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

March 4, 2025 Meeting

Agenda

Welcome & Roll Call	**5 min**
Data Topic Updates 1. PCP Assignment Improvement 2. AMH Data Interfaces Timeline Standardization 3. Risk Stratification Communication Standardization	**30 min**
AMH Data Topic Prioritization Survey	**5 min**
HIE Use Cases	**40 min**
Public Comment	**5 min**
Wrap-Up and Next Steps	**5 min**

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
	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

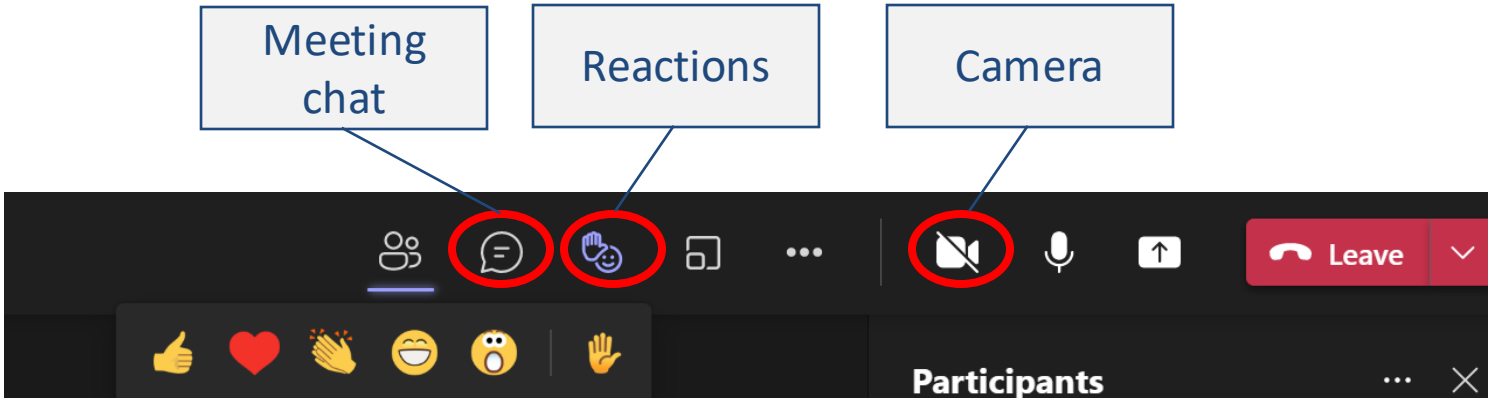
NCDHHS and Advisors

NCDHHS						
Kristen Dubay	**Andrew Clendenin**	**Loul Alvarez**	**Judy Lawrence**	**Saheedat Olatinwo**	**Evelin Lazaro**	**Liz Kasper**
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	Care Delivery and Payment Reform Senior Advisor, 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

PCP Assignment Improvement
Issue Description and Root Cause Analysis

Issue Description

AMH practices and CINs have reported **challenges with member PCP assignments**, including frequent changes to assignment lists and assignment of members to providers who don't serve their age or gender.

The **root causes of these assignment issues** continue to be investigated on a case-by-case basis. Some identified causes include:

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

Impact Analysis

Data Subcommittee Members highlighted the continued occurrence of misassignments and the resulting impacts to:

1. the **effective administration** of medical home and care management services and
2. the **accuracy of medical home and care management payments**.

PCP Assignment Improvement
Resolution Activities and Next Steps: Updates

1. **Establish acceptable reasons for reassignment** to allow PHPs to process reassignment requests from providers more quickly and consistently
    - *DHB has developed proposed scenarios in which provider-requested reassignment is appropriate without member consent (see following slides).*
2. **Identify and resolve discrepancies in assignment lists** from PHPs and NCTracks
    - *PHPs and DHB have reviewed examples provided by Data Subcommittee members to identify root cause (see following slides).*
3. **Establish formal monitoring of age/gender misassignments**
    - *The Department will regularly identify discrepancies between Provider's age and gender panel restrictions and member assignment using data from NCTracks.*
4. **Enhance monthly reporting submitted by PHPs** by refining the clarity of PCP reassignment requests and reasons, as well as panel information
    - *The BCM077-J is a monthly PCDU report that captures PCP change requests, panel data, and ongoing assignment activities to support the Department's monitoring efforts.*

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

PCP Assignment Improvement

Reassignment Scenarios: Proposed permissible w/out Member consent

1. **Panel Closure (Zeroing Out)**
    - Automatic reassignment if the panel is fully closed
2. **Aging Out of Pediatric Practice**
    - Members over the panel's age limit can be reassigned
3. **Provider Contract Termination / Network Exit**
    - PHPs should adhere to contractual requirements for provider terminations and reassignments
    - If the provider leaves the network, the member is assigned to another AMH per current State requirements
4. **For Cause Member Dismissal**
    - Permissible with documented practice policy violations (e.g., abusive behavior, repeated no-shows)
5. **Incorrect Auto-Assignment (Demographic Error)**
    - Demographic misalignment (e.g., age/gender) can be corrected without member consent

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1. **What is the Data Subcommittee's feedback regarding how these scenarios are categorized?**
2. **Are there any scenarios that you believe are missing?**
    - ➢ **Please submit written feedback by March 14 to Medicaid.AdvancedMedicalHome@dhhs.nc.gov**

PCP Assignment Improvement

Reassignment Scenarios: Proposed impermissible w/out Member consent

1. **Unengaged Members**
   - "Unable to reach" alone isn't sufficient; reassignment will not resolve underlying issue
   - Providers should continue proactive outreach attempts to engage members, aligning with Medicaid's goal of preserving continuity of care
2. **In-State Moves Without Member Request**
   - Member preference remains the deciding factor when members relocate within the state. If they wish to stay with their current PCP, no reassignment should occur unless the member explicitly requests it.
3. **Displacement Due to Disaster**
   - Typically brief; maintain continuity unless the member formally requests a change.
4. **Out-of-State**
   - Currently up to 12 months out-of-state before DSS reevaluates eligibility.
   - Reassigning to another in-state provider does not resolve underlying root cause.
5. **Recent Claims at a Different PCP**
   - PHPs may only reassign a Member w/informed Member consent and must update the assignment in NC FAST to reflect the change.
   - DHB is separately considering a recurring bulk reassignment process to account for updated claims data for members who have not selected a PCP or been manually reassigned.

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1. **What is the Data Subcommittee's feedback regarding how these scenarios are categorized?**
2. **Are there any scenarios that you believe are missing?**
   - **Please submit written feedback by March 14 to Medicaid.AdvancedMedicalHome@dhhs.nc.gov**

PCP Assignment Improvement
Assignment List Discrepancies

- **PHPs and DHB have reviewed examples of discrepancies between the BA File and PCP Enrollee report provided by Data Subcommittee members to identify root causes.**
  - **Beneficiary assignment file:** File sent from PHPs to AMHs and CINs that contains beneficiary information on those assigned to Tier 3 AMHs
  - **PCP Enrollee report:** Report used by providers (all Tiers) that originates from NCTracks that provides information on member assignments
- **Root causes for the discrepancies between these two files varied and included:**
  1. Only members assigned to Tier 3 locations are on the BA file
  2. Referring to the incremental BA file rather than the full BA file for member information
  3. PHPs assigning members to individual PCPs instead of the AMH
  4. Lack of clarity on the process for members who reside out of state
- **These root causes have been resolved for the examples provided.**

- **If there are discrepancies, please collaborate with PHPs to identify causes and resolutions.**
- **If escalation is required, providers should submit a Help Center ticket with all supporting documentation to Medicaid.ProviderOmbudsman@dhhs.nc.gov.**

Data Topic Updates:
2. AMH Data Interfaces Timeline Standardization

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
- 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

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 several fields on the various claims files to be updated*

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

Key Activities for Implementation

	2024			2025
Milestone	**Summer**	**Fall**	**Winter**	**Spring**
Data Specifications Update				
Plan and Provider Development				
Internal Testing and SIT				
Go-Live				

? Are there additional questions or feedback?

Data Topic Updates:
3. Risk Stratification Communication Standardization

Risk Stratification Communication Standardization
Issue Description and Current Status

Issue Description

Standard Plans, AMH Tier 3 practices, and CINs have **varying approaches to conducting risk stratification**, making it challenging to interpret risk stratification data.

There may be additional issues with data completeness, formatting and accuracy (e.g., files not sent or received, missing data elements, invalid data values, etc).

Current Status

- To improve stakeholders' **understanding of their respective risk stratification approaches**, DHB executed an amendment to the Standard Plan contracts on Dec. 30, 2024, that included updated risk stratification communication guidance.

- The updated risk stratification guidance (PHP Risk Stratification Communication Standardization Guidance):
  1. Requires PHPs to describe and share their risk stratification approaches with applicable AMH Tier 3 practices and CINs; and
  2. Encourages, but does not require, AMH Tier 3 practices and CINs to describe and share their risk stratification approaches with PHPs

PHPs asked DHB to consider creating a requirement for AMH Tier 3 practices and their contracted CINs and/or data partners to describe and share their risk stratification approaches with PHPs.

Risk Stratification Communication Standardization
Next Steps

Information Gathering Activities

During calls with Standard Plans in January, the Department asked:

1. When/if PHPs receive AMHs'/CINs' risk stratification approaches, how would they use the information?
2. Would PHPs prefer to receive the risk stratification approaches in the same template currently required for sharing with providers, and would receiving this information on a regular cadence be beneficial?

The consensus among the Standard Plans was that they would value receiving standardized descriptions of AMH Tier 3 practices' and CINs' risk stratification processes.

Recommended Next Steps

- DHB believes that Standard Plans are in the best position to work with their AMH Tier 3 practices to request information on their risk stratification approaches (e.g., via their provider contracts).
- DHB will monitor operationalization progress over the coming year and continue to work with Standard Plans and providers to improve communication of risk stratification.

AMH Data Topics Prioritization

AMH Data Topics Prioritization
Overview of the 2024 Survey

In March 2024, the Department asked Data Subcommittee Members to provide written feedback on the relative importance and urgency to resolve key data issues.

Survey Goals and Structure

The survey prompted respondents to:

A. **Validate** a list of identified data issues and **define** any additional issues encountered

B. **Prioritize** the issues across two dimensions:

- Impact on Critical Operations (High / Medium / Low)
- Urgency for Resolution (immediate / near term / long term)

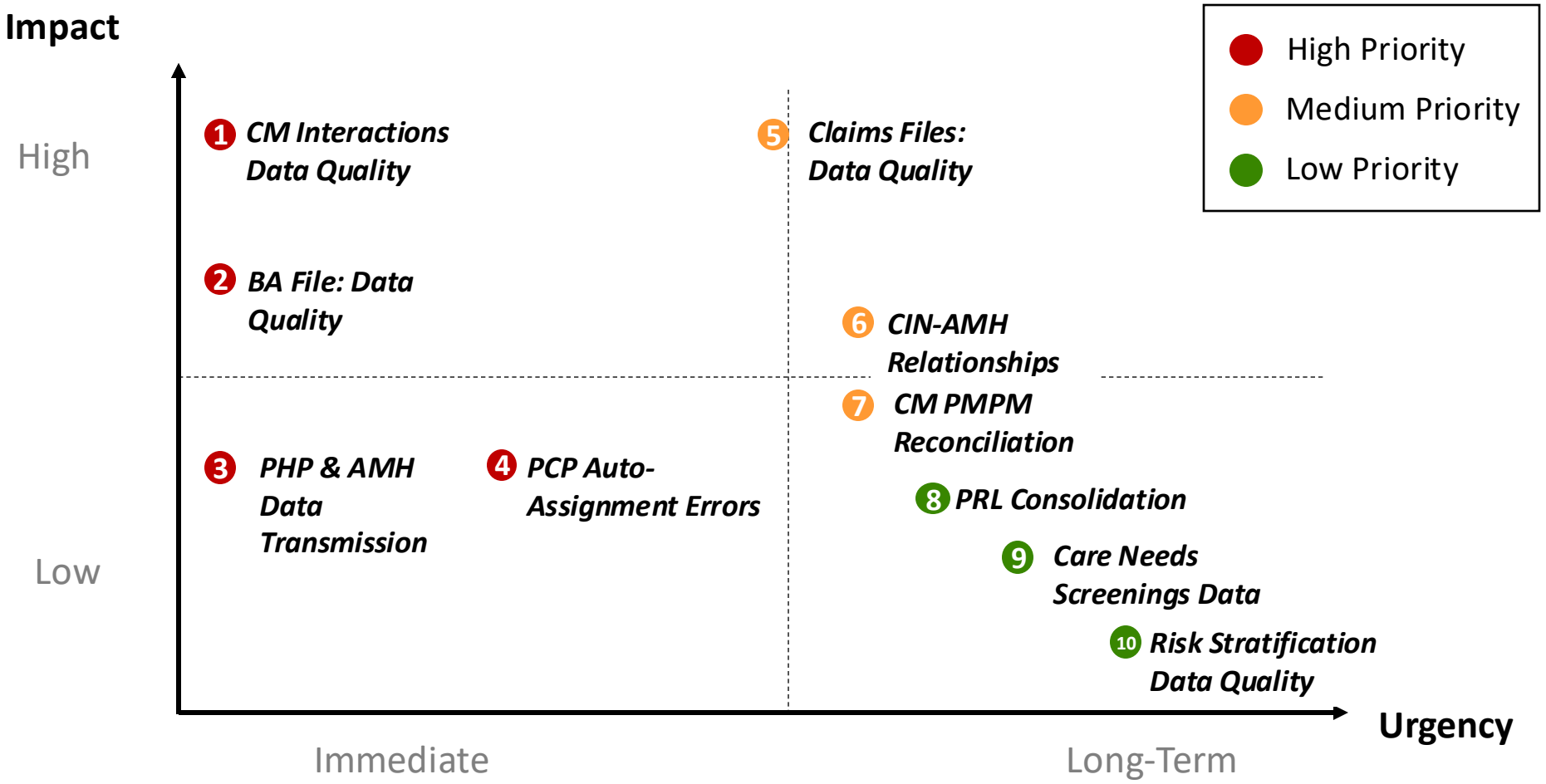
C. **Comment** on the nature, impact, urgency of the issue and/or potential solutions

Data Issues

1. PCP Assignment Errors
2. Beneficiary Assignment File Data Quality
3. Tracking CIN-AMH Relationships
4. PHP & AMH Data Transmission Timing
5. Risk Stratification Data Quality
6. Care Management Data Quality
7. Patient Risk List Consolidation
8. Care Management Payment Reconciliation
9. Claims Files Data Quality
10. Care Needs Screenings Data

AMH Data Topics Prioritization
2024 Survey Results

Data Subcommittee Members identified four data issues as high priority, the most critical being Care Management Interactions Data Quality challenges.



NOTES: Non-Data Subcommittee responses were excluded from the results.

AMH Data Topics Prioritization
2025 Survey

The insights gleaned from prior surveys has been integral to informing the Department's and stakeholders' allocation of resources.

The Department will administer a new survey to Data Subcommittee members in 2025 that seeks input on the impact and urgency to address the following data topics.

1. Primary Care Provider Assignment Improvements
2. Beneficiary Assignment File – Data Quality
3. Care Management Data – Data Quality
4. Patient Risk List Consolidation
5. Care Needs Screenings Data

Data Subcommittee members will have an opportunity to identify additional topics that are not included in the list above.

With respect to timing, the Department will release the survey later in March.

HIE Use Cases

HIE Use Cases
Strategy and Specific Use Cases

Strategy: Leverage NC HealthConnex's statewide infrastructure to support high-value, Medicaid-focused use cases.

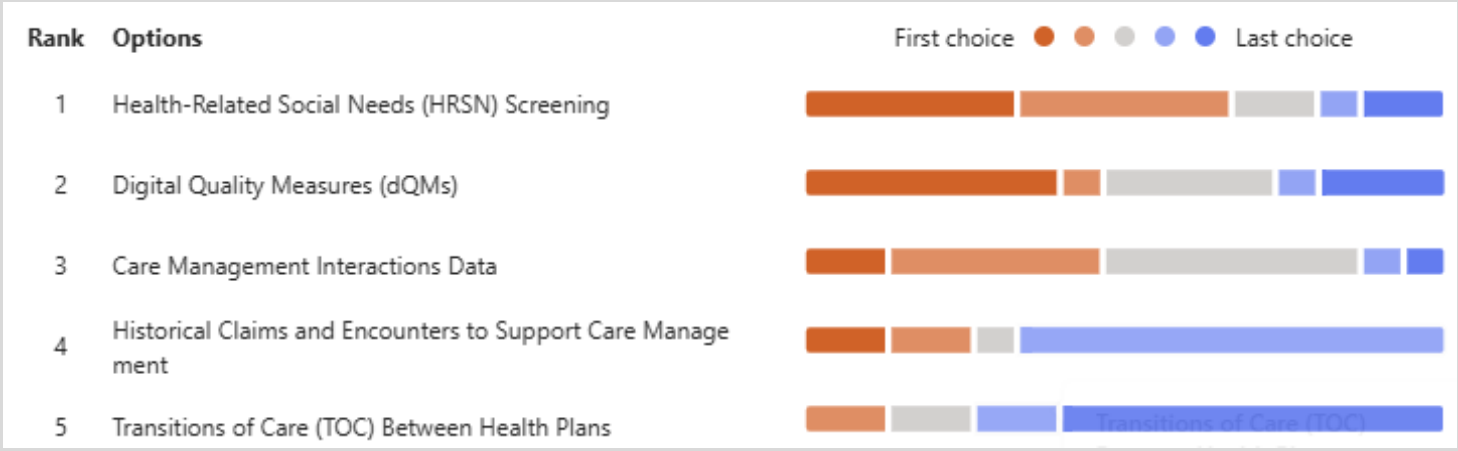
The Use Cases

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

HIE Use Cases
AMH TAG Data Subcommittee Survey Results

AMH TAG Data Subcommittee members ranked the importance of the HIE use cases and provided a rationale for their rankings

Overall Ranking by AMH TAG Data Subcommittee Respondents*



Use Case	Data Subcommittee Members' Rationales for Higher Prioritization
HRSN Screening	1. Expected to benefit patients and improve care the most 2. Reduce redundant patient assessments 3. Faster implementation, already in pilot stage
dQMs	1. Reduce manual operational expense & improve patient care 2. Support state quality, withhold measures and star rating accreditation 3. Synergy with CMS/MSSP quality reporting 4. Already in pilot stage and NC HIEA is well positioned to exchange quality measure data

**Additional details on the AMH TAG Data Subcommittee members' ranks and rationales are provided in the Appendix*

HIE Use Cases
Stakeholder Engagement and Communications

The Department and NC HIEA are increasing efforts to engage stakeholders.

- Details on the use cases, including milestones and timelines, were provided in the December 10, 2024, Data Subcommittee meeting and are available online: AMH TAG DSC Meeting 14_Dec 3_2024.
- Updated information is now available on the NC HIEA website: HIE Medicaid Services that includes:
  - Participation FAQs
  - A HRSN screening use case flyer
  - A dQM use case flyer
  - (A Care Management flyer will be posted soon)
- Questions and suggestions can be emailed directly to NC HIEA's HIE Medicaid Service program email: hms.hiea@nc.gov.

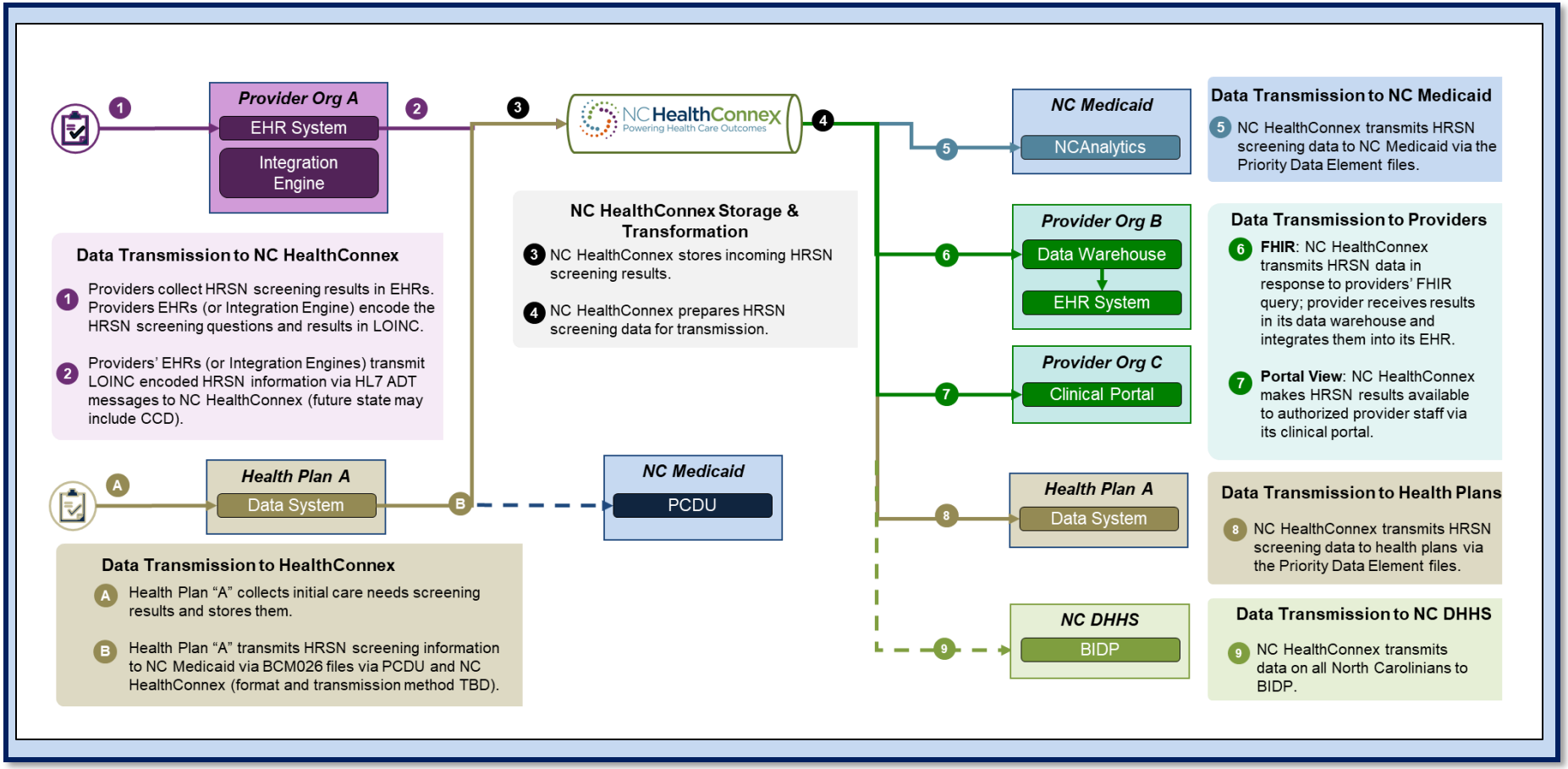
HRSN Screening Use Case
Vision and Goals

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

HRSN Screening Use Case Goals

1. **Improve Access to HRSN Screening Data**: Develop capabilities to access and integrate Medicaid beneficiaries' 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 beneficiaries' HRSN to connect them with the necessary services

HRSN Screening Use Case
Envisioned Data Flow



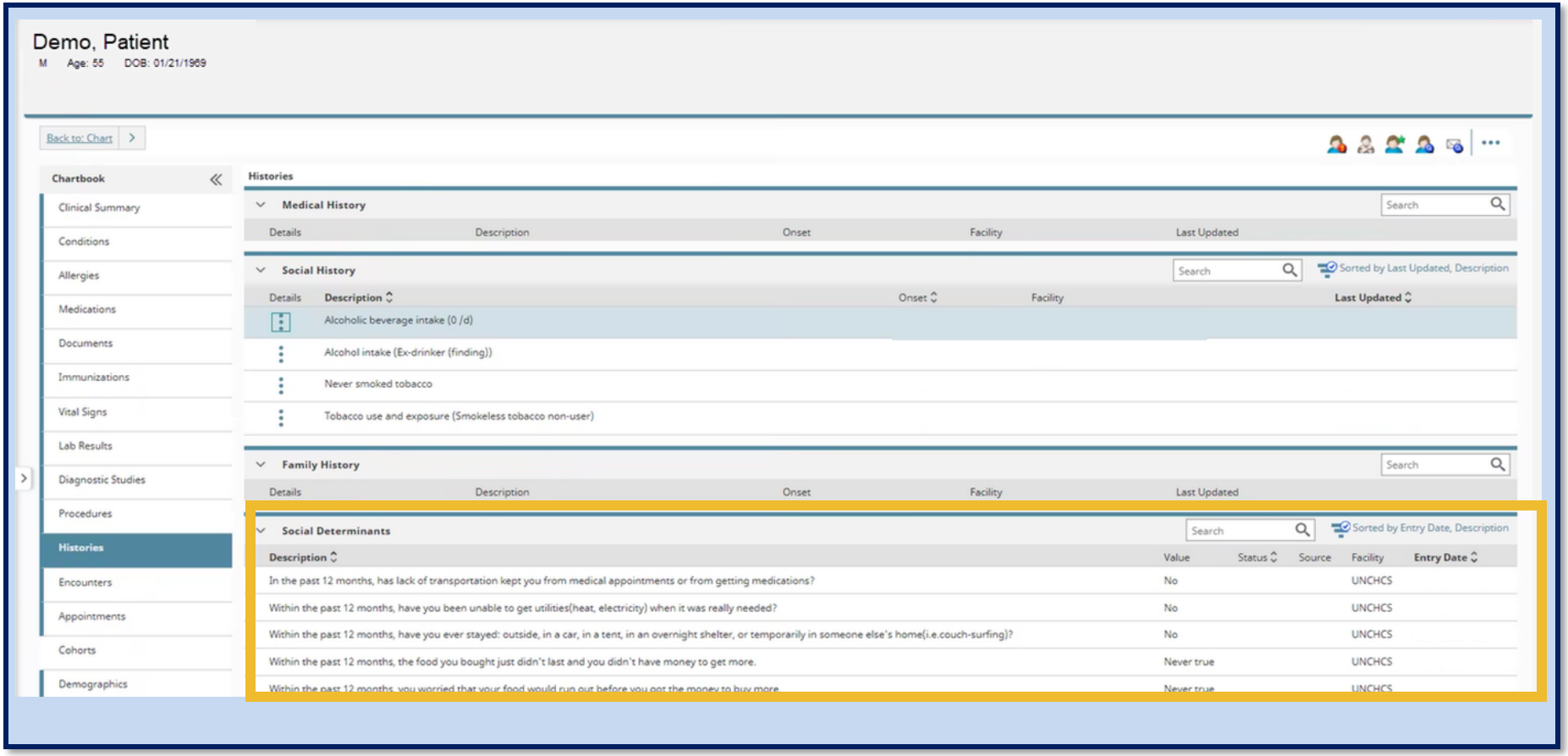
HRSN Screening Use Case
Progress to Date

HRSN Screening Data Currently Available in NC HealthConnex

1. Two hospitals have been transmitting HRSN screening data since 2024:
   - **UNC Health**: Began transmitting HRSN screening information in June 2024
   - **Duke Health**: Began transmitting HRSN screening information in September 2024
2. Using the Medicaid population active as of November 2024, **2.94% of NC Medicaid beneficiaries** have at least one HRSN screening question/answer recorded.
3. Expanding to all patients adds an additional 287,227 non-Medicaid patients for a total of **374,131 distinct patients (Medicaid and Non-Medicaid)** with at least one HRSN screening question/answer documented.

HRSN Screening Use Case

HRSN Data in the NC HealthConnex Clinical Portal



HRSN Screening Use Case
Next Steps

1. Provider Onboarding

- Identify and support early adopters
- Collect HRSN data from a minimum of nine additional provider organizations by the end of September 2025

2. Access to HRSN Screening Information

- Add demonstration data for the NC HealthConnex Clinical Portal as part of participant training
- Develop capabilities for FHIR-based API queries

3. Health Plan Access to HRSN Screening Information

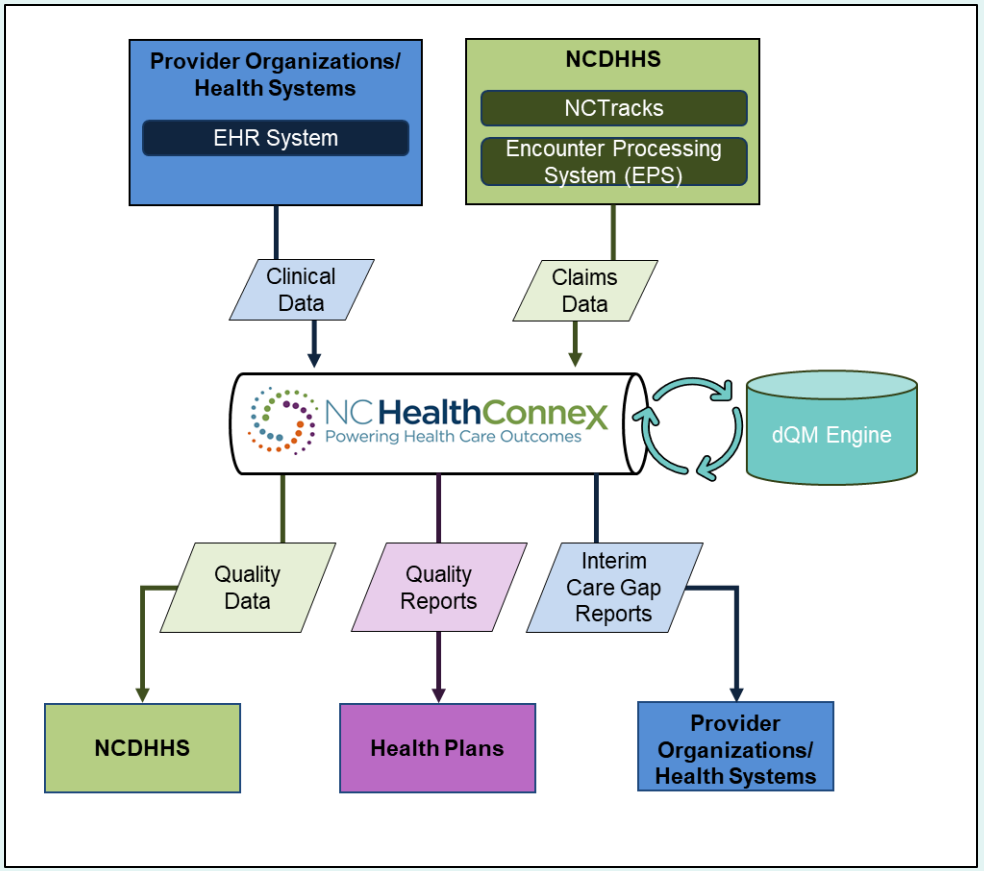
- Modify the Priority Data Element file to include HRSN screening information

dQM Use Case
Vision, Goals, and Data Flows

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

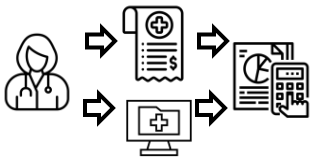
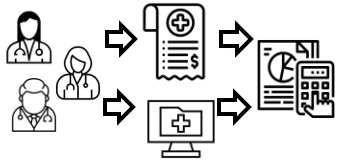
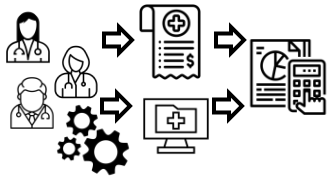
dQM Use Case Goals and Future Data Flows

1. **CMS has a goal of transitioning to dQMs for all quality measures used in its reporting programs.**
2. **Initial focus is on three priority quality measures:**
   1. Controlling High Blood Pressure (CBP) [NCQA]
   2. Glycemic Status Assessment for Patients with Diabetes (GSD) [NCQA]
   3. Screening for Depression and Follow-Up Plan (CDF) [CMS]
3. **Standardized measure results can be shared via NC HealthConnex with health plans and providers to support quality improvement.**



dQM Use Case
Improvements Using HIE Data

The 2022 national average for Medicaid HMOs for Controlling High Blood Pressure was 60.9%

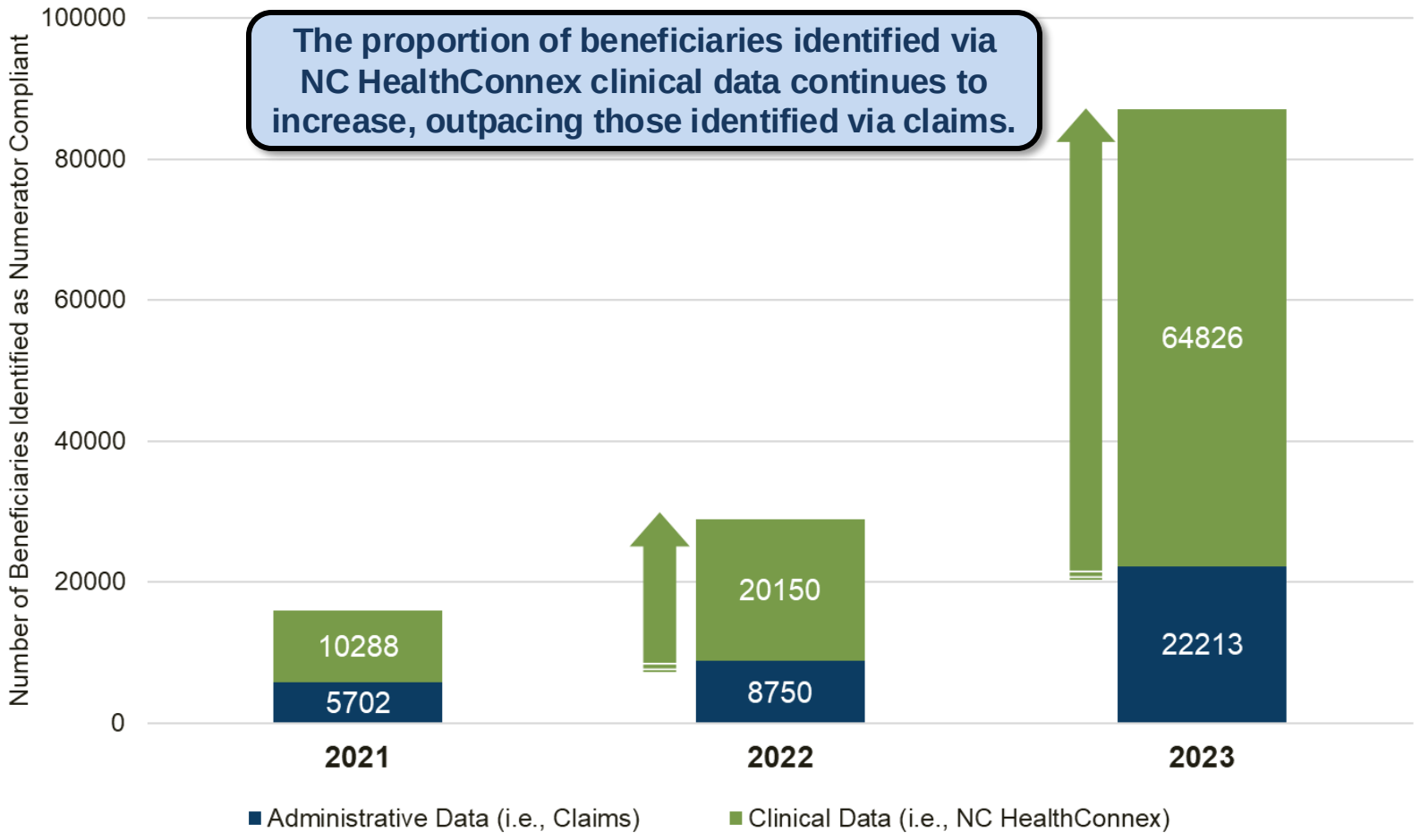
Traditional	Supplemental Data from HIE	Additional HIE Connections	Improvements in HIE Submissions
			
2020 CBP Rate: **4.58%**	2020 CBP Rate: **20%**	2022 CBP Rate: **40.92%**	2023 CBP Rate: **52.5%**

Of those beneficiaries diagnosed with hypertension, how many were identified as having their blood pressure under control via administrative (claims) versus clinical data?

Source: Synthesis of NC Medicaid administrative data and NC HealthConnex clinical data, 2020-2024.

dQM Use Case
Improvements Using HIE Data

Number of Medicaid Beneficiaries with Hypertension Identified as Having Their Blood Pressure Under Control by Source (Administrative vs. Clinical Data).



dQM Use Case
Progress to Date and Next Steps

Progress To Date

1. **Sharing Clinical Data via the monthly Priority Data Element Files**
2. **Participation in NCQA's Data Aggregator Validation Program**
3. **Assessing Participants' Data Quality**

Next Steps

1. Provider Onboarding

- Identifying and supporting early adopters

2. Expanding the Data Aggregator Validation Program

- Expanding the number of providers participating in NCQA's Data Aggregator Validation program

3. Expanding and Improving Data

- Integrating claims data into NC HealthConnex
- Collaborating with providers on improving data quality for priority quality measures, including technical upgrades and workflow changes

Care Management Use Cases
Vision, Goals, and Areas of Focus

Vision: Improve the exchange of care management-related data in support of the NC Medicaid program

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

Areas of Focus

Beneficiary Assignment (BA): Streamline the exchange and use of NC Medicaid's Beneficiary Assignment (BA) file between Medicaid managed care plans and providers, allowing providers who have relationships across multiple health plans to receive a single BA file

Transitions of Care (TOC): Provide the capabilities to generate and share TOC data for members changing health plans

Claims and Encounters: Provide the capabilities to share historical claims and encounters data currently transmitted from Medicaid health plans to AMH Tier 3 practices/CINs when a patient transitions between providers

Care Management Interactions: Provide the capabilities to share care management interactions data (e.g., number and type of interactions, risk stratification) that Standard Plans, AMH Tier 3, and CINs currently share via multiple data interfaces and reports

Care Management Use Cases
Next Steps

Collaborative Workgroup

1. To support the implementation of the Care Management use cases, the team has requested Plans, providers, and CINs to join a Collaborative Workgroup
2. The Collaborative Workgroup will provide inputs on: (a) the current challenges and (b) the opportunities to streamline data transfers across all stakeholders
3. The Collaborative Workgroup charter will be shared with the members
4. The Collaborative Workgroup will start later this month

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 AMH TAG Data Subcommittee meetings will occur quarterly.
The next meeting is scheduled for June 3, 2025.

Appendix

Data Topic Status Updates (1/3)

Data Topic	Topic Description	Current Status	Next Steps
Beneficiary Assignment File Data Quality	Beneficiary Assignment files have issues with data completeness, formatting, and accuracy (e.g., missing members or required data elements, invalid data values).	Data quality issues are continuously being raised and investigated.	Some BA File updates and standardization are being executed as part of the AMH Interface Timeline Standardization and PCP Assignment work.
Tracking CIN-AMH Relationships	There is no standard system across Standard Plans to process CIN-AMH delegation changes. Delayed information about delegation changes can impact the timeliness of data getting to an AMH to support member care.	The Department submitted a draft contract amendment to implement a new requirement for Standard Plans to provide a quarterly report on CINs and affiliated AMHs.	Ensure operationalization of new reporting requirement is successful.
Patient Risk List Consolidation	Standard Plans (e.g., AmeriHealth) have noted that Patient Risk List v1 does not include sufficient data to allow for them to monitor care management processes completed by the AMH/CINs. Standard Plans and AMH/CINs also noted challenges with managing the different versions of the Patient Risk List file for AMH, CMARC/CMHRP, and InCK populations.	QPHE is working to consolidate PRL file versions to streamline data requirements.	QPHE continues efforts to consolidate PRL file versions to streamline data requirements.

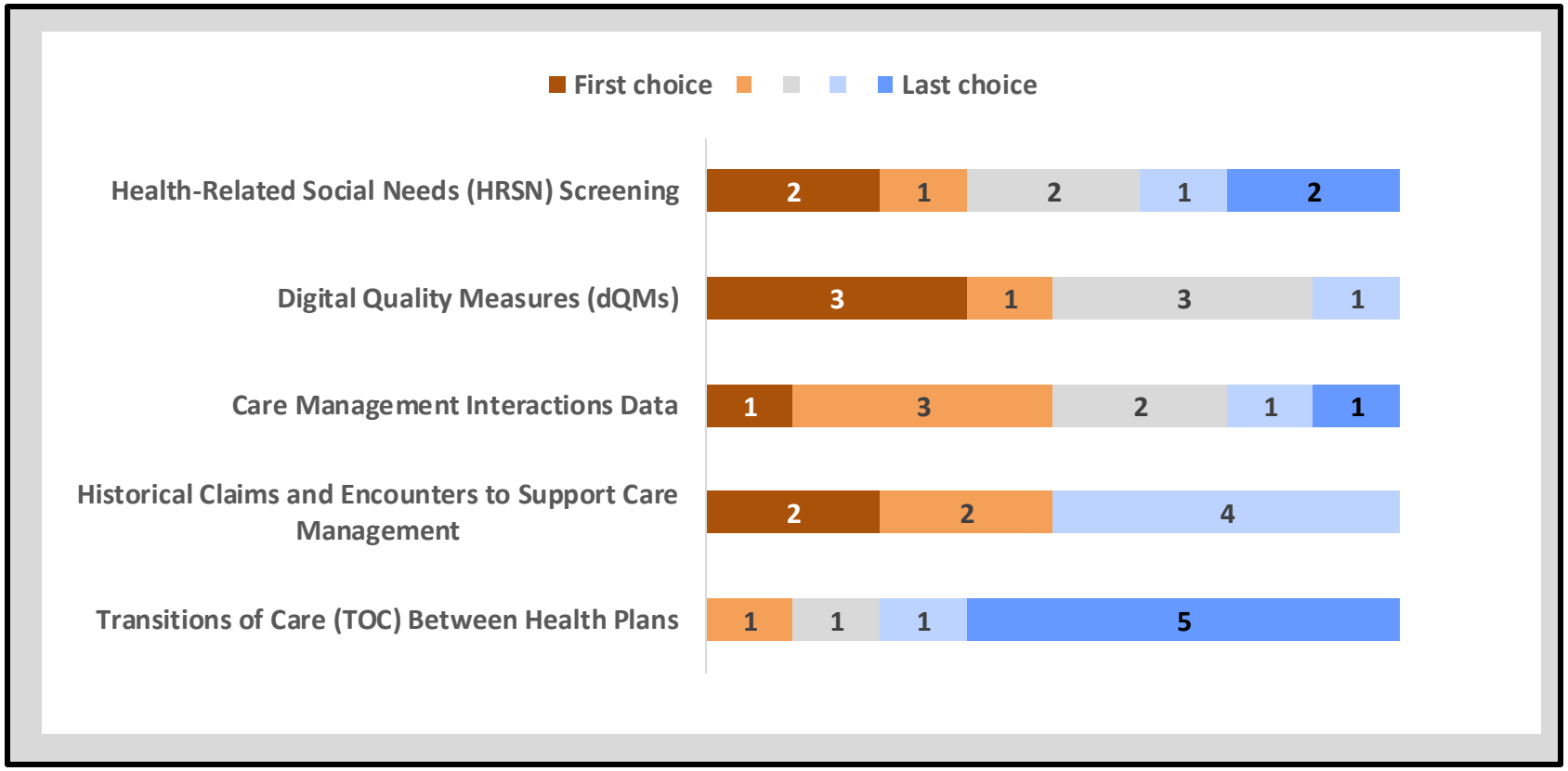
Data Topic Status Updates (2/3)

Data Topic	Topic Description	Current Status	Next Steps
Care Management Payments Reconciliation	Providers have expressed concerns with receiving data from Standard Plans on their care management PMPM payment at a sufficient level of detail, in a consistent format, or on a regular cadence	QPHE developed a set of minimum necessary required data elements for Standard Plans to share with AMH Tier 3 practices and CINs to support care management payment reconciliation	QPHE is consolidating feedback and plans to update minimum requirements via a contract amendment
Claims Data Quality	Claims files shared between Standard Plans, AMH Tier 3 practices, and CINs have issues with data completeness, formatting, and accuracy, including: • Inconsistency in populated data elements (e.g., sensitive service or 42 CFR Part 2 data) • Mismatched information between header and line files • Incomplete or missing data These data issues have been observed among both plan-to-plan and plan-to-provider data exchange.	QPHE reviewed current encounters and claims data issues and resolution strategies with the AMH Data Interfaces Timing Standardization Workgroup	Prior to implementation of timeline standardization, QPHE will update the claims interfaces data specifications to address ambiguities and issues raised by the AMH Data Interfaces Timeline Standardization Workgroup

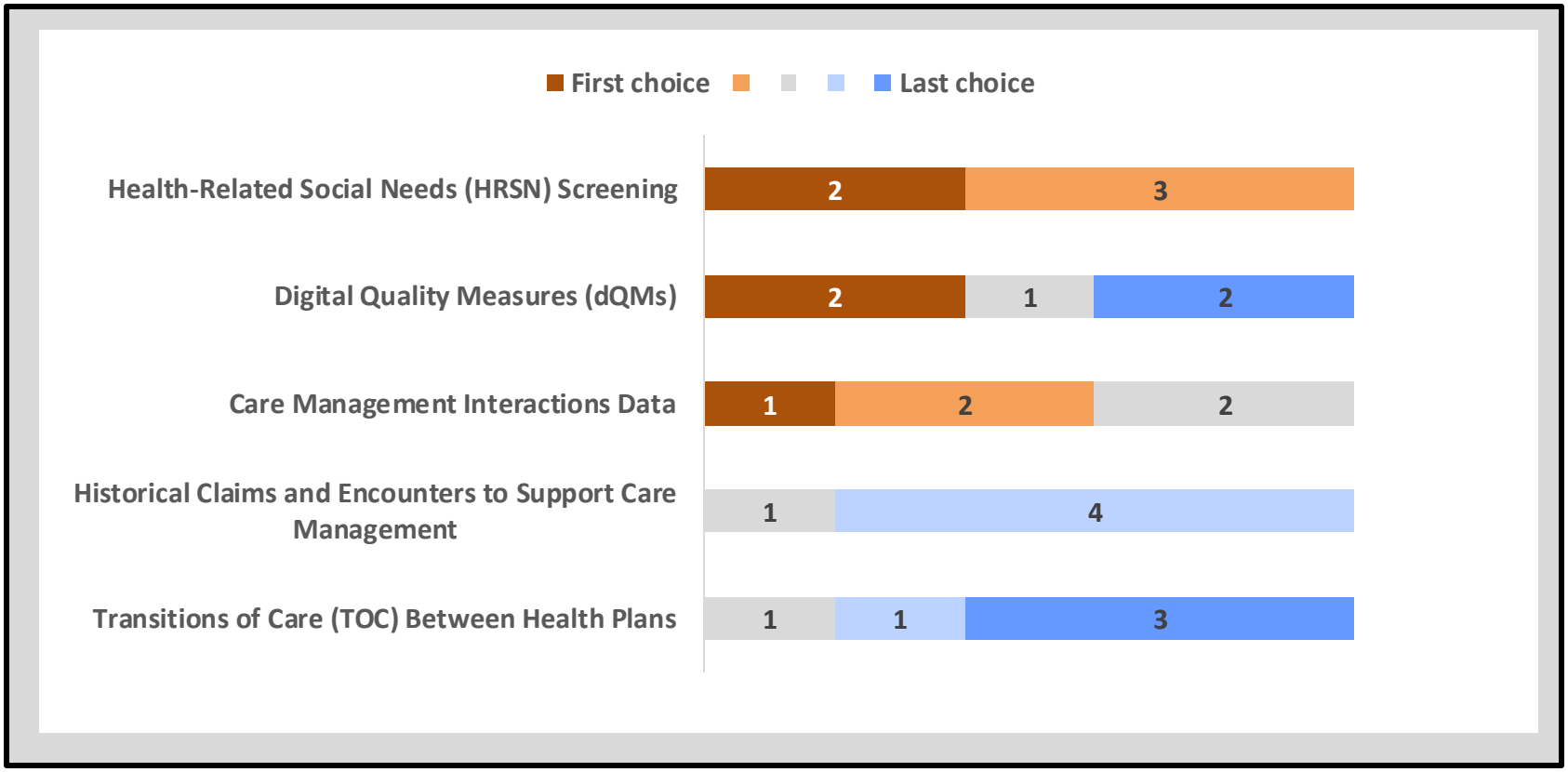
Data Topic Status Updates (3/3)

Data Topic	Topic Description	Current Status	Next Steps
42 CFR Part 2 Data	Health plans and providers have reported two issues with 42 CFR Part 2-related data sharing: • 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	As of November 2024, QPHE determined after follow-up with CINs that 42 CFR Part 2 data issues are not significantly prevalent and has thereby shifted	None
Care Needs Screenings Data	There is no standardized format to exchange Care Needs Screening data among Standard Plans, AMH Tier 3 practices, and CINs, potentially limiting the ability for care managers to use screening data to inform care management activities	QPHE is determining next steps for solutioning activities, including gathering stakeholder feedback	None

HIE Use Case Prioritization: Provider Ranking



HIE Use Case Prioritization: Standard Plan Ranking



HIE Use Case Prioritization: Respondents' Rationales (1 of 2)

Rank	Use Case	Rationale for Higher Priority	Rationale for Lower Priority
1	**Health-Related Social Needs (HRSN) Screening**	1. Faster implementation, already in pilot stage 2. Expected to benefit patients and improve care the most 3. Reduce redundant patient assessments 4. Data not currently shared	▪ Requires work on behalf of providers and question of why LOINC codes and not Z codes
2	**Digital Quality Measures (dQMs)**	1. Already in pilot stage and NC HIEA is well positioned to exchange quality measure data 2. Reduce manual operational expense and improve patient care 3. Synergy with CMS/MSSP quality reporting 4. Support state quality, withhold measures and star rating accreditation	▪ dQMs are not useful to PHPs until HIE gets DAV certified which could be a very long process ▪ Potential limitation that many practices are not sharing data with HIE and data validity issues with submitted data to HIE
3	**Care Management Interactions Data**	1. Reduce administrative burden and improve operational efficiency 2. Accurate care management interaction data is important and providers need the PRL to match the BA for each payor to ensure accurate reporting 3. Current limitations in what PHPs receive for PRL, and improving care management data exchange would allow PHPs greater insight into care management services provided by AMH Tier 3 providers	▪ Exchanges already in place so less urgent

HIE Use Case Prioritization: Respondents' Rationales (2 of 2)

Rank	Use Case	Rationale for Higher Priority	Rationale for Lower Priority
4	**Historical Claims and Encounters to Support Care Management**	1. Significant data quality issues in the claims data need to be addressed 2. Reduce the number of data exchanges to improve care management efficiency and improve the quality and timeliness of data exchanged 3. Potential to improve ACR risk segmentation to identify high risk 4. Single source of truth for BA and historical claims expected to improve data quality 5. Prioritize complete plan data for all required elements to support the program	▪ Exchanges already in place so less urgent
5	**Transitions of Care (TOC) Between Health Plans**		▪ CIN/AMH 3s not impacted by TOC use case ▪ Exchanges already in place so less urgent ▪ Lower volume of data and patients impacted