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

December 3, 2024 Meeting

Agenda

Welcome & Roll Call	**5 min**
Data Topic Updates 1. PCP Assignment Improvement 2. AMH Interface Standardization 3. Remittance Advice Data Requirements	**30 min**
HIE Use Cases	**45 min**
Public Comment	**5 min**
Wrap-Up and Next Steps	**5 min**

Note: *The Department continues to advance progress on other data topics, including (1) standardizing 42 CFR Part 2 data exchange, (2) publishing the Risk Stratification Guidance, and (3) improving Care Management Interactions Data Quality. Please see the Appendix for a brief progress update on each of those topics.*

AMH TAG Data Subcommittee Roll Call

Entity	Organization Name
Health Plans	AmeriHealth
	Carolina Complete Health
	Healthy Blue
	United Healthcare
	WellCare
Providers (CINs)	Atrium Health Wake Forest Baptist
	CCNC / CCPN
	CHESS Health Solutions (aka Emtiro)
	Duke Health / Duke Connected Care
	ECU Health / Access East
	Mission Health Partners
	NCCHA / Carolina Medical Home Network
	UNC Health / UNC Health Alliance

Entity	Organization Name
Providers (Ind.)	Children First of NC
	Sandhills Pediatrics / CCPN
	Blue Ridge Pediatrics / CCPN
Others	Tribal Option

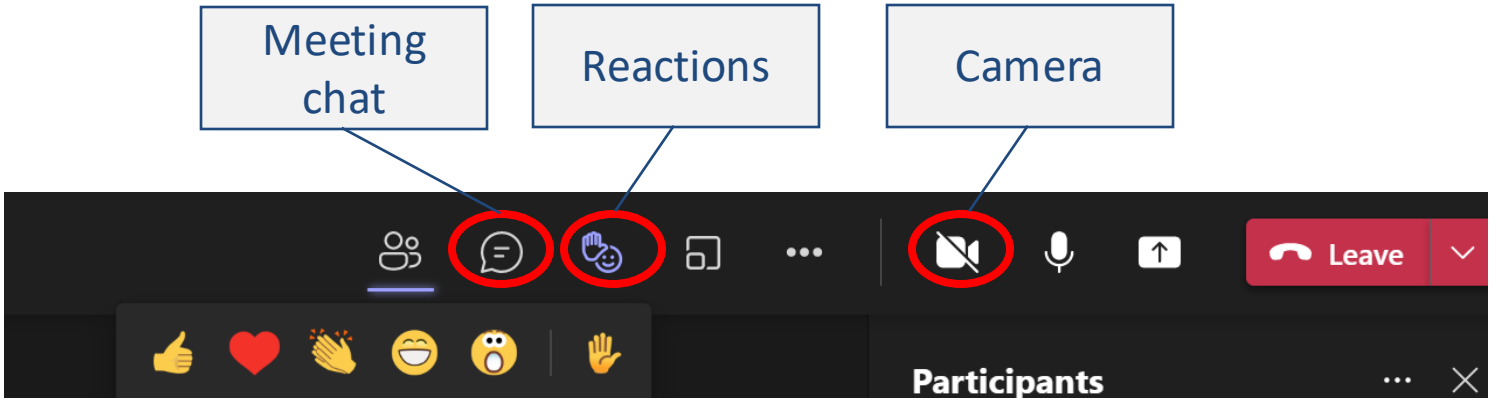
NCDHHS and Advisors

NCDHHS					
Kristen Dubay	**Andrew Clendenin**	**Loul Alvarez**	**Judy Lawrence**	**Saheedat Olatinwo**	**Evelin Lazaro**
Chief Population Health Officer, DHB	Deputy Director, Population Health, DHB	Associate Director, Population Health, DHB	AMH Sr. Program Manager, Population Health, DHB	AMH Program Lead, Population Health, DHB	AMH Program Specialist, Population Health, DHB

Advisors				
Vik Gupta	**Sachin Chintawar**	**Jordan Wuest**	**Shani Ranatunga**	**Lammot du Pont**
Project Executive, Quality & Population Health, Accenture	Project Manager, Quality & Population Health, Accenture	Project Manager, Quality & Population Health, Accenture	Project Manager, Quality & Population Health, Accenture	Senior Advisor, Manatt Health Strategies

Meeting Engagement

We encourage subcommittee members to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



AI Policy

Please note that we are not recording this call, and request that no one record this call or use an AI software/device to record or transcribe the call.

NCDHHS is awaiting additional direction from our Privacy and Security Office on how we need to support these AI Tools.

Thank you for your cooperation.

HIPAA-covered NCDHHS agencies which become aware of a suspected or known unauthorized acquisition, access, use, or disclosure of PHI shall immediately notify the NCDHHS Privacy and Security Office (PSO) by reporting the incident or complaint to the following link: https://security.ncdhhs.gov/

Data Topic Updates:

1. PCP Assignment Improvement

2. PCP Assignment Improvement
Issue Description and Root Cause Analysis

Issue Description

AMH Tier 3 practices/CINs have reported **substantive member misassignments**, resulting in frequent changes to provider panels.

The **root causes of these misassignments** are investigated on a case-by-case basis. Some identified causes include:

1. PHPs' auto-assignment algorithm errors; and
2. Lack of timely and up-to-date panel requirements from providers in NCTracks.

Root Cause Analysis

- Data Subcommittee Members highlighted the continued occurrence of misassignments and the resulting impacts to:
  - (a) the **effective administration** of care management programs and
  - (b) the **accuracy of care management payments**.

2. PCP Assignment Improvement
Resolution Activities and Next Steps: Updates

Issue Resolution Activities: Updates and Next Steps

- ❑ **Establish acceptable reasons for reassignment** to allow PHPs to process reassignment requests from providers more quickly and consistently.
  - *DHB is reviewing feedback received from DSC and health plans on potential improvements to reassignment processes and guidelines.*
- ❑ **Identify and resolve discrepancies in assignment lists** from PHPs and NC Tracks.
  - *PHPs are reviewing examples provided by DSC members to identify root cause.*
- ❑ **Identify root cause of current assignment issues** for subsequent resolution.
  - *The Department is identifying discrepancies between Provider's age and gender panel restrictions and member assignment.*
- ❑ **Conduct an external review** of the accuracy of PHPs' beneficiary assignment processes, including potential misalignment between PHPs' auto-assignment algorithms and provider panel restrictions.
  - *Draft results under review by DHB.*

DHB will continue to share updates and requests for DSC feedback as this work continues in the coming months.

2. PCP Assignment Improvement
Resolution Activities and Next Steps

Reminders for Provider Organization Data Subcommittee Members

- ❑ **Continue to update NC Tracks records in a timely manner.**
- ❑ **Confirm with each plan that your panel limits are up to date.** Open/closed/age/gender limits must be updated with each plan a provider is contracted with. See this fact sheet for additional information.
- ❑ **Submit tickets to Provider Ombudsmen** to report PCP assignment errors, including Medicaid IDs of affected members: **Medicaid.ProviderOmbudsman@dhhs.nc.gov.**

Data Topic Updates:
2. AMH Data Interfaces Timeline Standardization

1. AMH Data Interfaces Timeline Standardization

Issue Description and Resolution Approach

Issue Description

Standard Plans have **different schedules for sharing standard data interfaces** between Standard Plans and AMH Tier 3 practices or CINs.

Receiving data on differing schedules impacts AMHs'/CINs' ability to:

- Efficiently execute downstream processes (e.g., automated ETL) to provide more complete, accurate, and timely data to their care managers; and
- Provide timely updates to their care management systems, creating a data lag in what is getting reported back to the Standard Plans

Resolution Approach

- Data Subcommittee Members agreed that **streamlining data exchange could improve data timeliness** and downstream data ingestion process issues.
- Data Subcommittee Members expressed support for:
  - **Standardizing** file transmission schedules,
  - **Reducing** the frequency of required file exchange, and
  - Using a **centralized** platform to facilitate data exchange.

1. AMH Data Interfaces Timeline Standardization

Data Transmission Schedule

To address current issues with data exchange timeliness, the Department will require AMH partners to adhere to the following standardized data transmission schedule.

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)

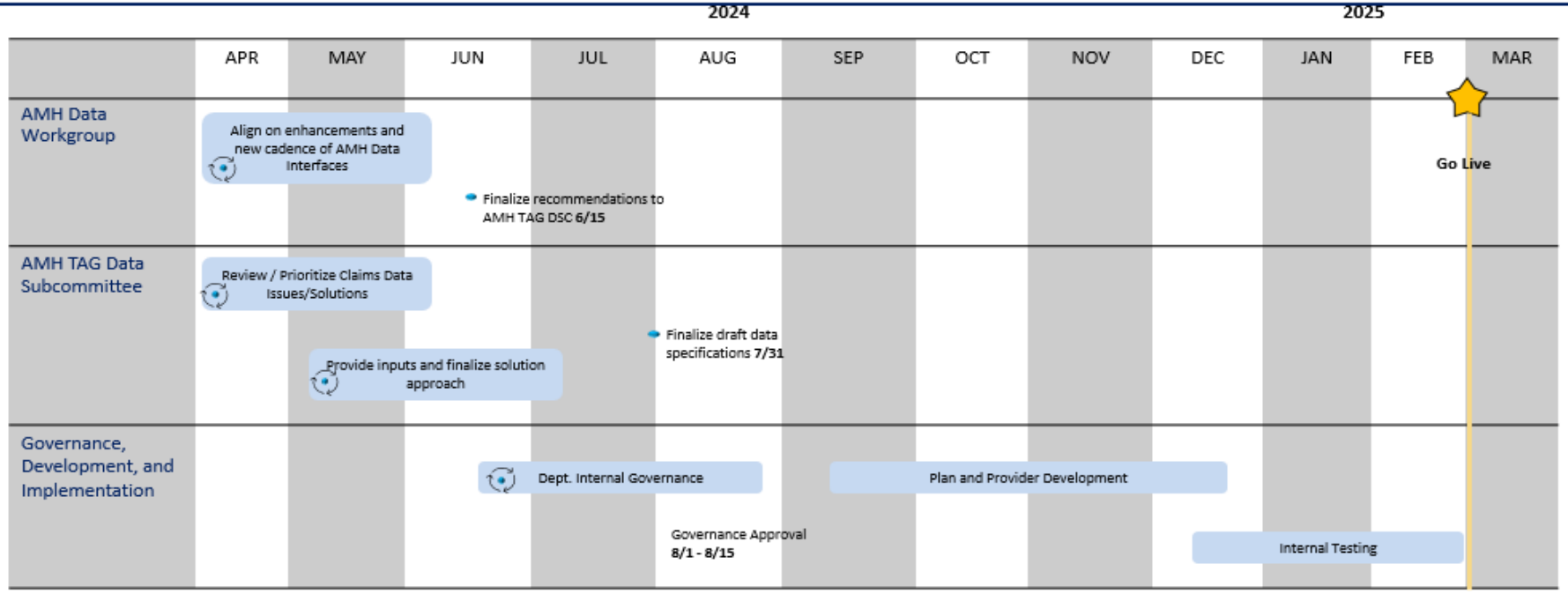
** BA File naming convention to be updated*
*** Status of Mandatory vs. Optional vs. Situational for a number of fields on the various claims files to be updated*

**** Updated Data Specifications found on State website:*** Advanced Medical Home Data Specification Guidance | NC Medicaid

1. AMH Data Interfaces Timeline Standardization
Next Steps

Next Steps

The Department anticipates implementation of new data specifications, including standardized data transmission timelines, by early spring 2025.



Are there additional questions?

Data Topic Updates:
3. Remittance Advice Data Requirements

Background: Issue Description and Approach

Issue Description

- Providers expressed concerns with receiving information from Standard Plans on their care management PMPM payment at a sufficient level of detail, in a consistent format, or on a regular cadence.
- The providers experiencing these issues are not able to confirm if they are receiving the monthly payments they are contracted to receive from plans, which as a result can hurt the integrity of the AMH program.

Resolution Approach

- The Department is proposing an amendment to the Standard Plan contract that would require PHPs to
  - Provide a minimum set of information on their PMPM payments to providers in the remittance advice
  - Issue remittance advice to providers electronically

Today's discussion is to align with Plans and Providers in the AMH TAG Data Subcommittee on the minimum requirements and ensure that the proposed changes are sufficient to address the concerns raised.

Remittance Advice to Providers: 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

For discussion:

- Do these minimum requirements address providers' concerns regarding PMPM level of details?
- Would any of these updates require system development? What is the level of effort required to make these changes?

Next Steps

Next Steps for DHB

- ❑ Consolidate feedback from this discussion and update the minimum requirements
- ❑ Submit contract amendment

Next Steps for Data Subcommittee Members

- ❑ PHPs to share timeline for any development work and implementation based on the discussion
- ❑ Provide additional feedback to: Medicaid.AdvancedMedicalHome@dhhs.nc.gov

Thank you for the discussion and feedback!

HIE Use Cases

Introduction

"One Solution"

NC HealthConnex
Powering Health Care Outcomes

"Three Use Cases"

- **Health-Related Social Needs (HRSN)**
- **Digital Quality Measures (dQMs)**
- **Care Management Data**

"Many Partners"

State Agencies
NCDHHS, NC HIEA

Federal Agencies
CMS

Medicaid Managed Care Plans
Standard Plans, Tailored Plans

Providers
Health systems, AMH practices, TCM providers, PCPs, CINs

Technology Partners
SAS Institute, IBM

Agenda

Vision and Strategy	**5 min**
Health Related Social Needs (HRSN) Screening Use Case	10 min
Digital Quality Measures (dQM) Use Case	10 min
Care Management Use Cases	20 min
Next Steps	

Vision

Vision: Support North Carolina Medicaid's quality, population health, and care management efforts by improving data exchange.

Current Challenges	Proposed Solutions
1 **Limited, Fragmented Information**: In many instances, the needed data aren't available, or it takes too long to access them.	Increase the volume, types, completeness, and timeliness of data available to be exchanged.
2 **Multiple Data Connections and Recipients**: Information resides in silos and/or requires exchanges between multiple entities and systems.	Expand existing capabilities and infrastructure to consolidate and exchange data
3 **Operational Complexity:** Data formats and specifications vary, so time and resources must be spent to translate and normalize.	Define and implement consistent, standardized data formats and specifications

Strategy: “One Solution, Three Use Cases”

The Solution: Leverage NC HealthConnex’s statewide infrastructure to support high-value, Medicaid-focused use cases.

The Use Cases

Health-Related Social Needs (HRSN)	▪ Develop the capabilities to share HRSN screening questions and responses from and with: (1) providers; (2) Medicaid managed care plans; and (3) NC Medicaid.
Digital Quality Measures (dQMs)	▪ Develop the capabilities to calculate a set of high-priority quality measures combining both administrative data (i.e., claims and encounters) with clinical information from providers' EHRs for more frequent, accurate, and timely results.
Care Management Data	▪ Improve the ability to exchange: (1) encounter data between PHPs and local care management entities; (2) transitions of care information when members move PHPs; and (3) care management interaction details.

Key Considerations

1. **A Long-term Endeavor**
   - Each use case has distinct stakeholders, data flows, and will take time to develop.
   - The use cases will evolve at different paces.

2. **Need for Near-term Investments and Prioritization**
   - To achieve the envisioned efficiencies, project partners will need to invest in the near term.
   - Prioritization is required to ensure scarce resources are allocated most efficiently and effectively.

3. **Funding Sources**
   - The project is being supported by CMS, which carries certain obligations and requirements.

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HRSN Screening: Vision, Current State, Goals

Vision: Improve the availability, accuracy, and timeliness of Medicaid members' HRSN screening information.

The Current State of HRSN Screening

1. Providers and health plans use differing screening instruments, and there is a lack of consistency in the wording of various HRSN screening questions.
2. Providers collect HRSN screening information using differing instruments and systems that don't communicate with each other.
3. Lack of data exchange infrastructure for HRSN screening information, namely for bidirectional exchange.

HRSN Screening Use Case Goals

1. **Improve Access to HRSN Screening Data**: Develop capabilities to access and integrate Medicaid members' HRSN data across health plans, providers, and NC Medicaid.
2. **Reduce Administrative Burden**: Reduce the need for care managers and providers to conduct potentially duplicative HRSN screens.
3. **Improve Member Experience**: Gain a deeper understanding of Medicaid members' HRSN to connect them with the necessary services.

HRSN Screening Use Case Data Elements and Standard Codes

The use case initially focuses on <u>six</u> of NCDHHS's eleven questions covering the following HRSN domains:

- ❑ **Food** (*Questions 1 and 2*)
- ❑ **Housing/Utilities** (*Questions 3, 4, and 5*)
- ❑ **Transportation** (*Question 6*)

Provider organizations will map their HRSN screening questions and members' responses to codes defined in the Logical Observation Identifiers Names and Codes (LOINC) standards. For example:

Domain	NCDHHS "SDOH" Question	LOINC Code	LOINC Question	Answers
Transportation	Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?	93030-5	Has lack of transportation kept you from medical appointments	LA33-6 = Yes LA32-8 = No

HRSN Screening: Scope & Phasing

1 Scope Considerations

1. **Flexibility in Collecting and Storing HRSN Screening Information**
   The use case leverages the Department's standardized HRSN screening questions, but….
   - It will not require providers to use a specific assessment instrument.
   - It will not dictate which data systems providers use to collect and store the HRSN screening results.

2. **HRSN Referral Information is NOT in Scope**
   The use case focuses on HRSN screening information and doesn't address the creation, transmission, or management of HRSN-related referrals through closed loop referral systems like NCCARE360.

2 Phases

Phase 1: Collecting Providers' HRSN Screening Information

Phase 2: Sharing Providers' HRSN Screening Information with Providers and Health Plans

Phase 3: Collecting and Sharing Health Plans' HRSN Screening Information

Phase 1: Collecting Providers' HRSN Screening Data

Envisioned Data Flow

HRSN Screening Capture and Transmission

1. Providers collect HRSN screening results in EHRs. Providers EHRs (or Integration Engine) encode the HRSN screening questions and results in LOINC.
2. Providers' EHRs (or Integration Engines) transmit LOINC encoded HRSN info via HL7 ADT messages to NC HealthConnex

NC HealthConnex Receipt & Storage

3. NC HealthConnex stores incoming HRSN screening information

Key Components

Data Format and Specifications

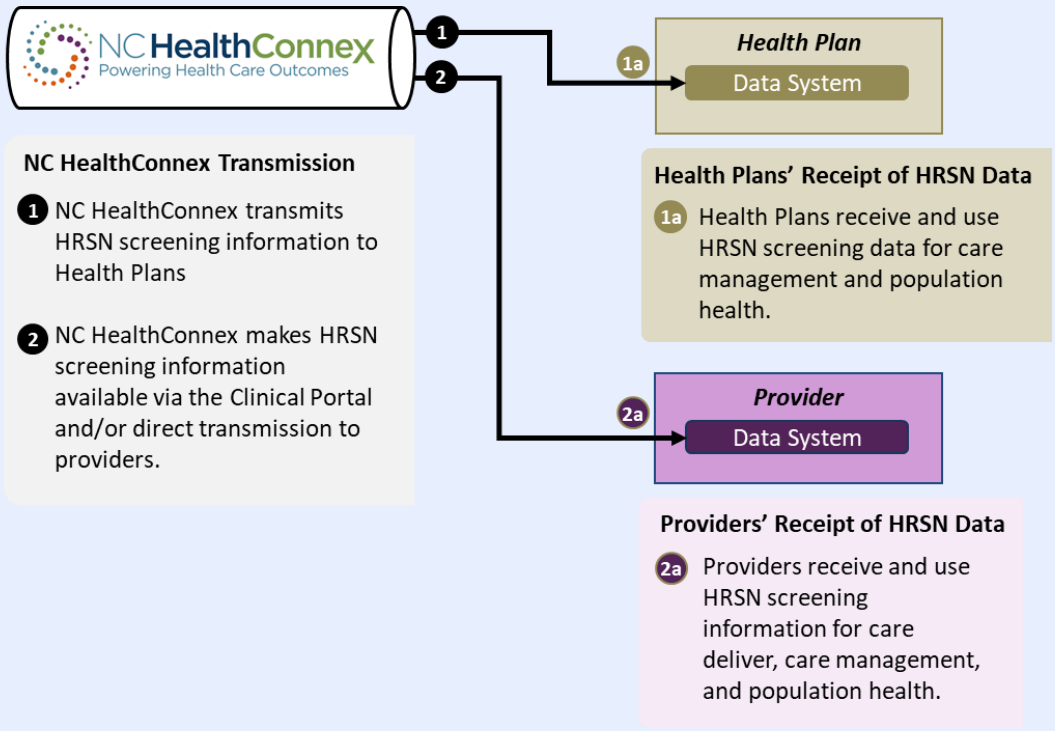
- NC HIEA has developed data specifications for provider organizations' transmission of LOINC-encoded HRSN screening information.

Provider Involvement and Onboarding

1. Duke Health and UNC Health currently transmitting HRSN screening information to NC HealthConnex
2. Additional provider organizations will be onboarded beginning Jan 1, 2025
3. Priority will be given to providers with high volumes of Medicaid members and that have the required technical capabilities.

Phase 2: Sharing Providers' HRSN Screening Data

Envisioned Data Flow



NC HealthConnex Transmission

1. NC HealthConnex transmits HRSN screening information to Health Plans
2. NC HealthConnex makes HRSN screening information available via the Clinical Portal and/or direct transmission to providers.

Health Plans' Receipt of HRSN Data

1a. Health Plans receive and use HRSN screening data for care management and population health.

Providers' Receipt of HRSN Data

2a. Providers receive and use HRSN screening information for care deliver, care management, and population health.

Key Components

Data Format and Specifications

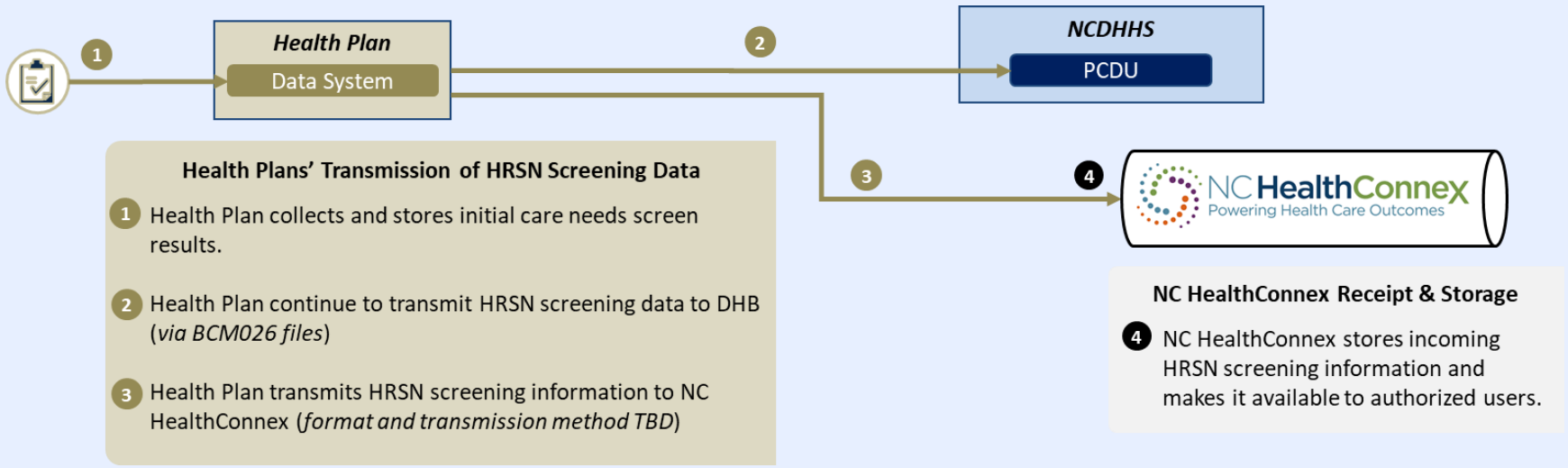
- For health plans, HRSN screening information will be added to the Priority Data Element files that Standard Plans currently receive from NC HealthConnex.
- For providers, NC HealthConnex will make HRSN screening data available via the Clinical Portal and/or in response FHIR-based queries.

Next Steps

1. **Workgroup Sessions**: Begin in January 2025

Phase 3: Collecting & Sharing SPs' HRSN Data

Envisioned Data Flow



Health Plans' Transmission of HRSN Screening Data

1. Health Plan collects and stores initial care needs screen results.
2. Health Plan continue to transmit HRSN screening data to DHB (*via BCM026 files*)
3. Health Plan transmits HRSN screening information to NC HealthConnex (*format and transmission method TBD*)

NC HealthConnex Receipt & Storage

4. NC HealthConnex stores incoming HRSN screening information and makes it available to authorized users.

Next Steps

1. **Working Group Sessions**: Begin Q4 2025

2. **SPs Begin Transmission of HRSN Screening Data to NC HealthConnex**: TBD

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Vision and Strategy	5 min
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Next Steps	

dQMs: Vision and Current State

Vision: Improve the accuracy, timeliness, and ease of collecting, calculating, and sharing quality performance information.

The Current State of Quality Measurement

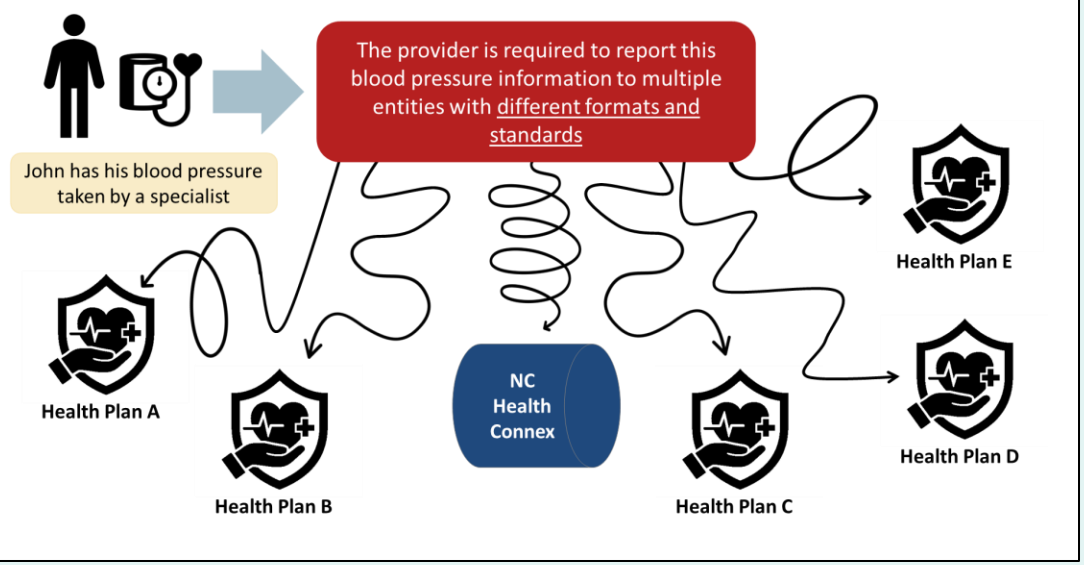
Current State

Quality measurement efforts rely on claims data which aren't as timely and complete as information from other sources.

Key Challenges

1. Data needed to calculate performance measures are often incomplete and non-standardized.
2. Exchange of quality data between PHPs and providers is often decentralized and requires many different interfaces.
3. Practices and health plans face significant and growing administrative burdens.

The Reporting Burden Challenge



dQM Use Case: Goals, Scope and Phasing

1 Goals

1. Improve collection of clinical data from providers' EHRs to support better, more complete quality measure results.
2. Decrease administrative burden by collecting quality measure data elements in NC HealthConnex.
3. Improve gap reporting to inform providers' quality improvement and patient outreach.
4. Align with CMS's Digital Quality Measure "Strategic Roadmap"

2 Scope Considerations

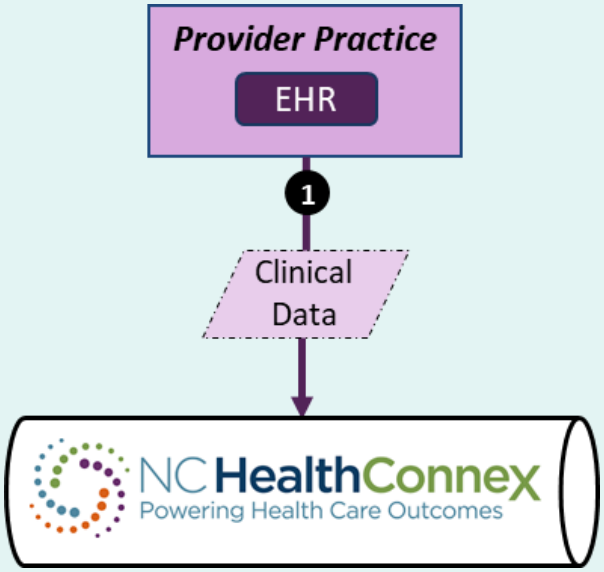
- **Initial Set of Quality Measures**: The initial focus will be on three priority quality measures:
  1. Controlling High Blood Pressure (CBP)
  2. Glycemic Status Assessment for Patients with Diabetes (GSD)
  3. Screening for Depression and Follow-Up Plan (CDF)

3 dQM Use Case Phases

- Phase 1: Collecting Providers' Clinical Data to Inform Measure Calculation
- Phase 2: Calculating Quality Performance
- Phase 3: Sharing Quality Performance Information with Providers, Plans, and DHB

Phase 1: Collecting Data for Measure Calculation

Envisioned Data Flow



Key Components

DAV Certification

- Providers will complete Data Aggregator Validation (DAV) certification, a process by which their approach to data management and exchange is reviewed and approved by NCQA. This process will ensure all clinical data submitted are appropriate for use in measurement.

Data Format and Specifications

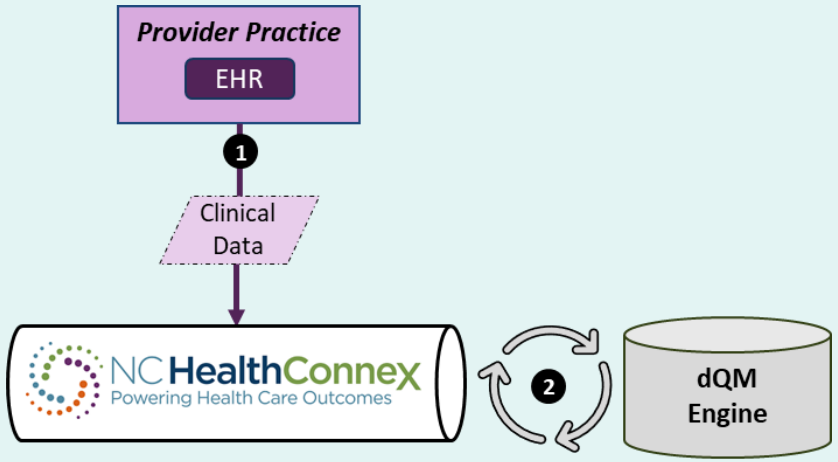
- All data used for measurement will be submitted in the required format and according to measure specifications.

Provider Onboarding

- Goal is to onboard five provider organizations by Oct 1, 2025.

Phase 2: Calculating Quality Performance

Envisioned Data Flow



Key Components

dQM Engine

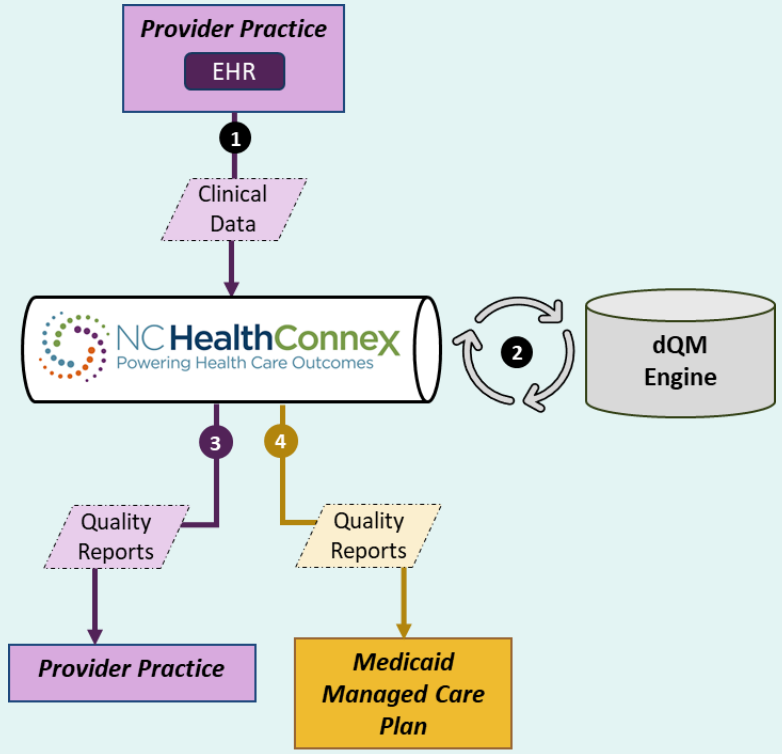
- The dQM engine will be a tool that calculates the quality measures.

Proposed Timeline

- **Procurement of the dQM engine:** Q2-Q3 2025

Phase 3: Sharing Quality Performance Data

Envisioned Data Flow



Key Components

Types of Reports

1. Gap reports
2. Performance reports

Proposed Timeline

1. **Develop interim gap reports and work with applicable databases**: Q3 2025-Q3 2026.

2. **Develop a roster of practices successfully submitting data and a report of practices that are not submitting data**: Q3 2026.

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Vision and Strategy	5 min
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Care Management: Vision, Current State, Goals

Vision: Improve the exchange of: (1) encounter data between PHPs and local care management entities; (2) transitions of care information when members move PHPs; and (3) care management interaction details.

The Current State of Care Management Information Exchange

Current State

Currently, the transmission of beneficiary assignment file data, claims data, transition of care information, care management interaction reports requires thousands of one-to-one interfaces between health plans, providers, and DHB.

Key Challenges

1. **Complexity of Maintaining Multiple Data Exchanges**: Exchange of care management data between PHPs and providers is often decentralized and requires many different interfaces.
2. **Data Transparency Across Stakeholders**: Data exchanges across DHB, Plans and providers is not shared uniformly. This leads to manual issue resolutions and hours or research across all stakeholders. Ex: Patient Risk List
3. **Administrative Burdens**: Practices and health plans face significant and growing administrative burdens maintaining interfaces across all Plans.

Care Management Use Case Goals

1. **Minimize Interfaces**: Reduce the number of interfaces managed to support data exchanges
2. **Establish a Single Source of Truth**: Data from defined operational source of truth is available to all stakeholders
3. **Minimize Custom Enhancements:** All interfaces will be based on AMH TAG standardized and approved specifications.

Care Management Use Cases: Overview

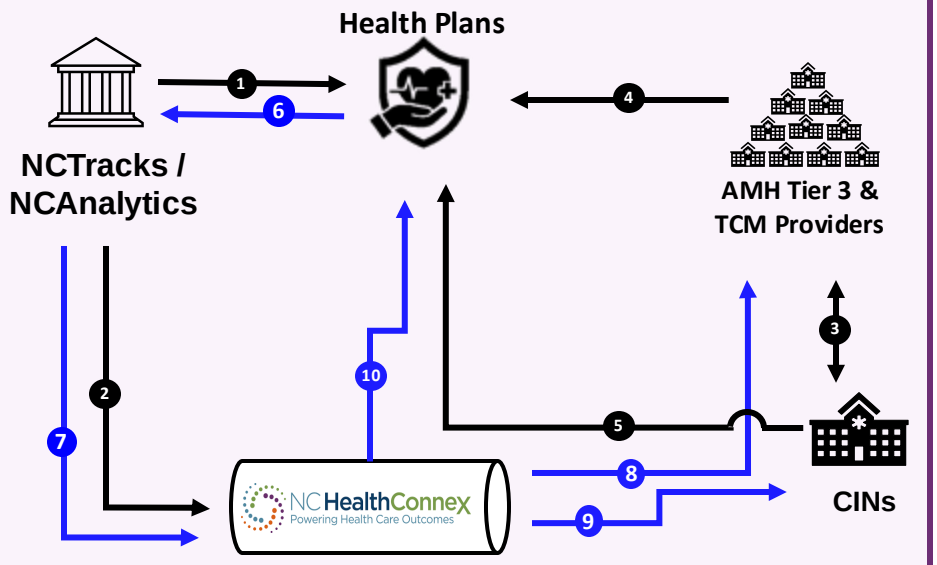
1. **Care Management Use Cases**
   1. Beneficiary Assignment File
   2. Transitions of Care (TOC) Between Health Plans
   3. Claims and Encounters to Support Care Management
   4. Care Management Interactions Information Exchange

2. **Key Design Considerations**
   1. Current standardized layouts across all interfaces are maintained with **no change** to the data formats and layouts.
   2. Any changes to AMH interface layouts have to go through appropriate governance (e.g., AMH TAG) before they are implemented.
   3. Plans are requested to share CIN-AMH relationship data with the Department.

3. **Today's Discussion**
   - We will focus on the Care Management components of most relevance to you, including: (1) data sources and targets; (2) data flows; (3) envisioned technical capabilities.

Beneficiary Assignment Use Case (Future State)

Envisioned Data Flow



Existing flows that will remain unchanged

Flows that will be created for the use case

Detailed Steps/Processes

1. DHB shares the daily 834 file with Plans which provides member enrollment information. For Tailored Care Management (TCM)* DHB also shares the Acuity Tier data via the Care Management Interface to Plans.
2. DHB shares the 834 file with NC HealthConnex on a daily basis which includes member enrollment data.
3. Advanced Medical Home (AMH) Tier 3 providers and Tailored Care Management (TCM) providers may contract with Clinically Integrated Networks (CINs)/ data partners for services to support some of their (Tailored) Care Management obligations.
4. AMH 3 and TCM providers share CIN / data partners relationships with Health Plans.
5. CINs contracting with AMH 3 / TCM provider practices and having direct relationships with Health Plans may also share their AMH 3 / TCM provider relationships with Health Plans.
6. Health plans share AMH 3/ TCM provider and CIN/Data Partner relationships with Department through an operational report.
7. Department validates the CIN-AMH relationship operational report for data quality and once approved shares this information with HIE.
8. 9. 10. HIE shares Beneficiary Assignment (BA) file with member enrollment data on a on a daily (incremental)/weekly (full file) basis with AMH 3 / TCM Providers and / or their CINs based on:
   - 834 file
   - Relationship between the AMH 3 / TCM provider practices and CINs/Data Partners
   - Member Acuity Tier Information (for TCM only)
   - Provider Network Response File (PNrF)

Beneficiary Assignment Use Case

Envisioned Data Flow

Design Consideration

- No change in data formats and specifications.
- Providers who have relationships across multiple Plans will receive a single Beneficiary Assignment File.
- Plans will receive a single Beneficiary Assignment File for all providers contracted with them.
- Roll-out will be with a small set of providers before full launch.

Next Steps

1. **Launch Collaborative Workgroup of Plans, select Providers and CINs**: January 2025
2. **NC HealthConnex transmits BA File to a select set of Providers / CINs**: Summer 2025

Transition of Care Use Case (Future State)

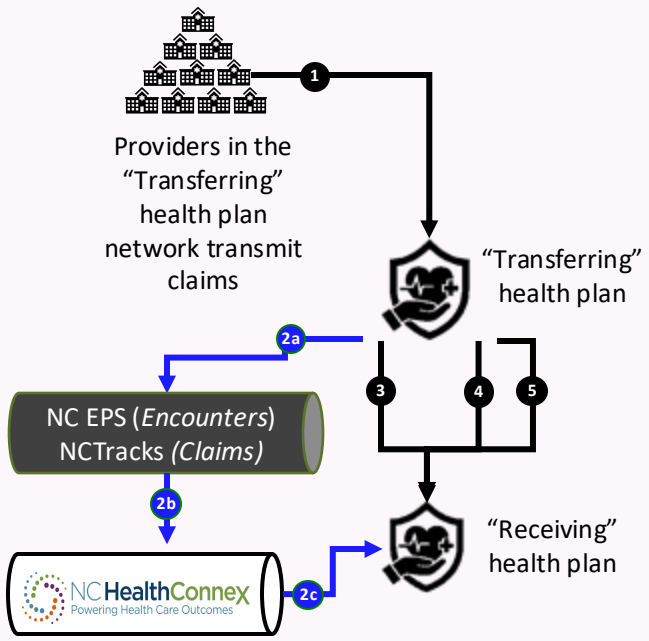
Key Assumptions

Initial Focus on Standard Plan to Standard Plan Transitions of Care: Transitions of care data exchange for Members transitioning to or from Medicaid Direct or Tailored Plans/ PIHPs will be phased in later.

Phased Implementation Across Data Types: The use case will initially focus on encounters/claims data where the Department is the operational source of truth. Data specifications will align with decisions made in the encounters/claims data use case.

Location of Transitions of Care File Creation: NC HealthConnex will be the locus for generating transitions of care data in response to a transitions of care event. NC HealthConnex would be responsive to the business needs, requirements, and data specifications as directed by NC Medicaid and informed by stakeholders.

Data Flows in "Future" State



Existing flows that will remain unchanged →

Flows that will change/be created as part of use case →

Detailed Steps/Processes

1. Providers transmit claims to "Transferring" health plan.

2a. "Transferring" health plan transmits Medicaid encounters to NCDHHS's EPS.

2b. NC EPS transmits encounter data and NCTracks transmits Medicaid Direct claims to NC HealthConnex.

2c. NC HealthConnex transmits encounter data to "Receiving" health plan.

3. "Transferring" PHP transmits pharmacy lock-in data to the "Receiving" health plan.

4. "Transferring" PHP transmits prior authorizations to the "Receiving" health plan.

5. "Transferring" PHP transmits care management info to the "Receiving" health plan.

Transition of Care Use Case (Future State)

Envisioned Data Flow

Design Consideration

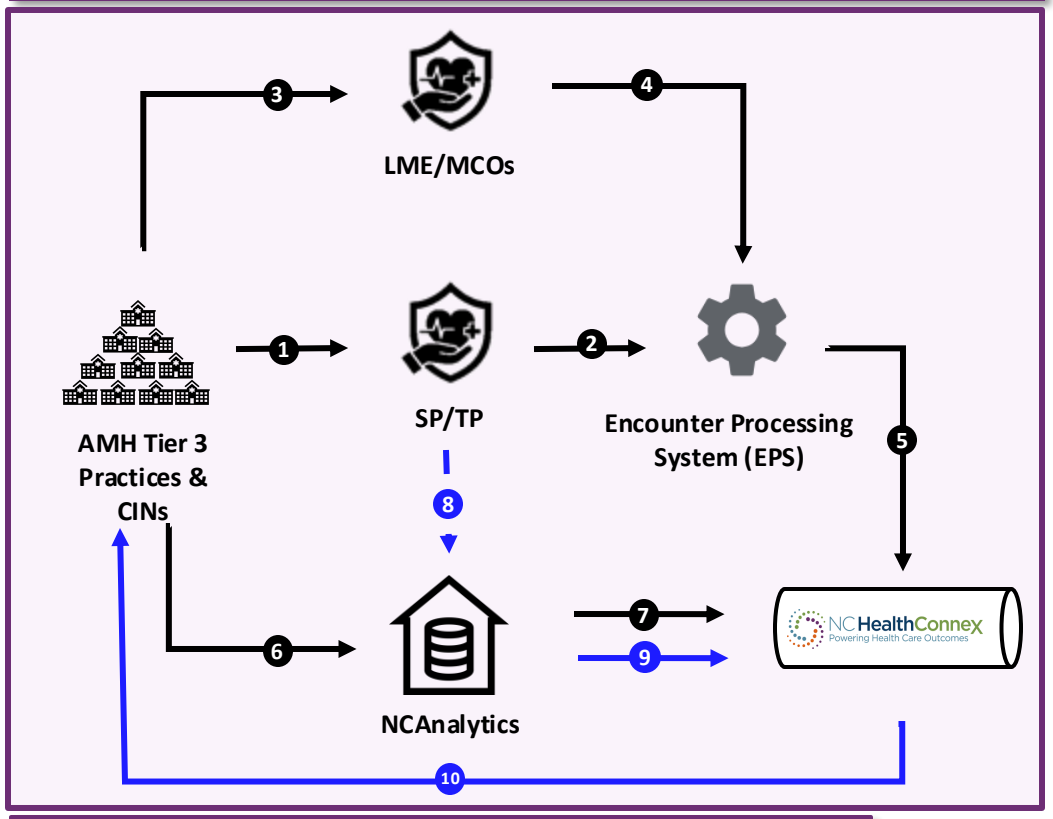
- No change in data formats and specifications.
- Rollout will be limited to Claims and Encounters data, other TOC files will be phased in the future
- Rollout will be limited to Standard Plans; other Plans will be phased in the future.

Next Steps

1. **Launch Collaborative Workgroup of Plans, select Providers and CINs**: January 2025
2. **Develop timelines with the Workgroup on moving to Future State**

Claims and Encounters Future Data Flow

Data Flows in "Future" State



Existing flows that will remain unchanged

Flows that will be created for the use case

Detailed Steps/Processes

1. Providers send Managed Care claims data (837 file) to Health Plans (Standard and Tailored Plans).
2. Health Plans (SP/TP) send encounter data (paid and denied) to EPS.
3. Providers serving Behavioral Health needs for Medicaid Direct population send BH Claims to LME/MCOs
4. LME/MCOs send BH Encounters (paid and denied) to EPS
5. EPS sends Managed care encounters to HIE on a daily basis.
6. Providers serving Medicaid Direct population send Physical Health claims data directly to NCTracks.
7. NCTracks sends Claims data for Medicaid Direct members to HIE.
8. NCT / NCA receives CIN – Provider relationship data from Plans
9. NCA send the CIN – Provider relationship data to HIE.
10. HIE sends the claims and encounters data to appropriate AMH tier 3 members and / or their CINs based on
    - 834 File
    - CIN – Provider relationship file

Claims and Encounters Future Data Flow

Envisioned Data Flow

Design Consideration

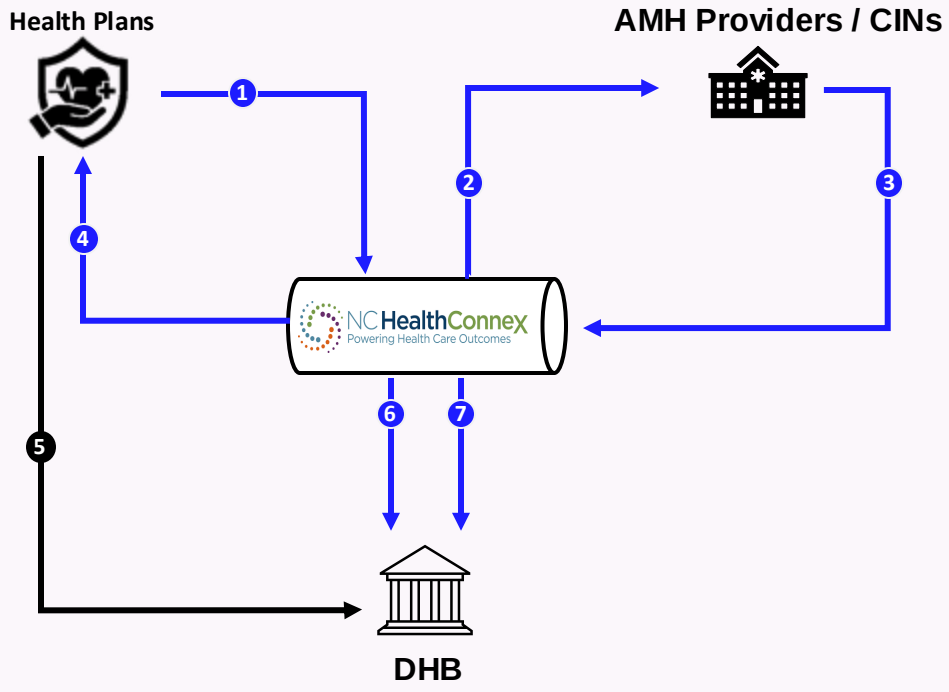
- No change in data formats and specifications.
- Rollout will be limited to Claims and Encounters data,
- Rollout will be limited to Standard Plans; other Plans will be phased in the future.

Next Steps

1. **Launch Collaborative Workgroup of Plans, select Providers and CINs**: January 2025
2. **Develop timelines with the Workgroup on moving to Future State**

CM Interactions Report (PRL) Future Data Flow

Future State



Existing flows
New data flows or modification to existing data flows

Detailed Steps/Processes

1. PHPs transmit member's care management interaction data via the Patient Risk List (PRL) file to NC HealthConnex. The file will have the PHP Risk stratification, priority population and other mandatory fields as defined in the data specification document.
2. NC HealthConnex transmits the PHP's PRL file to the applicable AMH provider and/or their CIN/Data Partner based on
   - the AMH-CIN relationship data
   - the Beneficiary Assignment File data
3. AMH Tier 3 practice or their CIN/ Data Partner transmits members' PRL file to NC HealthConnex. The data will contain provider risk score, Care Management interactions and other mandatory fields as defined in the data specification document.
4. NC HealthConnex transmits members' AMH PRL file to the appropriate PHPs for the reporting month.
5. PHPs use the AMH Tier 3 PRL information to generate the Care Management Interaction report (BCM051) and transmit to DHB.
6. NC HealthConnex transmits the PHPs' PRL files to DHB.
7. NC HealthConnex transmits AMH Tier 3 practices' PRL files to DHB

CM Interactions Report (PRL) Future Data Flow

Envisioned Data Flow

Design Consideration

- Plans, Providers and DHB have access to the Patient Risk List data.

Next Steps

1. **Launch Collaborative Workgroup of Plans, select Providers and CINs**: January 2025
2. **Develop timelines with the Workgroup on moving to Future State**

Agenda

- Vision and Strategy — 5 min
- Health Related Social Needs (HRSN) Screening Use Case — 10 min
- Digital Quality Measures (dQM) Use Case — 10 min
- Care Management Use Cases — 20 min
- **Next Steps**

Public Comments

Wrap-Up & Next Steps

Next Steps

Subcommittee Members will:

1. Provide additional feedback on today's discussion topics to: Medicaid.AdvancedMedicalHome@dhhs.nc.gov

NCDHHS will:

1. Post today's presentation and a summary of today's meeting on the NCDHHS website.

Future Advanced Medical Home TAG Data Subcommittee meetings will occur on a quarterly cadence. The next meeting is scheduled for Q1 2025.

Appendix

Data Topic Status Updates (1/2)

Data Topic	Topic Description	Current Status	Next Steps
Risk Stratification Guidance	Standard Plans and AMH/CINs reported **difficulty interpreting and using risk stratification data** they receive due to (1) variability in risk categorization and (2) lack of information on how to interpret the risk categorization.	NCDHHS has developed draft **Risk Stratification Guidance** that requires Standard Plans to share descriptions of their risk stratification approaches with AMH/CINs in a standard format and manner.	The Risk Stratification Guidance has been re-circulated to Standard Plans in August 2024 and the requirements will be executed with the next contractual amendment.
Care Management Interactions Data Quality	Standard Plans, AMH Tier 3 practices, and CINs have **varying approaches to document care management interactions** on the Patient Risk List file and BCM051 report, resulting in potentially inconsistent and inaccurate care management data.	NCDHHS plans to **update the Patient Risk List file and BCM051 report templates** to incorporate initial stakeholder feedback and clarify ambiguities. NCDHHS also is **conducting an external audit** to validate care management interactions data sent on the Patient Risk List file and BCM051 operational reports.	NCDHHS has begun to engage with AMH partners on proposed template changes. Results of the HSAG audit are anticipated to be available in late fall/early winter 2024.

Data Topic Status Updates (2/2)

Data Topic	Topic Description	Current Status	Next Steps
42 CFR Part 2 Data Exchange	AMH TAG Data Subcommittee Members have previously raised the following issues: • Health plans vary in their implementation of Part 2 data protections. • Providers and health plans do not consistently ask for or leverage patient consent to share Part 2 data for care management purposes. Inconsistent implementation of federal 42 CFR Part 2 regulations acts as a barrier to complete and timely encounters/claims data exchange, thereby impacting plans' and providers' ability to provide whole-person care and implement advanced value-based payment and delivery models.	After soliciting feedback from AMH TAG DSC members and other stakeholders, the Department has concluded that the prevalence and impact of the data issue is low.	The Department will continue to monitor and pursue solutioning activities as needed.