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

June 6, 2023 Meeting

Agenda

Welcome	**5 min**
Progress on Data Issues • Beneficiary Assignment • CIN-AMH Relationship Tracking • Patient Risk List	**7 min**
Risk Stratification	**30 min**
Leveraging NC HealthConnex to Advance Quality and Population Health	**30 min**
Public Comments	**5 min**
Next Steps	**3 min**

AMH TAG Data Subcommittee Roll Call

Entity	Organization	Representative(s)
Health Plan	AmeriHealth Caritas North Carolina	Hazen Weber
Health Plan	Blue Cross Blue Shield of North Carolina (Healthy Blue NC)	Carla Slack
Health Plan	Carolina Complete Health	Matt Lastrina
Health Plan	UnitedHealthcare Community Plan of North Carolina	Atha 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
Provider (CIN)	Community Care Physician Network (CCPN)	Carlos Jackson
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 (Ind.)	Children First of NC	Deb Aldridge
Provider (Ind.)	Sandhills Pediatrics/CCPN	Christoph Diasio
Provider (Ind.)	Blue Ridge Pediatrics/CCPN	Gregory Adams
Tribal Option	Cherokee Indian Hospital Authority	Sarah Wachacha

DHHS and Advisors

DHHS

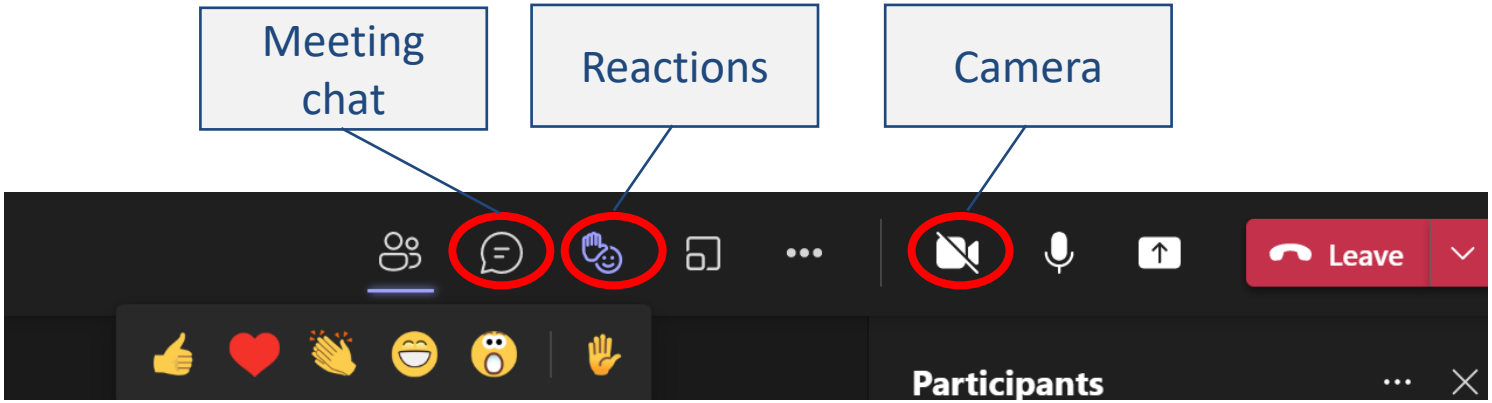
- **Kristen Dubay**, Chief Population Health Officer, DHB
- **Loul Alvarez,** Associate Director, Population Health, DHB
- **Evelin Lazaro**, AMH Program Specialist, Population Health, DHB

Advisors

- **Vik Gupta,** Medicaid Transformation Project Executive, Quality & Population Health, Accenture
- **Sachin Chintawar,** Medicaid Transformation Project Manager, Quality & Population Health, Accenture
- **Gigi Cloney**, Medicaid Transformation Project Management Lead, 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.



Review of Data Topics

Data Topics

Today, we will provide brief updates on progress to address three previously identified data topics.

Data Topics	
★	**Beneficiary Assignment**
★	**Tracking CIN-AMH Relationships**
★	**Patient Risk List**
	Quality Measures
	Claims Files
	PHP & AMH Data Transmission Timing
	Care Needs Screening

Progress Update on Data Topics
Beneficiary Assignment

Issue Description

AMHs have reported that PHPs have assigned members to providers:

1. who **do not serve the member population type** (e.g., an adult assigned to a pediatric practice), and
2. who **are not accepting new patients** (e.g., assignment exceeds the provider's panel size limits).

Many of these misassignments are due to **errors in PHPs' auto-assignment algorithms**.

Current Status

The Department expects ongoing work from PHPs to resolve auto-assignment algorithm issues.

Progress Update on Data Topics
Tracking CIN-AMH Relationships

Issue Description

There is no standard system across PHPs 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.

Potential Solution

Create a **single source of truth** for CIN-AMH relationships and create a **standardized process** to document, maintain, and update CIN-AMH relationships.

Current Status

The Department is developing a new **Provider Data Management/ Credentialing Verification Organization (PDM/CVO) modular system** to replace certain functions of NCTracks. The PDM/CVO module is scheduled to be implemented in 2024.

DHB will **develop business requirements** to incorporate CIN-AMH relationship tracking functionalities into the PDM/CVO module.

Progress Update on Data Topics
Patient Risk List

Issue Description

PHPs and AMH/CINs have reported receiving Patient Risk List files with:

(1) Formatting issues (i.e., data do not align with DHHS format requirements), and

(2) Completeness issues (i.e., missing data elements such as header tables, risk stratification category, NPI, and full panel lists).

Current Status

To address the issues, DHB has:

- ✓ **Published the** Patient Risk List Companion Guide with additional guidance for how to complete data fields on the Patient Risk List.
- ✓ **Published** Patient Risk List FAQs with responses to frequently asked questions on the Patient Risk List.

In recent months, DHB has observed few reports of Patient Risk List issues. AMH partners should continue to communicate with DHB of any new Patient Risk List data issues.

Risk Stratification

Risk Stratification
Challenges and Recommended Solutions

Challenges

PHPs, AMH Tier 3 practices, and CINs reported difficulty interpreting and using the risk stratification information they receive due to:

1. Variability in risk categorization (e.g., differing approaches for what qualifies as “high risk”)
2. Lack of information on how to interpret the risk categorization

Solutions

In January 2023, the AMH TAG Data Subcommittee recommended that DHHS take the following steps to address risk stratification challenges.

1. **Improve the Interpretation of Key Terms**: Continue efforts to improve the definition and consistent interpretation of key terms (e.g., “priority populations”, “rising risk”)
2. **Improve Communication of Risk Stratification Approaches**: Develop guidance and standardized templates to describe and communicate risk stratification approaches

Risk Stratification
Proposal to Improve Communication of Risk Stratification

Proposed Approach

PHPs would be <u>required</u> to share descriptions of their risk stratification approaches.

- ✓ PHPs would provide their descriptions to AMH Tier 3 practices and CINs.
- ✓ PHPs would provide their descriptions in a standard format and manner.
- ✓ PHPs would provide sufficient detail to inform the interpretation of risk stratification results.
- × PHPs would NOT be required to standardize how they conduct risk stratification.
- × PHPs would NOT be required to share proprietary or confidential information.

AMH Tier 3 practices and CINs would be <u>encouraged</u> to share descriptions of their risk stratification approaches in the same format used by PHPs**.**

Today's Discussion

- **We seek feedback on the proposed risk stratification <u>content</u> and <u>communication methods</u>.**

Risk Stratification Documentation Requirements
1. General Methodology

Proposed Documentation Requirements		
Component	**Description**	**Example Responses**
1. Description of risk scoring & stratification methodology	Describe your risk scoring and stratification methodology.	*Our risk stratification process uses a commercial predictive modeling tool called "Predictive Risk Assessment" and has been empirically demonstrated to correlate with future health care utilization and hospitalizations.* *The tool uses predictive modeling to generate risk scores based on a set of over 100 potential data inputs that are identified below.* *In conjunction with the "Predictive Risk Assessment" tool, we use the following variables to assign the Department's risk stratification categories to a member: (1) inclusion in the Department's Priority Populations and (2) risk stratification information on the member from downstream AMH Tier 3 practices or CINs.*

Risk Stratification Documentation Requirements

2. Data Inputs

Proposed Documentation Requirements		
Component	**Description**	**Example Responses**
2. Data inputs and sources for risk scoring and stratification	Describe the data elements that are used to generate your organization's risk scoring and stratification categories. Provide information on the sources of your organization's data (optional).	*Our "Predictive Risk Assessment" tool uses the following data elements as inputs to the risk stratification algorithm:* • *Age (834 files);* • *Chronic disease (Claims);* • *Multiple co-morbidities (Claims);* • *Physical limitations or frailty;* • *Behavioral and mental health;* • *Recent or frequent health care utilization;* • *Polypharmacy; and* • *Social drivers of health.*

Risk Stratification Documentation Requirements
3. Sub-Population Differences

Proposed Documentation Requirements		
Component	**Description**	**Example Responses**
3. Differences in risk stratification by sub-population	Describe how your risk scoring and stratification methodology differs for sub-populations, including but not limited to: • Care management program type (e.g., AMH, CMARC, CMHRP) • The Department's Priority Populations • Other vulnerable populations (e.g., children, pregnant women, older adults, individuals with disabilities) Please provide brief descriptions of your sub-populations.	*Our risk algorithm uses different data inputs, weights, and criteria to assign the Department's risk stratification categories to the following populations:* • *Population 1: Children Under 5 (Age<5)* • *Population 2: Pregnant People* • *Population 3: Older Adults (Age>65)* • *Population 4: All Other Individuals* *Children and pregnant people identified as high risk are referred to their local health department (LHD) for the Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnancies (CMHRP) programs, respectively.*

Risk Stratification Documentation Requirements
4. Translation to DHHS Risk Stratification Categories

Proposed Documentation Requirements		
Component	**Description**	**Example Responses**
4. Translation of risk scores into the Department's risk stratification categories	Describe how your organization translates the results of its risk scoring and stratification methodology into the Department's four risk stratification categories: "high", "medium", "low", and "null". Include descriptions of any data specification logic.	*Overall, we combine scores from "Predictive Risk Assessment" with data regarding the Department's priority populations to classify members into the Department's stratification categories. As mentioned above, we employ different risk stratification methodologies for different sub-populations.* *The table on the next page describes our data specification logic for each sub-population.*

Risk Stratification Documentation Requirements

4. Translation to DHHS Risk Stratification Categories… continued

Hypothetical PHP's Risk Stratification Methodology and Data Specification Logic				
DHHS's Risk Category	**Population 1:** Children Under 5 (Age<5)	**Population 2:** Pregnant People	**Population 3:** Older Adults (Age>65)	**Population 4:** All Other Individuals
High	"Risk Assessment" score within top 5%, OR the individual is in more than two Priority Populations	"Risk Assessment" score within top 5%, OR the individual is in more than two Priority Populations	"Risk Assessment" score within top 5%, OR the individual is in more than two Priority Populations	"Risk Assessment" score within top 1%, OR the individual is in more than two Priority Populations
Medium	"Risk Assessment" score within top 6-10%, OR the individual is in one Priority Population	"Risk Assessment" score within top 6-10%, OR the individual is in one Priority Population	"Risk Assessment" score within top 6-10%, OR the individual is in one Priority Population	"Risk Assessment" score within top 2-5%, OR the individual is in one Priority Population
Low	"Risk Assessment" score outside top 10%, AND the individual is in NO Priority Populations	"Risk Assessment" score outside top 10%, AND the individual is in NO Priority Populations	"Risk Assessment" score outside top 10%, AND the individual is in NO Priority Populations	"Risk Assessment" score outside top 5%, AND the individual is in NO Priority Populations
Null	Insufficient data to assign risk score			

Risk Stratification Documentation Requirements

5. Distribution Across Categories & Alignment w/ Need Stratification

Proposed Documentation Requirements		
Component	**Description**	**Example Responses**
5. Anticipated risk stratification distribution and alignment with Department's care management assumptions	Describe how your organization anticipates your population to be distributed across the four risk stratification categories and how that may align with the Department's care management rate assumptions for low, moderate, and high-needs.	*We anticipate that 80% of our attributed population will be categorized as "low risk," 15% of our attribution population will be categorized as "medium risk," and 5% of our attributed population will be categorized as "high risk."* *Our risk stratification results are not intended to align with the Department's assumptions on care management needs. AMH Tier 3 practices and CINs should conduct a Comprehensive Assessment to determine care management needs.*

Risk Stratification
Communication Requirements for PHPs

Communication Methods

1. **PHPs would communicate their risk scoring and stratification approach with:**
   - ❑ Designated contact(s) at AMH Tier 3 practices and CINs who receive the PRL reports
   - ❑ AMH Tier 3 practices and CINs upon their request.

2. **PHPs would post their risk stratification descriptions on a public website.**

?

1. **Which are the preferred communication methods?**
2. **What other communications methods should be considered?**

Risk Stratification
Next Steps

AMH TAG Data Subcommittee members will provide feedback by Friday, June 16th, 2023.

DHB will develop draft guidance for:

1. Implementation timing
2. Triggers for communicating updated versions
3. Additional considerations (e.g., definitions of rising risk)

Leveraging NC HealthConnex to Advance Quality and Population Health

The Vision

The Challenges

1. **Key data elements used for NC Medicaid programs are currently incomplete, non-standardized, and duplicative across multiple sources**
2. **Exchange of data between PHPs and providers is often decentralized and requires many different interfaces**
3. **Practices face increasing administrative burden related to paperwork, documentation, and data sharing**

The Impact

According to DHHS data…

- Less than 1% of adolescent members receive an appropriate screening for clinical depression
- Fewer than 4% of adult members with diabetes have a HbA1c level less than 9.0%

Are we really providing low quality care, or are we failing to capture the data correctly?

? **How can we provide actionable data to support care management and quality improvement, while also reducing provider burden related to data exchange?**

Key Goals

1. **Improve near-real-time exchange of key quality measure data elements between entities**
2. **Improve accuracy, completeness, and timeliness of DHB's quality measurement**
3. **Reduce administrative burden**
4. **Support care managers with complete, timely, and accurate data to inform their clinical decision-making and outreach**
5. **Develop a solution that can be supported by federal matching funds**

Potential Solution
Leveraging NC HealthConnex, North Carolina's HIE

A health information exchange (HIE) is a secure, electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway.

Leveraging NC HealthConnex would…

1. Reduce administrative burden and improve processes
2. Align with federal interoperability and quality objectives
3. Support DHHS's goals and priorities

*Graphic provided by the NC Health Information Exchange Authority (NC HIEA)

Priority Use Cases

1. **Quality Measurement**
2. **Exchange of Social Drivers of Health Data**
3. **Exchange of Data to Support Care Management**

Public Comments

Next Steps

Next Steps

Subcommittee Members will:

1. Provide additional feedback on today's discussion topics to Gigi Cloney (giovanna.cloney_acn@dhhs.nc.gov).

DHHS will:

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

Future AMH TAG Data Subcommittee meetings will occur on a quarterly cadence. The next meeting is scheduled for September 5, 2023.