North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) Data Subcommittee Meeting
August 19th, 2022, 3:00-4:30 PM ET

Attendees:

AMH TAG Data Subcommittee Members	Organization
Hazen Weber	AmeriHealth Caritas North Carolina, Inc.
Carla Slack	Blue Cross and Blue Shield of North Carolina
Sharon Greer	Carolina Complete Health, Inc.
Lisa Tucker	UnitedHealthcare of North Carolina, Inc.
Nathan Barbur	WellCare of North Carolina, Inc.
Debra Roper	Access East / Vidant Health / ECU Physicians
Misty Hoffman	Atrium Health Wake Forest Baptist
Sanga Krupakar	Carolina Medical Home Network
Carlos Jackson	Community Care Physician Network (CCPN)
Mary Schilder	Duke University Health System
Alexander Lindsay	Emtiro Health
Cynthia Reese	Mission Health Partners
Shaun McDonald	UNC Health System
NC DHHS Staff and Speaker	**Title**
Kelly Crosbie, MSW, LCSW	Chief Quality Officer
Loul Alvarez	Associate Director
Lauren Burroughs	Program Manager
Advisors	**Title**
Vik Gupta	Medicaid Transformation Project Executive, Quality & Population Health, Accenture
Sachin Chintawar	Medicaid Transformation Project Manager, Quality & Population Health, Accenture
Lammot du Pont	Senior Advisor, Manatt Health Strategies

Agenda

- Welcome and Roll Call
- Data Topic Roadmap
- Updates on Data Topics
    - Patient Risk List
    - CIN-AMH Relationship Tracking
    - Beneficiary Assignment
    - Quality Measures
- Public Comments
- Next Steps

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Data Topic Roadmap (Kelly Crosbie)

Key Takeaways

- The Department reviewed progress on the seven data topics identified by AMH TAG Data Subcommittee members and highlighted four topics (*****) for further discussion during the meeting.
    - **Beneficiary Assignment***
    - **Tracking CIN-AMH Relationships***
    - **Patient Risk List***
    - PHP & AMH Data Transmission Timing
    - Claims Files
    - **Quality Measures***
    - Care Needs Screening

Patient Risk List: Key Issues (Sachin Chintawar)

Key Takeaways

- PHPs, CINs, and AMH Tier 3 practices have raised two data issues that limit the use of exchanged Patient Risk List (PRL) files:
    - Varying interpretations of risk stratification categories among PHPs, CINs, and AMH Tier 3 practices, and
    - Incomplete or incorrectly formatted PRL files, potentially due to non-compliance with DHHS requirements or unclear guidance.

Patient Risk List Root Cause 1: Varying PHP Definitions of Risk Level Categories (Sachin Chintawar)

Key Takeaways

- Risk level category definitions (e.g., "high", "medium", and "low") vary among PHPs, which makes consistent interpretation of an individual's clinical risk by CINs and AMH Tier 3 practices challenging.

- The Department is considering the following potential solutions:
    - Assess PHP risk level definitions and values with CINs and AMH Tier 3 practices (i.e., better understand PHPs' current risk category definitions and classifications)
    - Convene PHPs, CINs, and AMH Tier 3 practices to discuss feasibility of developing standard risk stratification category definitions and classifications. Developing and implementing standardization would improve: (1) the ability for AMH Tier 3 practices and CINs to interpret risk classifications across the PHPs they engage with and (2) the ability for DHHS to interpret the percentage of members in risk categories across PHPs.

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Comment**: AMH TAG Data Subcommittee members agreed that additional exploration of this issue would be helpful.
    - **Response**: The Department will assess options for increased standardization of risk stratification categories and engage data subcommittee members on the advantages/disadvantages of the options.

- **Comment**: Multiple AMH TAG Data Subcommittee members cautioned that PHP risk stratification algorithms are proprietary and reflect careful adjustment from PHPs' clinical teams. One AMH TAG Data Subcommittee member suggested the Department should define expectations for risk category definitions.
    - **Response**: The Department will review the suggestion and assess considerations for implementation.

- **Comment**: Multiple AMH TAG Data Subcommittee members noted that uniformity around risk category definitions is less of a concern than the ability to complete expected care management responsibilities for assigned populations. An unexpectedly large percentage of "high-risk" patients would stretch limited CIN/AMH resources and risk non-compliance with care management policies in CIN/AMH service-level contracts with PHPs.
    - **Response**: The Department noted the issue and will consider the impacts on CIN/AMHs of varying percentages of members in PHP risk categories.

Patient Risk List Root Cause 2: Files with Format and/or Completeness Issues (Sachin Chintawar)

Key Takeaways

- The Department has observed issues with PRL file formats and completeness.
    - Some PRL files contain data that do not align with DHHS format requirements. Ambiguities in DHHS guidance may contribute to non-compliance.
    - Some PRL files are missing important data elements, including header tabs, Risk Score Category, duplicate members, Care Management Entity NPI numbers, and full panel lists.

- The Department is considering the following solutions:
    - Assess current guidelines to identify areas where additional detail or clarity would be helpful;
    - Update PRL guidance, including creating a "single source of truth" checklist for the PRL file, to help with internal validation before file transmission; and
    - Promote the new guidance across stakeholders.

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Comment**: AMH TAG Data Subcommittee members agreed to provide feedback on the current PRL guidance documents and specific recommendations to clarify ambiguous areas.
    - **Response**: The Department will formally share the current PRL guidance document and solicit written feedback from AMH TAG Data Subcommittee members.

Tracking CIN-AMH Relationships (Sachin Chintawar)

Key Takeaways

- PHPs' understanding of CIN-AMH assignment is not always reflective of the latest CIN-AMH contract relationships. Outdated CIN-AMH relationship information can result in member data being shared between PHPs and CINs/AMH practices that does not reflect presently assigned populations. No current single source of truth exists to track CIN-AMH relationships.

- To address this data issue, the Department proposes to develop a single source of truth for CIN-AMH relationships and create a standardized process to document, maintain, and update CIN-AMH relationships. This solution will include the following policy changes:
    - CINs will be required to register with CINs. Once registered, CINs will notify DHHS of existing affiliations with AMH practices and CMAs. Active CINs will be required to keep their provider affiliations up to date and report affiliation changes to DHHS.
    - AMHs will also be required to attest to their affiliated CINs (e.g., two-way validation process).
    - Upon validation of CIN-AMH affiliation, CINs will receive monthly panel reports from DHHS with member assignment data.

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Comment**: AMH TAG Data Subcommittee members recommended continued engagement on solution design and implementation.
    - **Response**: The Department emphasized its commitment to engage with the AMH TAG Data Subcommittee on solution design and implementation.

- **Comment**: An AMH TAG Data Subcommittee member inquired whether the proposed solution would integrate into the existing provider enrollment file (PEF).
    - **Response**: The Department clarified that PEF integration would be considered after the initial CIN-AMH affiliation and tracking solution is implemented.

- **Comment**: An AMH TAG Data Subcommittee member noted the potential financial costs, operational considerations, and clinical impact for implementing incremental system changes.
    - **Response**: The Department noted the concern and will explore mitigation options.

- **Comment**: Several AMH TAG Data Subcommittee members noted that requiring AMH practices to validate the CIN-AMH relationship would increase providers' administrative burden. One AMH TAG Data Subcommittee member recommended validation of CIN-AMH relationships using PHPs' documentation of the current CIN-AMH relationships and only require practice validation when the CIN and PHPs' data do not match.
    - **Response**: The Department will review this option and assess legal considerations since the CIN-AMH relationship triggers the transfer of information from PHPs to the AMHs' designated CINs.

Beneficiary Assignment: Key Issues

Key Takeaways

- The Department highlighted two beneficiary assignment issues observed and reported:
    - High levels of beneficiary assignment churn at a practice-level, and
    - Inconsistent data quality of the beneficiary assignment file

- Three root causes have been identified:
    - Assignment errors,
    - Documentation of providers' practice location changes, and
    - Inaccuracies in beneficiary assignment files.

Beneficiary Assignment Root Cause 1: Assignment Errors

Key Takeaways

- The Department has observed that some beneficiaries are being incorrectly assigned to AMH Tier 3 practices. Areas of concern include: (1) providers not currently accepting patients, (2) providers who do not serve their population (e.g., adults assigned to pediatrics), and (3) mismatch of members assigned in NC Tracks and the beneficiary assignment file.

- To address assignment errors, the Department will:
    - Develop a new provider bulletin on PCP expectations for panel assignment management and updated panel limits,
    - Request PHPs to conduct a self-audit of auto-assignment rules for potentially mismatched assignments, and
    - Investigate reasons for high PCP reassignment.

Beneficiary Assignment Root Cause 2: Providers' Practice Location Changes

Key Takeaways

- The Department reviewed issues associated with providers' practice location changes. When an AMH Tier 3 provider moves practice locations, their members are reassigned to other providers. This occurs when the old location codes are retired before the new location codes are operationalized.

- To address this issue, the Department will develop new guidance to help ensure that providers do not lose their assigned beneficiaries when they change practice locations.

Beneficiary Assignment Root Cause 3: Inaccurate Beneficiary Assignment File

Key Takeaways

- The Department noted that beneficiary assignment fields are being sent to AMH practices with missing or invalid values.

- To address this issue, the Department will conduct an end-to-end audit of beneficiary assignment file transmission to assess current processes and identify issues to inform solution strategies. The Department will also continue to (1) improve communications and training, and (2) as appropriate, provide Notice of Damages for recurring impacts.

Quality Measures: Key Issues and Updates

Key Takeaways

- The Department has observed and stakeholders have reported inconsistent data quality for quality and performance measure data, limiting their meaningful use. These data quality challenges include:
    - Inconsistent approaches to quality metrics reporting,
    - Inconsistent use of supplemental data, and
    - Data timeliness and accuracy concerns.

- To address these identified issues, the Department has undertaken the following efforts.
    - *Launch annual review of the quality measure set*: The Department reviews its quality measure sets as part of regular monitoring and maintenance processes. The Department is currently synthesizing and incorporating stakeholder feedback for the 2022 Quality Measure Technical Specifications guide.
    - *Work with stakeholders to facilitate greater use of clinical data for quality measures*: The Department is currently collaborating with the North Carolina Health Information Exchange Authority (NC HIEA) to create a clinical data conduit for North Carolina Medicaid Managed Care. The Department and NC HIEA have developed data extracts of priority data elements and will begin monthly transmission of these data extracts to PHPs and CCNC in September 2022. The Department is also supporting NC HIEA efforts to participate in NCQA's Data Aggregator Validation Program.
    - *Continue to track quality reporting as it improves over time*: The Department will continue to track reporting of quality data over time.

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Comment**: One AMH TAG Data Subcommittee member noted significant differences in how PHPs calculate quality measures and implement HEDIS specifications, particularly related to care gap reporting.
    - **Response**: The Department encourages AMH TAG Data Subcommittee members to submit quality issues to the Department or EQRO for resolution.

- **Comment**: Several AMH TAG Data Subcommittee members asked about the rationale for the Department's focus on NC HIEA to exchange clinical data among the Department, PHPs, and CINs/AMH practices.
    - **Response**: The Department believes that leveraging the health information exchange would allow for all stakeholders to use a uniform tool to collect, exchange, and use clinical data to improve care management and support transitions of care.

Wrap-Up and Next Steps

- In the next weeks, the Department will formally solicit feedback on the PRL file guidance. AMH TAG Data Subcommittee members are invited to submit additional feedback on any of the discussed data topics in the meantime.

- The next AMH TAG Data Subcommittee meeting will be held on ***October 14, 2022, from 3:00 PM – 4:30 PM***. Please submit any additional questions and comments on meeting topics and/or logistics to Lauren Burroughs (lauren.burroughs@dhhs.nc.gov).

The meeting adjourned at 4:00 PM.