North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) Data Subcommittee Meeting
December 3, 2024, 3:30-5:00 PM ET

Attendees:

AMH TAG Data Subcommittee Members	Organization Type
AmeriHealth	Health Plan
Carolina Complete Health	Health Plan
WellCare of North Carolina	Health Plan
Atrium Health Wake Forest Baptist	Provider (CIN)
CCPN	Provider (CIN)
CHESS Health Solutions	Provider (CIN)
Duke Health	Provider (CIN)
Mission Health Partners	Provider (CIN)
Carolina Medical Home Network	Provider (CIN)
UNC Health [UNC Health Alliance]	Provider (CIN)
Children First of NC	Provider (Independent)
Cherokee Indian Hospital Authority	Tribal Option
NC DHHS Staff and Speaker	**Title**
Kristen Dubay	Chief Population Health Officer
Andrew Clendenin	Deputy Director, Population Health
Loul Alvarez	Associate Director, Population Health
Judy Lawrence	AMH Sr. Program Manager
Saheedat Olatinwo	AMH Program Lead
Evelin Lazaro	AMH Program Specialist
Elizabeth Kasper	Care Delivery and Payment Reform Sr Advisor
Advisors	**Title**
Vik Gupta	Medicaid Transformation Project Executive, Quality & Population Health, Accenture
Sachin Chintawar	Project Manager, Quality & Population Health, Accenture
Jordan Wuest	Project Manager, Quality & Population Health, Accenture
Shani Ranatunga	Project Manager, Quality & Population Health, Accenture
Lammot du Pont	Senior Advisor, Manatt Health Strategies

Agenda

- Welcome & Roll Call
- Data Topic Updates
    - PCP Auto Assignment Update
    - AMH Data Interfaces Timeline Standardization
    - Remittance Advice Data Requirements
- HIE Use Cases
- Public Comments
- Wrap Up & Next Steps

PCP Auto Assignment Update (Elizabeth Kasper)

Key Takeaways

- Identified root causes of misassignments include PHP's AA algorithm errors and lack of timely and up-to-date panel requirements from providers in NCTracks

- Four main issue resolution activities:
  - Establish acceptable reasons for reassignment to allow quick and consistent reassignment requests
  - Identify and resolve discrepancies in assignments from PHPs and NC Tracks
  - Identify root cause of current assignment issues
  - Conduct external review of accuracy of PHPs' beneficiary assignment processes including potential misalignment between PHP AA algorithms and provider panel restrictions

- Reminders for Provider Organization DSC Members:
  - Continue to update NCTracks timely
  - Confirm with each plan that panel limits are up to date
  - Submit tickets to Provider Ombudsmen for PCP assignment errors

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Feedback:** Does DHB plan to redesign its attribution methodology based on claims history? A significant issue with assignment is that we are not being assigned patients based on claims.
  - **Response:** Not something that we are focusing on at the moment. We did receive this feedback and will consider this moving forward.

- **Feedback:** Would it be possible to allow e-signatures on the Change my PCP form?
  - **Response:** This is something that we are exploring internally in terms of regulations and will provide feedback to the plans, who own the PCP change request forms.

- **Feedback:** We have recently encountered a new member assignment issue with multiple PHPs related to members being assigned who live further than the distance from the practice they are being assigned to.
  - **Response:** It would be helpful to report this via a ticket to Provider Ombudsmen so we can ask the plans how these assignments were made and identify root cause.

AMH Data Interfaces Timeline Standardization (Jordan Wuest)

Key Takeaways

- SPs have different schedules and we are in the process of resolving this by standardizing the timeline and requesting AMH partners to adhere to the data transmission schedule below:

File Type	Current Requirements	Draft Standardized Schedule
Beneficiary Assignment* Full File	Weekly	Weekly full files every Sunday and the last day of each month
Beneficiary Assignment* Incremental	Daily	Decommissioned
Patient Risk List Outbound to Providers	At least monthly on the 26th	Monthly on the 26th
Patient Risk List Inbound to Plans	At least monthly on the 7th	Monthly on the 7th
Encounters/Claims** Institutional, Professional, Dental, and Pharmacy	At least monthly	First full and ongoing incremental files every Tuesday
Pharmacy Lock-In Full File	Weekly	Weekly full files every Sunday (aligned with weekly BA full file)

- Next steps include implementation of new data specifications. We are currently in development for the plans and providers, which is expected to be completed in late December (Dec 20th), then will go into Internal Testing and SIT. Expected go live is March 1st

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Feedback:** What happens to the last four days of the month after the PRL is submitted?
  - **Response:** We are currently addressing this on the TP side but we can take this question back.

- **Feedback:** Would it make sense to retire PRL and add the risk information to the BA file?
  - **Response:** That is good feedback that we will consider.

Remittance Advice Data Requirements (Saheedat Olatinwo)

Key Takeaways

- Providers expressed concerns about PMPM payment information that is insufficiently detailed, inconsistently formatted and unregularly submitted

- As a resolution, the Department is proposing a SP amendment that would require a set minimum of information in the Remittance Advice plans share with providers.

- Proposed List of Minimum Requirements

Proposed List of Minimum Requirements for Remittance Advice	
1. PMPM Type	8. Payment date
2. PMPM Rate	9. Total payment for each PMPM type
3. Total Number of Assigned Members	10. Total payment for currently assigned members
4. Number of retro-eligible members assigned	11. Total payment for retro-eligible members
5. Number of retro-eligible members unassigned from the prior period	12. Total recoupment payment
6. Provider name and NPI/Location Code	13. Total payment adjustment
7. Tax Identification Number	14. Payment Reference Number

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Feedback:** I think the biggest issue is wanting to have this information in an excel format so it is navigable, so we would like this to be a top priority.
    - Other members agree.

- **Feedback**: Is there a place where we can email comments after the meeting about the remittance advice standards?
    - **Response**: Medicaid.AdvancedMedicalHome@dhhs.nc.gov

- **Comment:** It would help if there was also a list of the members included in the total number of assigned members.

- **Next Steps**:
    - PHPs to share timeline for any software development/update needed for implementation by Dec 20.
    - Provide any additional feedback to: Medicaid.AdvancedMedicalHome@dhhs.nc.gov by Dec 20.

HIE Use Cases (Larry Mull)

Key Takeaways

- One solution for three different use cases:
    - 1) Health-related social needs (HRSN)
    - 2) Digital Quality Measures (dQm)
    - 3) Care Management

- Our current challenges include limited/fragment information, multiple data connections & recipients, and operational complexity in data formats

- Key considerations for this project:
    - Long-term endeavor where each case has different stakeholder, data flows, and will evolve at different paces
    - Need for Near-term Investments and Prioritization for ensure scare resources are allocated efficiently and effectively
    - Funding from CMS requires a set of obligations

- Use Case 1: HRSN Screening
    - Vision: Improve the availability, accuracy, and timeliness of Medicaid members' HRSN screening information.
    - Goals include:
        - Improve access
        - Reduce administrative burden
        - Improve member experience
    - Scope considerations:
        - Flexibility in collecting and storing HRSN Screening information
        - HRSN Referral Information is NOT in Scope

  - Phases:
    - P1: Collecting Providers' HRSN Screening Data
    - P2: Sharing Providers HRSN information with providers and health plans
    - P3: Collecting and Sharing Health Plans' HRSN Screening Information

- Use Case 2: Digital Quality Measures
  - Vision: Improve the accuracy, timeliness, and ease of collecting, calculating, and sharing quality performance information
  - Goals:
    - Improve collection of clinical data
    - Decrease administrative burden by collecting quality measure elements in NC HealthConnex
    - Improve gap reporting to inform providers' quality improvement and patient outreach
    - Align with CMS's Digital Quality Measure
  - Scope Considerations:
    - Controlling High Blood Pressure (CBP)
    - Glycemic Status Assessment for Patients with Diabetes (GSD)
    - Screening for Depression and Follow-up Plan (CDF)
  - Phases:
    - P1: Collecting Providers' Clinical Data to Inform Measure Calculation
    - P2: Calculating Quality Performance
    - P3: Sharing Quality Performance Information with Providers' Plans, and DHB

- Use Case 3: Care Management
  - Vision: Improve the exchange of encounter data between PHPs and local care management entities, transitions of care information when members move PHPs, and care management interaction details
  - Goals:
    - Minimize interfaces
    - Establish a single source of truth
    - Minimize custom enhancements
  - Use Cases:
    - BA File
    - TOC between Health Plans
    - Claims and Encounters to support CM
    - CM Interactions (PRL) Information Exchange
  - Key Design Considerations:
    - Limit changes and approved data formats
    - Any changes will go through governance (AMH Tag)
    - Plans will share CIN-AMH relationship with the Department

Discussion/Feedback from AMH TAG Data Subcommittee Members

- **Comment:** Is this statewide aggregate data, or will it be refined to the practice level? If data is reported at the practice level, panels and attribution accuracy is really important.

  - **Response**: The Department appreciates this feedback and expects that Medicaid member data collected for the dQM use case will be considered at the practice and plan levels as applicable. As this is an evolving use case that will be implemented over time, the Department will be following best practices for attribution of the data.

- **Comment:** Will embedding these loinc codes to responses from the NC DHHS SDOH survey questions allow the data to be usable for CMS measure specs like eCQMs and MIPS as well? I think it is important to crosswalk the proposed LOINC codes with the CMS value sets
  - **Response:** The Department appreciates this question and seeks to align the codes and value sets where feasible.

- **Comment:** The collection of clinical data is also important for commercial dual eligibles.

- **Comment:** UNC is currently experiencing these administrative challenges. We have been using NC DHHS SDOH questions, but the responses are slightly different from the original published assessment and don't have LOINCs. This is a requirement for the ACO REACH contract. We are being told by CMS that we must exactly match the NC DHHS questions & responses. But if we do that, we will break the current exchanging with NC Health Connex b/c there won't be a LOINC.
  - **Response**: The Department appreciates your feedback and requests that you send the question to the Medicaid.AdvancedMedicalHome@dhhs.nc.gov for further discussion.

- **Feedback:** With respect to the HRSN Screening Use Case, is UNC Health and Duke Health using CCDs as the data exchange format and would NC HIEA accept data in CCDs from other providers?
  - **Response:** Currently, health providers transmit clinical data to NC HealthConnex in accordance with NC HealthConnex Onboarding Packet and Technical Specifications_v3.2.pdf either via: (1) HL7 Admission, Discharge, and Transfer (ADT) messages or (2) Clinical Document Architecture (CDA) documents or related structures like Continuity of Care Documents (CCDs). During the initial SDOH LOINC Data Exchange Pilot that Duke and UNC participated in, participants were asked to translate screening questions and answers into LOINC codes and transmit this information to NC HealthConnex via ZPV segments of HL7 v2 ADT messages. Based on learnings from this Pilot, the team is working to finalize a user guide with detailed technical specifications for the transmission of HRSN data that will be used to onboard additional participants to the HRSN Use Case. If you are interested in participating in future phases of the HRSN Use Case, would like to review the technical specifications document, or have any additional questions, please reach out to HMS.HIEA@nc.gov. In later phases of the HRSN Use Case, NC HIEA aims to develop capabilities to receive HRSN screening information from providers via CCDs.

- **Feedback:** On Phase 1 for DQM, is data pulled for every Medicaid beneficiary that's been seen at that provider organization or is it limited to people that have an established primary care relationship there?
  - **Response**: It is what is going to be sent to HIE that will be shared.

- **Feedback**: On Phase 3 for DQM, think about the role of CINs in terms of data receipt.
    - **Response**: It includes CINs, and we are currently figuring out data receipt in terms of legal and security compliance.

- **Feedback**: Does the DHHS have technical specifications for all of the different formats that the data can be exchanged? What are the actual components you are asking from the providers?
    - **Response**: This is something that we can take back to the team for internal discussion.

- **Comment:** Understanding the services received under coordination of benefits and/or dual-commercial-eligibles will be important.

Public Comments (Saheedat Olatinwo)

No comments.

Next Steps (Saheedat Olatinwo)

- Members will:
    - Provide any additional feedback on today's discussion, along with any desired agenda topics for the next AMH TAG Data Subcommittee, to: Medicaid.AdvancedMedicalHome@dhhs.nc.gov.

- The Department will post a presentation and summary of the meeting on the NCDHHS website and respond to any outstanding member questions as appropriate.

- The next AMH TAG Data Subcommittee meeting is scheduled for Q1 of 2044.