## Standard Operating Procedure for Data Reporting

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PURPOSE
The purpose of this Standard Operating Procedure (SOP) and its activities is to outline a specific, measurable, actionable, realistic and timely strategy for collecting, analyzing and sharing data from community service organizations, providers, claims systems and the Health Related Social Needs (HRSN) survey. Our strategy provides partner community service provider and clinical delivery sites with multiple modalities to submit data and leverages Rocky Mountain Health Plans (RMHP), Quality Health Network (QHN) and Colorado 2-1-1’s extensive experience in creating and sharing actionable business data that support a multitude of provider, plan and community use cases.

INTENDED AUDIENCE
- **RMHP**: To provide a clearly outlined strategy for achieving its data reporting obligations as a bridge organization and to ensure that workflows support the health of Members.
- **Data/Technology Vendors**: To provide a well-defined set of roles and responsibilities.
- **CMMI**: To provide a clear and transparent strategy to CMMI for feedback and accountability.
- **Clinical Delivery Sites/Community Service Providers**: To provide a succinct description of how data will be collected, processed, shared and used. Clear instructions of data submission processes support successful data delivery and provide organizations with an understanding of how to best leverage data to better serve Members.

DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCM</td>
<td>Accountable Health Communities Model: RMHP’s specific model that covers 21 counties in Western Colorado</td>
</tr>
<tr>
<td>Colorado 2-1-1</td>
<td>Current community resource database.</td>
</tr>
<tr>
<td>Community Leads</td>
<td>Regional leaders responsible for helping to organize and implement our model see leads defined above in “Participants.””</td>
</tr>
<tr>
<td>CommunityCare</td>
<td>CommunityCare is our care navigation platform that will be deployed to care coordinators. Through community care navigators, providers and RMHP will be able to enter data, track HRSN survey results and services that Members are receiving.</td>
</tr>
<tr>
<td>Diff-n-Diff</td>
<td>Difference in Differences: An analytical technique that looks at the average change of a response variable (e.g., total health care costs) before and after an event (e.g., receiving housing services) compared to the change in that same response variable (total health care costs) for those who were not involved in the event (receiving housing services) over the same time period. This technique produces an “Average Treatment Effect” by comparing the difference over time of the affected group versus difference over that same time period of the non-affected group.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>HRSN Survey</td>
<td>Health Related Social Need Survey.</td>
</tr>
<tr>
<td>Member</td>
<td>Proper noun describing individuals (Medicaid, Medicare-Medicaid, and Medicare Enrollees) served by the Accountable Health Communities Model.</td>
</tr>
<tr>
<td>QHN</td>
<td>Quality Health Network – Current Health Information Exchange partner and entity responsible for administration the Community Resource Network that will serve as the technology backbone of our model.</td>
</tr>
<tr>
<td>RMHP</td>
<td>Rocky Mountain Health Plans – Bridge organization</td>
</tr>
<tr>
<td>Community Service Providers</td>
<td>Organizations partnering with the bridge organization to support the health service related needs of Members (excludes clinical delivery sites).</td>
</tr>
<tr>
<td>CRN</td>
<td>Community Resource Network is the combination of our Health Information Exchange and Social Information Exchange operated by QHN.</td>
</tr>
<tr>
<td>CRS</td>
<td>Community Referral Summary a list of social services tailored to the demographics, geography and social needs of a Member.</td>
</tr>
<tr>
<td>Truven / BIDM</td>
<td>Truven is Colorado Medicaid’s data and analytics vendor for the state’s Business Intelligence and Data Management (BIDM) system.</td>
</tr>
<tr>
<td>Vision Link</td>
<td>Data and technology vendor that will develop source code to support communication and coordination between providers.</td>
</tr>
</tbody>
</table>

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DRAFT
A. DATA STRATEGY SUMMARY

The diagram below summarizes our data infrastructure strategy. At the core of the data infrastructure is a data hub imbedded within Community Resource Network (CRN) and data analytics and logic run by Vision Link. The data strategy allows multiple ways for Members / clinical sites to collect and submit Health Related Social Needs (HRSN) Survey data and to receive a community referral summary (CRS). The CRN/Vision Link data warehouse will merge data from clinical sites into one database that will push data to RMHP for Community Navigation and reporting to CMS. Community Service Providers will be able to receive automated referrals through CRN and submit Member level service records through an automated portal or quarterly “batch” data files. The data process will be supported by a 2-1-1 community resource database and claims data from Truven.

Collection of HRSN Data
- Navigator Interfacing through Online Portal (Vision Link) ex: River Valley
- Clinical staff interface through QHN portal (All Scripts) or through EHR ex: Primary Care Partners
- Navigator interface through CommunityCare
- Member enters data through online portal (Patient Tools?)

CRN / Vision Link Data Hub
- Create/Maintain Data Form:
  - Demographics: Identifier, name, age, etc.
  - Social Screening Information
  - ER Visits
- Create Community Referral Summary:
  - Use HRSN survey data, 2-1-1 data and logic
- Logic:
  - Produces data files for reporting
  - Identifies Members eligible for navigation

RMHP:
- Use data for:
  - Navigation (CommunityCare)
  - Reporting to CMS
- Produce Data:
  - Services provided by community service providers

Community Service Providers connected to CRN system
- Automated Referrals
- Automated Service Records
- CRS Print Out
- Community Service Providers not connected through CRN system
- Batch Service Records
- QHN Data Transfer
- CRS Print Out

2-1-1 Community Resource Database
- CRS Print Out
- Patient Tools (web based)
- CRS Print Out
- Secure API Transfer
- CRS Print Out

Navigator Interfacing through Online Portal
- Web Based Data
- CRS Print Out

RMHP Claims Data Submission
- BIDM Claims Data (Truven)
B. COMMUNITY SERVICE DATA

1. Description: This section defines policies and procedures to collect community service provider utilization data into our centralized information exchange - Community Resource Network (CRN). Data submission to CRN will come through two tracks (1) automated data connectivity or (2) quarterly “batch” files. The section also describes how RMHP will securely share that data with community service providers, clinical sites, and CMS. The integration of community service data into CRN will allow RMHP and its partners to facilitate closed loop referrals and conduct program evaluation on the effects of community services on health outcomes.

2. Processes:
   a) Develop policies and procedures for the sharing and use of data.
      i) The AHCM Program Director will support the community service providers in developing internal procedures for the collection and use of data.
      ii) QHN will ensure that its policies and procedures for CRN and its accompanying eCommerce agreements with clinical and community service providers cover data use requirements for all data sharing within the CRN network.
      iii) The AHCM Screening process will include collection of consent for release of information
   b) Develop modalities for secure transfer of data from service providers.
      i) QHN will develop modalities for community service organizations to submit Member level data to CRN. The specific modalities will be determined through a bilateral planning process between QHN and local community service providers. Modalities will include two tracks:
         (1) The ability to submit data through an automated information exchange
         (2) The option to submit data through quarterly “batch” files
      ii) Community Navigators will track service use through CommunityCare, which will act as a portal for data submission into CRN or they will submit data directly into the CRN.
   c) Each modality defined in (b) will include the following Member-Level data:
      i) Service provider organization
      ii) Service category (housing, food, transportation)
      iii) Date of service
      iv) Service description
      v) Cost of services provided using a menu of average costs connected to services provided
      vi) Unique identifier that will be at least one of the following: Medicaid ID, full name and date of birth or Social Security Number.
   d) Supporting Community Organizations:
      i) RMHP and Community Leads will support community service providers in getting the necessary approvals to share data. Data sharing agreements will be managed by QHN through CRN eCommerce agreements. Many Community Service Providers will require board sign off or approval from state or federal funders.
ii) RMHP, QHN, and Community Leads will work with community service providers to identify the best modality for submitting data and provide organizations with training, technical assistance and support for adopting data delivery systems.

iii) Each quarter, indicators (see process (e) below) will be reviewed with social service providers to identify gaps in reporting. RMHP and Community Leads will work with each service organization to address and fix reporting gaps.

e) Processing Data:

i) QHN will de-duplicate data to ensure that each service is recorded only once (e.g., both a care coordinator and the food bank report serving the same Member would count only as one service delivery).

ii) QHN will merge data from each of the modalities defined in (b) to create a centralized database of services provided to each Member that is linked to that Member’s identifiable information.

iii) Data merged by QHN will be available to organizations through CRN and community navigators will have access to the data through CommunityCare.

f) Model Monitoring and Evaluation (service indicators):

i) QHN will merge service delivery data with referral data in CRN (see Section B, Screening, Referral and Navigation below).

ii) Using data from CRN, RMHP will report the indicators listed below for each service category by county, sub-region and for the entire AHCM service area. RMHP will also calculate each indicator for each service organization.

(1) Service Penetration Rate
   (a) Numerator: Number of Unduplicated Members provided services (1+ encounter within service category)
   (b) Denominator: Number of Enrolled Members

(2) Percent of Members in need provided with services
   (a) Numerator: Number of Unduplicated Members provided services (1+ encounter within service category)
   (b) Denominator: Number of Members with an identified need through screening or who receive services

(3) Close Loop Referral Rate
   (a) Numerator: Number of Members who received a referral for a service category and received services in that category
   (b) Denominator: Number of Members who received a referral for a service category

iii) Indicators will be shared with community organizations, all AHCM leadership groups and CMS (upon request) to identify gaps in resources and opportunities for improving the health of Members.

g) Model Monitoring and Evaluation (effect on health outcomes):

i) RMHP will merge service delivery data with medical claims data (see section (D) Medicaid’s Claims Data) to conduct Diff-n-Diff analysis. This analysis will seek to identify changes in health outcomes (e.g., total cost, ER utilization, HEDIS Measures) and how they change when a Member receives services. This evaluation will be used to develop an evidence base for community needs assessment and for the effectiveness of services.
h) **Submitting Data to CMS:**
i) RMHP will submit clean and compliant person-level and identifiable community service utilization and cost data to CMS through CMS’s secure portal on a quarterly basis. To support this process:
   1. QHN will build an internal validation system to ensure that data files meet validation requirements prior to submission.
   2. QHN will create user facing data validation to ensure that data is entered correctly and completely.
   3. RMHP will submit data to the CMS portal at least 3 days before the submission deadline to give RMHP time to correct any data files that do not meet the CMS validation process.

3. Required resources:
   a) **Data Strategy and Analytics Lead (RMHP .25 FTE)**: Provides leadership and accountability for the Data Reporting SOP and conducts core RMHP processes defined above.
   b) **Community Lead Staff**: Provides training and coordination with local service organizations to adopt and implement data reporting structures.
   c) **CommunityCare**: Technology platform used by community organizations to track service delivery and the platform that provides care coordinators and organizations access to a Member’s service history.
   d) **Community Resource Network (CRN)**: Technology (run by QHN) that gathers and shares community service data and clinical data with community service and clinical providers.
   e) **Statistical / Database Software**: Software such as SAS, STATA, SQL or Excel used by analysts to merge process and report data.

4. Anticipated challenges and mitigation strategies.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
</table>
| Data not submitted to QHN         | Community organizations may elect not to submit data to QHN because of challenges/time necessary to enter service data. | • Provide multiple modalities for data submission and allow a broad range of Member identifiers to be used (full name + date of birth, Social Security Number or Medicaid ID number).  
• Provide local leadership, training and technical assistance through Community Leads.  
• Create Diff-n-Diff analysis for organizations to develop an evidence base for that program to incentivize data reporting.  
• Require all Community Organizations to sign an MOU that includes a commitment to submit data to QHN.  
• Creating a data system that allows for duplicative data entry to broaden the number of places that data can be captured |
| Merging and maintaining clean data | Multiple ways to submit data lowers the barrier for service organizations to participate, but also creates challenges for merging, cleaning and | • Maintain an experienced Data Strategy and Analytics Lead to oversee the development of modalities for data submission.  
• Contract with QHN a leader in data collection, processing, management and exchange.  
• Create user facing data validation to ensure that data is |
5. Responsible party:
The RMHP Data Strategy and Analytics Lead is the responsible party for working with community organizations to submit data to QHN, processing data and submitting data to CMS. The other members of the data sub-committee will support the Data Strategy and Analytics Lead. The data sub-committee will work with Community Leads that have local connections with regional service organizations. QHN will provide the technology infrastructure as the backbone of our data reporting strategy. See organization chart below.
6. Timing/frequency:

<table>
<thead>
<tr>
<th>Task / Activity / Process</th>
<th>Frequency / Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-lateral planning with QHN and community service providers to develop data entry modalities for social service data into CRN</td>
<td>Ongoing starting</td>
</tr>
<tr>
<td>Sign eCommerce agreements with community service providers</td>
<td>Ongoing starting</td>
</tr>
<tr>
<td>Develop script for informed consent of AHCM screening data</td>
<td>By Oct 1, 2017</td>
</tr>
<tr>
<td>Develop data interpretability requirements and develop CRN infrastructure to support social service data</td>
<td>By</td>
</tr>
<tr>
<td>Develop automated modalities for community service providers to submit data to CRN</td>
<td>By</td>
</tr>
<tr>
<td>Develop modalities for community service providers to submit data to CRN through quarterly batches</td>
<td>By</td>
</tr>
<tr>
<td>Develop data modality for service utilization to be entered through CommunityCare</td>
<td>By</td>
</tr>
<tr>
<td>Piloting of automated deliver of service data in CRN</td>
<td>By</td>
</tr>
<tr>
<td>Data submitted CRN through CommunityCare</td>
<td>Ongoing starting Jan 1, 2019</td>
</tr>
<tr>
<td>Data submitted to CRN through quarterly batch files</td>
<td>Ongoing starting May 1, 2018</td>
</tr>
<tr>
<td>Training and technical assistance for community service providers</td>
<td>Ongoing starting</td>
</tr>
<tr>
<td>Conduct diff-n-diff analysis (for social service providers)</td>
<td>Annually beginning in July of 2019</td>
</tr>
<tr>
<td>Submit data to CMS through portal</td>
<td>Quarterly (within 30 days of last day of the quarter)</td>
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</table>

C. SCREENING, REFERRAL, NAVIGATION DATA

1. Description: This section explains how RMHP will create a multi-platform methodology for collecting HRSN survey data from Members in clinical settings. This section also describes how HRSN survey data will be submitted to CMS and combined with 2-1-1 data to create customized Community Referral Summaries (CRS) used by Members and community navigation staff.

2. Process:
   a) **Develop modalities for secure screening:** To support participation of a diverse set of rural and frontier clinical sites, they will be permitted to do the screening in a number of different electronic platforms.
      i) **Navigator Interfacing through Online Portal (Vision Link):** Vision Link will develop a secure online portal where clinical staff may log in and complete the HRSN survey with Members. The secure online-based interface will allow screening data to be sent to the data hub and for the staff member to receive the CRS to be printed.
      ii) **QHN Interfaces:**
          (1) Practices may modify their electronic medical record and QHN will develop infrastructure to extract data through its “reports” function. After data extraction QHN will send the CRS to the practice to be printed.
(2) QHN will develop a portal in its EHR where practices can complete the survey with Members. QHN will extract data and send the CRS to the practice to be printed.

iii) CommunityCare: RMHP will adapt CommunityCare technology infrastructure so that providers adopting CommunityCare can complete HRSN surveys with Members directly in the CommunityCare interface. CRS will be sent back to the clinical staff through CRS to be printed for Members.

iv) Secure Online Portal: RMHP will work with external vendors (potentially Patient Tools) to develop an online form that Members can complete themselves to submit survey data. CRS will be printed at the clinical site for Members.

b) Each modality defined in (a) will include the Member-Level data and allow beneficiaries to provide either a Health Insurance Claim Number or Medicare Beneficiary Identifier. Member level data (First and last name, address, zip code, birth date and current benefits program ID) will be merged to each record through the CRN/Vision Link data hub.

c) Supporting Providers:
   i) RMHP, QHN, and Community Leads will work with providers to identify the best modality for submitting HRSN survey data and provide organizations with training, technical assistance and support for adopting data delivery systems.
   ii) Each quarter indicators (see process (f) below) will be reviewed with social services providers to identify gaps in reporting. RMHP, QHN, and Community Leads will work with each clinical provider to address and fix reporting gaps.

d) Making Referrals:
   i) RMHP will leverage the Colorado 2-1-1 database, which will include information on community resources.
   ii) RMHP will work through QHN and QHN’s Vision Link (vendor) to create technology infrastructure that takes HRSN survey data from community providers and community resource data from to 2-1-1 to match a Member’s social needs with local resources. This system will be able to produce a list of relevant resources to be printed (the CRS), make automated digital referrals to organizations, identify Members eligible for navigation services and record if Member refuses referrals or navigation.
   iii) Referrals will be sent in real time from the Vision Link technology through CRN run by QHN. QHN will then send relevant alerts and referrals to Members, social service organizations, providers and care navigators.

e) Navigation Data:
   i) As described in section (d) above technology infrastructure will be developed through Vision Link to identify Members who qualify for navigation and a flag will be developed within the central database. Once a Member is flagged as eligible for navigation an automated referral will be made through RMHP to connect the Member to a community navigator who will provide outreach to the Member (see community navigation SOP for details on how Members will be assigned to community navigation). If a Member declines navigation that will be noted in the CRN data infrastructure.
   ii) Each navigator will use CommunityCare to track services and develop care navigation plans or will be able to upload Navigation data into CRN. Members
can track their appointments through CommunityCare’s online portal and they can sign off on their care plans on CommunityCare tablets.

iii) Navigation and community resources will be tracked through CommunityCare, which will be connected to the CRN run by QHN. This allows us to track and monitor all navigation activities and to create a closed loop referral process where providers, navigators and participating service organizations can track each referral made for a Member and whether the Member has been provided the services associated with the referral.

f) Monitoring and Evaluation (service indicators):

i) To monitor the screening process RMHP will report the indicator listed below for provider, as well as by county, sub-region and for the entire AHCM service area.

(1) Screening Penetration Rate:
   (a) Numerator: number of Members completing screening
   (b) Denominator: number of enrolled Medicaid or Medicare Members (in the case of a practice the number of Members attributed to that practice using claims data).

ii) To monitor the referral process RMHP will report the indicators listed below for each service category by county, sub-region and for the entire AHCM service area. RMHP will also calculate each indicator for each service organization.

(1) Service Penetration Rate
   (a) Numerator: Number of Unduplicated Members provided services (1+ encounter with a service category)
   (b) Denominator: Number of enrolled Members

(2) Percent of Members in need provided with services
   (a) Numerator: Number of Members with an identified need through screening or who receive services.
   (b) Denominator: Number of enrolled Members

(3) Close Loop Referral Rate
   (a) Numerator: Number of Members who received a referral for a service category and received services for in that category
   (b) Denominator: Number of Members who received a referral for a service category

iii) To monitor the navigation process, RMHP will report the indicators listed below by county, sub-region and for the entire AHCM service area.

(1) Navigation penetration rate
   (a) Numerator: Number of unduplicated Members provided with navigation.
   (b) Denominator: Number of enrolled Members

(2) Percent of Members with navigation needs
   (a) Numerator: Number of unduplicated Members eligible for navigation services
   (b) Denominator: Number of Members

(3) Close loop navigation rate
   (a) Numerator: Number of Members who are eligible for navigation and received navigation
   (b) Denominator: Number of Members who are eligible for navigation
g) **Model Monitoring and Evaluation (effect on health outcomes):**
   i) RMHP will merge referral and navigation with medical claims data (see section (C) Medicaid’s Claims Data) to conduct Diff-n-Diff analysis. This analysis will seek to identify changes in health outcomes (e.g., total cost, ER utilization, HEDIS Measures) and how they change when a Member is provided with navigation services.

h) **Submitting Data to CMS:**
   i) RMHP will submit clean and compliant person-level and identifiable HRSN, referral and navigation data to CMS through CMS’s secure portal on a quarterly basis. To support this process we will:
      1. QHN will build an internal validation system to ensure that data files meet validation requirements prior to submission.
      2. QHN will create user facing data validation to ensure that data is entered correctly and completely.
      3. RMHP will submit data to the CMS portal at least 3 days before the submission deadline to give RMHP time to correct any data files that do not meet the CMS validation process.

3. Required resources:
   a) **Data Strategy and Analytics Lead (RMHP .25 FTE)**: Provides leadership and accountability for the Data Reporting SOP and conducts core RMHP processes defined above.
   b) **Community Lead Staff**: Provides training and coordination with local service organizations to adopt and implement data reporting structures.
   c) **CommunityCare**: Technology platform used by community organizations to track service delivery and the platform that provides care coordinators and organizations access to a Member’s service history.
   d) **Community Resource Network**: Technology (run by QHN) that gathers merges and shares community service data.
   e) **Statistical / Database Software**: Software such as SAS, STATA, SQL or Excel used by analysts to merge process and report data.
   f) **Technology to Match Needs to Referrals**: Technology will be developed through Vision Link (vendor of QHN) to complete this function.
   g) **Online Portal for Submission of HRSN Survey Data**: RMHP will use a vendor to create this secure portal.
   h) **Navigation Staff**: Hired through AHCM funds to provide navigation to Members.

4. Anticipated challenges and mitigation strategies.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
</table>
| Practices elect not to adopt data submission modalities | Providers may elect to not submit data to CRN because of challenges/time necessary to enter HRSN survey data. | • Provide multiple modalities for data submission.  
• Provide local leadership, training and technical assistance through Community Leads.  
• Create Diff-n-Diff analysis for providers to develop an evidence base for the transformation efforts (to incentivize data reporting).  
• Require all clinical delivery sites to sign an MOU that |
includes a commitment to submit data to CRN.
- Allow clinical delivery sites to adopt screening, referrals and data entry for ALL patients regardless of line of business to create more consistent workflows and increase the value add of technology adoption.

### Merging and maintaining clean data

- Multiple ways to submit data lowers the barrier for service organizations to participate, but also creates challenges for merging, cleaning and processing data.
- Maintain an experienced Data Strategy and Analytics Lead to oversee the development of modalities for data submission.
- Contract with QHN a leader in data collection, processing, management and exchange.
- Create user facing data validation to ensure that data is entered correctly and completely.

### Submitting compliant data to CMS

- Ensuring that data submitted to CMS meets the data submission requirements
- Create an internal validation system to ensure that data files meet validation requirements prior to submission.
- Create user facing data validation to ensure that data is entered correctly and completely.
- Submit data to the CMS portal at least 3 days before the submission deadline to give RMHP time to correct any data files that do not meet the CMS validation process.

5. Responsible party:

The RMHP Data Strategy and Analytics Lead is the responsible party for working with community practices to submit data to RMHP, processing data and submitting data to CMS. The other members of the data sub-committee will support the Data Strategy and Analytics Lead. The data sub-committee will work with Community Leads that have local connections with regional clinical delivery sites. Quality Health Network will provide the technology infrastructure as the backbone of our data reporting strategy. See organization chart presented earlier.

6. Timing/frequency:

<table>
<thead>
<tr>
<th>Task / Activity / Process</th>
<th>Frequency / Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop capacity in CRN for tracking HRSN survey data</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop Vision Link Online Portal for HRSN survey data entry</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop CRN portal within QHN for HRSN data entry</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop CRN capacity to pull HRSN data from EHR</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop capacity for CommunityCare HRSN survey data entry</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop portal for Members to complete HRSN survey</td>
<td>Once, by</td>
</tr>
<tr>
<td>Develop referral technology to create CRS from HRSN survey and 2-1-1 data (through Vision Link)</td>
<td>Once, by</td>
</tr>
<tr>
<td>Training/technical assistance practices adopt data submission platforms</td>
<td>Ongoing starting</td>
</tr>
<tr>
<td>Practices send data to CRN</td>
<td>Real Time (daily)</td>
</tr>
<tr>
<td>Referrals are made using HRSN survey and community resource database and sent to providers, navigators and service organizations</td>
<td>Real Time (daily)</td>
</tr>
<tr>
<td>Navigators are assigned to Members, provide outreach to Members and provide ongoing navigation</td>
<td>Real Time (daily)</td>
</tr>
</tbody>
</table>
Calculate service indicators | Quarterly (within 30 days of last day of the quarter)
Submit data to CMS through portal | Quarterly (within 30 days of last day of the quarter)
Conduct Diff-n-Diff analysis | Annually (starting in 2019)

D. MEDICAID CLAIMS DATA

1. Description: This section describes our policies and procedures for submitting claims data to CMS or its contractors. Colorado is working towards T-MSIS production, in the interim RMHP will use claims data that it receives through Colorado’s vendor (Truven) to submit data to CMS.

2. Process:
   a) **Receive and process monthly claims files**
      i) RMHP receives detailed, identified Medicaid claims data on a monthly basis from Truven.
      ii) RMHP staff clean and maintain claims data in a centralized database.
   b) **Submitting Data to CMS:**
      i) RMHP will submit clean and compliant person-level and claims data to CMS through CMS’s secure portal on a quarterly basis. To support this process we will:
         1) Create an internal validation system to ensure that data files meet validation requirements prior to submission.
         2) Submit data to the CMS portal at least 3 days before the submission deadline to give RMHP time to correct any data files that do not meet the CMS validation process.
   c) **Using Claims Data:**
      i) See above sections on how claims data will be used to conduct Diff-n-Diff analysis.
   d) **Evaluation:**
      i) Evaluation will be based on delivering compliant data on time to CMS though its portal.

3. Required resources:
   a) **Data Strategy and Analytics Lead (RMHP .25 FTE)**: Provides leadership and accountability for the Data Reporting SOP and conducts core RMHP processes defined above.
   b) **Statistical / Database Software**: Software such as SAS, STATA, SQL or Excel used by analysts to merge process and report data.
   c) **Network**: RMHP will leverage its current network for this purpose.

4. Anticipated challenges and mitigation strategies.
### Challenge Description Mitigation Strategy

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data is poorly formatted and difficult to use</td>
<td>Claims data provided by Truven are not “cleaned” and contain inconsistent data values</td>
<td>• RMHP and its vendors are working to create an automated system to clean and make the data easy to use in day-to-day workflows.</td>
</tr>
</tbody>
</table>
| Submitting compliant data to CMS | Ensuring that data submitted to CMS meets the data submission requirements | • Create an internal validation system to ensure that data files meet validation requirements prior to submission.  
• Submit data to the CMS portal at least 3 days before the submission deadline to give RMHP time to correct any data files that do not meet the CMS validation process.  
• Maintain a strong working relationship with Colorado Medicaid that can be used if changes to raw data are necessary. |

5. Responsible party: The RMHP Data Strategy and Analytics Lead is the responsible party for submitting claims data to CMS. Internal analysts and RMHP’s actuarial vendor (Lief Associates) will support this process.

6. Timing/frequency:

<table>
<thead>
<tr>
<th>Task / Activity / Process</th>
<th>Frequency / Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop automated system for cleaning and maintaining a database of claims data from Truven</td>
<td>Once, by 12/1/2017</td>
</tr>
<tr>
<td>Submit data to CMS through portal</td>
<td>Quarterly (within 30 days of last day of the quarter)</td>
</tr>
</tbody>
</table>