Tailored Care Management 103:

Health IT Requirements and Data Sharing

October 15, 2021

Tailored Care Management Webinar Series

Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider community and any anyone else who is interested.

Date *Fridays 12 -1 PM*	**Topic**
October 1, 2021	Introduction to Tailored Care Management
October 8, 2021	Becoming an AMH+/CMA
October 15, 2021	**Health IT Requirements and Data Sharing**
October 22, 2021	Partnering with a Clinically Integrated Network and Other Partners
October 29, 2021	Delivery of Tailored Care Management
November 5, 2021	Transitional Care Management Community Inclusion Activities
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December 3, 2021	Billing
December 10, 2021	Oversight and Quality Measurement/Improvement

Tailored Care Management Webinar Series

- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
  - You may ask a question at any time throughout the presentation, using the Q&A text box
  - Q&A Text Box is located at the lower right-hand side of the screen
  - Simply type in your question and click send

For additional questions on Tailored Care Management, please email:
Medicaid.TailoredCareMgmt@dhhs.nc.gov

- A recording of today's presentation and the slide deck will be available at the below website.

For more information on Tailored Care Management, please visit:
https://medicaid.ncdhhs.gov/transformation/tailored-care-management

Presenters

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agenda

- Tailored Care Management Data Strategy Source Documents
- Key AMH+ Practice & CMA HIT Requirements
- Key AMH+ Practice & CMA Data Exchange Requirements
- AMH+ Practice & CMA Risk Stratification
- Support & Resources Available to AMH+ Practices & CMAs
- Question & Answer

Additional Learning Opportunities

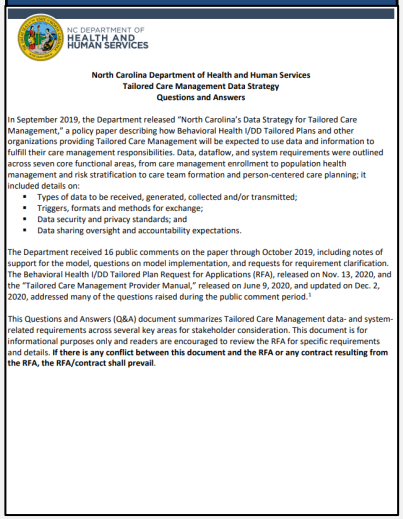
Today's training covers the key HIT & data exchange requirements related to the Tailored Care Management model. In the future, DHHS will hold a training on the detailed data specifications for the Tailored Care Management model.

Tailored Care Management
Data Strategy Source Documents

Tailored Care Management Data Strategy Source Documents

The Tailored Care Management Provider Manual is the primary source for AMH+ practice and CMA data exchange and HIT requirements. The Tailored Care Management Data Strategy FAQ and Care Management Data System Guidance may also be helpful resources.

Tailored Care Management Data Strategy FAQ



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management Data Strategy
Questions and Answers

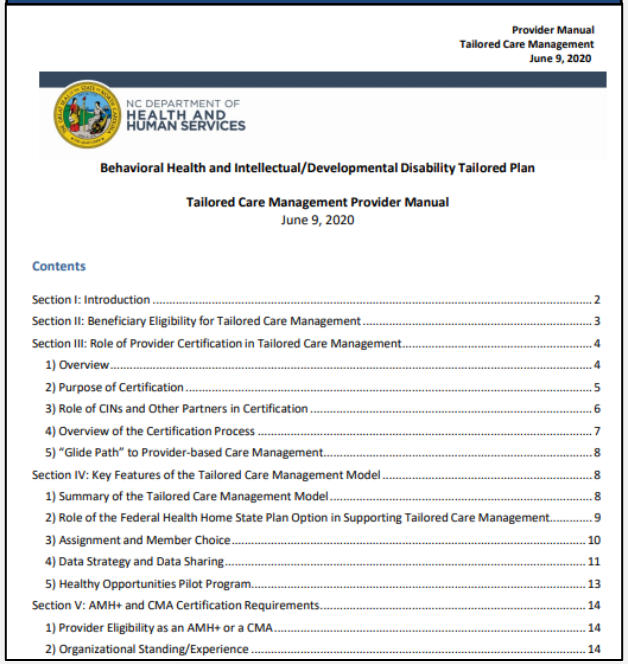
In September 2019, the Department released "North Carolina's Data Strategy for Tailored Care Management," a policy paper describing how Behavioral Health I/DD Tailored Plans and other organizations providing Tailored Care Management will be expected to use data and information to fulfill their care management responsibilities. Data, dataflow, and system requirements were outlined across seven core functional areas, from care management enrollment to population health management and risk stratification to care team formation and person-centered care planning; it included details on:

- Types of data to be received, generated, collected and/or transmitted;
- Triggers, formats and methods for exchange;
- Data security and privacy standards; and
- Data sharing oversight and accountability expectations.

The Department received 16 public comments on the paper through October 2019, including notes of support for the model, questions on model implementation, and requests for requirement clarification. The Behavioral Health I/DD Tailored Plan Request for Applications (RFA), released on Nov. 13, 2020, and the "Tailored Care Management Provider Manual," released on June 9, 2020, and updated on Dec. 2, 2020, addressed many of the questions raised during the public comment period.[1]

This Questions and Answers (Q&A) document summarizes Tailored Care Management data- and system-related requirements across several key areas for stakeholder consideration. This document is for informational purposes only and readers are encouraged to review the RFA for specific requirements and details. **If there is any conflict between this document and the RFA or any contract resulting from the RFA, the RFA/contract shall prevail.**

Tailored Care Management Provider Manual



Provider Manual
Tailored Care Management
June 9, 2020

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual
June 9, 2020

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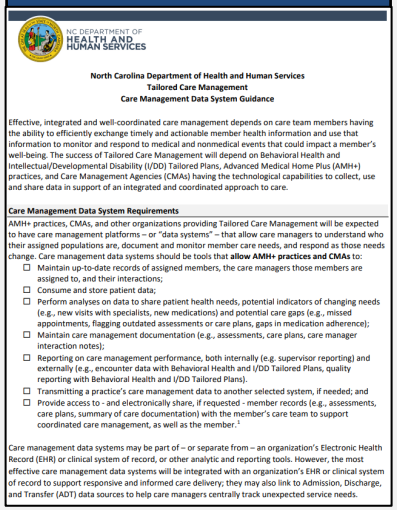


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management
Care Management Data System Guidance

Effective, integrated and well-coordinated care management depends on care team members having the ability to efficiently exchange timely and actionable member health information and use that information to monitor and respond to medical and nonmedical events that could impact a member's well-being. The success of Tailored Care Management will depend on Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans, Advanced Medical Home Plus (AMH+) practices, and Care Management Agencies (CMAs) having the technological capabilities to collect, use and share data in support of an integrated and coordinated approach to care.

Care Management Data System Requirements

AMH+ practices, CMAs, and other organizations providing Tailored Care Management will be expected to have care management platforms – or "data systems" – that allow care managers to understand who their assigned populations are, document and monitor member care needs, and respond as those needs change. Care management data systems should be tools that **allow AMH+ practices and CMAs** to:

- ☐ Maintain up-to-date records of assigned members, the care managers those members are assigned to, and their interactions;
- ☐ Consume and store patient data;
- ☐ Perform analyses on data to share patient health needs, potential indicators of changing needs (e.g., new visits with specialists, new medications) and potential care gaps (e.g., missed appointments, flagging outdated assessments or care plans, gaps in medication adherence);
- ☐ Maintain care management documentation (e.g., assessments, care plans, care manager interaction notes);
- ☐ Reporting on care management performance, both internally (e.g. supervisor reporting) and externally (e.g., encounter data with Behavioral Health and I/DD Tailored Plans, quality reporting with Behavioral Health and I/DD Tailored Plans).
- ☐ Transmitting a practice's care management data to another selected system, if needed; and
- ☐ Provide access to - and electronically share, if requested - member records (e.g., assessments, care plans, summary of care documentation) with the member's care team to support coordinated care management, as well as the member.[1]

Care management data systems may be part of – or separate from – an organization's Electronic Health Record (EHR) or clinical system of record, or other analytic and reporting tools. However, the most effective care management data systems will be integrated with an organization's EHR or clinical system of record to support responsive and informed care delivery; they may also link to Admission, Discharge, and Transfer (ADT) data sources to help care managers centrally track unexpected service needs.

1. North Carolina's "Tailored Care Management Provider Manual". December 2, 2020. https://files.nc.gov/ncdma/Tailored-Care-Management-Provider-Manual20201202.pdf
2. Tailored Care Management Care Management Data System Guidance. July 13, 2021. https://medicaid.ncdhhs.gov/tailored-care-management-data-system-guidance/
3. Tailored Care Management Data Strategy FAQ. July 2021. https://medicaid.ncdhhs.gov/documents/tailored-care-management-data-strategy-questions-and-answers/

Key AMH+ Practice & CMA HIT Requirements

Tailored Care Management HIT Systems Overview

AMH+ practices and CMAs must meet the following HIT requirements prior to Tailored Plan launch.

Use an electronic health record (EHR) or clinical system of record*

Use a care management data system

Use NCCARE360 (once operational)

AMH+ practices/CMAs may meet the HIT requirements by:

(1) Implementing or using their own systems;
(2) Partnering with a Clinically Integrated Network (CIN) or Other Partner; or
(3) Using the Tailored Plan's care management data system

* Use of an electronic health record (EHR) or clinical system of record is required to apply for and certify as an AMH+ practice/CMA. See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

What is a CIN or Other Partner & How Can They Help?

A "CIN or Other Partner" is an organization with which AMH+ practices/CMAs may partner that helps them meet Tailored Care Management requirements.

CINs or Other Partners may offer a wide range of support, including:

- Providing local care management staffing, functions and services
- Meeting the HIT requirements (e.g., care management data systems)
- Supporting AMH+ practice/CMA data integration, analytics, and use (e.g., importing and analyzing claims/encounter data)
- Supporting AMH+ practice/CMA quality measurement, performance improvement, and reporting
- Clinical consultation—to provide subject matter expertise and advice to the care team

Partnering with one or more CINs or Other Partner may help make the model more cost effective and financially sustainable for AMH+ practices and CMAs (e.g., partnering for HIT support versus an AMH+ practice/CMA purchasing a system on their own).

See Non-Binding Statement of Interest for Potential CINs and Other Partners for additional detail on the types of services offered by each.

Who May Act as a CIN or Other Partner?

CINs and Other Partners supporting AMH+ practices and CMAs may take many forms.

Potential CINs or Other Partners (*Non-Exhaustive List*)

1. Hospital or health system
2. Integrated delivery network
3. Independent Practice Association (IPA) or Managed Services Organization (MSO)
4. Another provider-based network or association
5. Another provider
6. Technology vendor
7. Tailored Plan may serve as an "Other Partner" for health IT support

Statement of Interest Responses

- To help providers get more information about potential CINs and Other Partners, the Department released a non-binding statement of interest.
- Six organizations responded with information about their capabilities.
- This information is available on the Tailored Care Management website.

Partnering with a CIN or Other Partner will be covered in greater detail in the next webinar in the series.

For additional information on how a CIN or Other Partner can support care management data needs, please visit: https://files.nc.gov/ncdhhs/documents/CIN-Other_Partners_policy-paper_20190305.pdf

See Non-Binding Statement of Interest for Potential CINs and Other Partners for additional detail on the types of services offered by each.

HIT Systems: Electronic Health Record

Use an Electronic Health Record (EHR) or Clinical System of Record: AMH+ practices and CMAs must have implemented an EHR or clinical system of record in-place to support care management, by electronically recording, storing and transmitting member clinical information.*

* Use of an electronic health record (EHR) or clinical system of record is required to apply for and certify as an AMH+ practice/CMA. See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

HIT Systems: Care Management Data System (1/2)

Use a care management data system.
AMH+ practices and CMAs must use a care management data system, which may comprise EHRs and/or separate care management platforms or analytic/reporting tools, that can:

- Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers;
- Electronically document and store care management comprehensive assessments, re-assessments, care plans and Individual Support Plans (ISPs);
- Consume and store claims and encounter data; and
- Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements.

*Care management data systems are not required to perform data analytics, but they must, at a minimum, be able to transmit data that supports data analytics performed by other systems and data tools.
See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

HIT Systems: Care Management Data System (2/2)

The care management data system should allow care managers to:

- Identify risk factors for individual members;
- Monitor and respond to changes in a member's health;
- Monitor a member's medication adherence;
- Develop actionable care plans and ISPs;
- Track a member's referrals and provide alerts where gaps in care occur;
- Share reports and summaries of care records with other care team members;
- Support data analytics and performance;* and
- Record and transmit quality and performance metrics for assigned populations.

*Care management data systems are not required to perform data analytics, but they must, at a minimum, be able to transmit data that supports data analytics performed by other systems and data tools.
See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

HIT Systems: NCCARE360

Use NCCARE360, once certified as fully functional statewide to identify community-based resources and connect members to such resources. AMH+ practices and CMAs must:

- Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;
- Refer members to the community-based organizations and social service agencies available on NCCARE360; and
- Track closed-loop referrals.

NCCARE360 is North Carolina's statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection.

See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.
See nccare360.org for more on NCCARE360.

Key AMH+ Practice & CMA Data Exchange Requirements

Data Exchange Requirements Overview

Data Types from Tailored Plan to AMH+ Practices/CMAs[1]

1. Member assignment information[1]
2. Member claims/encounter data[1]
3. Acuity tiering and risk stratification data[1]
4. Quality measure performance information
5. Other data to support Tailored Care Management (e.g., previously established care plans, historical member clinical info)

Tailored Plan

AMH+ Practices/CMAs

Data Types from AMH+ Practices/CMAs to Tailored Plan[1,2]

1. Care manager contacts
2. Care management comprehensive assessments
3. Care plans and individual support plans (ISPs)
4. Quality measure and reporting (measure set TBD)

1. These data types will be shared through consolidated standard data interfaces. The data interfaces used to transmit these data types will be described in a future training.

2. DHHS is working on standardizing the sharing of care needs and assessment data.

Tailored Plan to AMH+ Practice/CMA Data Exchange

Tailored Plan to AMH+ Practice/CMA Data Exchange Requirements[1]

Tailored Plans will be expected to share the following data in a machine-readable format with AMH+ practices, CMAs, or their designated CINs or Other Partners, for their attributed members to support Tailored Care Management:

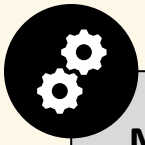
1. **Member assignment information**, including demographic data and any relevant clinical and available eligibility information[2]
2. **Member claims/encounter data**, including historical physical (PH), behavioral health (BH), and pharmacy (Rx) claims/encounter data at least monthly, or as described in the specification documents[2]
3. **Acuity tiering and risk stratification data.** Tailored Plans required to transmit acuity tier assignments to AMH+ practices/CMAs (and results & methods of any risk stratification they conduct)[2]
4. **Quality measure performance information** at the practice level
5. **Other data** to support Tailored Care Management (e.g., previously established care plans, historical member clinical info)

1. Member consent to share data will be obtained to the extent it is required by law or DHHS policy.
2. These data types will be shared through consolidated standard data interfaces.

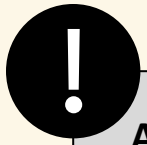
AMH+ Practice/CMA Data Acquisition & Use

Data-Driven Tailored Care Management Functions

AMH+ practices and CMAs will be expected to consume, analyze, and apply the following types of data to support critical Tailored Care Management program functions:



Member clinical, claims, and encounter data will be used to guide care manager assignment, inform the care management comprehensive assessment, aid in developing actionable care plans or individual support plans (ISPs), and support ongoing care management (e.g., providing information on member diagnoses, medications, and active treatments).



Admission, Discharge, and Transfer (ADT) information will be used to identify when members are transitioning into or out of the hospital and trigger systematic, clinically appropriate processes to support care transitions.

See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

AMH+ Practice/CMA to Tailored Plan Data Exchange

AMH+ Practice/CMA to Tailored Plan Data Exchange Requirements[1]

AMH+ practices, CMAs, or their designated CINs or Other Partners, will be expected to share the following data with Tailored Plans to support Tailored Care Management:

1. **Care manager contacts.** AMH+ practices/CMAs must share information on care manager contacts with assigned members with the Tailored Plan.
2. **Care management comprehensive assessments.** AMH+ practices/CMAs must ensure that the care management comprehensive assessment are shared with the Tailored Plan within 14 days of completion.[2]
3. **Care plans and individual support plans (ISPs).** AMH+ practices/CMAs are required to ensure that care plans and ISPs are documented, stored, and made available to Tailored Plans within 14 days of completion of the care plan or ISP.
4. **Quality measurement and reporting.** AMH+ practices/CMAs are required to gather, process, and share data with Tailored Plans for the purpose of quality measurement and reporting. (measure set TBD)

AMH+ Practices and CMAs will also provide important information to Tailored Plans through the claims/encounters they submit and the data those claims/encounters possess about members' service utilization and conditions.

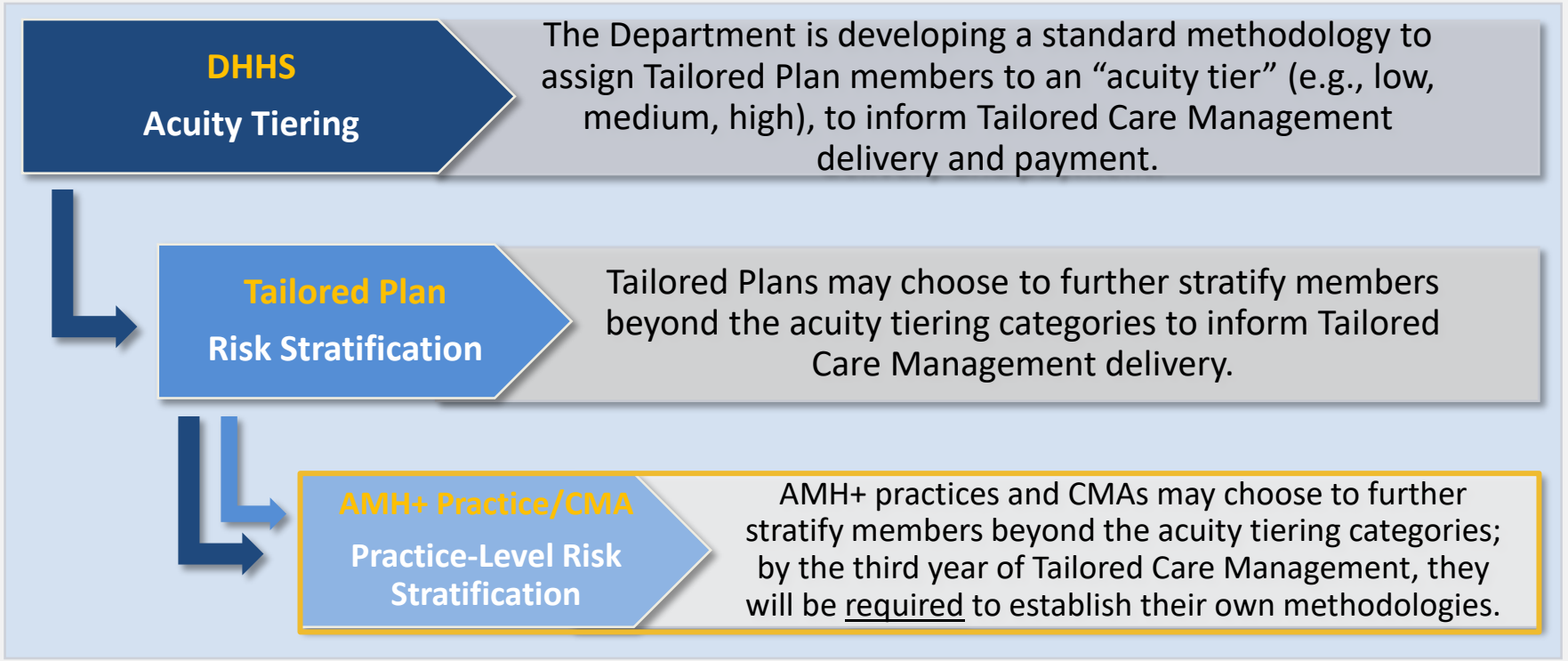
1. Member consent to share data will be obtained to the extent it is required by law or DHHS policy.
2. DHHS is currently evaluating feedback from the field on comprehensive assessment data sharing requirements and will provide additional guidance in the future.

See the Tailored Care Management Provider Manual for additional detail on AMH+ Practice/CMA to Tailored Plan data exchange requirements.

AMH+ Practice & CMA Risk Stratification

Acuity Tiering & Risk Stratification Overview

Acuity tiering will likely serve as the primary risk stratification method used by stakeholders to differentiate member need during the Tailored Care Management program's early years.



See the Tailored Care Management Provider Manual for additional detail on AMH+ Practice/CMA risk stratification.

Support & Resources Available to AMH+ Practices & CMAs

Tailored Care Management Technical Assistance

The Department is offering a technical assistance (TA) program that will help providers become certified AMH+ practices and CMAs and prepare them to be successful high-quality providers of Tailored Care Management.

- NC Medicaid contracted NC Area Health Education Centers (AHEC) to provide education, practice support services and TA across all 100 counties, to providers who applied for AMH+ practice/CMA certification and passed the desk review.

- NC AHEC Tailored Care Management TA will prepare AMH+ practice and CMA candidates for a successful site review and certification and help AMH+ practices and CMA succeed before and after Tailored Plan go-live (July 1, 2022).

- Practice support coaches with expertise in behavioral health and I/DD provide TA and education at no cost to AMH+ practice and CMA candidates through:
  - 1:1 TA
  - Tailored Care Management Gap Analysis Tool (*approved by NC Medicaid and required*)
  - Learning collaboratives, with opportunity to earn continuing education (CE) credits
  - Education modules, with opportunity to earn CE credits

Tailored Care Management Technical Assistance

Additional AHEC TA Resources

- Visit https://www.ncahec.net/tailored-care-management for information about NC AHEC & NC Medicaid Tailored Care Management Educational Programming.
- For additional questions about NC AHEC practice support services, please contact practicesupport@ncahec.net.
- More Practice Support information is listed at Practice Support | NC AHEC.
- AHEC's offers TA in a variety of additional areas including, Medicaid managed cared education and issue resolution, clinical workflow redesign and process improvement, quality improvement, EHR optimization, telehealth integration, HIE training and optimization, social determinants of health workflows optimization

Capacity Building Overview

Recognizing that the current provider-based care management capabilities need to be enhanced significantly, DHHS anticipates distributing approximately $90 million in capacity building funds across the state to prepare as many providers as possible to offer Tailored Care Management in the early years of the Tailored Plans.

Key Areas of Investment

- Care management related health information technology (HIT) infrastructure
- Workforce development (hiring and training care managers)
- Operational Readiness (e.g., developing policies/procedures/workflows)

Federal Requirements

- The capacity building program was designed to meet federal requirements for a managed care performance incentive arrangement, which allows the state to obtain federal Medicaid matching funds for capacity building activities.[1]
  - Under the federal regulations funds must flow through managed care plans and must be earned based on performance (e.g. achieving milestones set by the state).

DHHS will take an equity lens in distributing capacity building funds:

- Targeting investments to address health disparities and improve health and wellness for all Medicaid members.
- Ensuring the needs of rural provider and providers who have been historically underutilized are identified and addressed.
- Building a robust care management workforce and provider networks that are representative of the diverse population in the state.

1. 42 CFR 438.6(b)(2)

Funds Flow Overview

Tailored Plan awardees will be eligible to earn capacity building payments on a quarterly basis for meeting defined targets and milestones related to partnering with AMH+ practices and CMAs to support development of needed care management capacity.

- The first milestone will be for Tailored Plan awardees to develop a distribution plan that is based on an assessment of regional needs and lays out the proposed approach for meeting other milestones (including a proposed budget and quarterly targets).

Distribution plans must include an approach for meeting the needs of rural and historically underutilized providers, building a diverse workforce, and addressing health disparities.

- Once the distribution plans are submitted and approved, the Department will release funds to Tailored Plan awardees so that they can begin working with contracted AMH+ practices and CMAs to build capacity at their site(s).

- Then, on a quarterly basis, Tailored Plan awardees will report on progress made by their contracted AMH+ practices/CMAs and as milestones are achieved, funding will be released.

Capacity Building Milestones

To date, DHHS has identified six milestones aimed at enhancing HIT infrastructure, building the care manager workforce across the state, and promoting operational readiness. These milestones will also include sub-milestones, including some targeted at supporting rural and historically underutilized providers.

Milestone 1	Submission of a detailed distribution plan that specifies the Tailored Plan's approach (including quarterly targets) and proposed budget for meeting the remaining capacity building milestones, for DHHS approval *Distribution plan will be based on assessment of regional needs*
Milestone 2	Submission of a Tailored Care Management training curriculum and conducting trainings for care managers employed by Tailored Plan awardee and contracted AMH+ practices and CMAs
Milestone 3	Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices/CMAs
Milestone 4	Hiring new care managers and supervisors at AMH+ practices and CMAs
Milestone 5	Completing Tailored Care Management training for AMH+ practice and CMA care managers and supervisors
Milestone 6	AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management (e.g., development of policies and procedures and education and outreach to members on the Tailored Care Management outreach)

Tailored Plan awardees will provide quarterly updates to the Department on progress towards achieving all milestones at the aggregate (regional) levels. AMH+ practices/CMAs will provide at least quarterly reports to the Tailored Plan awardees on their organizational/site level capacity building progress for milestones 3-6.

Questions?

Tailored Care Management Webinar Series

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