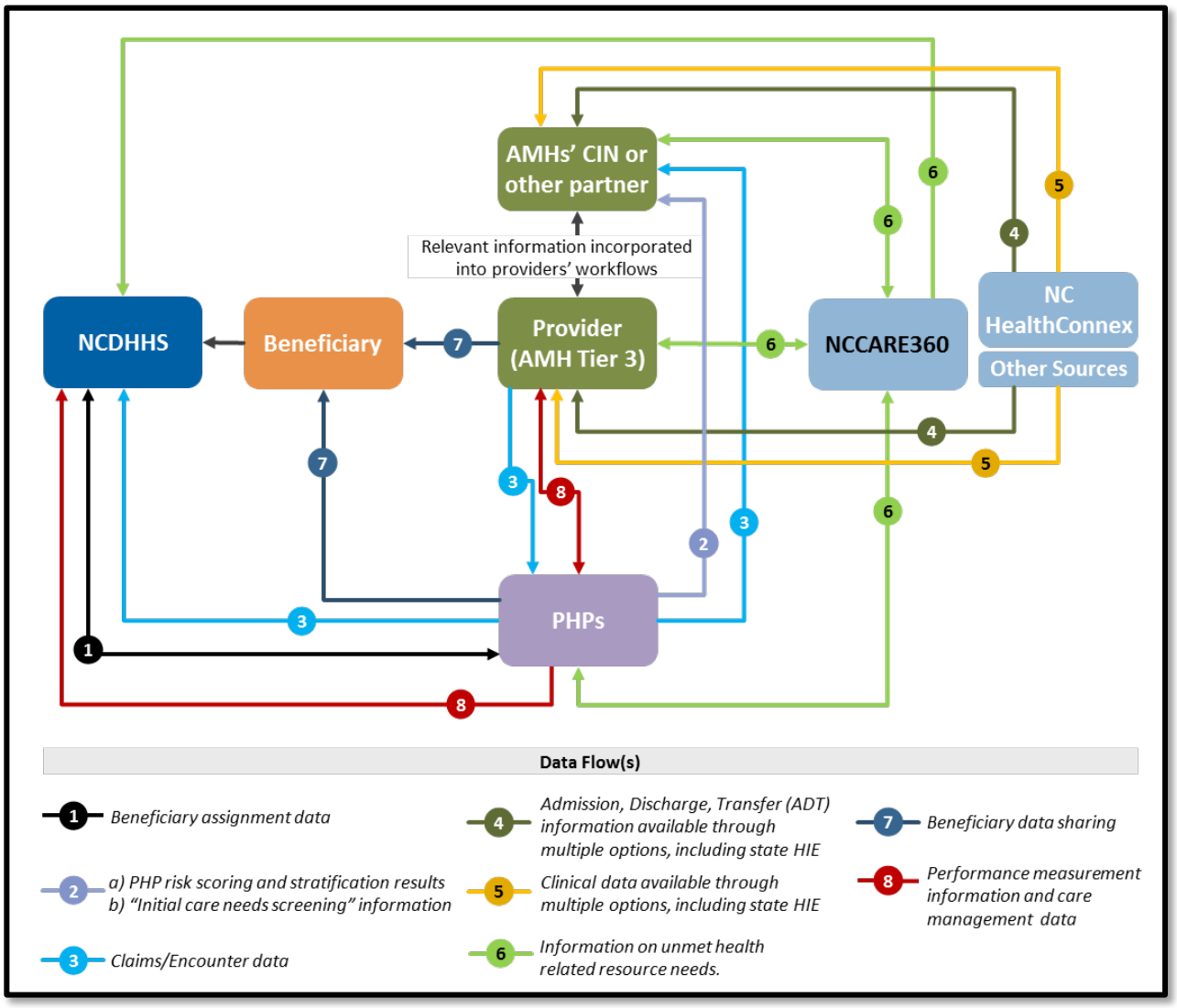


- At a minimum, AMHs and any contracted CINs or other partners will be expected to have a valid and signed Data Use Agreement (DUA) in place before submitting any request for data from a PHP. In conformance with applicable federal and state privacy and security laws, the AMHs and CINs and other partners must certify that their requests involve only their attributable patients and must restrict their use of the data for care coordination activities improving the quality and efficiency of care.

III. Tier 3 AMHs' Data-related Responsibilities and Requirements

To perform their delegated management roles and responsibilities, Tier 3 AMHs need to collect, compile, analyze, and exchange data with multiple entities. In the managed care environment, there will be a varied and complex landscape of multiple PHPs and provider organizations, multiple data types (e.g., utilization, financial, clinical), varying data formats, and variable data transmission methods. An illustration of the range of stakeholders and information flows for advanced Tier 3 AMHs is provided in Figure 2 below.[9]

Figure 2. Advanced Medical Home Tier 3 High-level Data Flow



While the care management environment will be complex, the Department envisions AMHs utilizing information technology to create a unified care management and population health approach for all Medicaid beneficiaries, regardless of the PHP to which they belong. Consistent with the Department's

[9] From this point hereafter, the Issue Brief describes and references requirements applicable to Tier 3 AMHs. Additional details on the requirements of Tier 4 AMHs will be forthcoming.

data strategy for AMH care management, the Department seeks to enable innovation and improve efficiency of care management.

To streamline information exchange and reduce costs and administrative burden for all stakeholders, the Department will pursue the following strategies: (1) support data consistency where appropriate; (2) promote common formats for data exchange that can be used for multiple purposes; (3) provide technical reference guides and implementation specifications; and (4) engage stakeholders to plan appropriate end-to-end testing and training for exchange of key data elements.

With respect to supporting consistency, the Department will require the use of standards where they exist and are widely implemented, e.g., the 837 Healthcare Claim Transaction Set for the exchange of claims data. In areas where standards are emerging (e.g., HL7 Fast Healthcare Interoperability Resources for sharing care plans) or have yet to be developed (e.g., risk stratification scales and scores), the Department will convene stakeholders through advisory groups to identify opportunities for consistent approaches to data types, formats, and transmission methodologies.

To help AMHs and their CINs and other partners handle data from multiple sources, the Department will promote common formats for data exchange that can be used for multiple purposes. For example, the Department will require PHPs to use a specific file layout and format for the transmission of encounter data to the Department. The Department will require PHPs to use a similar file layout and format for its transmission of beneficiary encounter data to AMHs.

For several key data transmissions between PHPs and the Department, the Department will provide technical reference guides. For example, the Department will provide a detailed attribution file layout and a technical reference guide with details for encounter data that will align with the following standards: X12 EDI format, 837 Healthcare Claim Transaction Set, and National Council for Prescription Drug Programs (NCPDP) format for pharmacy encounter data. The Department will provide PHPs a technical reference guide for encounter data in the first quarter of 2019.

Finally, to support preparations for care management, PHPs must demonstrate successful end-to-end testing of the exchange of specific data, including beneficiary assignment and encounter information, with AMHs and CINs and other partners prior to the launch of managed care. The Department will provide additional details on the timing and scope of end-to-end testing efforts.

While the Department and stakeholders will strive to reduce data variability where appropriate, the complexity of multiple data flows may still prove challenging for some practices that lack the in-house technical capabilities and staff. For example, many independent primary care practices will not have a secure data warehouse or data experts on staff to analyze data from multiple sources.

Tier 3 practices choosing to take on more responsibility for care coordination and care management may need to augment their own capabilities in such areas as handling data, performing analytics for population health, and in the delivery of advanced care coordination and care management functions. AMHs can contract with CINs and other to meet any gaps in they have in their data capabilities or systems that are detailed in the examples below.

IV. CINs' and other Partners' Potential Data-related Roles and Data Flows

CINs and other partners can provide valuable support to help Tier 3 AMHs meet their care management data needs by aggregating data from multiple sources; normalizing data; and making unified, actionable data readily available and to support care management and other population health use cases.

This section identifies nine care management functions that Tier 3 AMHs are expected to perform, and that CINs and other partners data services could support:

(1) Aggregating beneficiary assignment
(2) Receiving encounter data
(3) Compiling and conducting risk stratification
(4) Receiving initial care needs screening
(5) Conducting comprehensive assessments
(6) Creating and curating care plans
(7) Coordinating transitional care management
(8) Analyzing practice performance for improvement
(9) Reporting performance results to PHPs

For each function listed above, this section: (a) identifies the relevant PHP and AMH data-related requirements; (b) highlights the relevant standards and/or approach to data consistency and applicable end-to-end testing and training efforts; (c) provides examples of potential supporting roles that CINs or other partners could perform; and (d) depicts the data flows with descriptions of the paths.

1. Aggregating Beneficiary Assignment

To help AMHs manage their assigned beneficiaries, the Department requires that PHPs share beneficiary assignment information with all AMHs.[10] For transmission of beneficiary assignment information from the Department to PHPs, the Department will provide an attribution file layout and a companion guide with technical details that aligns with Electronic Data Interchange (EDI) 834 Benefit Enrollment and Maintenance standard.

For PHPs' transmission of beneficiary assignment information to AMHs, the Department expects that PHPs will support approaches that align with AMHs and their CINs' and other partners' technical capabilities to accept beneficiary assignment files. Further guidelines will be published in the beneficiary assignment companion guide.

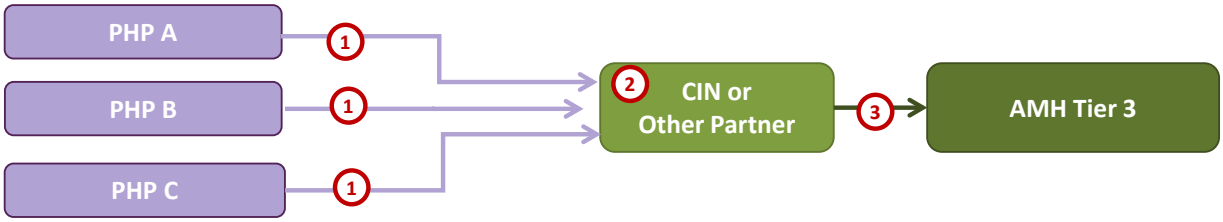
To support the exchange of beneficiary assignment information among authorized entities, PHPs must demonstrate successful end-to-end testing of beneficiary assignment data with AMHs and CINs and other partners prior to the launch of managed care.

As illustrated in Figure 3 below, CINs and other partners can collect and organize beneficiary assignment information on behalf of AMHs to help the AMHs reconcile patient lists, identify beneficiaries in need of higher intensity care management, and create care plans.

[10] PHPs must transmit: (1) point-in-time assignment information on at least a monthly basis; (2) projected assignment information for the following month (to the extent information is available); (3) information about newly-assigned Beneficiaries to the PHP, within seven business days of enrollment (more rapid notification may be required for assignment of newborns); (4) Notifications of any ad-hoc changes in assignment as they occur, within seven business days of each change.

Figure 3. Beneficiary Assignment Flows and Potential CIN and Other Partner Roles

Relevant AMH Tier 3 Data Requirement: Practice must ensure that the assignment lists transmitted to the practice by each PHP are reconciled with the practice's panel list and up to date in the clinical system of record.



Path	Description

1	• PHPs required to transmit beneficiary assignment data to AMH Tier 3 practices per below requirements:
	  • Information about newly assigned members to the PHP, within seven business days of enrollment
	  • Notifications of any ad-hoc changes in assignment as they occur, within seven business days of each change
	  • Point-in-time assignment lists at least monthly

2	• CIN or Other Partner collects and organizes member assignments
3	• CIN or Other Partner transmits member assignments to AMH Tier 3 to assist with care management assignment, risk stratification, etc.

CINs and other partners may also use the beneficiary assignment files to help AMHs generate and transmit lists of beneficiaries that can be shared with external organizations to obtain automated alerts and aggregated clinical information. For example, CINs and other partners could share beneficiary assignment files with North Carolina's statewide health information exchange system, NC HealthConnex or the North Carolina Healthcare Association, to ensure that AMHs have information on beneficiaries' admission, discharge, and transfers to hospitals, emergency departments, and outpatient settings. Additional details on CINs' and other partners' potential use of beneficiary assignments lists to locate and aggregate beneficiary information is provided below.

2. Receiving Encounter Data

To support their administrative, care management, and population health responsibilities, Tier 3 AMHs (directly or, more likely, through their CINs or other partners) are expected to have the ability to receive encounter data from PHPs on a regular basis.

> In addition to transmitting encounter data to the Tier 3 AMHs on an ongoing basis, the Department expects PHPs to share the initial set of 18 months of beneficiaries' historic fee-for-service claims data that they receive from the Department at manage care launch. Additional details on the timing and process for the transmission the beneficiaries' historic encounter data will be provided in forthcoming documentation.

The Department believes that consistent use of encounter data formats and standards will benefit AMHs that need to receive information from multiple sources and PHPs that are required to share data with multiple AMHs.

To help AMHs and their CINs and partners handle encounter data from multiple PHP sources, the Department requires that PHPs share consistently specified encounter data with Tier 3 AMHs. The Department will require PHPs to transmit encounter data to the Department in a consistent format in accordance with the following standards: X12 EDI format, 837 Healthcare Claim Transaction Set, and National Council for Prescription Drug Programs (NCPDP) format for pharmacy encounter data. The Department will provide PHPs a technical reference guide for encounter data..

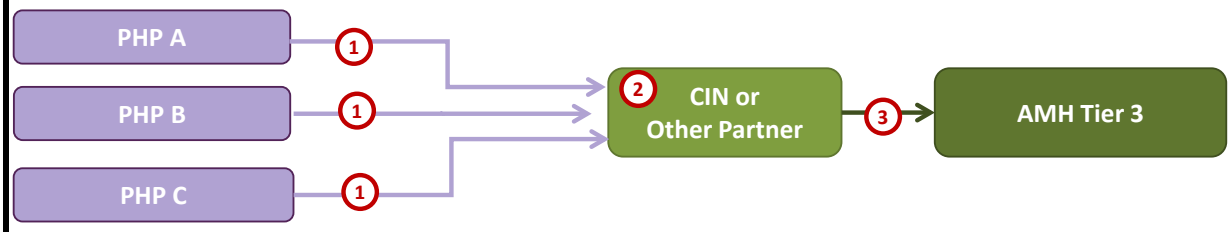
For PHPs' transmission of encounter data to AMHs, the Department expects that PHPs will support approaches that align with AMHs and their CINs' and other partners' technical capabilities to accept encounter information. The Department expects that PHPs will transmit encounter data to AMHs either using a format that is consistent with the PHP's transmission to the Department or a format that PHPs, AMHs, CINs, and other partners determine to be more effective and efficient.

The Department will provide PHPs further guidelines regarding encounter data requirements in a technical reference guide. To support the exchange of encounter data among authorized entities, PHPs must demonstrate successful end-to-end testing of encounter data with AMHs and CINs and other partners prior to the launch of managed care.

As depicted in Figure 4, CINs and other partners can compile PHPs' encounter and pharmacy claims data to inform critical care management functions including risk stratification and care planning.

Figure 4. Medical Encounter and Pharmacy Encounter Flows and Potential CIN and Other Partner Roles

Relevant AMH Tier 3 Data Requirement: The practice must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.



Path	Description

1	• PHPs required to transmit encounter data to AMH Tier 3 practices per below requirements:
	  • provide encounter, data at least monthly, or more frequently as requested by the Department.
	  • deliver pharmacy data at least weekly, or more frequently as requested by the Department.

2	• CIN or Other Partner collects and organizes encounter data.
3	• CIN or Other Partner transmits encounter data to AMH Tier 3 to assist with risk stratification, care plan creation, and other care management processes.

3. Compiling and Conducting Risk Stratification

Risk stratification of beneficiaries is a foundational element of care management and can occur at multiple levels.

Tier 3 AMH practices are required to have the capacity (directly or through their CINs or other partners) to risk stratify all of their Medicaid Managed Care beneficiaries. Tier 3 AMHs must:

- use PHP assessments to inform delivery of care management
- use a consistent method to assign and adjust risk status
- use a consistent method to combine risk scoring information from PHPs with clinical information to score and stratify empaneled patients
- identify priority populations
- ensure entire care team understands basis of risk scoring methodology
- define the process of risk score review and validation

PHPs are required to use risk scoring and stratification to identify beneficiaries who are part of priority populations for care management. 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.

The Department requires PHPs to share risk stratification information with all AMH practices. To help inform the AMHs' care management activities, the Department encourages PHPs to share with AMHs details on the categories of their risk model inputs, guidance for understanding their methodology, and training and tools to interpret the risk scores.

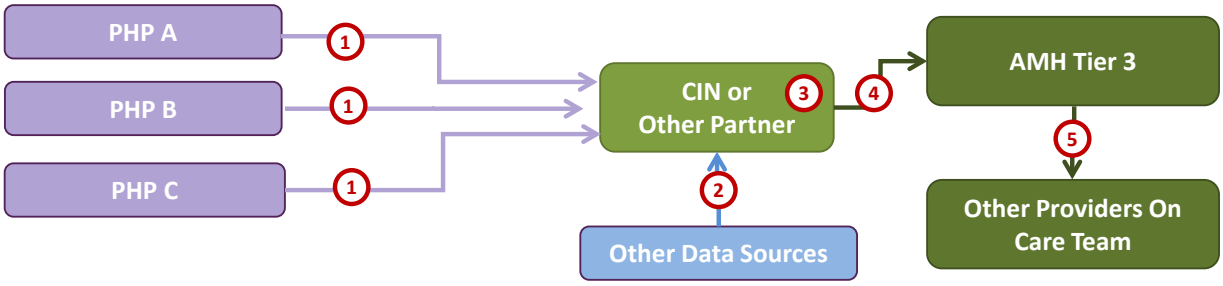
While there will be varying risk stratification approaches in the marketplace, AMH Tier 3 providers have the flexibility to choose the models that work best for them. AMHs can utilize the PHPs' risk scoring and stratification results or integrate the PHPs' risk scoring results with their own. Given the wide spectrum of organizational structures and analytic capabilities and needs across AMH practices, the Department expects PHPs and AMHs will work together through the AMH Technical Advisory Group to determine the appropriate format and frequency for the sharing of such information.

As illustrated in Figure 5, CINs and other partners, in support of Tier 3 AMHs' risk stratification, could:

- assist in defining process for risk score review and validation
- adjust and normalize risk status for each assigned patient based on risk scoring data from multiple PHPs
- incorporate into the risk stratification calculation potentially relevant information including gaps-in-care data, clinical data, or social determinants of health information
- perform or assist in identification of priority populations based on risk scoring
- incorporate risk-stratification findings into the Care Plan, once a risk level has been assigned
- use analytics to develop more detailed risk assessments and customized care management approaches

Figure 5. Risk Stratification and Potential CIN or Other Partner Role

Relevant AMH Tier 3 Data Requirement: Tier 3 AMH practices must be able to risk stratify all empaneled patients. The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel.



Path	Description

1	• PHPs required to transmit risk stratification information to AMH practices per below requirements:
	  • The PHP shall share PHP-furnished risk scoring results with all AMH practices (regardless of tier), including (where possible and relevant) Member-level information about cost and utilization outliers.
	  • The PHP shall notify AMHs when Members fall into required Department priority population categories
	  • The PHP is encouraged to share types or categories of risk stratification model inputs that can inform specific actions by the AMH.

2	• CIN or Other Partner collects data from other sources to inform the beneficiaries' risk stratification score calculation.
3	• CIN or Other Partner compiles and organizes risk stratification information data.
4	• CIN or Other Partner transmits risk stratification information to AMH Tier 3 to assist with risk stratification, care plan creation, and other care management processes.
5	• AMH (or CIN/Other Partner at its behest) transmits risk stratification information to ensure that the whole care team understands the basis of the practice's risk scoring methodology

4. Receiving Initial Care Needs Screening

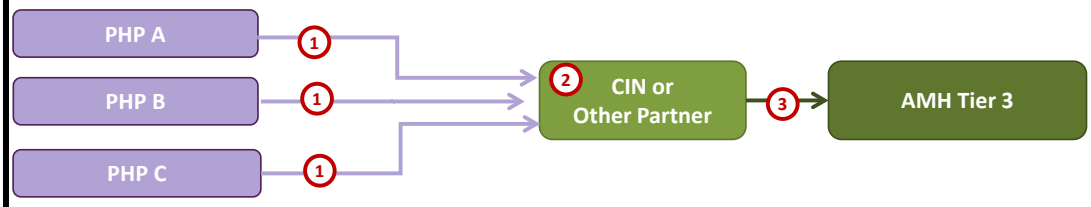
To help inform the AMH's comprehensive assessment and care planning efforts, the Department requires PHPs to share initial care needs screening information with all AMHs within seven days of screening..

As illustrated and described in Figure 6, CINs and other partners can compile and/or parse specific elements from the care needs screening to inform critical care management functions including their risk stratification, care assessment, and care planning.

With respect to AMHs' population health needs, CINs or other partners could aggregate beneficiaries' care needs screening results to identify patterns and inform the AMHs' performance. See Figure 6.

Figure 6. Initial Care Needs Screening Flows and Potential CIN or Other Partner Role

Relevant AMH Tier 3 Data Requirement: 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 PHP (if available).



Path	Description
1	• PHPs required to transmit initial care needs screening data to AMH practices per below requirements: • The PHP shall share the results of all available Initial Care Needs Screenings with primary care providers in all AMH tiers within seven (7) days of screening, or within seven (7) days of assignment of a new PCP or AMH, whichever is earlier.
2	• CIN or Other Partner collects and organizes initial care needs screening data.
3	• CIN or Other Partner transmits initial care needs screening data to AMH Tier 3 to assist with risk stratification, care plan creation, and other care management processes.

5. Conducting Comprehensive Assessments

To support their care management requirements and care planning responsibilities, Tier 3 AMHs will need timely access to comprehensive assessment information furnished by PHPs. PHPs will be required to complete a Comprehensive Assessment within thirty (30) calendar days of identifying a beneficiary as being part of one or more priority populations or having received a referral for care management. The PHPs must share the results of the Comprehensive Assessment with the beneficiary, beneficiary's AMH/PCP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with beneficiary consent to the extent required by law.

In situations where the AMH develops the Comprehensive Assessment, the AMH must share the results of the Comprehensive Assessment with the beneficiary's PHP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with beneficiary consent to the extent required by law. In preparation for the assessment, AMH care team members may consolidate information from a variety of sources, and must review the Initial Care Needs Screening performed by the PHP (if available).

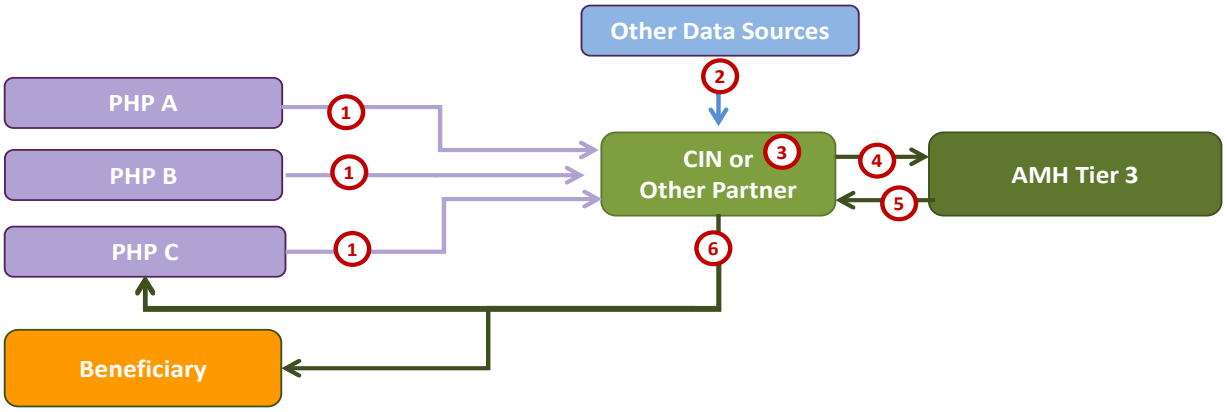
In order to reduce operational complexity and costs, the AMH TAG will address opportunities for the use of consistent format and data transmission methods for Comprehensive Assessments shared among PHPs and AMHs.

In support of Tier 3 AMHs' assessment requirements, CINs or other partners could:

- provide tools for practices to streamline administration of assessments
- aggregate PHPs' assessments
- collect critical clinical and social determinants of health information from other data sources
- prepare the comprehensive assessment to be transmitted to the PHPs and beneficiaries in a document or machine-readable format

Figure 7. Comprehensive Assessments and Potential CIN or Other Partner Role

Relevant AMH Tier 3 Data Requirement: AMH must share the results of the Comprehensive Assessment with the Member's PHP; in preparation for the assessment, AMH care team members may consolidate information from a variety of sources, and must review the Initial Care Needs Screening performed by the PHP (if available).



Path	Description
1	• PHPs required to transmit comprehensive assessments to AMH practices : • The PHPs must share the results of the Comprehensive Assessment with the Member, Member's AMH/PCP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law.
2	• CIN or Other Partner collects and organizes information (e.g., clinical, SDOH) from other data sources.
3	• CIN or Other Partner collects and organizes comprehensive assessment data.
4	• CIN or Other Partner transmits comprehensive assessment data to AMH Tier 3 to assist with care plan creation and other care management processes.
5	• If applicable, AMH Tier 3 conducts a comprehensive assessment and shares it with CIN or Other Partner.
	• CIN or Other Partner transmits comprehensive assessment data to PHP and/or Beneficiary as appropriate.

6. Creating and Curating Care Plans

PHPs and Tier 3 AMHs with delegated care management responsibilities must create a care plan for each high-need beneficiary receiving care management. The care plan must contain, at a minimum:

- measurable goals
- medical needs including any behavioral health or dental needs
- interventions including addressing medication management, including adherence
- intended outcomes
- social, educational, and other services needed by the beneficiary

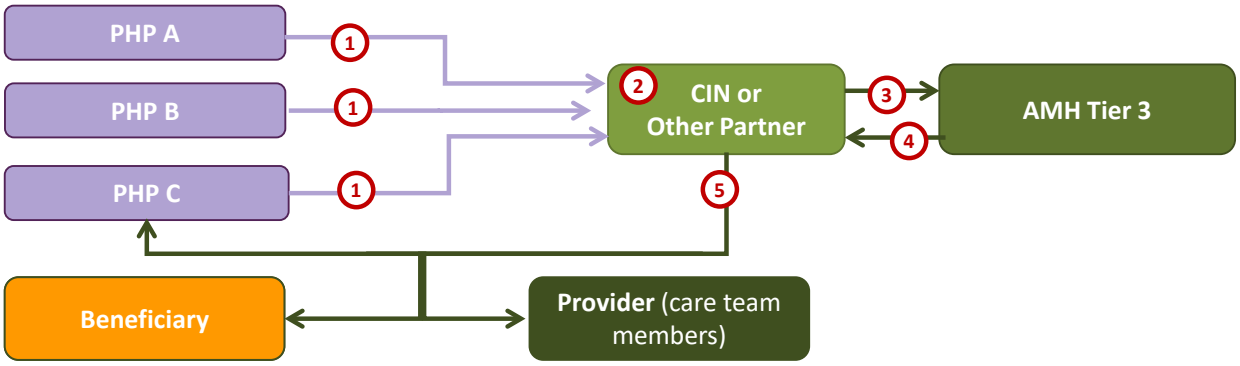
The Department requires PHPs and Tier 3 AMHs to update the care plan regularly to address gaps in care, incorporating input from care team members and beneficiary. They must ensure that each care plan is documented and stored and made available to the beneficiary and care team beneficiaries. In order to reduce operational complexity and costs, the AMH TAG will address opportunities for the use of consistent format and data transmission methods for care plans shared among PHPs and AMHs.

In support of Tier 3 AMHs' care planning requirements, CINs and other partners could, as illustrated below:

- document and store the care plan
- incorporate findings from the PHP care needs screening and risk score to create an actionable plan
- integrate practice-based risk stratification, comprehensive assessments, and clinical information and unmet health related resource needs
- provide data systems that identify and manage gaps in care and referrals
- develop workflows for updating the Care Plan on an ongoing basis
- develop mechanisms for sharing care plans with the PHP and/or the beneficiary

Figure 8. Care Plans and Potential CIN or Other Partner Role

Relevant AMH Tier 3 Data Requirement: The AMH must update the care plan regularly to address gaps in care, incorporating input from care team members and member. They must ensure that each care plan is documented and stored and made available to the member and care team members.



Path	Description
1	• PHPs required to create care plan for each high-need beneficiary receiving care management and transmit the care plans to AMH practices .
2	• CIN or Other Partner collects and organizes care plan data.
3	• CIN or Other Partner transmits care plan data to AMH Tier 3 to assist with AMH's care plan creation and other care management processes.
4	• If applicable, AMH Tier 3 creates a care plan and shares it with CIN or Other Partner.
5	• CIN or Other Partner transmits care plan data to PHP, other members of care team , and beneficiary.

7. Coordinating Transitional Care Management

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, or transfer and who are at risk of readmissions and other poor outcomes. The Tier 3 AMH practice must 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

Effective care coordination among providers requires that the AMH care managers know: (1) the location of their beneficiaries in the care continuum and (2) their status along key clinical and social determinants of health indicators.

7.1. Automated Event-Notifications

AMHs will need access to timely notifications when beneficiaries have been admitted, transferred or discharged from a hospital or emergency department. The Department believes that timely access to and use of ADT information is crucial for the success of the AMH program, especially for practices in Tier 3 that are responsible for timely, proactive functions on behalf of Medicaid Managed Care beneficiaries. In support of their care management requirements, PHPs and Tier 3 AMHs are required to utilize admission discharge and transfer (ADT) feeds.

Accordingly, all Tier 3 AMHs must demonstrate that, at a minimum, they have active access to an ADT data source that correctly identifies specific empaneled Medicaid Managed Care beneficiaries' admissions, discharges or transfers to/from an emergency department 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.

Providers have numerous options to receive ADT information. NC HealthConnex requires hospital connectivity to NC HealthConnex for ADT notifications, and plans to provide access to ADT information for all AMHs participating in the HIE at no additional charge.

In addition, providers can access ADTs from other sources, such as the North Carolina Healthcare Association, at their discretion. Importantly, practices and/or CINs and other partners will need the capacity to filter an ADT file to the specific attributed beneficiaries for whom AMH practices are responsible, and track utilization across hospitals and related facilities in their catchment areas.

Regardless of the ADT source, Tier 3 AMHs must agree to design and implement their own systematic, clinically appropriate care management process using ADT information.

In support of Tier 3 AMHs' event-notification requirements, CINs or other partners could:

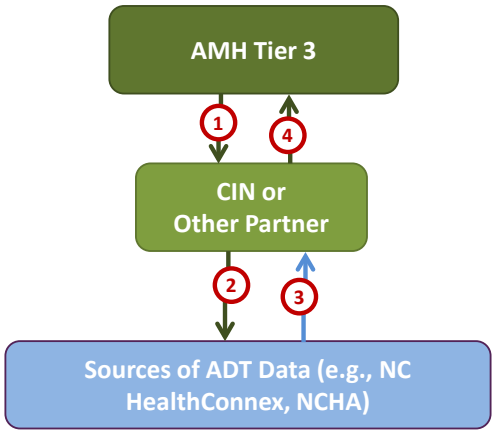
- create beneficiary lists to transmit to sources of ADT data such that they can create subscription-based alerts for the AMH's assigned beneficiaries
- compile data on beneficiaries from multiple sources of ADT data
- develop their processes to respond to certain high-risk ADT alerts received in real time (e.g., same-day outreach for certain high-risk subsets of the empaneled population and within a several-day period for other beneficiaries for whom ADT information is received (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)
- use daily batched ADT information to facilitate beneficiary prioritization for care management or coordination activities. For example, care managers could access a list of all empaneled beneficiaries who were admitted, discharged, or transferred to or from the hospital in the prior 24-hour period as an input into their daily care management queue
- leverage their access to ADT information to identify patterns and trends that can further inform care delivery and management and support practice-level population health efforts

- develop systems to ingest ADT information into their electronic health records and/or care management systems so this information is readily available to beneficiaries of the care team on future office visit(s)

An illustration of CIN and other partner's roles in support of ADT-based notification is provided in Figure 9.

Figure 9. Automated Event-Notifications and Potential CIN or Other Partner Roles

Relevant AMH Tier 3 Data Requirement: Practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local EDs and hospitals, through active access to an 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.



Path	Description
1	• AMH transmits up-to-date attributed beneficiary lists to CIN or other partner.
2	• CIN or Other Partner transmits AMH's attributed beneficiary list to ADT data sources.
3	• ADT data sources transmits ADT data for AMHs' attributed beneficiary list
4	• CIN or Other Partner compile and make actionable ADT data to the AMHs.

7.2. Relevant Beneficiary Clinical Information and Unmet Health Related Resource Needs

In order to manage the care of individual beneficiaries, AMHs will need timely access to certain clinical information including beneficiaries' test results, select lab values, gaps in care, and unmet health related resource needs (e.g., transportation insecurity, food insecurity, housing instability, interpersonal violence and toxic stress).

AMHs have several choices for how and where they choose to access clinical data, subject to State and federal beneficiary privacy protections. AMHs may also access information from NC HealthConnex[11] or

[11] Per North Carolina Session Law (S.L.) 2015-241, as amended by S.L. 2017-57, North Carolina providers reimbursed by the Department for providing health care services under the Medicaid program, must join NC HealthConnex. As of June 1, 2018,

other health information exchange (HIE) services.[12] Providers and their partners may also access such information from other sources, such as prescribing information from vendors in the market (e.g., Surescripts).

AMHs will receive certain information about a beneficiary's unmet health related resource needs through the transmittal of the care needs screening information from the PHP. Additionally, in the future, AMHs will also be able to track beneficiaries' referrals to and access of social services via the NCCARE360, a statewide technology platform that will serve as a robust and updated resource directory and a referral and feedback loop platform that will and allow users, such as AMHs, insurers and human service providers, to connect people who have an identified unmet resource need (e.g., housing, transportation, food) with available community resources.[13]

To further help address Medicaid beneficiaries unmet resource needs, care managers in Tier 3 AMHs may also interact with North Carolina's Healthy Opportunities Pilots. The Department will launch Healthy Opportunities Pilots in two to four geographic areas of the state to test evidence-based interventions designed to reduce costs and improve health by more intensely addressing housing instability, transportation insecurity, food insecurity, interpersonal violence and toxic stress for eligible Medicaid beneficiaries.[14] Additional information regarding the data exchange roles and relationships between PHPs, LHDs, AMHs, Lead Pilot Entity and human service organizations that are necessary to implement the Healthy Opportunities Pilots will be forthcoming.

With respect to transmitting clinical information and unmet resource needs to other entities, the Department requires that AMHs transfer the enrollee's medical record to the receiving practice upon the change of primary care provider (PCP) at the request of the new PCP or PHP (if applicable) and as authorized by the enrollee within 30 days of the date of the request.

In support of Tier 3 AMHs' needs to collect clinical and resource needs information; integrate the relevant data into assessments, care plans, and medical records; and share the information with other entities, CINs and other partners could:

- aggregate and compile clinical information from HealthConnex and other providers of HIE services
- collect beneficiaries' referral information and their receipt of social services
- compile relevant beneficiary clinical and health related resource needs information to create a medical record for a beneficiary's new PCP

An illustration of CIN and other partner's roles supporting the collection of beneficiaries' clinical data and unmet health related resource needs is provided in Figure 10.

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hospitals, physicians and nurse practitioners who currently have an electronic health record (EHR) system are to be connected to NC HealthConnex to receive payments for North Carolina Medicaid and NC Health Choice services.

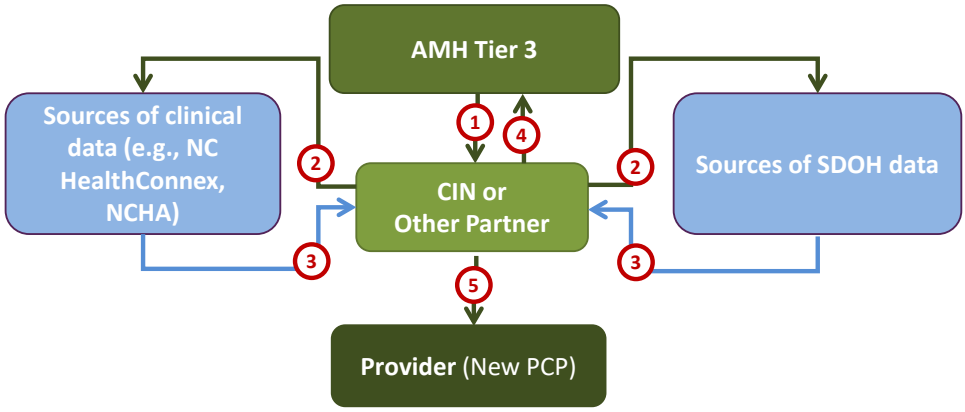
[12] Practices currently affiliated with a health system or hospital group may have access to clinical data for other providers affiliated with the same system in the health system's EHR software.

[13] "Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina" released by the Department April 5, 2018.

[14] "Healthy Opportunities Pilots Fact Sheet," released by the Department October 2018.

Figure 10. Relevant Beneficiary Clinical Information and Unmet Health Related Resource Needs and Potential CIN and Other Partner Roles

Relevant AMH Tier 3 Data Requirement: Tier 3 AMHs must transfer the enrollee's medical record to the receiving practice upon the change of primary care provider (PCP) at the request of the new PCP or PHP (if applicable) and as authorized by the enrollee within 30 days of the date of the request.



Path	Description
1	• AMH transmits up-to-date attributed beneficiary lists to CIN or other partner.
2	• CIN or Other Partner transmits request for relevant clinical and SDOH data for AMH's attributed beneficiaries
3	• Clinical and SDOH data sources transmit relevant clinical and SDOH data for AMH's attributed beneficiaries
4	• CIN or Other Partner compile and make actionable clinical and SDOH data to the AMH.
5	• CIN or Other Partner compile and transmit clinical and SDOH data to the new primary care provider.

8. Analyzing Practice Performance for Improvement

In addition to the provision of care management directly to Medicaid beneficiaries at the individual level, AMHs will also assess their own performance across all their attributed beneficiaries at a population health level.

To help inform these internal practice improvement activities, the Department requires PHPs to provide encounter data at least monthly and feedback on quality scoring results to each AMH practice on both an annual and an interim basis for selected measures The Department will provide guidance on the content and format of these data in the first quarter of 2019..

In addition to encounter and performance reports provided by the PHPs, AMHs could also access aggregated beneficiary information from other data sources (e.g., North Carolina Immunization Registry, North Carolina Controlled Substance Reporting System).

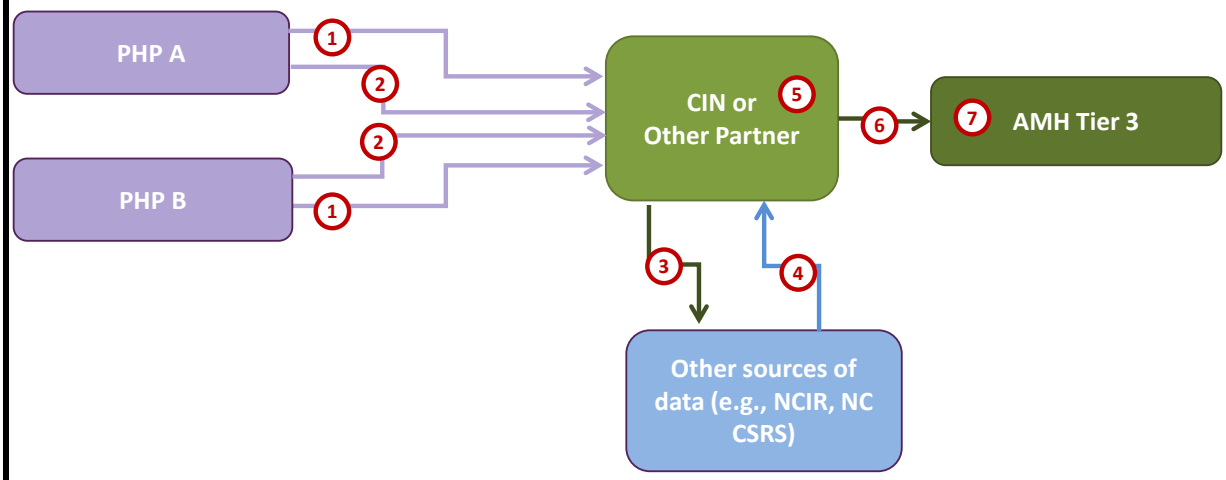
In support of Tier 3 AMHs' performance assessment needs, CINs and other partners could:

- compute quality performance information across PHPs to identify and resolve any discrepancies in PHP-calculated performance and AMH's perceptions of performance before measures become final
- aggregate performance data at the practice level to provide dashboards on quality measures
- analyze data to assess performance related to specific interventions, identify gaps in care, and/or ascertain opportunities to target resources more efficiently

An illustration of CIN and other partner's roles supporting AMHs' quality improvement needs is provided in Figure 11.

Figure 11. Assessing and Analyzing Performance and Potential CIN or Other Partner Role

Relevant AMH Tier 3 Data Requirement: The practice must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.



Path	Description
1	• PHPs required to transmit encounter data to at least monthly, or more frequently as requested by the Department.
2	• PHP required to transmit quality performance assessments, gap reports, and other data on an annual and interim basis.
3	• CIN or Other Partner transmits AMH's attributed beneficiaries list to other data sources.
4	• CIN or Other Partner collects and organizes aggregated information on the AMH's attributed beneficiaries.
5	• CIN or Other Partner compiles encounter, performance assessment reports, and other data.
6	• CIN or Other Partner provides actionable performance information, gap reports, etc. to AMH Tier 3.
7	• AMH Tier 3 integrates actionable information and reports into its clinical point-of-care systems.

9. Reporting Performance Results to PHPs

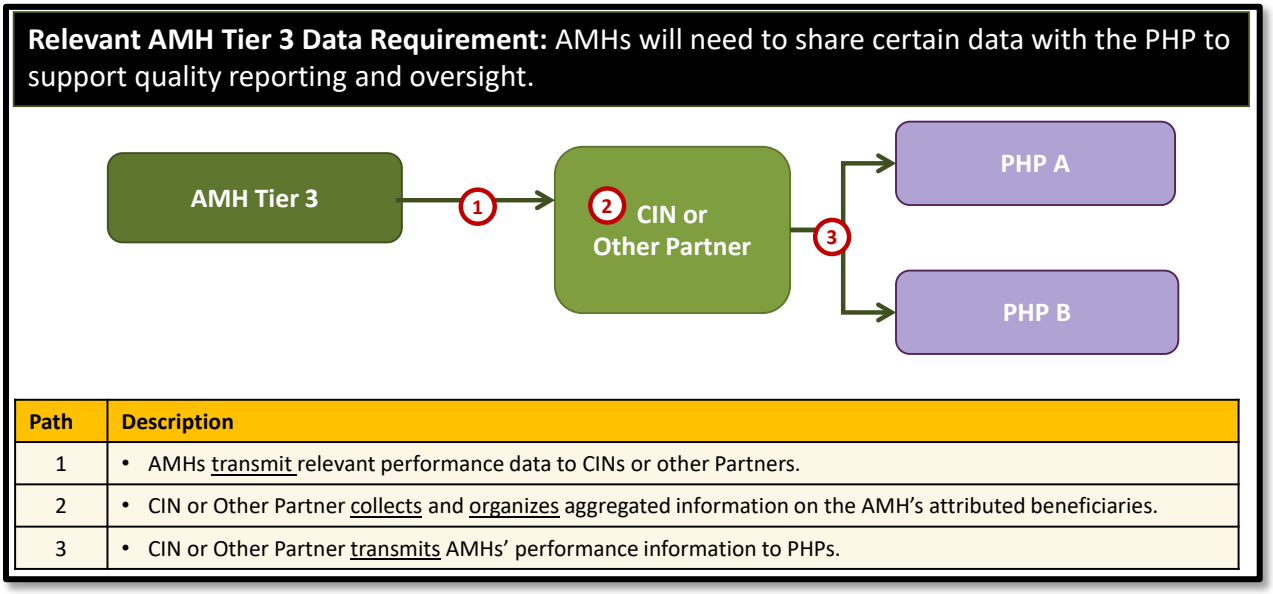
PHPs will be ultimately accountable for the quality and health outcomes of their beneficiaries. In order to perform quality reporting and oversight, Tier 3 AMHs will need to transmit process-related performance data and other information to PHPs.

In support of Tier 3 AMHs' reporting of performance results and other information to PHPs, CINs and other partners could:

- collect and compile aggregated information on the AMH's attributed beneficiaries
- parse and transmit performance information to the AMHs' respective PHPs

An illustration of CIN and other partner's roles supporting AMHs' performance reporting is provided in Figure 12.

Figure 12. Reporting Performance Results to PHPs and Potential CIN or Other Partner Role



Path	Description
1	• AMHs transmit relevant performance data to CINs or other Partners.
2	• CIN or Other Partner collects and organizes aggregated information on the AMH's attributed beneficiaries.
3	• CIN or Other Partner transmits AMHs' performance information to PHPs.