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

January 27, 2023 Meeting

Agenda

Welcome	**5 min**
Review Data Subcommittee Objectives and Roles	**5 min**
Review of Data Topics and Prioritization	**15 min**
Update on Progress • Beneficiary Assignment • Patient Risk List	**25 min**
Public Comments	**5 min**
Next Steps	**5 min**

AMH TAG Data Subcommittee Roll Call

Stakeholder	Organization	Representative(s)
Health Plan	AmeriHealth Caritas North Carolina	**Hazen Weber**
Health Plan	Carolina Complete Health	Sharon Greer **Matthew Lastrina**
Health Plan	Healthy Blue	Ebony Gilbert Seth Morris **Carla Slack**
Health Plan	UnitedHealthcare Community Plan of North Carolina	**Russ Graham** Atha C Gurganus
Health Plan	WellCare of North Carolina	**Keith Caldwell**
Provider (CIN)	Atrium Health Wake Forest Baptist	**Misty Hoffman**
Provider (CIN)	North Carolina Community Health Center Association (NCCHA) [Carolina Medical Home Network]	**Sanga Krupakar** Anshita Chaturvedi
Provider (CIN)	Community Care Physician Network (CCPN)	Gregory Adams Anna Boone **Carlos Jackson** Trista Pfeiffenberger
Provider (CIN)	Duke Health [Duke Connected Care]	**Mary Schilder**
Provider (CIN)	ECU Health [Access East]	**Debra Roper**
Provider (CIN)	Emtiro Health	**Alexander Lindsay**
Provider (CIN)	Mission Health Partners	**Cynthia Reese**
Provider (CIN)	UNC Health [UNC Health Alliance]	**Shaun McDonald**
Provider (Independent)	Sandhills Pediatrics/CCPN	**Christoph Diasio**
Provider (Independent)	Blue Ridge Pediatrics/CCPN	**Gregory Adams**
Tribal Option	Cherokee Indian Hospital Authority	**Sarah Wachacha**

The name of each organization's lead representative is in **bold.**

DHHS and Advisors

DHHS

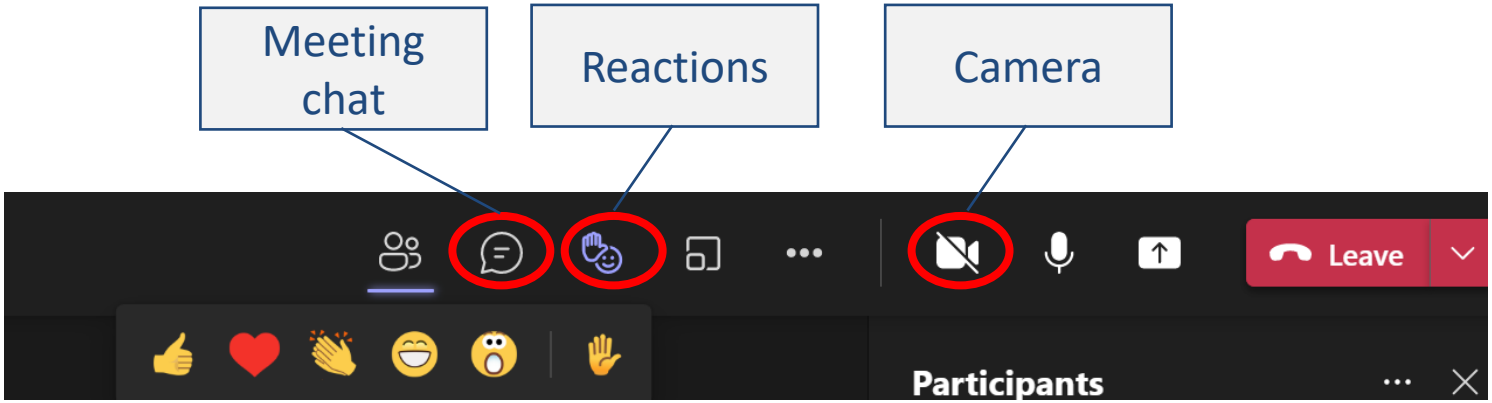
- **Loul Alvarez,** Associate Director, Population Health, DHB
- **Seirra Hamilton,** Data Analyst, Population Health, DHB

Advisors

- **Vik Gupta,** Medicaid Transformation Project Executive, Quality & Population Health, Accenture
- **Sachin Chintawar,** Medicaid Transformation Project Manager, Quality & Population Health, Accenture
- **Lammot du Pont,** Senior Advisor, Manatt Health Strategies

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.



AMH TAG Data Subcommittee Objectives and Roles

AMH Data Strategy: Roles and Relationships

DHHS gathers feedback and recommendations on key topics from the AMH TAG and the TAG Data Subcommittee.

North Carolina DHHS

↑

AMH TAG

(Clinical Leaders)

Role

- Advise DHHS on key aspects of the design and evolution of the AMH program
- Identify key AMH-related data priorities and concerns; charge Data Subcommittee with providing feedback and developing recommendations on priorities and concerns

↓↑

AMH TAG Data Subcommittee

(Data and Information System SMEs)

Role

- Identify and consider critical AMH-related data, data exchange, and HIT priorities and concerns; identify opportunities for data system efficiencies and alignment
- Provide subject-specific counsel to the AMH TAG and DHHS and propose recommendations through consensus, as needed
- Serve as ambassadors to their networks, sharing and collecting input on data issues

Review of Data Topics and Prioritization

Data Topics and Prioritization

Data Topics Survey

In Spring 2022, Data Subcommittee members provided feedback for seven data issues.

Data Issues
1. PHP & AMH Data Transmission Timing
2. Tracking CIN-AMH Relationships
3. Beneficiary Assignment
4. Patient Risk List
5. Care Needs Screening
6. Claims Files
7. Quality Measures

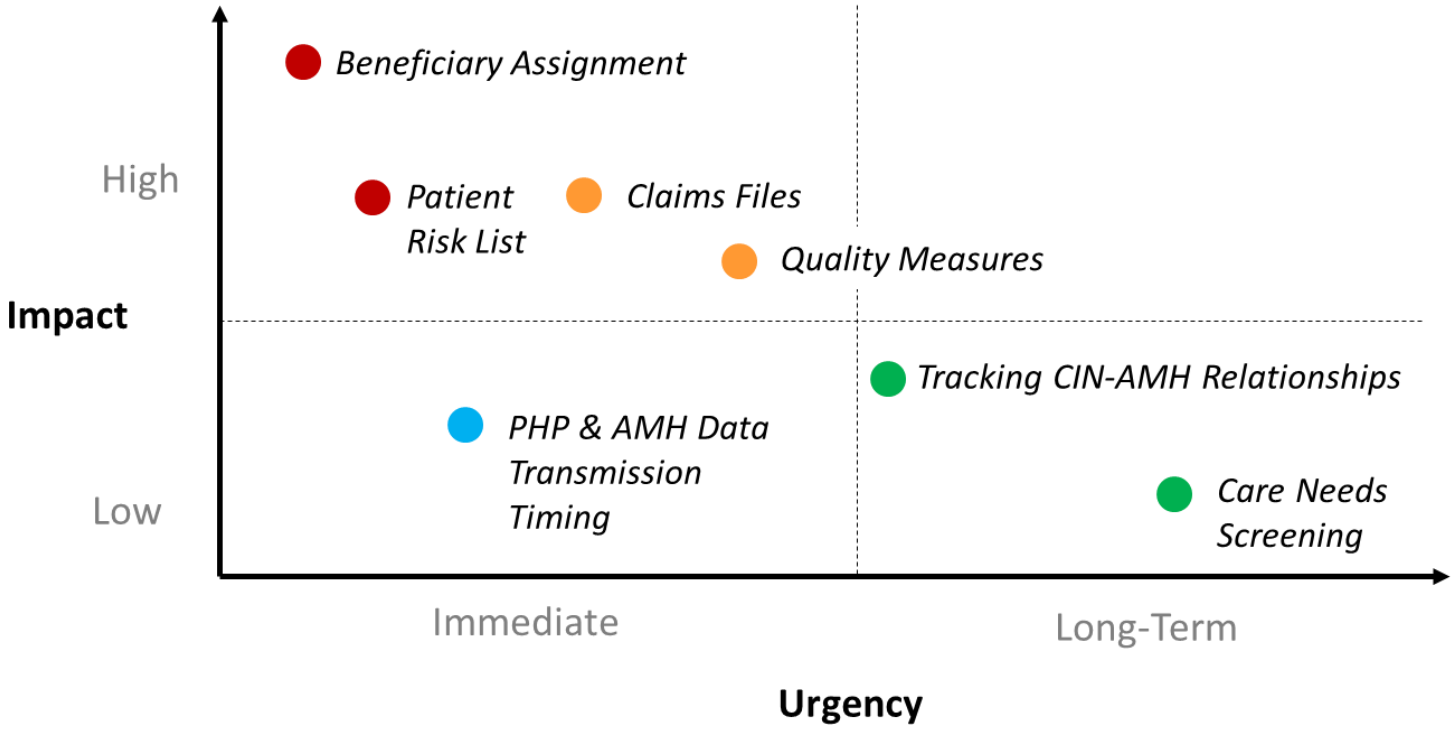
Requested Feedback

- Comments on the **nature and root causes** of the issue
- Ratings on the issue's **impact** on operations
  - High (*significant impact*)
  - Medium (*moderate impact*)
  - Low (*minimal impact*)
- Ratings on the **urgency** for resolution
  - Immediate (*within next 6 months)*
  - Near term (*between 6-9 months*)
  - Long term (*after 9 months*)

Data Topics and Prioritization

Survey Results

DHB plotted the feedback received by the AMH TAG DSC across two axis: the <u>impact</u> on operations and the <u>urgency</u> for resolution.



?

Does this categorization of issues still remain true?
Are there other issues that we should consider?

Update on Progress

Beneficiary Assignment

Beneficiary Assignment

Recap: Key Issues, Root Causes, and Initial Findings

Issue Description

DHHS has observed and stakeholders have reported the following issues:

1. High Levels of Beneficiary Assignment Churn

A percentage of Medicaid enrollees are being re-assigned to a new AMH practice/CIN each month.

2. Inconsistent Data Quality

Beneficiary assignment files are missing members and/or required data elements. Some beneficiary files are being transmitted with invalid data values.

Root Cause Analysis

To date, three root causes have been identified and discussed:

1. Assignment Errors
2. Documentation of AMH Tier 3 providers' practice location changes
3. Inaccurate Beneficiary Assignment files

Beneficiary Assignment

Root Cause 1: Assignment Errors

Root Cause Analysis

Some beneficiaries are incorrectly assigned to AMH Tier 3 practices. Areas of concern include:

1. Individuals assigned to providers who do not serve their population (e.g., adults assigned to pediatrics)

2. Individuals assigned to providers who are not currently accepting patients

Status Update

The Department is assessing the underlying causes of the assignment errors through the following actions:

- ✓ **PHP Reporting of Reassignment Protocols.** DHHS requested and received PHPs' descriptions of their reassignment protocols. *(complete)*
- ✓ **PHP Analysis of 500 Member Reassignments.** The Department has analyzed PHPs' reassignment reasons for their most recent 500 member reassignments. *(complete)*
- ✓ **DHHS' Ongoing Surveillance of Help Center Tickets.** The Department continues to assess Help Center tickets related to assignment errors. *(ongoing)*
- ✓ **PHPs' Reporting of Assignment Errors.** DHHS is assessing PHPs monthly reports (BCM903) on new member assignment issues, reassignment reasons, and steps for resolution. *(ongoing)*

Beneficiary Assignment

Analysis of PHPs' Sample Reassignments

Approach

- The Department developed a sample of 500 members who were recently reassigned and requested PHPs to categorize the reasons for reassignment.
- Three of the PHPs submitted the sample with responses.

Initial Insights

- Based on the sample data from three PHPs, a portion of member reassignments (38%) were attributed to enrollment segment extensions.
- PHPs' internal analysis similarly suggests that eligibility expiration was the root cause for 29% of member reassignments, on average, across all five PHPs.
- The Department will work with PHPs to validate the data submitted, address identified root causes, and understand other issues driving member churn.

Beneficiary Assignment

Analysis of DHHS's Help Center Tickets

The largest volume of tickets are for assignments to providers with age / gender restrictions.

Category	Open Tickets (Jan 2023)	*Open Tickets (Nov 2022)*	Total Closed Tickets (Jan 2023)	*Total Closed Tickets (Nov 2022)*	Average Time to Closure (Jan 2023)	*Average Time to Closure (Nov 2022)*
Assigned to providers with age / gender restriction	**42**	*20*	**109**	*35*	**89 days**	*68 days*
BA File – NCTracks Discrepancies	**0**	*3*	**10**	*2*	**83 days**	*45 days*
Other BA file issues (member transitions from retired NPIs, panel churn)	**9**	*8*	**71**	*17*	**76 days**	*107 days*

Beneficiary Assignment

Analysis of PHP Panel Issue Reports (BCM903)

Category	Open Tickets (Jan 2023)	*Open Tickets (Nov 2022)*	Total Closed Tickets (Jan 2023)	*Total Closed Tickets (Nov 2022)*	Average Time to Closure (Jan 2023)	*Average Time to Closure (Nov 2022)*
Assigned to providers with age / gender restriction	**42**	*20*	**109**	*33*	**89 days**	*68 days*
Excess of Panel Limit Size	**0**	*1*	**3**	*2*	**59 days**	*59 days*
Mismatch between NC Tracks and BA file	**0**	*1*	**10***	*2*	**83 days**	*45 days*
Outdated information in NCTracks on service LOC or group NPI	**1**	*2*	**31**	*1*	**97 days**	*122 days*
Provider loses members from their panel for unknown reasons	**1**	*1*	**10**	*2*	**136 days****	*169 days*
Provider is not assigned members	**0**	*1*	**2**	*0*	**147 days**	*N/A*
Other (Includes AMH closures, provider relocation…)	**7**	*4*	**16**	*14*	**23 days**	*77 days*

* Includes one closed ticket but may not have been fully resolved

** Does not include closed tickets with missing resolution dates.

Beneficiary Assignment

Root Cause 2: Providers' Practice Location Changes

Root Cause Analysis

When an AMH Tier 3 Provider moves practice locations, their members are reassigned to other providers.

This occurs when the old location codes are retired before the new location codes are operationalized.

Status Update

The DHHS Provider Team is **developing new guidance** to address situations in which a provider changes practice locations to help ensure that the provider does not lose their assigned beneficiaries.

Beneficiary Assignment

Root Cause 3: Inaccurate Beneficiary Assignment File

Root Cause Analysis

Beneficiary Assignment files sent to AMH practices are missing values or do not have valid values.

Status Update

- The Department will conduct an **end-to-end audit of Beneficiary Assignment file transmission** to assess current processes and identify issues to inform solution strategies.
  - The Department recently approved the scope of the Beneficiary Assignment file audit.
  - The Department will identify CINs to participate in the audit starting in the spring of 2023.

Updates on Progress

Patient Risk List

Patient Risk List

Recap: Key Issues, Root Causes, and Initial Findings

Root Cause Analysis & Initial Findings

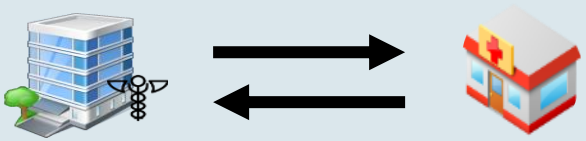
DHHS and Accenture engaged stakeholders and reviewed Technology Operations and Help Center tickets to better understand root causes.

Two root causes for have been identified to date:

1. Files with format and/or completeness issues, potentially due to non-compliance and unclear guidance
2. Varying definitions for the risk level categories

Files with Format and/or Completeness Issues
Status Update

Root Cause Analysis



PHPs **AMH Practices/CINs**

Format Issues: PHPs, AMH practices, and CINs are receiving Patient Risk List (PRL) files with data that do not align with DHHS format requirements. DHHS guidance ambiguities may contribute to field non-compliance.

Completeness Issues: Some PRL files are missing important data elements including header tabs, Risk Score Category, duplicate members, Care Management entity NPI numbers, and full panel lists.

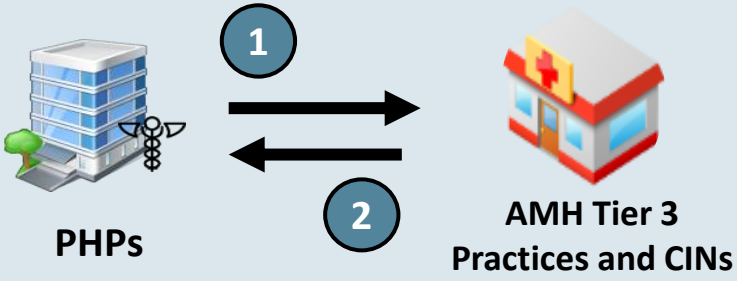
Status Update

To address PRL formatting & completeness issues, the Department has:

- ✓ **Assessed PRL Guidance.** DHB reviewed the current Patient Risk List file and identified areas requiring clarification.
- ✓ **Published the PRL Companion Guide**. DHB published the Patient Risk List Companion Guide with additional guidance on how to complete the Patient Risk List.
- ❑ **Drafted the PRL FAQs Guide.** DHB is developing a document containing responses to frequently asked questions on the Patient Risk List file.

Varying Definitions of Risk
Status Update

Root Cause Analysis



Definitions of risk level category categorizations (e.g., “high”, “medium”, “low”) vary among PHPs, AMH Tier 3 practices and CINs, which makes consistent interpretation of an individual’s clinical risk challenging.

Status Update

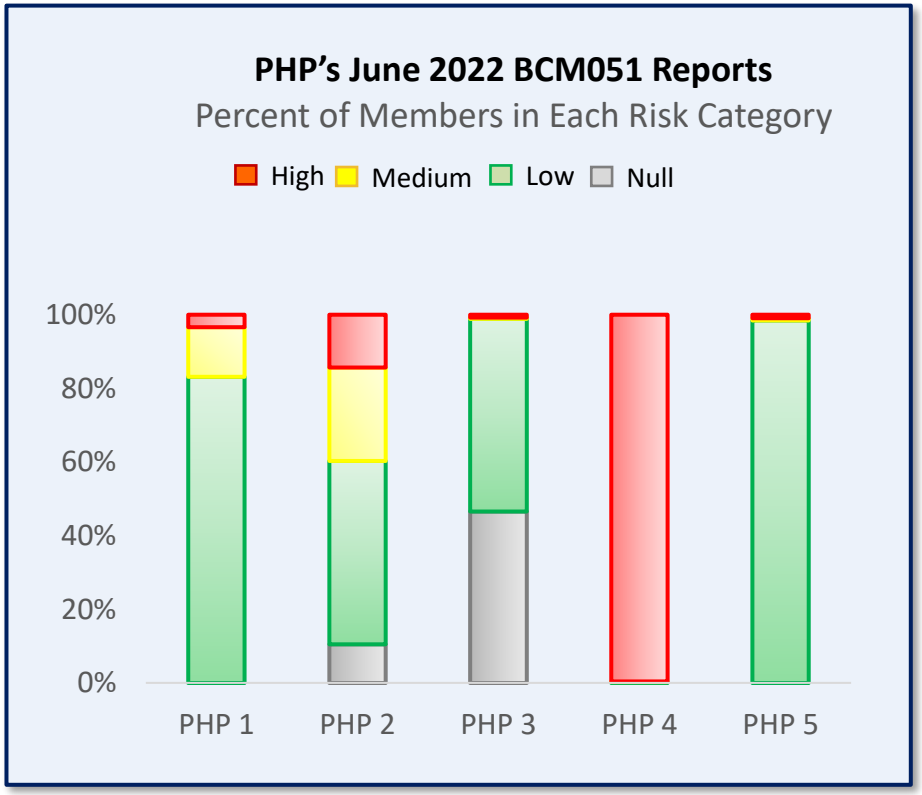
To better understand the impact of varying risk level category definitions, the Department is currently:

1. Analyzing PHPs’, AMH Tier 3 practices’, and CINs’ risk stratification approaches and their impact on care management

Risk Stratification Categories

Observed variation in PHPs' categorization of risk stratification

In Aug 2022, DHB analyzed PHP's care management reports (BCM051) and found significant variation in the PHPs' reporting of risk categories for their assigned members.



DHB sought to understand the extent and the impact of divergent risk stratification classifications on operations, care management payments, and program monitoring.

NC Care Management and Risk Stratification
Assessment of Risk Stratification

This fall, DHB assessed PHPs', AMH Tier 3 practices', and CINs' risk stratification approaches.

Assessment Scope

1. **Determine the degree of definitional variability in the risk stratification classifications (e.g., high, medium, low, and null).**
2. **Determine the impact of definitional variability on:**
   - **Operations**: PHPs', AMH Tier 3 practices', and CINs' ability to conduct care management
   - **Financing:** Financial implications for AMH Tier 3 practices
   - **Program Monitoring:** The ability for DHCS to monitor stakeholders' care management efforts

Assessment Approach

1. **Review of PHPs' "Comprehensive Care Management Policy" Reports (i.e., BCM03).** These reports are submitted annually and describe the PHPs' polices for risk scoring and stratification (including criteria for each risk stratum).
2. **Interviews with the five PHPs.**
3. **Interviews with AMH Tier 3 practices and CINs.**

NC Care Management and Risk Stratification
Interview Findings

1. **PHPs, AMH Tier 3 practices, and CINs** reported difficulty interpreting risk stratification categories due to:
   - **Lack of guidance** on how entities generate risk scores and translate the risk scores into DHHS's mandated risk categories
   - **Variability in risk stratification definitions** (i.e., different meanings for 'null' or 'rising risk')
   - **Confusion regarding the rationale** and reasons for a members' risk stratification designation

2. **In general, PHPs, AMH Tier 3 practices, and CINs are not leveraging DHHS's defined risk stratification categories or the Patient Risk List to drive their care management efforts.**

3. **PHPs, AMH Tier 3 practices, and CINs indicated that efforts to enhance care management guidance (including the Patient Risk List companion guide) are positive and helpful.**

? **Are these findings consistent with Data Subcommittee members' experiences?**

NC Care Management and Risk Stratification
Observed Impacts

Operational Impacts on Care Management Efforts

The variation is having <u>minimal operational impact</u> on PHPs, larger AMH Tier 3s practices, and CINs

- *The PHPs, larger AMH Tier 3 practices, and CINs <u>currently</u> rely on their own risk stratification approaches and reported that they don't currently find value in trying to use PHPs' risk categorization.*

The variation is having <u>more significant impacts</u> on smaller AMH Tier 3 practices

- *Smaller AMH Tier 3 practices indicated that they were hoping to leverage PHPs' risk stratification categories, but they have been hindered by the variation in PHPs' approaches and the limited explanation of their risk stratification methods.*

Financial Impacts

No financial impact on AMH Tier 3 practices

- *PHPs' care management payments are fixed PMPM payments; no PHP tied any payments to risk stratification categories.*

Monitoring and Oversight Impacts

The definitional variability has significant impact on DHHS's ability to monitor risk stratification categories across stakeholders

? Are these impacts consistent with Data Subcommittee members' experiences?

NC Care Management and Risk Stratification
Proposed Recommendations for Discussion

1

Improve Stakeholders' Communication of Their Risk Category Approaches and Definitions

- ❑ DHHS proposes to work with PHPs, AMH Tier 3 practices and CINs to develop a template that describes and communicates risk stratification approach and definitions.

2

Provide Additional Guidance on the Interpretation and Use of Key Terms

- ❑ DHHS proposes to continue working with stakeholders to improve the definition and consistent interpretation of key terms (e.g., "priority populations", "high need").

? **Are there other recommendations that the Department should consider?**

Public Comments

Next Steps

Next Steps

Subcommittee Members will:

1. Provide additional feedback on today's discussion topics to Seirra Hamilton (seirra.n.hamilton@dhhs.nc.gov).

DHHS will:

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

The next AMH TAG Data Subcommittee meeting is scheduled for March 10, 2023.

Appendix

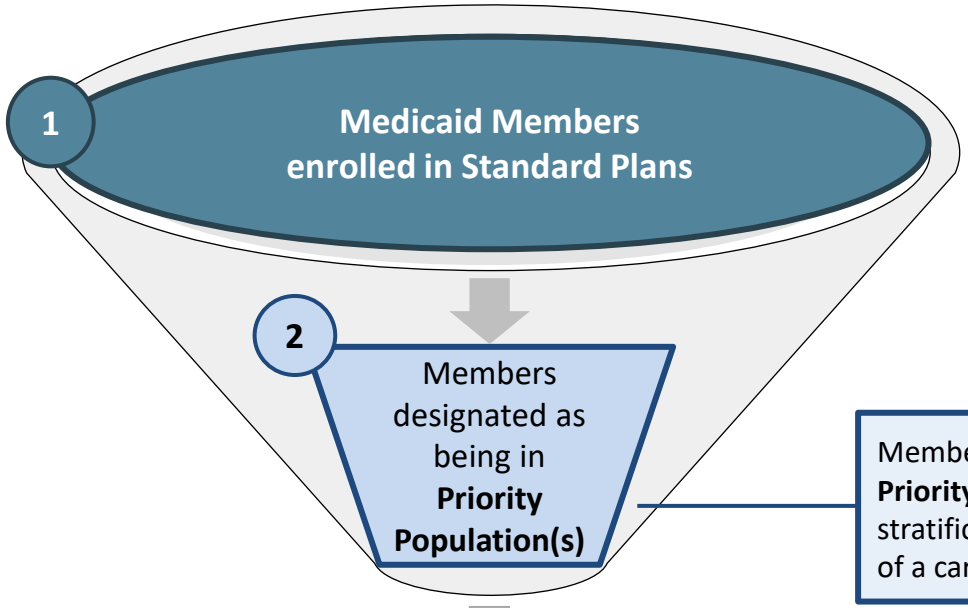
Data Topics and Prioritization
Survey Questions

#	Brief Title	Description of Issue(s)
1	**PHP & AMH Data Transmission Timing**	PHPs have differing schedules for sharing data through the standard interfaces that the Department has defined for data sharing between them and AMH/CINs.
2	**Tracking CIN-AMH Relationships**	Providers and PHPs contractual relationships vary and can be multi-faceted and complex. PHPs' information on the relationships between CINs and their associated AMHs may not reflect up-to-date contractual relationships, and as a result, the files that PHPs and CINs routinely share may have incomplete or inaccurate information.
3	**Beneficiary Assignment**	Beneficiary assignment data transmitted by the PHPs to AMH/CINs have data quality and completeness issues.
4	**Patient Risk List**	Patient Risk List (PRL) files shared between PHPs and AMH/CINs can have the following issues: 1. Files missing attributed members (e.g., some AMH/CINs transmit files to the PHPs that do not include the full list of attributed members originally sent by the PHP to the AMH/CIN). 2. Challenges interpretating certain data elements for which no standards have been created (e.g., risk stratification levels of "high", "medium", "low").
5	**Care Needs Screening**	Care needs screening results transmitted by the PHPs to AMH/CINs are not transmitted in a standardized format, creating administrative burdens for AMH/CINs to manage these data.
6	**Claim Files (Pharmacy, Dental, Institutional)**	Claims files transmitted by the PHPs to AMH/CINs have data quality and completeness issues.
7	**Quality Measures**	Quality measure issues include: 1. There is variability in PHPs' use of supplemental data to calculate certain measures: some PHPs use supplemental data; others do not. For those that use supplemental data, the format and methods that they accept supplemental data varies. 2. Variations in PHPs' quality report formats can be challenging for providers who work with multiple PHPs.

NC Care Management and Risk Stratification

DHHS's Approach for Identifying "High-Need" Members

DHHS defines "high-need" members as those "in need of more intense care management." The process for identifying "high-need" members involves multiple steps.



Members are designated as being in **Priority Populations** based on PHP's risk stratification assignments and the results of a care need screen.

- Members in Priority Populations are designated as **high-need** based on the results of a comprehensive assessment.
- DHHS assumes 22% of members will receive some form of care management and **2% will receive "high-need" care management**.

NC Care Management and Risk Stratification

DHB's Requirements for AMH Care Management*

1 **For all assigned members, PHPs must identify Priority Populations (i.e., "populations likely to have care management needs and benefit from care management").** PHPs identification of individuals in Priority Population(s) is based on the results of two processes:

- Care Needs Screen
- Risk Stratification

PHPs' risk stratification approach must take into consideration a standard set of data inputs and identify a standardized risk category (e.g., high, medium, low). However, PHPs are not required to use a standardized risk algorithm to classify members.

AMH Tier 3s practices must "assign and adjust risk status" of assigned members, but they may rely on other entities to conduct the risk stratification.

Priority Population?

If yes

2 **For members designated as being in a Priority Population,** the PHP or AMH Tier 3 practice must conduct a Comprehensive Assessment to determine care management needs and identify "high-need" populations.

High-Needs?

If yes

3 **For members designated as high need,** the PHP or AMH Tier 3 practice:

- Assigns a care manager
- Develops a care plan

If no

END

If no

END

* Applicable contractual and programmatic requirements: (1) DHB-PHP contract Amendment Number 3/4; (2) AMH Provider Manual 2.4.3.