Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #7: Healthy Opportunities in Medicaid Managed Care 101; Tier 2 Reversion Guidance; Data Subcommittee Meeting #3 Review

October 16, 11:30 am – 2:30 pm

Williams Building, 1800 Umstead Drive, Room 123B

AMH TAG Membership Introductions and Rollcall

Name	Organization	Stakeholder
C. Marston Crawford, MD, MBA	Pediatrician Coastal Children's Clinic – New Bern, Coastal Children's	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Zeev Neuwirth, MD	Senior Medical Director of Population Health Carolinas Physician Alliance (Atrium)	Provider (CIN)
Amy Russell, MD	Medical Director Mission Health Partners	Provider (CIN)
Kristen Dubay, MPP	Senior Policy Advisory Carolina Medical Home Network	Provider (CIN)
Jan Hutchins, RN	Executive Director of Population Health Services UNC Population Health Services	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office	Provider (CIN)
Paul Rubinton, MD	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc.	PHP
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	PHP
Michelle Bucknor, MD	Chief Medical Officer UnitedHealthcare of North Carolina, Inc.	PHP
Thomas Newton, MD	Medical Director WellCare of North Carolina, Inc.	PHP
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	PHP
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member

Agenda

1	Recap: Advanced Medical Home (AMH) TAG Meeting #6	11:30 am – 11:40 am
2	Healthy Opportunities in Medicaid Managed Care	11:40 am – 12:45 pm
3	Break	12:45 pm – 1:00 pm
4	Discussion: Tier 2 Reversion Guidance	1:00 pm – 1:30 pm
5	Recap: Data Subcommittee Meeting #3	1:30 pm – 2:15 pm
6	Public Comments	2:15 pm – 2:25 pm
7	Next Steps	2:25 pm – 2:30 pm

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Recap: AMH TAG Meeting #6

1

Milestone	Regions 2 and 4	Regions 1, 3, 5, and 6
Enrollment Packets Mailed	*6/28/2019 (already occurred)*	10/1/2019
Open Enrollment Begins	*7/15/2019 (already occurred)*	10/14/2019
Provider Contracts Must be Signed for Inclusion in Auto-Assignment	**Mid-November**	
Open Enrollment Ends	12/13/19	
Auto-Assignment to PHPs and PCPs	Starting 12/16/19	
Standard Plan Effective Date	2/1/2020	

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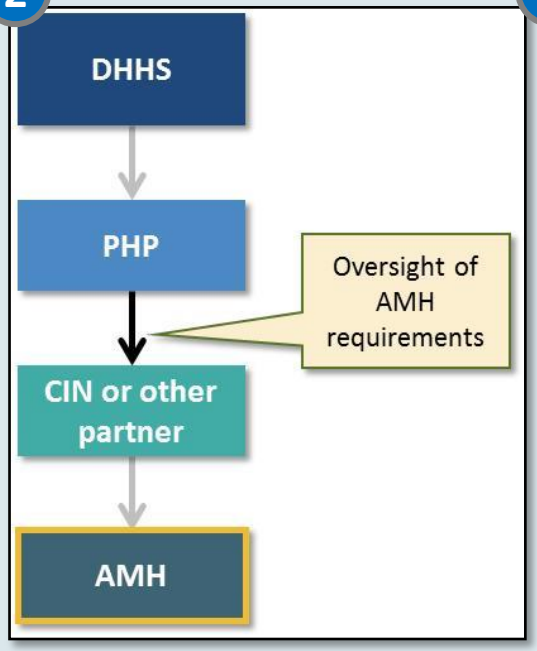

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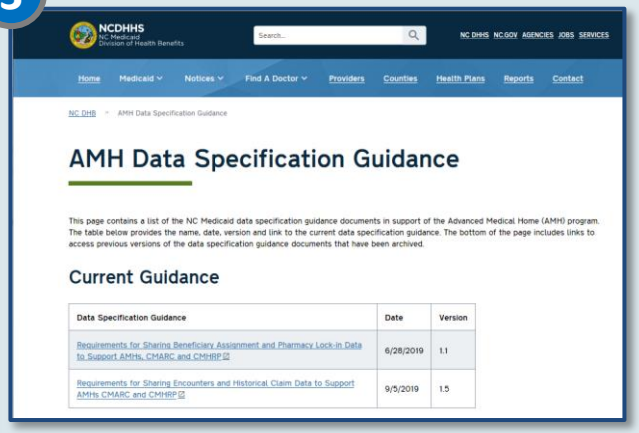

1. Managed Care Timeline Update

2. Prepaid Health Plan (PHP) Oversight of AMH Program

3. Data Subcommittee: AMH Data Governance Process

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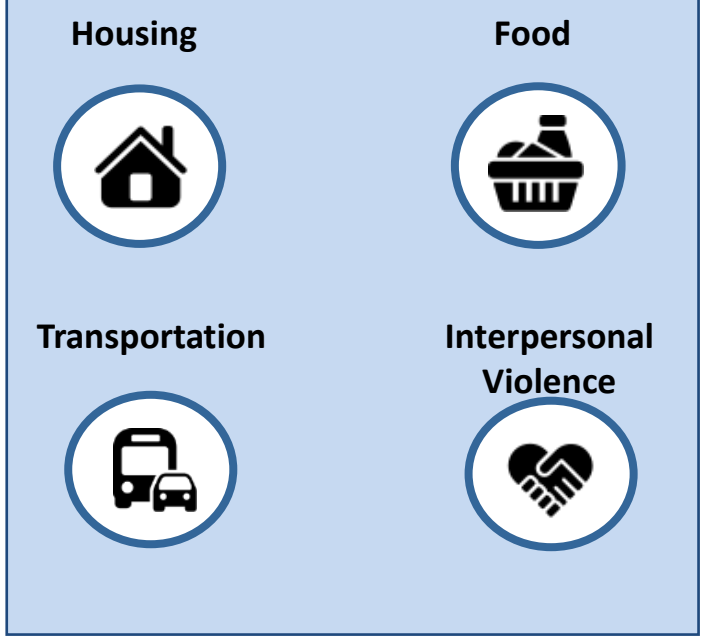
Why Focus on Healthy Opportunities?

"Healthy Opportunities," commonly referred to as the social determinants of health, are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result.
- Addressing the factors that directly impact health is a key component of meeting DHHS's mission to improve the health, safety and well-being of all North Carolinians while being good stewards of resources.

North Carolina's Healthy Opportunities Priority Domains



North Carolina's Strategies to Embed Healthy Opportunities into Statewide Medicaid Managed Care

Promoting "Healthy Opportunities" is a core focus of North Carolina's transformation to Medicaid Managed Care—for both Standard Plan (SPs) and Behavioral Health and Intellectual and Developmental Disability Tailored Plans (BH I/DD TPs)*

Key Healthy Opportunities Initiatives


Care Management


NCCARE360


Quality Strategy


Value-Based Payment Strategies


Value-Added Services/In-Lieu of Services


Voluntary PHP Contributions to Health-Related Resources


Healthy Opportunities Pilots

* Additional detail on BH I/DD TP Pilot-related obligations is forthcoming

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Addressing Social Needs Through Care Management

The care management model requires PHPs and care managers to take steps to address beneficiaries' unmet resource needs.

Addressing Unmet Resource Needs through Care Management

- The State's care management model drives a focus on addressing beneficiaries' unmet resource needs.
- PHPs identify a broad range of individuals from rising risk to high-risk (including those with social needs) and provide care management or delegate care management to qualified local entities—e.g., Tier 3 Advanced Medical Homes, Care Management Agencies, and Local Health Departments
- **Care managers and other members of the multi-disciplinary care team will play a significant role in addressing the non-medical drivers of health.**

Addressing Social Needs Through Care Management (cont'd)

- **PHPs must identify and provide care management to beneficiaries with "high unmet resources needs."** PHPs will identify such individuals through a combination of methods, including:
  - Use of State-standardized SDOH screening
  - Analysis of claims, encounters and other available data;
  - Provider, patient and family referral.
- **Care managers will conduct a comprehensive assessment** with identified beneficiaries that addresses physical, behavioral, pharmacy, long term services and supports, and social areas of need.
- **PHPs are accountable for addressing identified needs**, including by:
  - Providing in-person assistance with select human service applications (e.g., TANF & Food and Nutrition Services);
  - Connecting beneficiaries to needed social resources and tracking outcomes using NCCARE360;
  - Having a housing specialist;
  - Providing access to medical-legal partnerships for legal issues adversely affecting health.

High Unmet Resource Needs

PHPs must define high unmet resource needs to include beneficiaries who are:

- Homeless;
- Experiencing or witnessing domestic violence or lack of personal safety; and;
- Showing unmet needs in three or more SDOH domains (e.g. food, transportation and housing)

Care Management Deep Dive: Standardized SDOH Screening

Screening Tool

- PHPs will use DHHS' standardized SDOH screening questions as part of an initial Care Needs Screening to identify individuals eligible for care management due to high unmet resource needs.
- PHPs must ask these standardized SDOH screening questions across the four priority domains to every beneficiary within 90 days of enrollment.

Providers are encouraged but not required to use these standardized screening questions as part of their intake processes.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

NCCARE360 Overview

NCCARE360 is a statewide resource and referral platform that allows key stakeholders to connect individuals with needed community resources.

- **NCCARE360 (NC Resource Platform) is a telephonic, online and interfaced IT platform, providing:**
  - A robust **statewide resource repository** of community-based programs and services at community-based organizations, social service agencies and other organizations.
  - A **referral platform** that allows health care providers, insurers and human service providers to connect people to resources in their communities. It supports "closed-loop referrals," giving them the ability to track whether individuals accessed the community-based services to which they were referred.
- **PHPs will, at minimum, use NCCARE360 to:**
  - Identify community organizations to meet a beneficiary's needs
  - Make a referral on behalf of the beneficiary, and
  - Track closed-loop referrals.

Providers are encouraged but not required to onboard onto and use NCCARE360.

NCCARE360 Functionalities

	Functionality	Partner	Timeline
Resource Directory & Call Center	Directory of statewide resources that will include a call center with dedicated navigators, a data team verifying resources, and text and chat capabilities.	NORTH CAROLINA 211	Phased update 2019 – Spring 2020 * Currently has verified resources across all counites and all domains
Resource Repository	APIs integrate NCCARE360 directory with resource directories across the state to share resource data in one repository.	Expound	Phased Approach
Referral & Outcomes Platform	An intake and referral platform to connect people to community resources and allow for a feedback loop.	UNITE US	Rolled out by county January 2019 – December 2020

Hands on, in-person technical assistance and training to on-board providers and community organizations.

Coordination Platform at Work

Improving coordination efficiency and accuracy

Traditional Referral

Client | Healthcare Provider | Housing Provider

- ✗ Service provider cannot always exchange PII or PHI via a secure method
- ✗ Limited prescreening for eligibility, capacity, or geography
- ✗ Onus is usually on the client to reach the organization to which he/she was referred
- ✗ Service providers have limited insight or feedback loop
- ✗ Client data is siloed & transactional data is not tracked

Through NCCARE360

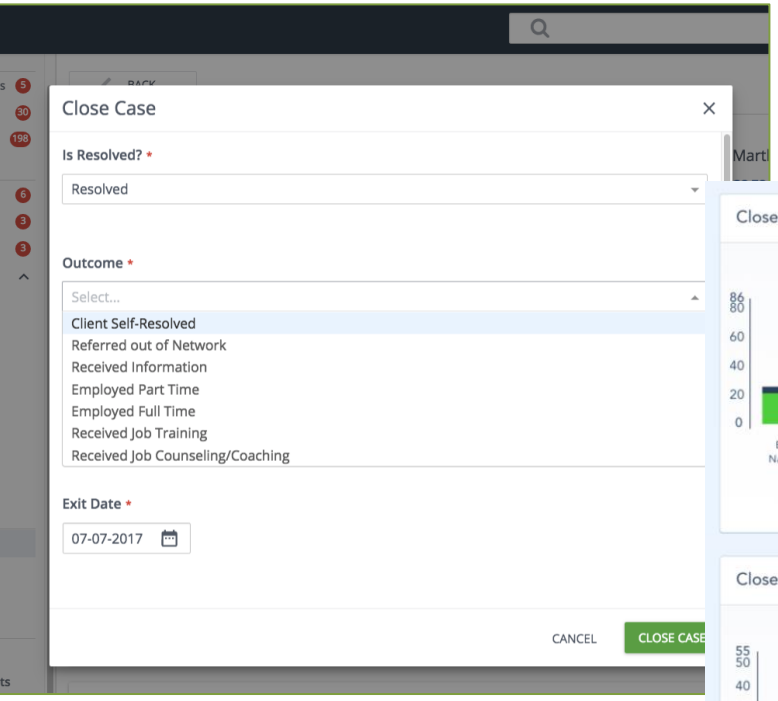
Client | Healthcare Provider | Housing Provider

- ✓ All information is stored and transferred on HIPAA compliant platform
- ✓ Client is matched with the provider for which he/she qualifies
- ✓ Client's information is captured once and shared on his/her behalf
- ✓ Service providers have insight into the entire client journey
- ✓ Longitudinal data is tracked to allow for informed decision making by community care teams

No Wrong Door Approach

Configurable & Structured Data

Real-time reporting of outcomes, performance & efficiency



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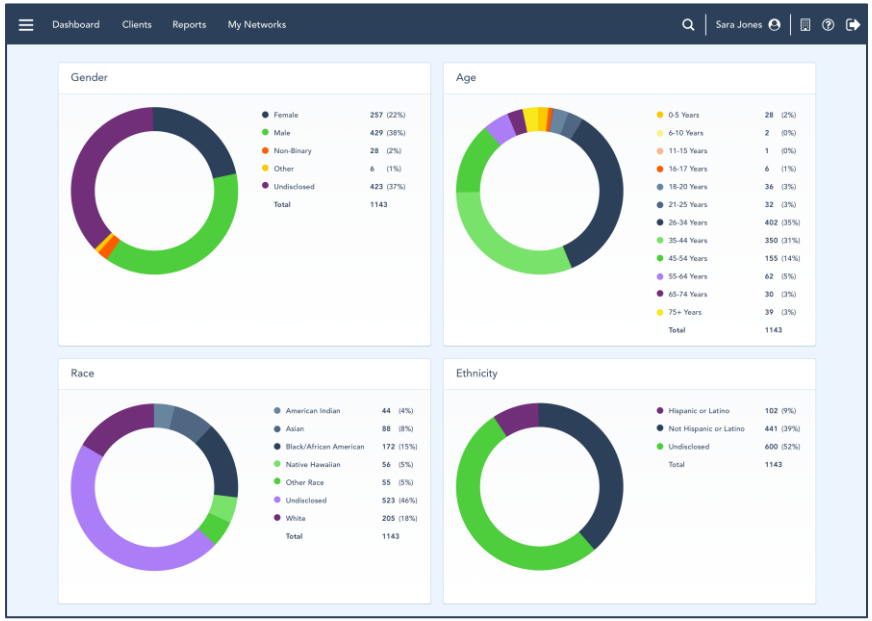
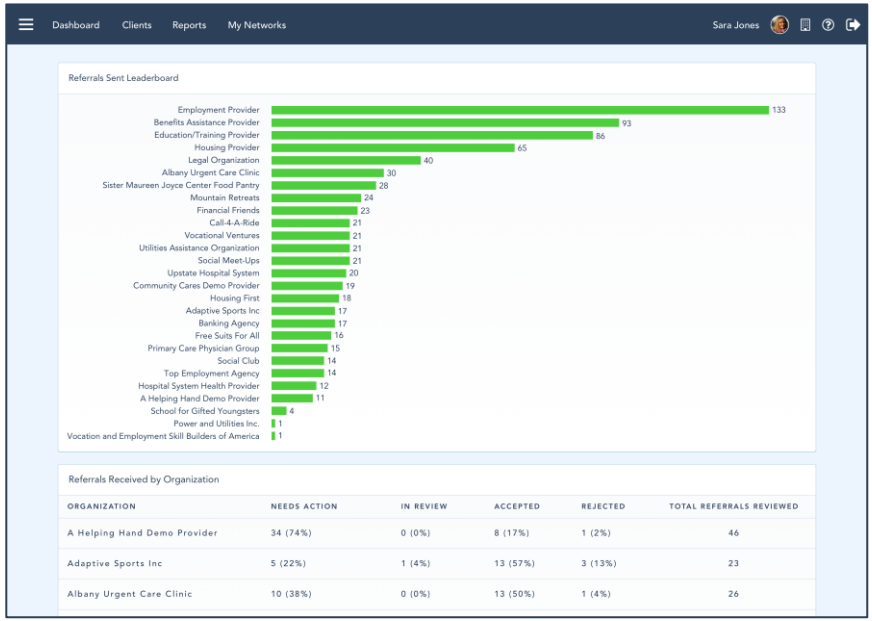




Patient Level Coordination & Tracking

Patient Demographics, Access Points, Service Delivery History, Outcomes

Network Level Transparency & Accountability

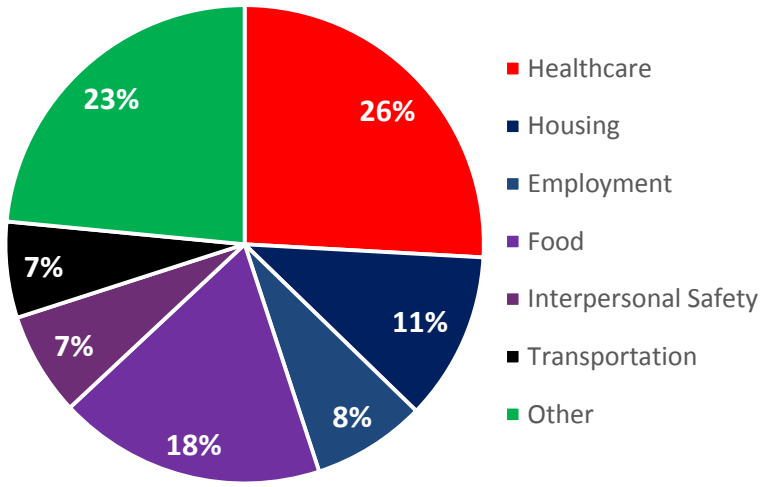
Service Episode history, Referrals Created, Structured Patient Outcomes

Status Update (as of 10/14/19)

NCCARE360 Implementation Status Update	
21	Counties launched (Alamance, Beaufort, Bertie, Brunswick, Chowan, Durham, Edgecombe, Franklin, Guilford, Granville, Hertford, Johnston, Martin, New Hanover, Pender, Person, Pitt, Rockingham, Vance, Wake and Warren)
29	Counties started on implementation
1540	Organizations engaged in socialization process
388	Organizations with NCCARE360 licenses
1609	Active Users
1069	Referrals Sent

NCCARE360 Resource Repository	
2,954	Organizations verified
10,736	Programs verified

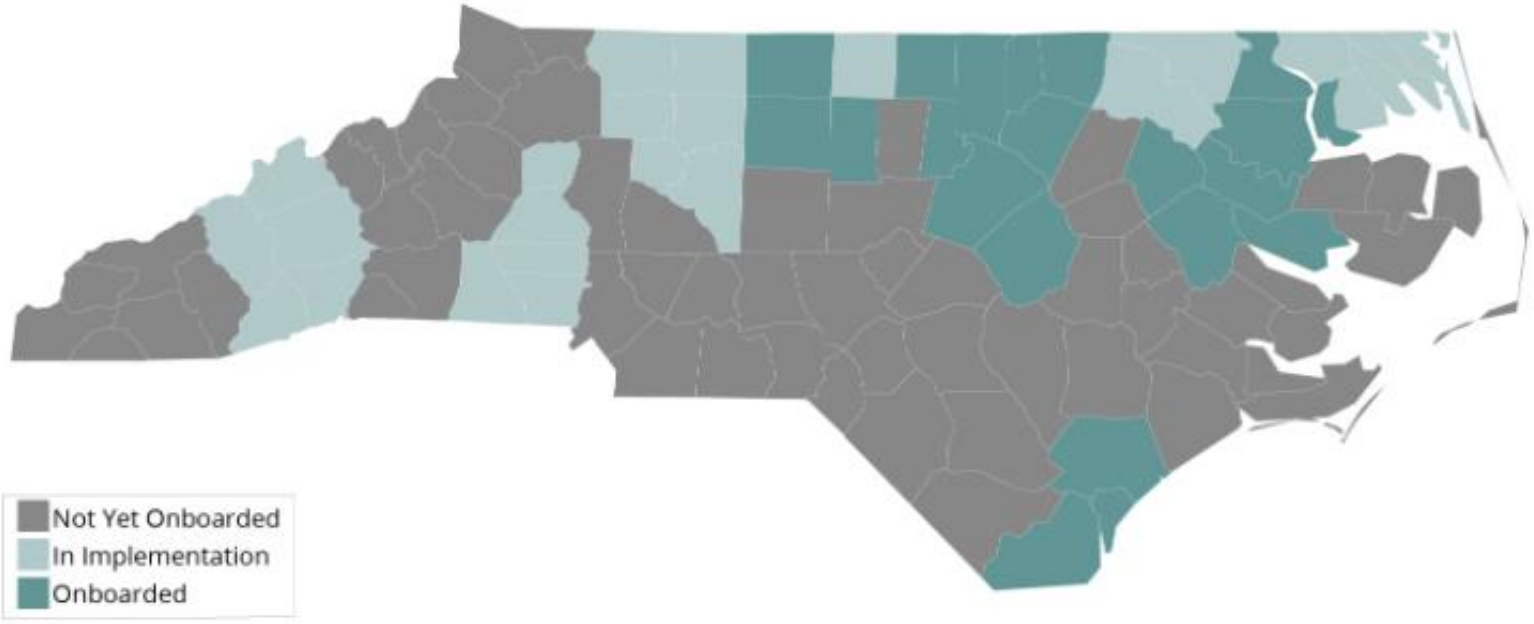
Engaged Organizations by Service Type



NCCARE360 will be implemented statewide by end of 2020

State Coverage

Began rollout January 2019, statewide by December 2020



Using the Quality Strategy to Promote Healthy Opportunities

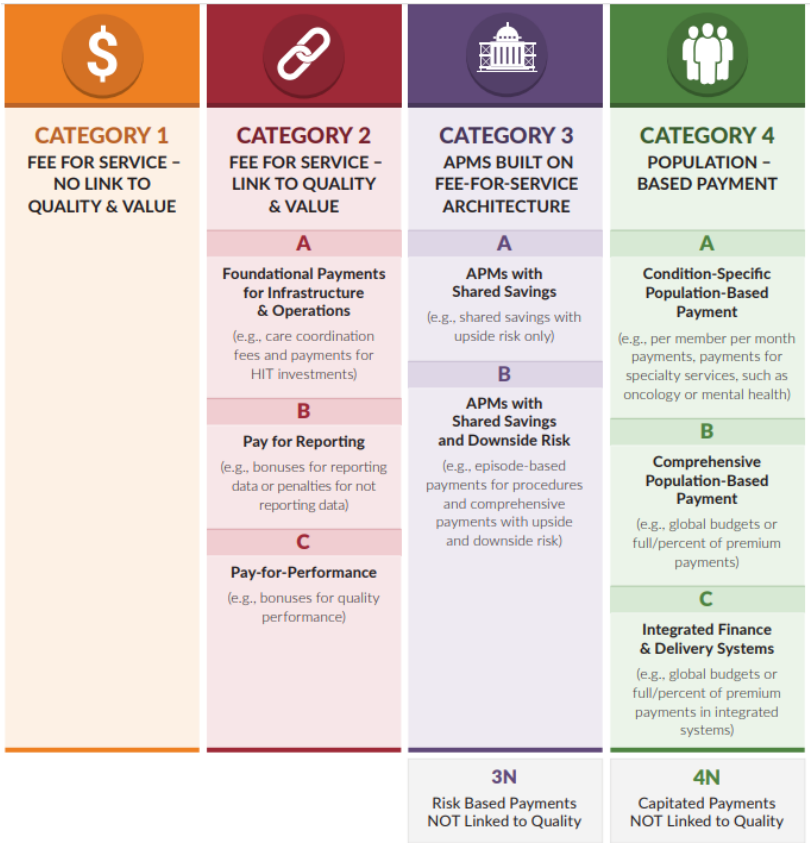
North Carolina's Quality Strategy details how PHPs are held accountable for achieving desired outcomes, including those linked to Healthy Opportunities.

- Addressing unmet resource needs is a critical component of the NC's Quality Strategy and approach to improving population health.
- PHPs must conduct at least one non-clinical Performance Improvement Project annually.
- PHPs will work with communities to improve population health, and promote the aim of healthier people and healthier communities within North Carolina.
- PHPs will report on rates of completed SDOH screenings in Year one of managed care. PHPs may be asked to report on referrals to services to address identified needs in future years.

Incorporating Healthy Opportunities into Value-Based Payment Strategies

VBP Overview

- Value-based payments give providers flexibility to decide how best to use payments, including by paying for health-related social supports that may be more cost-effective than traditional medical care.
- The State's VBP strategy will encourage PHPs and other providers to consider how they can incorporate and promote healthy opportunities into their VBP contracts.



Leveraging In-Lieu of (ILOS) and Value Added (VAS) services to Promote Healthy Opportunities

- PHPs are encouraged to use ILOS to finance services that improve health through connecting members with social resources to address unmet resource needs, and other supports upon receipt of approval from DHHS.
- PHPs are also encouraged to offer value-added services that address unmet resource needs.

What are ILOS?

PHPs may use ILOS to deliver a service or utilize a setting not covered in North Carolina's State Plan or its managed care contract. The State must determine the service to be both medically appropriate and a cost-effective substitute for a state plan service.

- **Example:** Offering medically tailored meals *in lieu of* a hiring a contracted home health aide

Encouraging Voluntary PHP Contributions to Health-Related Resources

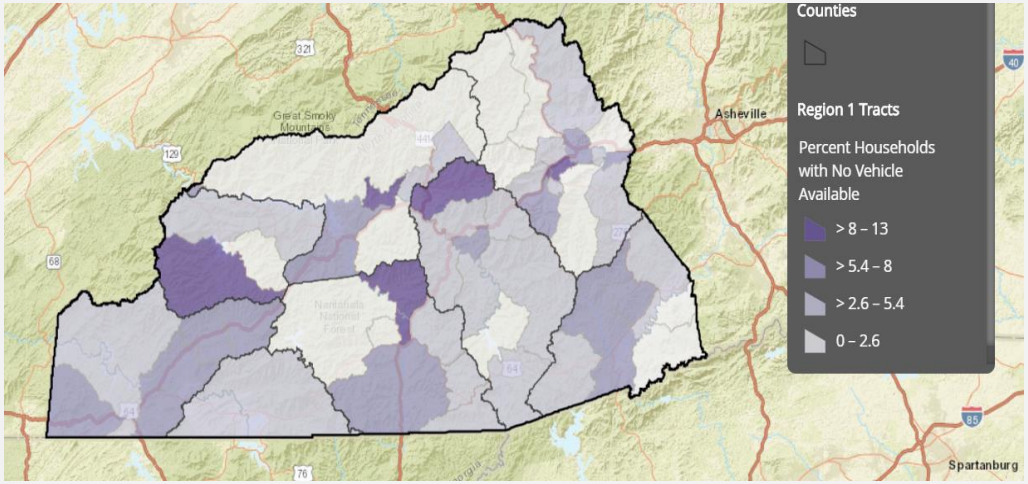
PHPs are encouraged to make contributions to health-related resources that help to address members' and communities' unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to contribute to health-related resources that improve health outcomes and cost-effective delivery of care in the communities they serve.
- PHPs that voluntarily contribute to health-related resources may count the contributions in the numerator of their MLR.
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes.

Providers may wish to give input to PHPs on how to direct their contributions in their communities.

Percent of Households Without Access to a Vehicle in Region 1

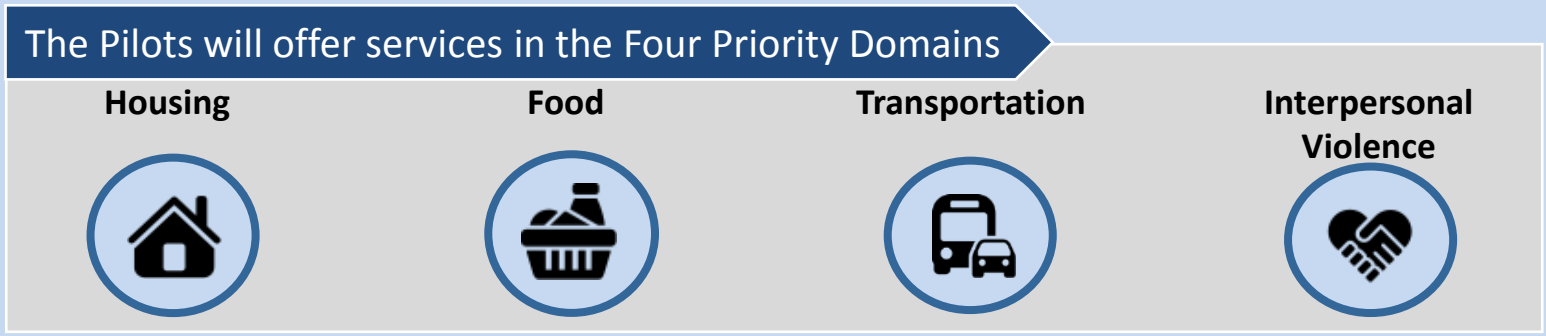


The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state **and can strategically guide contributions to health-related resources.**

What Are the Healthy Opportunities Pilots?

The federal government authorized up to $650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

- **PHPs in two to four geographic areas of the state will work with their communities to implement the "Healthy Opportunities Pilots," as approved through North Carolina's 1115 waiver**
- **Pilot funds will be used over the five-year demonstration period to:**
  - Cover the cost of federally-approved Pilot services
  - Support capacity building to establish "Lead Pilot Entities" that will develop and manage a network of human service organizations (HSOs), and strengthen the ability of HSOs to deliver Pilot services
    - *DHHS will procure Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers.*



Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must have:

At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children, ages 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

What Services Can Enrollees Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.

Housing

- Housing navigation, support and sustaining services
- Housing quality and safety inspections and improvements
- One-time payment for security deposit and first month's rent
- Short-term post hospitalization housing

Food

- Linkages to community-based food resources (e.g., SNAP/WIC application support)
- Nutrition and cooking education
- Fruit and vegetable prescriptions and healthy food boxes/meals
- Medically tailored meal delivery

Transportation

- Linkages to existing transportation resources
- Payment for transportation to support access to pilot services, (e.g., bus passes, taxi vouchers, ride-sharing credits)

Interpersonal Violence (IPV)

- Case management/ advocacy for victims of violence
- Evidence-based parenting support programs
- Evidence-based home visiting services

Key Entities' Roles in the Pilots

PHPs *(SPs and BH I/DD TPs)*

- Manage a Pilot budget
- Approve which of their enrollees qualify for Pilot services and which services they qualify to receive
- Ensure the provision of integrated care management to Pilot enrollees
- Prevent duplication of services

Care Managers

- Frontline service providers predominantly located at Tier 3 AMHs, CMAs, LHDs and PHPs interacting with beneficiaries
- Assess beneficiary eligibility for Pilot, identify recommended pilot services, and manage coordination of pilot services, in addition to managing physical and behavioral health needs
- Ensure individuals are enrolled in other federal/ state programs if eligible (e.g. SNAP and TANF)
- Track enrollee progress over time

Lead Pilot Entities

- Competitively procured by DHHS
- Develop, manage, pay and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- Convene Pilot entities to share best practices

Human Service Organizations

- Frontline social service providers that contract with the LPE to deliver authorized, cost-effective, evidence based Pilot services to Pilot enrollees
- Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered

Care Managers will play a critical role in operationalizing the Pilots. Other providers may be helpful in identifying Medicaid enrollees who may be eligible for the Pilots

Additional Healthy Opportunities Resources

Resources

1. **Healthy Opportunities Website:** https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities

2. **Healthy Opportunities Pilots Policy Paper:** https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf

3. **Draft Healthy Opportunities Pilots Service Definitions and Pricing Methodology:** https://files.nc.gov/ncdhhs/documents/Public-Feedback-Pilot-Service-Definitions-and-Pricing-Inputs-FULL-PACKAGE-FINAL.pdf

Watch the Healthy Opportunities Website for updates regarding the Pilot Fee Schedule and LPE RFP.

Healthy Opportunities: *For Discussion*

- What role can AMH practices play in promoting “Healthy Opportunities” and non-medical drivers of health?
- What responsibilities will care managers and other providers have in the Pilots? How do they differ from their responsibilities in managed care generally?

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Goals of Today's Discussion on Tier 2 Reversion Guidance

- ***Review the established process for practices who wish to revert from AMH Tier 3 to Tier 2***
- ***Discuss implications for AMH practices and PHPs***

Overview: AMH Tier 2 Reversion

AMH Tier 3 is intended to provide an opportunity for practices to assume primary responsibility for care management in exchange for additional reimbursement from PHPs.

- **If a practice certified for AMH Tier 3 determines that it requires additional time to meet the Tier 3 requirements prior to managed care launch, it may change its certification status with the Department to Tier 2 without penalty.**

- **The Department encourages practices who will not be ready to assume Tier 3 responsibilities prior to February 1, 2020, either alone or in partnership with a CIN/other partner, to change their Tier status to AMH Tier 2 as soon as possible to ensure that contracting will be complete by mid-November.**

Process for AMH Practices Choosing to Revert from Tier 3 to Tier 2

- **Providers who wish to change their Tier status must submit a letter to the Department on practice letterhead containing the following:**
  - A request to change the AMH Tier from Tier 3 to Tier 2;
  - The Organization Name (DBA, Service Location Name may be included) per the NCTracks provider record
  - The NPI and Service Location address of practice
  - The signature of the NCTracks assigned Office Administrator (OA)
  - The contact information of OA, to include at minimum:
    - Printed Name
    - Phone Number
    - Email

- **The preferred method of submission is via email to: *Medicaid.StateAMHchangerequest@dhhs.nc.gov*. If a provider is unable to submit the request by email, they may instead choose one of the following options:**
  - Fax their request to Provider Services at 919-715-0672, or
  - Mail the request to the Division of Health Benefits, Provider Services Section, 2501 Mail Service Center, Raleigh, NC 27699-1950.

- **Providers will receive a notification of the disposition of their request via email to the Office Administrator's email address on record in the NCTracks portal.**

Tier 2 Reversion: Key Takeaways for PHPs and AMH Practices

For AMH Practices:

- Changes to a practice's AMH Tier status will not impact providers' standing as Medicaid enrolled providers, nor will it impact their ability to see patients or have patients attributed to them in auto-assignment
- Practices that downgrade to Tier 2 will still receive regular FFS payments for services rendered in addition to Medical Home Fees ($2.50/$5.00 PMPM payments); downgrading will only impact a practice's ability to earn negotiated Care Management Fees and, potentially, Performance Incentive Payments
- Practices may re-attest to Tier 3 through NCTracks at any time; PHPs will then be required to contract with them as Tier 3 practices

For PHPs:

- If a practice voluntarily downgrades to Tier 2, that practice will no longer count in the denominator of AMH Tier 3 practices for which PHPs are accountable for contracting in each PHP region.
- The Department will notify PHPs of any changes to a provider's Tier status on the Medicaid Credentialed Provider File, but practices should ensure that PHPs are aware of their Tier status as they engage in contracting discussions.

Tier 2 Reversion Guidance: *For Discussion*

- At this juncture in the contracting process, does the TAG believe that a significant number of practices will take this option?
  - To what extent does the TAG foresee practices that are not ready for Tier 3 taking this pathway vs continuing as Tier 3s (potentially necessitating PHP-driven “downgrades”)?
- To what extent are attested Tier 3 practices still deciding about affiliation with a CIN ahead of February 1?
- To what extent does the TAG foresee practices taking this option now and re-attesting into Tier 3 ahead of Managed Care Year 2 (July 2020)?

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Recap: Data Subcommittee Meeting #3 (10/3/19)

1. Discussed process to communicate data specification guidance
2. Reviewed findings from interviews and research on use of financial data to support care management and value-based payments (VBP)
3. Developed recommendation regarding modification of the encounter data file specification
4. Reviewed and considered other priority AMH Data topics for future Subcommittee meetings

Request For AMH/CIN Access to Payment Amount Information

Goals and Follow-up Steps

Goals

Ensure that providers have actionable and appropriate information to support (1) their care management efforts and (2) their participation in VBP

Follow-up Steps

1. Assessment of how Medicaid stakeholders in other states share financial information

2. Discussions with PHPs and CINs regarding their current and planned approaches to use financial information in support of care management and value-based payments

Accessing Financial Information for Care Management & VBP

Summary of Findings from PHP and CIN Interviews

The Process

Asked PHPs and CINs to describe the current and planned approaches to using financial information in support of their: (1) care management; and (2) VBP efforts

Interviewed PHPs & CINs

PHPs

- BCBS NC
- Carolina Complete Health

CINs

- CCPN
- Emtiro
- UNC Health Alliance

Key Findings

1. Payment amounts are important input for some CINs' risk stratification methods

2. Access to financial information, particularly paid claim amount, is important for upside risk arrangement and essential for downside risk and Total Cost of Care (TCOC)

3. PHPs are eager to transmit actionable and appropriate financial information

4. PHPs may be able to transmit "paid claim" amounts without violating disclosure prohibitions

5. Preferences voiced for PHPs to serve as the source of truth via a common transmission method

- PHPs preferred to be the source of truth and transmit paid claim data in the existing encounter file format
- CINs preferred to receive paid claim amount directly from the PHPs and in the existing encounter file format

6. If changes are to be made to the encounter file format, they should be made ASAP

Accessing Financial Information for Care Management & VBP

Proposal and Next Steps

1 DHHS Modifies the Encounter Specifications to Include Fields for Financial Information

Proposal: Modify the current encounter specification to include a new fields as follows:

Header Level

1. Total Claim Charge Amount
2. Claim allowed Amount
3. Payers Claim Payment Amount

Line Level

1. Line Item Charge Amount
2. Claim allowed amount
3. Payers Claim Payment Amount

2 DHHS Neither Mandates nor Prohibits PHPs' Transmission of Financial Information

DHHS understands that PHPs are committed to transmitting the financial information that providers need to be successful in both their care management effort and VBP arrangements. Rather than establishing a mandate, DHHS seeks to provide PHPs with the flexibility to determine how best to share financial information with providers.

3 DHHS Updates the Encounter Specifications With New Financial Fields

DHHS revised the current encounter specification to include the new fields for financial information and transmitted Version 2 to the PHPs on Oct 4th.

Approach and Actions to Address AMH Data Topics

Approach

DHHS is listening to stakeholders to determine if, how, and when to address AMH data issues and challenges

Possible Actions

Depending on the data topic and the anticipated challenges, there are a range of actions that could be taken:

- increase standardization
- streamline the data that are being requested
- Improve clarity by refining the definitions of valid responses
- implement more effective, efficient transmission methods
- support increased access to and/or availability of certain types of data services

AMH Data Topics Addressed To Date

Data Topic	Actions Taken	Immediate Next Steps
1. Beneficiary Assignment [*PHPs' transmission of beneficiary assignments to AMHs and CINs*]	1. DHHS team worked with PHPs/CIN to develop initial specifications 2. DHHS published final specifications 3. PHPs and AMHs/CINs have begun testing and implementation	1. Finalize testing (including payment amount fields)
2. Encounter Data [*PHPs' transmission of encounter data to AMHs and CINs*]		
3. Care Management Encounter Data [*PHPs' collection of care management encounter data and transmission to DHHS*]	1. DHHS is working with PHPs to review and revise the data fields in the current specification for the "Care Management Beneficiary Extract" template	1. Engage CINs to help finalize the file specifications

Prioritization of Additional AMH Data Topics

Suggestions from Data Subcommittee Members During Previous Meetings

- **Initial Care Needs Screen Results**
- **Prior Authorization**

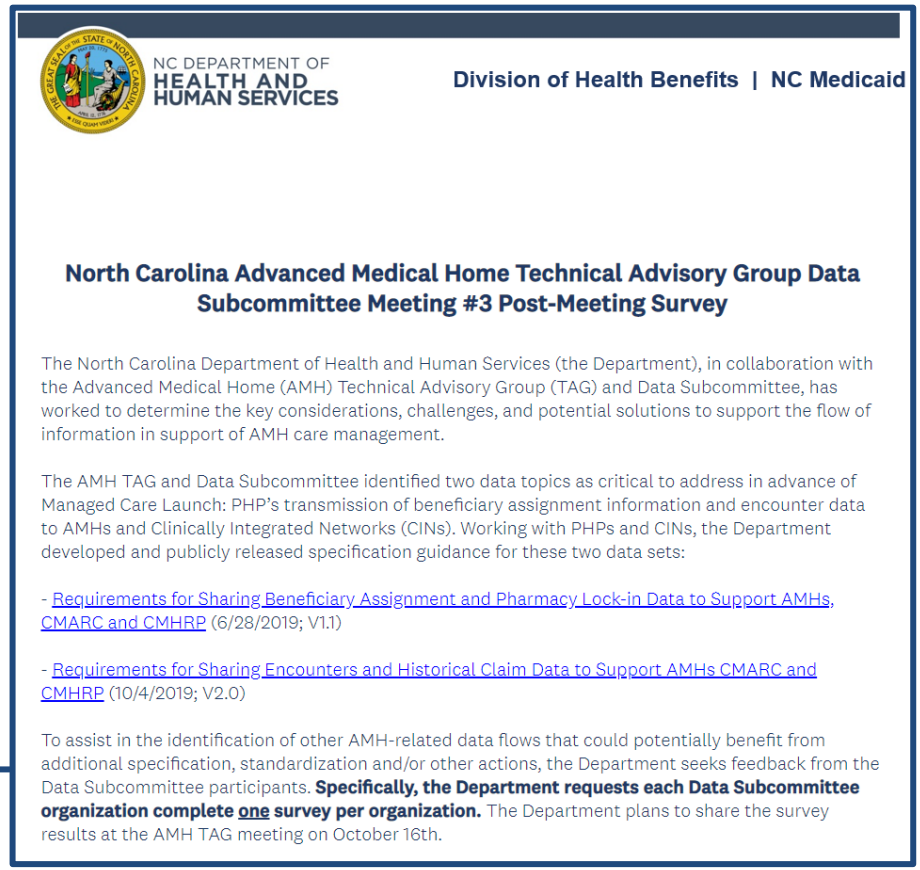
Suggestions from AMH TAG Members During September 17 Meeting

- **Risk Stratification**
- **Access to ADT Information**

Polling of Priorities

1. To determine which data topics to address and when, the Department sought prioritization feedback

2. Following the Data Subcommittee meeting on October 3rd, the Department distributed a survey to the Data Subcommittee Member organizations and each organization was asked to complete and submit one survey



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

North Carolina Advanced Medical Home Technical Advisory Group Data Subcommittee Meeting #3 Post-Meeting Survey

The North Carolina Department of Health and Human Services (the Department), in collaboration with the Advanced Medical Home (AMH) Technical Advisory Group (TAG) and Data Subcommittee, has worked to determine the key considerations, challenges, and potential solutions to support the flow of information in support of AMH care management.

The AMH TAG and Data Subcommittee identified two data topics as critical to address in advance of Managed Care Launch: PHP's transmission of beneficiary assignment information and encounter data to AMHs and Clinically Integrated Networks (CINs). Working with PHPs and CINs, the Department developed and publicly released specification guidance for these two data sets:

- Requirements for Sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support AMHs, CMARC and CMHRP (6/28/2019; V1.1)

- Requirements for Sharing Encounters and Historical Claim Data to Support AMHs CMARC and CMHRP (10/4/2019; V2.0)

To assist in the identification of other AMH-related data flows that could potentially benefit from additional specification, standardization and/or other actions, the Department seeks feedback from the Data Subcommittee participants. **Specifically, the Department requests each Data Subcommittee organization complete one survey per organization.** The Department plans to share the survey results at the AMH TAG meeting on October 16th.

Overall Ranking of AMH Data Topics

Across the PHPs and CINs, there is a strong desire to explore opportunities to standardize: (1) risk stratification scores and (2) initial care needs screen results

Prioritization of Data Topics to Address [*Data Sources-> Targets*]
1. Risk Stratification Scores [*PHPs -> AMHs, LHDs, CINs*]
2. Initial Care Needs Screening Results [*PHPs -> AMHs, LHDs, CINs*]
3. Admission, Discharge, Transfer (ADT) Information [*HIEs -> AMHs, CINs*]
4. Comprehensive Assessment Results [*PHPs -> AMHs, LHDs, CINs*]
5. Care Plans [*PHPs -> AMHs, LHDs, CINs*]
6. Quality Measures Performance Information [*AMHs, LHDs, CINs -> PHPs*]
7. Clinical Information [*HIEs -> PHPs & AMHs, CINs*]
8. Prior Authorizations [PHPs -> AMHs]
9. Unmet Health-related Resource Needs [*PHPs, AMHs, CINs Human Service Organizations*]
10. Quality Measure Performance Information [*PHPs -> AMHs, LHDs, CINs*]
11. Immunization Data [*NC Immunization Registry -> PHPs, AMHs, CINs*]
12. Controlled Substance Data [*NC CSRS -> PHPs & AMHs, CINs*]
13. Sharing Data with Patients and Caregivers [*AMHs -> Patients*]
14. Sharing Data with Patients and Caregivers [*PHPs -> Patients*]

Ranking Description: *Survey Participants (n = 10) were tasked with ranking data topics and flows from 1-14, with 1 being the highest importance and 14 being the lowest importance relative to the ability to successfully begin care management beginning February 1, 2020.*

Comments on the Top Ranked Data Topics

Highest Priority Data Flows	Respondents' Discussion of the Relative Value	Responses on Challenges to the Data Flow	Responses Regarding Timing	Potential Next Steps
1. Risk Stratification Scores [PHPs -> AMHs, LHDs, CINs]	• High value-add for all partners ingesting data • Will allow AMHs/CINs to incorporate into care management as quickly as possible	• Risk score normalization vs. standardization	• Of few responses, prefer to have solutions ready for Managed Care Launch (2/1/2020)	• For discussion
2. Initial Care Needs Screening Results [PHPs -> AMHs, LHDs, CINs]	• Can provide early direction on care management as AMHs/CINs are processing and analyzing claims/encounter data • Informs care plan development	• Will require significant lead-time for AMHs/CINs to develop methods for integration of data into clinical and care management records	• Of few responses, prefer to have solutions ready for Managed Care Launch (2/1/2020) or shortly thereafter • Could have glidepath to standardization, focusing first on clarification of minimum necessary layout	• For discussion
3. Admission, Discharge, Transfer (ADT) Information [HIEs -> AMHs, CINs]	• Necessary for conducting effective transitional care management	• Variety of options in the market • Timeliness and frequency variability	• No preferences or considerations regarding timing	• Data Subcommittee members have been asked to provide information on how they currently plan to access ADT information and alerts, and to identify any potential current or future challenges

Next Steps

- ***AMH TAG Members to review findings with organizations and Data Subcommittee representative***
- ***DHHS to continue collecting information on how PHPs' and CINs' currently and plan to ADT information and alerts***

Agenda

1	Recap: Advanced Medical Home (AMH) TAG Meeting #6	11:30 am – 11:40 am
2	Healthy Opportunities in Medicaid Managed Care	11:40 am – 12:45 pm
3	Break	12:45 pm – 1:00 pm
4	Discussion: Tier 2 Reversion Guidance	1:00 pm – 1:30 pm
5	Recap: Data Subcommittee Meeting #3	1:30 pm – 2:15 pm
6	Public Comments	2:15 pm – 2:25 pm
7	Next Steps	2:25 pm – 2:30 pm

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Next Steps

1. **TAG Members to provide any additional feedback on Tier 2 Reversion Guidance**
2. **TAG Members to continue communication with DHHS TAG leads to identify topics for future meetings**
3. **DHHS to finalize and share pre-read materials for upcoming session:**

    - **AMH TAG Meeting #8 (November 20th; 10:00 am – 1:00 pm)**

Appendix