North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) Meeting #35 (Conducted Virtually) February 13, 2024, 4:00 PM ET

AMH TAG Attendees:

- North Carolina Academy of Family Physicians
- Cherokee Indian Hospital
- Mission Health Partners
- Carolina Medical Home Network
- Emtiro Health
- Duke Population Health Management Office
- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina
- North Carolina Area Health Education Centers (AHEC)
- WellCare of North Carolina, Inc.
- Carolina Complete Health (CCH)
- United Healthcare
- Community Care Physician Network
- Atrium Health
- Children First of North Carolina
- CHESS Health Solutions

NC DHHS Staff and Speakers Name	Title
Kristen Dubay	Chief, Population Health
Hannah Fletcher	Survey Team Lead
Grace Ruffin and Zoe Shipley	Student Quality Measurement Evaluator, Student Survey Analyst
Jess Kuhn	Quality Measurement Lead
Jenell Stewart	Assistant Director, NC Health Information Exchange (HIE) Authority

Agenda

- Welcome and Roll Call (5 minutes)
- Federally Facilitated Marketplace Eligibility Determinations (FFM-D) (5 minutes)
- Panel Management Satisfaction Survey (3 minutes)
- NC Medicaid Quality Fact Sheets (15 minutes)
- Prenatal and Postpartum Care F Codes (15 minutes)
- NC HealthConnex Data Aggregator Validation (DAV) (15 minutes)
- Wrap-Up and Next Steps (5 minutes)

Federally-Facilitated Marketplace Eligibility Determinations (FFM-D)

- As of February 1st, North Carolina is connected to FFM and is now determining eligibility for Medicaid Expansion-eligible individuals through the Marketplace.

- When people go to the Marketplace, they will have their Medicaid eligibility determined as well, and they will be sent to NC Medicaid if eligible.
- Starting later in February, CMS is mailing letters to more than 500,000 people indicating they may be eligible for Medicaid, and encouraging them to login to Healthcare.gov.

Panel Management Satisfaction Survey

- DHB is working on a 7-question survey about panel management satisfaction to get feedback to guide improvement efforts.
- Responses to the survey are open until March 26th.
- The survey will ask questions about the level of satisfaction and accuracy of panel management.
- DHB will share the survey again in the Summer and Fall to understand changes in satisfaction over time as the Division works on improvements.
- AMH TAG members asked if they could share the survey with their networks. DHB responded that TAG members should feel free to share widely with their networks.
- The link to the survey is: https://customervoice.microsoft.us/Pages/ResponsePage.aspx?id=3IF2etC5mkSFw-zCbNftGQWNjUl2plJAlkpduuO0Le5UOVgxN1VXSTZRTDFTTTBZUVVCRjY1NlhCSy4u

NC Medicaid Quality Fact Sheets

- DHB provided an in-depth look at the Behavioral Health (BH) Fact Sheet, one of three that the Division has released in the goal of capturing intersecting work from the Quality, Population Health, and Evaluation (QPHE) Team to shed light on the collaborative efforts that evaluate and improve beneficiary experiences.
    - The fact sheets can be found here: https://medicaid.ncdhhs.gov/reports/quality-management-and-improvement. Any new fact sheets will be uploaded to this page on a rolling basis.
- DHB explained the BH fact sheet's rationale, formatting, and provided details on the components of the fact sheet, including how the Division uses both survey and quality measures to better understand member outcomes and experiences.
- An AMH TAG member asked if DHB knows what percentage of Tailored Plan-eligible individuals are currently receiving care management services.
    - DHB shared that more than 20% of individuals with a Tailored Care Management (TCM) assignment have received engagement with a TCM provider to date.
    - An AMH TAG member asked if care coordination was lower than 20% prior to TCM.
        - DHB responded that they do not believe there is a comparable baseline.
- An AMH TAG member asked if data shows members who may have gone to their primary care provider after a hospital discharge within a 7-30 day window that may not have seen a BH provider.

- DHB shared that there are several follow-up measures including the percentage of members that saw a primary care provider 7-30 days after a discharge. DHB is looking into this measure more and considering how they might structure incentives and provide guidance, so TCM drives performance on those measures.

Prenatal and Postpartum Care F Codes

- DHB shared that two new F codes (0500F and 0503F) are being added to NC Medicaid's clinical policy (revision of NC Medicaid Obstetrical Services Clinical Coverage Policy No: 1E-5) to assist with capturing initial prenatal and subsequent postpartum care visits. This is, in part, response to historical underperformance on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal and Postpartum Care (PPC) measure, in particular among providers that use global billing codes.
  - Both F codes are defined in the NCQA HEDIS value set and aim to support more complete data collection.
  - DHB shared the policy is in the penultimate phase of the policy revision process, with the goal to finalize in the Spring.
  - The Division is still discussing whether the codes would be required by the Department for reimbursement, noting that PHPs have the flexibility to set their own standards for how they accept or deny claims without the documentation of the F codes, regardless of what the Department decides.
  - Providers will be able to submit retrospective claims with F codes to account for any prenatal or postpartum services that were delivered prior to the updated policy.
  - In a survey of providers, 70% were able to select the 0500f and 0503F codes in their EHR systems.
  - Once DHB posts the final policy, they will publish a bulletin and work with AHEC to conduct provider coaching. DHB will also post a fact sheet with information on using the F codes.
- An AMH TAG member responded to the discussion question about whether the F codes are currently used by their organization, sharing their organization does not use the F codes and finds the global codes to be sufficient. They shared the global billing claims are compliant with the measure, and suggested the Division's analysis could've gone deeper on which global billing codes weren't compliant.
  - DHB noted that this issue is raising more questions, given their understanding is that global payments don't tell the Division whether care started in the first trimester.
  - DHB shared they would be interested in learning more about potential ways to demonstrate how global billing is tracking first trimester care.
- An AMH TAG member shared that the HEDIS specifications say the global billing codes are accepted when the date(s) of prenatal and postpartum visits are on the claim form,

and suggested analysis be done to determine if there are patterns for when that's not happening.

- DHB confirmed that the F codes will be used in addition to the global billing codes.
- An AMH TAG member asked how codes would be submitted for EHRs that do not have the capability, and if there is a secondary submission process.
- An AMH TAG member noted that primary care practices with few obstetric providers in their network may lack control over how widespread or complete the use of the F codes will be for their population.
- An AMH TAG member asked if the F codes will have a charge, noting they have seen past quality codes need a charge of $0.01 to trigger the numerator.
- An AMH TAG member asked if DHB is planning to issue a quality fact sheet on the glucose measure given that NCQA has renamed the HbA1c measure to glucose, which may be confusing to providers.
    - DHB shared they likely will not because they do not have robust clinical data to support accurate measurement for GSD.

NC HealthConnex Data Aggregator Validation (DAV)

- The Health Information Exchange (HIE) Authority provided an overview of the DAV program, which validates data from the HIE to ensure it is consistent with what you'd get from a participant.
- Benefits for DAV participants include:
    - Payers won't need to request clinical data from the participants, the HIE will be able to relieve that burden
    - Participants won't need to support reporting to all of the payers, HIE can relieve that burden
- HIE shared what the DAV process looks like end-to-end, which takes about 18 weeks to complete (for an annual program); elements reviewed by the DAV; and examples of some of the settings that could be used for data validation.
- In 2023 the DAV had 3 clusters that passed validation. In 2024 the HIE will be working on remediation efforts identified in 2023 and revalidating clusters from previous participants, adding one additional cluster in 2024. This will be a total of 4 clusters across 2 participants in 2024
- In 2025 HIE is looking to work with addition participants and look at more clusters.
- An AMH TAG member asked if DHHS still plans to do the provider HIE workgroup.
    - DHB is still planning to stand up the workgroup and expects it to kick off in the next few months. DHB will be reaching out soon to confirm that Phase 1 participants are still interesting in participating.
- An AMH TAG member asked what the timeline for certifying all providers that submit data to the HIEA.

- HIE shared they are looking to include more participants in 2025. Health systems will be broken out into inpatient and outpatient clusters, but ambulatory sites might need to be broken out into different clusters depending on their EHRs.