Medicaid Managed Care
Proposed Concept Paper

Data Strategy to Support the Advanced Medical Home Program in North Carolina

North Carolina Department of Health and Human Services

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Contents

I. Introduction

North Carolina is preparing to transition its North Carolina Medicaid and NC Health Choice programs from a predominantly Medicaid fee-for-service delivery system to Medicaid managed care. Care management is foundational to the success of North Carolina Medicaid[1], supporting high-quality service delivery in a partnership between providers and prepaid health plans (PHPs) led and, as feasible, delivered at a community level.

The North Carolina Department of Health and Human Service's (the Department) strategy for care management in Medicaid Managed Care will promote accountability for PHPs and providers to innovate toward improved care outcomes. To achieve that, entities responsible for care management must have timely access to complete, individual-level data to help them seamlessly manage care and population health activities across their Medicaid patient populations.

In March, the Department released its [strategy for care management[2] in Medicaid Managed Care](#) that introduced the Advanced Medical Home (AMH) model. This policy paper expands on the "Data Sharing" section to provide further information on the types of data that AMH practices are likely to need (and who should provide it) to perform care coordination and management, population health improvement and quality management functions for the members they serve. The Department welcomes input and recommendations.

AMH Data Strategy Guiding Principles

The Department's oversight of PHP data sharing with AMH practices will be informed by four guiding principles:

1. Ensure AMH professionals have timely access to relevant, individual-level information;

2. Equip AMH Tier 3 and Tier 4 practices to seamlessly manage care across their PHP populations;

3. Minimize administrative and cost burdens on AMHs and PHPs wherever possible;

4. Engage members in their own health and health care decisions by encouraging the secure and more widespread sharing of health information with members.

AMH Data Strategy Components

At the outset of Medicaid Managed Care, PHPs will be required to share certain data with all AMH practices in their networks, including member assignment information, PHP risk scoring and stratification results, "Initial Care Needs Screening" information, and common quality measure performance information. PHPs will also be required to share claims or encounter data feeds with Tier 3 and 4 AMH practices (through their partners). Tier 3 and Tier 4 AMH practices (and their partners) will also be required to access and use Admission, Discharge, Transfer (ADT) information, and Tier 1 and Tier 2 practices are also strongly encouraged to do so.

All AMHs should incorporate relevant clinical information (e.g., immunization status, lab results) into their population health and care management processes, and AMHs are encouraged to access information to support opportunities for health from a new NC Resource Platform, which is currently under development.

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[1] For purposes of this document, "Medicaid" refers to North Carolina Medicaid and NC Health Choice programs, unless specified otherwise.

[2] ["North Carolina's Care Management Strategy under Managed Care" released by the Department March 9, 2018.](#)

Finally, PHPs and AMHs are strongly encouraged to engage members in their own health through secure information sharing with members.

The Department will set up a data sub-group of the Technical Advisory Group supporting the AMH program, and will follow up with more specific guidance on data functionalities and requirements and the development of a published reference guide with relevant, detailed common specifications for claims/encounter and other data sharing.

II. Background

Under the AMH model, qualified PHPs selected through a competitive procurement process by the Department will be expected to contract directly with participating primary care practices and other providers to deliver local care coordination and care management services to Medicaid Managed Care members. The AMH model includes several tiers delineating different choices and roles providers will have regarding certain data/analytic, care coordination and care management functions on behalf of Medicaid Managed Care members.

- AMH **Tier 1 and Tier 2:** PHPs will have primary responsibility for care management functions. Tier 1 and Tier 2 practices will be required to closely coordinate with their contracted PHPs in the delivery of care management functions.

- **Tier 3 and Tier 4:** AMH practices will take the lead in organizing and delivering care management services for their Medicaid Managed Care members across all Medicaid PHPs with whom they contract, with care management oversight and support provided by PHPs. It is expected that Tier 3 and Tier 4 practices will perform these functions in partnership with third-party partners they will select (discussed below).

Given that care management and other functional requirements vary by AMH tier, PHPs' payments to practices will likewise vary by tier and other factors. AMH practices in all tiers will receive payments at the same level as they received under Medicaid Fee-for-Service, but under Medicaid Managed Care, those payments will be paid to providers by PHPs for delivering clinical services to Medicaid Managed Care members. In addition, under Medicaid Managed Care, PHPs will be required to pay minimum "Medical Home Fees" (with *minimum* payments determined by the Department) to AMH practices in all tiers. PHPs also will be required to pay an additional *minimum* "Care Management Fee" to Tier 3 and Tier 4 practices to reflect those practices' enhanced responsibilities for care management attributed to Medicaid Managed Care members.

It is important to note that the AMH model is intended to be a framework outlining *minimum* requirements. PHPs and AMHs are encouraged to innovate in care delivery, data sharing and payment models, according to their strategies, capabilities and preferences, and—most importantly—the needs and preferences of Medicaid Managed Care members. For example, building on the AMH model, some PHPs, and Tier 3 or Tier 4 AMHs, may contract with each other under innovative care delivery and payment arrangements such as shared-savings payment models when providers' care delivery efforts result in reductions in the growth of the total cost of care coupled with superior quality outcomes. Aspects of the Department's AMH model will evolve over time based on experiences in the market and input from stakeholders.

The Department recognizes that all practices participating in the AMH model, regardless of their tier, will need access to certain types of data to manage the health of individuals enrolled in Medicaid. Compared to AMH

Tier 1 and Tier 1, practices in AMH Tier 3 and Tier 4 will have enhanced data needs and associated requirements given their elevated care management and other responsibilities.[3]

III. Strategy Overview

In the transition to Medicaid Managed Care, PHPs contracted by the Department will establish contracts with providers for a range of services subject to network adequacy and other program requirements. Each PHP will bring its own data systems and tools to perform a variety of Medicaid Managed Care functions, including screening and identification of high-risk members, processing claims, conducting data analyses and other functions. The Department will play a contractual oversight role in the market, seeking 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.

AMH Data Strategy Guiding Principles

The Department's oversight of PHPs' data sharing with AMH practices will be informed by the following guiding principles, which are aligned with its broader guiding principles for care management[4]:

1. To the extent possible, AMH health care professionals, including care managers, should have access to timely and comprehensive individual-level information including demographic, utilization, clinical and other information.

2. AMH practice teams in Tier 3 and Tier 4 (directly or through their partners) should be equipped with an effective and secure data infrastructure, trained staff and mature business processes to manage their populations seamlessly across PHP populations.

3. 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.

4. As health care consumers, Medicaid Managed Care members are the primary owners of their own health information. PHPs and AMHs should engage and support members by making information sharing with members easier and more widespread.

Role of Clinically Integrated Networks and Other Partners in AMH Tier 3 and Tier 4

The Department appreciates that practices choosing to take on more responsibility for care coordination and care management (i.e., practices in Tier 3 or Tier 4) may need support augmenting their own capabilities in such areas as handling data, performing analytics, and in the delivery of advanced care coordination and care management functions. For example, most individual primary care practices may not have a secure data warehouse or data experts on staff to analyze data from multiple sources. Moreover, many practices may not have a full care team on staff, including social workers, pharmacists and others, needed to provide comprehensive care management. It would not be efficient for every practice to obtain these capabilities. The Department 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, the Department seeks to

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[3] Delegated services such as care management may require periodic reporting of statistics such as timeliness of care manager assignment, treatment plan compliance or other data elements set by the Department for PHP reporting. AMHs, particularly Tier 3 and Tier 4 AMHs, may need to provide data to PHPs to be included in the PHPs' reporting to the Department.

[4] "North Carolina's Care Management Strategy under Managed Care," March 9, 2018, page 14.

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.

To be successfully certified by the Department as a Tier 3 or Tier 4 AMH practice, a practice will need to attest that it (alone or with a named partner) has the capacity to perform care coordination and care management functions, and meet data requirements for AMH practices, as outlined in Section IV.[5] There will be more than one route for a practice (or groups of practices) to demonstrate the needed capabilities. For example:

- **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 or Tier 4 practice may receive data/analytics and care coordination and management support at a system level from their hospital or health system's Clinically Integrated Network (CIN). 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 and care coordination and management support. Such AMHs will communicate this choice also to their contracted PHPs, as the entity designated as the CIN for specific AMHs will receive (from PHPs and other sources) applicable data on behalf of the AMHs.

- **Independent practices.** The Department specifically aims to support independent primary care practices' participation in Tier 3 and Tier 4 of the AMH program without requiring or necessarily incentivizing such practices to be formally affiliated with or owned by a hospital or health system. Such practices may opt to partner with a third-party entity geared to independent practices to meet the program requirements. The partner in this case will deliver certain shared services to Tier 3 and Tier 4 practices, such as data, analytics/risk stratification, care coordination and care management functions. Independent practice AMHs will specify their partner/entity for data sharing and care management support in their AMH attestation. Such AMHs will communicate this choice to their contracted PHPs.

Providers will have free choice in their selection of a CIN or other partner, and the Department seeks a strong, competitive environment to enable that choice. The Department will certify AMH practices that apply to the program and attest to having Tier 3 or Tier 4 functions.[6] The Department will not separately certify CINs or third-party partners/entities selected by independent practices serving as AMHs. The Department expects that AMHs and PHPs will work together to define which functions will be performed at the practice level versus the partner/entity level, and will require that PHPs have general oversight to ensure all Tier 3 and Tier 4 functions are adequately performed, and applicable data privacy and security safeguards are met.

The Department may later issue guidance regarding the expected data privacy and security competencies and requirements of CINs and other third-party partners, and details for on minimum data, analytic and care management functions that such entities should demonstrate to serve AMH practices for purposes of the AMH program. This guidance would be intended in part to serve as practical support to providers and PHPs as they make decisions about various partnership options and requisite functions that such entities must demonstrate to providers and PHPs for data sharing requirements on PHPs to be applicable. Subject to this guidance, the Department will allow AMH practices discretion in how they decide to meet AMH program requirements.

AMH Data Strategy Components

The AMH data strategy establishes initial minimum requirements for data sharing, and highlights areas where additional work will be completed in the future. The strategy also identifies multiple types of information that

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[5] The Department will issue further guidance on Tier 3 attestation requirements, and an accompanying AMH manual.

[6] "North Carolina's Care Management Strategy under Managed Care" policy paper released by the Department March 9, 2018.

AMH practices, particularly those in Tier 3 and Tier 4, will need in order to perform care management functions for the Medicaid Managed Care members they serve.

The data discussion is divided into several distinct categories:

1. **Data PHPs will be required to share with all AMH practices (all tiers) in their networks**
   a. Beneficiary assignment information (i.e., an updated list of individual patients who are assigned/attributed to their practice)
   b. PHP risk scoring and stratification results
   c. "Initial Care Needs Screening" information
   d. Quality measure performance information

2. **Data PHPs will be required to share with AMH Tier 3 and Tier 4 practices**
   Claims or encounter data feeds for attributed members in a timely manner and in common formats

3. **AMH Tier 3 and Tier 4 practices will be required (and AMH Tier 1 and Tier 2 practices are strongly encouraged) to access Admission, Discharge, Transfer (ADT) information**
   ADT data feeds represent an essential data source that should be used to identify when attributed members are admitted, discharged, or transferred to/from an emergency department or hospital (or other care settings) and can support a variety of population health and care management functions

4. **All AMHs should incorporate relevant clinical information into their population health/care management process**
   Select member-level clinical information (e.g., immunization status, lab results data, other diagnostic results)

5. **All AMHs are encouraged to access the NC Resource Platform to support opportunities for health**
   Information regarding available community resources to address food, housing, transportation and other needs, and a referral platform to facilitate connection to and receive feedback from community resources

6. **PHPs and AMHs are encouraged to engage members in their own health through secure data sharing**
   The Department encourages the development and more widespread implementation of effective, secure ways of sharing health information with members

The AMH data strategy is intended to be a starting point for discussion and feedback from providers, PHPs and other stakeholders in North Carolina, and the Department expects to issue further guidance in the future as the Medicaid Managed Care program matures. As of the publication date of this policy paper, the PHP procurement has not yet taken place. As described in "North Carolina's Care Management Strategy under Managed Care," the Department will convene a Managed Care Technical Advisory Group (TAG) following the PHP award that will advise on crucial aspects of program design, and provide additional input on the program's design and implementation plan. As noted, the Department is considering a subgroup of this TAG that will focus on operationalizing the data strategy. Following initial PHP award, ongoing participation of PHPs, AMHs and other stakeholders in the TAG will be critical in reaching detailed agreement on each element of the data strategy.

IV. Data to Support AMH Practices in Delivering High-quality, Coordinated, Efficient Care to Medicaid Managed Care Members in North Carolina

Multiple data flows will be needed to support AMH practices in carrying out care management and related functions for their populations. Where helpful to reduce administrative burden, the Department will set uniform expectations and standards upfront to which PHPs and AMHs (either directly or through their designated CIN or other partner) will conform using a minimum set of standards for data elements, interchange formats and terminology. Where available, the Department will use nationally available standards.

PHPs and AMH practices will also be responsible for complying with all federal and North Carolina privacy and security requirements regarding the collection, storage, transmission, use and destruction of data.

1. **Information that PHPs must share with all AMH practices in their networks**

    PHPs will be required to share the following data with AMHs.

    a. **Beneficiary Assignment files**

        Every Medicaid beneficiary entering Medicaid Managed Care will be assigned to an AMH/primary care provider (PCP) either by their selecting an available AMH or PCP of their choice when they enroll in a PHP, or through auto-assignment by the PHP (if the beneficiary does not select a AMH/PCP) based on a Department-prescribed algorithm which aims to preserve historic patient-AMH/PCP relationships. AMH practices will need accurate, timely and complete information from PHPs about which members have been assigned to them. This information will serve to:

        -   Facilitate effective and timely patient outreach and care management

        -   Determine the level and accuracy of per member per month (PMPM) fees flowing from PHPs to the practice

        -   Serve as a key to access other applicable patient information about the assigned AMHs' members from the [North Carolina Health Information Exchange (HIE),](#) also known as NC HealthConnex.

        The Department currently plans to standardize requirements expected of PHPs regarding the timing and/or format of Beneficiary Assignment information to be shared with AMH practices. The Department recognizes that providers prefer assignment information as close as possible to real-time, reflecting such occurrences as new enrollees joining or exiting a PHP's membership and a practice's assignment list. The Department also recognizes that there can be tension between the timeliness of member assignment updates and data accuracy, since assignment data must cycle through multiple information systems before it is validated and passed to providers.

        Recognizing these tradeoffs, the Department's preliminary plan is to require PHPs to share with AMH practices regardless of tier:

- Point-in-time assignment information at least **monthly**. Ideally, this information would also include projected assignment information for the following month. These files will also serve as a reconciliation process between PHPs and AMH practices;[7]

- Information about newly assigned Medicaid Managed Care members to the PHP, within seven business days of enrollment; and

- Notifications of ad-hoc changes in assignment as they occur, within seven business days of each change.

After the PHP procurement, the Department's TAG data subgroup may further consider the detail of the requirements above, including the degree to which standardization of the format of assignment files passed to AMH practices is feasible and helpful to reduce administrative burdens on PHPs and AMHs.

b. **PHP risk scoring and stratification results**

A key aspect of Medicaid Managed Care is the PHPs' use of data and analytics to identify which members need various types of intervention. The Department expects that PHPs will use their own proprietary risk scoring and stratification capabilities for care management, population health and related purposes. PHPs are encouraged to develop and/or use their own innovative methodologies. This could include modeling techniques to predict outcomes or service utilization to deploy proactive care interventions to members who are receptive.

The Department expects that PHPs will share PHP-furnished risk scoring results with AMH practices (regardless of tier), including (where possible and relevant) member-level information about cost and utilization outliers.[8] Given the wide spectrum of organizational structures and analytic capabilities and needs across AMH practices, PHPs and AMHs will work together to determine the appropriate format and frequency for the sharing of such information. For clarity, Tier 3 and Tier 4 AMH practices will be required to have the capacity to risk stratify Medicaid Managed Care members across their Medicaid PHPs. It is expected that Tier 3 and Tier 4 AMH practices (again, in partnership with a CIN for health system-affiliated practices or another third-party partner in the case of independent practices) may use PHP-furnished risk scores as key inputs into that process.

To the extent that PHPs share results with AMHs of risk stratification or analytic models, they will be encouraged where possible to share types or categories of model inputs that can inform

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[7] The Health Care Payment Learning and Action Network (LAN), a convening of public and private payers supported by the federal government, recommended in a recent white paper on attribution that, "At the beginning of the performance period, providers should know which patients they are responsible for managing and the expected time period for management. Updated lists of patients should be shared periodically with provider groups and/or delivery systems…preferably monthly." See https://hcp-lan.org/workproducts/pa-whitepaper-final.pdf.

[8] For clarity, as part of the PHP rate development process, the Department will calculate PHP-specific risk scores that will adjust each plans' rate in a given region and premium group for the acuity of the population enrolled in the plan. The plan risk scores are an aggregation of each beneficiary's acuity level (or beneficiary risk score) as calculated through the Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model. On implementation, the Department will use Department fee-for-service data to populate the model, and derive the plans and beneficiary risk scores. As indicated in the Department's Managed Care Program Actuarial Request for Information released Nov. 2, 2017, the Department intends to update these scores every six months. To the extent that the Department opts to share beneficiary-level risk scores underlying these payment assumptions with PHPs, the Department would expect PHPs to share such information with AMH practices.

specific actions by the AMH (without providing all the detailed inputs into PHPs' analytic models). Some of these factors should be guided by other requirements that the Department will place on PHPs (for example, PHPs must identify members meeting the Department's definition of "Special Health Care Needs").[9]

c. **Initial Care Needs Screening information**

As described in "North Carolina's Care Management Strategy under Managed Care" policy paper, it is a federal requirement that Medicaid Managed Care plans make best efforts to conduct initial enrollee health and unmet resource need screenings within 90 days of enrollment.[10] In North Carolina, this step will be known as the "Initial Care Needs Screening."

PHPs will be required to share the results of available Initial Care Needs Screenings with primary care providers within seven days of screening, or within seven days of assignment of a new PCP, whichever is earlier.[11] Note that this requirement extends to all primary care practices, even those not participating in the AMH program. PHPs will have discretion regarding specific mechanisms for sharing these data with AMHs, including combining it with other types of data they are sharing with AMHs. As with other data elements, the TAG data group will further discuss potential standardization of this information to ease administrative burdens.

d. **Quality measure performance information at the practice level**

In the Department's Draft Quality Strategy, the Department defined a common set of quality measures that PHPs will be required to regularly track and report. The Department envisions that PHPs will use a subset of these standard Medicaid Managed Care quality measures (8 to 10 AMH-focused measures included in the priority measure set, which will be consistently used across all PHPs) to assess the quality of AMH practices and, where applicable, to develop and calculate performance-based payments.

The Department is also considering and seeks comment on a potential requirement that PHPs provide AMH practices with interim (e.g., quarterly or bi-annual) quality performance reports for selected measures in common formats. This potential requirement would be intended to serve a couple of purposes. First, it would provide a common basis for a practice in any AMH tier to understand its interim performance on the AMH measure set across its PHPs and thereby allow practices time to improve performance before the metrics become final. Second, while CINs or other third-party data/care management partners selected by AMHs should be able to compute quality performance information across PHPs, the potential requirement would provide the basis for AMHs to identify and resolve any discrepancies in PHP-calculated performance and AMH's perceptions of performance before measures become final. However, the Department appreciates that there are several design challenges and practical considerations to consider and, as such, the Department seeks input from potential PHPs, AMHs (and their partners) regarding the potential value of such a requirement.

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[9] "North Carolina's Care Management Strategy under Managed Care" policy paper, p. 18: https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf.

[10] 42 CFR 438.208

[11] Ideally, screening results should also be shared with Local Health Departments and county Departments of Social Services, in the form of a community health record that allows parties to be aligned regarding beneficiary eligibility for public benefits and any PHP special programs.

We envision that the TAG data subgroup will further consider and, if applicable, design a common data template and implementation timeline (e.g., quarterly reporting from PHPs to AMHs/CINs) for this purpose. Because quality performance measurement is dependent on data sharing between AMHs and PHPs, the AMHs should be prepared to share performance data with the PHP prior to and as part of the process of receiving performance analysis from the PHPs.

These potential requirements would not inhibit PHPs from monitoring practices' performance in other ways and sharing additional data with practices. For example, we anticipate that some PHPs will produce "gaps in care" reports to alert practices to preventive care gaps that can be acted on throughout the year as relevant. Such gaps in care reports could also be provided by CINs on behalf of applicable practices using data aggregated across each PHP and reportable by PHP.

2. **Encounter data PHPs must share with Tier 3 and Tier 4 AMH practices**

PHPs will receive claims resulting from member encounters with providers in their networks and will use these claims as a basis for payment according to their contracts with providers. All claims received and adjudicated by the PHP will become "encounter data." Given AMH Tier 3 and Tier 4 practices' elevated roles in analytics, care management, and care coordination activities, PHPs will be required to share encounter data they have available on a timely basis with AMH Tier 3 and Tier 4 practices subject to applicable data security and privacy requirements. The Department anticipates that as the aggregator of these data on behalf of AMHs, CINs supporting health system-affiliated practices and other partners supporting independent practices will consolidate PHPs' data from multiple PHPs to enable unified risk stratification, care coordination, care management and other functions for all attributed Medicaid Managed Care members.

The Department believes that consistent use of encounter data formats and standards will benefit PHPs that are required to share data with multiple AMHs (or their delegated CINs or partners) and for AMHs (or their delegated CINs or partners) who will need to receive information from multiple sources. We also recognize that encounter data sharing with providers is in nascent stages in North Carolina. Given these considerations, the Department's plan, subject to further input from stakeholders, is to require PHPs to provide encounter data directly to the designated CINs or third-party partners of Tier 3 and Tier 4 AMHs, as appropriate, using the same specifications that PHPs will use to share encounter data with the Department; i.e., X12 Electronic Data Interchange (EDI) format, 837 Healthcare Claim Transaction Set and National Council for Prescription Drug Programs (NCPDP) format for pharmacy data. These data flows from PHPs to AMHs' delegated partners of AMH Tier 3 and Tier 4 practices should be filtered to only include attributed members assigned to specific Tier 3 or Tier 4 practices or groups of specific Tier 3 or Tier 4 practices.

In terms of frequency of encounter data sharing, the Department envisions that certain types of commonly specified data (e.g., medical information) may be shared at a certain frequency (e.g., weekly or monthly) whereas other types of data (e.g., pharmacy information) may be transferred much more frequently (e.g., weekly or daily).

Details regarding PHPs' requirements to share encounter data with Tier 3 and Tier 4 AMHs will be further developed by the Department (consulting with the TAG data sharing group with input from stakeholders) and codified in a standard reference guide PHPs will be required to use for this purpose. The reference guide will define the specific data elements, data descriptions and formats applicable for

this data sharing requirement. As a practical matter, the initial reference guide will look like and build on the Department's existing companion guide for claims data, although the specific data elements applicable for the encounter data sharing requirement with Tier 3 and Tier 4 AMHs may initially represent a subset of these data elements.[12]

Over time, as secure data sharing capabilities improve and national standards evolve, the Department, consulting with the TAG data subgroup, will modify these minimum requirements and specifications. Directionally, the Department wants over time to take advantage of newly available standards for bulk data content and techniques for secure bulk data sharing. For example, the Argonaut Project coordinated by the U.S. Office of the National Coordinator for Health Information Technology (ONC) and the Creating Access to Real-time Information Now (CARIN) Alliance (a multi-sector alliance), among others, are actively leading the development of standards for bulk APIs (also known as flat Fast Healthcare Interoperability Resources, or Flat FHIR) for data content, transport and security. The Department and its TAG data subgroup will participate in and monitor progress of these developments with the goal of evolving data sharing requirements accordingly.

3. **AMH Tier 3 and Tier 4 practices must access Admission, Discharge, Transfer (ADT) information, and AMH Tier 1 and Tier 2 practices are encouraged to access ADT information**
AMHs will need access to timely notifications when members 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 and Tier 4 that are responsible for timely, proactive functions on behalf of Medicaid Managed Care members.

Accordingly, all Tier 3 and Tier 4 AMHs must demonstrate 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 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 at their discretion, such as through the North Carolina Healthcare Association. Importantly, practices and/or CINs will need the capacity to filter an ADT file to the specific attributed members 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 and Tier 4 AMHs must agree to design and implement their own systematic, clinically appropriate care management process using ADT information. For example:

- AMHs and/or CINs for health system-affiliated practices and other third-party partners for independent practices should develop their own 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, such as children with special health care needs admitted to the

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[12] For example, see current NC DHHS X12 Implementation Guides here:
https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html

hospital) and within a several-day period for other members for whom ADT information is received (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge).

- AMHs (and/or CINs or other partners) should further use daily batched ADT information to facilitate member prioritization for care management or coordination activities. For example, care managers could access a list of all empaneled members 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.

- AMHs (and/or their CINs) should 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.

- Finally, AMHs are also encouraged to develop systems to ingest ADT information into their electronic health records and/or care management systems so this information is readily available to members of the care team on the next (and future) office visit(s).

Tier 3 and Tier 4 AMHs must attest that they have ADT information covering all or nearly all applicable hospitals and related facilities in their catchment area. In addition to flexibility regarding how and where they may access ADT information (NC HealthConnex, the North Carolina Healthcare Association (NCHA), a PHP or health system, or another source), AMHs will have flexibility (subject to National Committee for Quality Assurance certification requirements on PHPs) regarding how precisely to operationalize ADT information in the clinical or care management workflow.

4. **All AMHs should incorporate relevant clinical information into their population health/care management process**

AMHs will need timely access to certain clinical information for care oversight and management, including information about members' test results, select lab values, and immunization data and gaps.

Given the wide spectrum of practice types and affiliations, AMHs have several choices for how and where they choose to access clinical data, subject to state and federal beneficiary privacy protections. For example, 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 electronic health record (EHR) software. 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 may also access information from NC HealthConnex. 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, hospitals, physicians and nurse practitioners who currently have an EHR system are to be connected to NC HealthConnex to receive payments for North Carolina Medicaid and NC Health Choice services.

In addition to data from EHRs, by the launch of Medicaid Managed Care if not sooner, NC HealthConnex will also have immunization data and controlled substances information provided by the Department. Recognizing the variance in adoption and use of health information technology and care management platforms, NC HealthConnex will support the various channels that PHPs, AMHs and data partners of AMHs can use to securely send empaneled patient lists and receive available clinical data on attributed members.

AMHs are encouraged to work directly with NC HealthConnex or other sources to establish data sharing governance, data-sharing approaches, and protocols to support care management and coordination activities under the AMH program. To assist in the coordination of data sharing, the Department will include in its TAG data sub-group representatives from NC HealthConnex, AMHs, CINs and other stakeholders.

5. **All AMHs (and/or CINs) are encouraged to access Social Determinants of Health information and Support Opportunities for Health**

In addition to "Initial Care Needs Screening" information outlining members' baseline social determinants of health needs and gaps upon entry into Medicaid Managed Care (described above), AMHs will need information regarding available resources to address such gaps on an ongoing basis.

The Department is working with the Foundation for Health Leadership & Innovation (FHLI) to create a new NC Resource Platform that will serve as a regularly updated database of community organizations and resources that will also allow users to connect people that screen positive for an unmet resource need (e.g., housing, transportation, food) with available community resources.[13] The NC Resource Platform will be a statewide resource open to all providers (including AMH practices), PHPs, care managers, community-based organizations, community health workers and other community members.

AMH practices, like other users, will be able to access the NC Resource Platform's online database functionality to identify social service and community-based resources in their communities for individuals that present at their practice. Once the NC Resource Platform is fully functional and deployed, AMHs will also have the option to connect with and use the NC Resource Platform to electronically refer members to community-based resources and track whether they receive services and what services they receive.

PHPs may also have similar resources above and beyond the NC Resource Platform. We include a reference to this information for clarity given the importance of data on available resources to address members' social determinant-related gaps and needs.

6. **PHPs and AMHs are also strongly encouraged to engage and support members by making data sharing with members easier and more widespread**

The Department is interested in developing new ways to use data to help members be better engaged, proactive, and empowered in their own health and health care. All Americans already have the legal right to their own health information held by doctors, hospitals, health plans, and others who provide health care services. However, accessing this information and sharing it with trusted parties via technologies and applications in a secured way can be practically challenging.

In recent years, several new national developments have made it easier for people to access and securely use their own health information. For example, established in 2010 as a joint effort of the Centers for Medicare & Medicaid Services (CMS) and the Veteran's Administration, the "Blue Button" initiative is a system for patients to view online and download their own personal health records. Among other purposes, data from Blue Button-enabled sites can be used to create portable medical histories to facilitate better communications among members of their care team.

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[13] This undertaking is described in more detail in "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.

Blue Button technology and data standards continue to evolve and improve. After launching in 2010 with an initial model supporting a "one-time download" of beneficiary claims information available through the CMS website (through which beneficiaries needed to repeat downloads to receive updated data), "Blue Button 2.0" now features an Application Programming Interface (API) that provides beneficiaries with greater authorization control over how their data can be used by third-party, credentialed applications, services and research programs they trust, with identity and authorization services controlled by the federal government and with the ability for beneficiaries to revoke access at any time.[14]

Today, the federal government and other entities are actively leading the development of standard open API frameworks through which consumers can direct the uses of their protected health information securely and consistently beyond Medicare, including Medicaid.

The Department strongly encourages PHPs and AMHs to develop and implement innovative strategies for secure information sharing with members. Further, the Department encourages PHPs and AMHs to be actively involved in national standards development and implementation projects designed to facilitate secure data sharing with members. The Department plans to add future requirements for data sharing (e.g., Blue Button for Medicaid) with members over time as national standards evolve.

V. Data Security and Privacy Standards

At all times, PHPs and AMH practices will be expected to comply with all federal, North Carolina and Department privacy and security requirements regarding the collection, storage, transmission, destruction and use of Medicaid claims and encounter data.

At a minimum, AMHs and any contracted CINs or third-party 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. The AMHs and CINs/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.

The AMHs and CINs/partners must establish appropriate administrative, technical, and physical safeguards which shall provide a level and scope of security that is not less than the level and scope of security requirements established by the following federal guidance:

- Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems

- Federal Information Processing Standard 200 "Minimum Security Requirements for Federal Information and Information Systems"

- Special Publication 800-53 "Recommended Security Controls for Federal Information Systems"

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[14] Blue Button 2.0 uses the HL7 FHIR standard for beneficiary data and the OAuth 2.0 standard for beneficiary authorization.

VI. Other Potential Data to Support AMHs

This document lays out the initial AMH data strategy at the outset of Medicaid Managed Care. However, we note several important points below regarding ongoing development of the AMH data strategy and its relation to other Department data-sharing initiatives.

- **Transition data files.** At enrollment, the Department will provide to PHPs "transition" data including historic Medicaid Fee-for-Service claims on enrolled members. In addition to the specific data types outlined in this document, the Department is considering requirements that PHPs share certain "transition" data with AMHs as well. This would include historical Medicaid Fee-for-Service data and potentially encounter data elements held by Local Management Entities/Managed Care Organizations (LME-MCOs) providing mental health, intellectual and developmental disability and substance use services to North Carolina citizens.[15] The aim of these potential requirements would be to ensure a comprehensive baseline understanding by AMHs of members' care experiences and needs.

- **Data sharing for members served by Medicaid Fee-for-Service.** The Department is considering options to continue to support care management for members that will be served outside Medicaid Managed Care through ongoing Medicaid Fee-for-Service and expects to contract with a single entity to support care management functions like those currently in place. This concept intentionally does not address data needs for the Medicaid Fee-for-Service population, but work is also underway in this area.

- **Data sharing to support Care Management for High-Risk Pregnancy and At-Risk Children:** The Department has issued initial guidance regarding the future of the Care Management for At-Risk Children (formerly known as CC4C) and Care Management for High-Risk Pregnancy (former known as OBMC) , which are implemented in concert with local health departments. This document does not explicitly address data sharing for the transition of these care management programs. Further guidance is forthcoming.

- **AMH obligations to share data with PHPs.** In addition to those provisions set forth in this document, the Department expects PHPs and AMHs to contract in ways that may impose requirements on AMHs to share data with PHPs. This data strategy paper is intended to clarify the PHP data-sharing requirements with AMHs. PHPs will be ultimately accountable for the quality and health outcomes of their members. As such, AMHs, coordinating with their contracted CIN or data partners, will need to share certain data with the PHP to support quality reporting and oversight. This paper intentionally does not address such obligations by and between PHPs and AMHs.

VII.   Oversight and Accountability for Data Sharing

PHPs and AMH practices will be accountable to the Department for adhering to this data strategy, through Managed Care contracting and the AMH certification process, respectively.

PHP Accountability

The Department will exercise oversight over PHPs to ensure that data sharing with AMHs occurs as required. Timely sharing of assignment files, risk stratification results, Initial Care Needs Screening results, quality

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[15] For clarity, under Medicaid Managed Care, LME-MCOs will not provide services to PHP enrollees. The LME-MCO data referenced here pertains to historical "transition" data.

performance feedback information and encounter data (Tier 3 and Tier 4 only) will be required in the Department's PHP contract. As part of annual reporting to the Department, PHPs will be required to demonstrate that they shared all identified elements of required data with AMH practices. Additionally, AMH practices will be able to raise any complaints with PHPs through a general PHP provider appeals process. Finally, to ensure that data transfer from PHPs to AMH practices occurs, the Department is considering tying financial withholds to PHPs' demonstration of PHP-to-AMH data transfer.

AMH Accountability

The Department will also exercise oversight of AMH practices through the attestation requirements and the certification process. Practices will be required to attest directly to the Department to successfully enter their respective AMH tiers. The Department will require that the standard contract template between AMH practices and PHPs includes the attestation requirements. Recognizing that requirements vary across the AMH tiers, the Department's attestation and certification requirements for Tier 3 will include specific provisions that address the Tier 3 practices' care management responsibilities and data sharing requirements that exceed those of Tier 1 and Tier 2.

Appendix A: Summary of Data Types, Who Provides and Department Role

	Data Types	Who Provides	Role for the Department
1.	**Information PHPs must share with all AMH practices (Tiers 1-4) in their networks**		
1a.	Assignment Files	PHPs must provide this information to AMH practices	The Department will require PHPs to share member information with all AMH 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 The Department will work with stakeholders to align specifications through the TAG process.
1b.	PHP Risk Stratification Results	PHPs must provide this information to AMH practices	The Department will require PHPs to share this information with all AMH practices. The Department will encourage PHPs to share with AMHs details on the categories of their risk model inputs to help inform the AMHs' care management activities.
1c.	Initial Care Needs Screening Results	PHPs must provide this information to PCPs and AMH practices	The Department will require PHPs to share this information with all AMHs as well as practices not participating in the AMH program.
1d.	Quality Measure Performance Information	PHPs must provide this information to AMH practices	The Department is considering requirements for PHPs to share interim performance information on a subset of the standard quality measures with AMHs. The Department will work with stakeholders to define the specific methods, timing and other details through the TAG process.
2.	**Encounter data PHPs must share with AMH Tier 3 and Tier 4 practices/CINs in their networks**		
	Encounter Data	PHPs must provide this information to AMHs in Tier 3 and Tier 4	The Department will define common specifications in a published reference guide that all PHPs will be required to use to share encounter data with Tier 3 and Tier 4 AMHs. The Department's initial plan is to require PHPs to transmit encounter data for specified members in the same format that the PHPs will be required to share data with the Department. PHPs will be expected to provide encounter data directly to the Tier 3 and Tier 4 AMHs (or their CINs/data partners), as appropriate, in the X12 Electronic Data Interchange (EDI) format, 837 Healthcare Claim Transaction Set and National Council for Prescription Drug Programs (NCPDP) format for pharmacy data.
3.	**Other information AMH practices/CINs may access from other (non-PHP) sources**		
	Admission, Discharge, Transfer Information	Tier 3 and Tier 4 AMHs must (and Tier 1 and Tier 2 AMHs are encouraged to) access this information from sources such as HIEA or NCHA	The Department will require that Tier 3 and Tier 4 AMHs (or their CINs/data partners) demonstrate that, at a minimum, they have active access to an ADT data source that correctly identifies when empaneled members are admitted, discharged or transferred to/from an emergency department or hospital, and a systematic, clinically appropriate care management process using ADT information.

	Data Types	Who Provides	Role for the Department
4.	**All AMHs are encouraged to access select clinical information**		
	Select Clinical Information	PHPs and AMHs may access this information from sources such as HIEA	AMHs should interact with NC HealthConnex and other sources to support effective, efficient and secure access to select clinical information.
5.	**AMHs are encouraged to access Healthy Opportunities Resource Platform information**		
	Social Determinants of Health information	PHPs and AMHs may access this information from the North Carolina Resource Platform	The Department will support use of the NC Resource Platform to support opportunities for health by PHPs, AMHs, and other stakeholders.
6.	**PHPs and AMHs are strongly encouraged to engage members in their own health through secure data sharing**		
	Claims/encounters, utilization gap information, other data	PHPs/AMHs	PHPs and AMHs are strongly encouraged to share relevant information with members. The Department will monitor national standards development and actively encourage PHPs/AMHs' efforts to share data securely with members.

Appendix B: Advanced Medical Home Tier 3 Data Strategy Flow

High-level diagram illustrating the various data flows envisioned by the AMH Data Strategy for a hypothetical Tier 3 AMH provider scenario
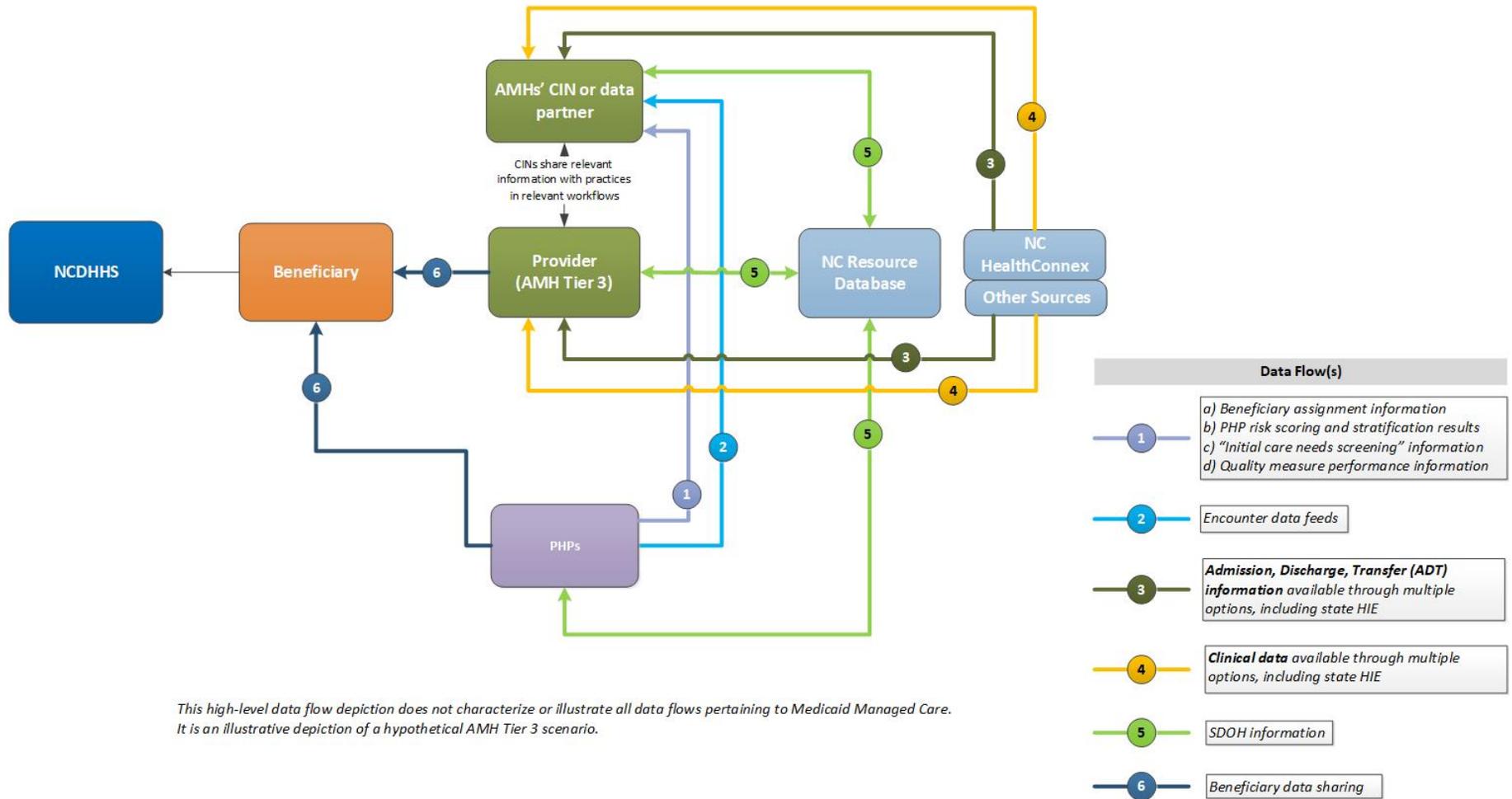
This high-level data flow depiction does not characterize or illustrate all data flows pertaining to Medicaid Managed Care. It is an illustrative depiction of a hypothetical AMH Tier 3 scenario.

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