Data Sharing: Accelerating and Aligning Population-Based Payment Models

April 26, 2016
1:00pm – 2:15pm

WELCOME

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Member
PBP Work Group

Senior Director of Research and Development

Leavitt Partners, LLC

SESSION OBJECTIVES

- Provide an overview of the PBP Work Group's preliminary recommendations related to sharing data within a population-based payment model.
- Provider insight into strategies for data sharing among payers, providers, patients and purchasers.
- Share stakeholder perspectives for implementation of draft recommendations.
- Offer opportunity for audience questions and facilitated discussion

PBP PANELISTS

Data Sharing

David Muhlestein, PhD, JD
Member
PBP Work Group

Senior Director of Research and Development

Leavitt Partners, LLC

Frank Opelka, MS, FACS
Member
Guiding Committee

Executive VP, *Louisiana State University System*

Medical Director, Quality and Health Policy

American College of Surgeons

Andy Baskin
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National Medical Director

Aetna

Elizabeth Mitchell
Member
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President and Chief Executive Officer

Network of Regional Healthcare Improvement

DATA SHARING

- Data Sharing is foundational for the success of PBP models.
- Payers must commit to sharing data that providers need in order to have a 360 view of their patient panels. Payers have an interest in working with providers with the capacity to use data to improve care and manage risks.
- Providers who participate in multiple PBP contracts with varied payers will need data from each of them.
- Willingness to share data will increase with shared risk between payers and providers, and will require fundamentally new relationships and actions among providers, payers, purchasers and patients.
- Providers will accept accountability for the cost and quality outcomes for a population only if they have sufficient data to understand and manage the financial risks and to motivate systematic changes to care processes.

DATA SHARING

There are 2 different types of data that are needed for the success of population based payment models:

- **Patient Level Data**
  - Providers need patient level information at point of care to make decisions with their patients.
  - Payers have an obligation to share administrative data with providers to ensure that providers have comprehensive understanding of the patient.
  - Providers have an obligation to share clinical and/or patient reported outcome data needed to score performance measures in PBP models.
- **Aggregate Data**
  - Payers have an obligation to share de-identified system-level information on the performance of providers and the PBP model.
  - Providers can use information to make changes in care delivery and risk management for their population and sub-populations (e.g., benchmarking their own performance against all diabetics, patients in a geographic area, etc.).

DATA SHARING RECOMMENDATIONS

The focus is on what by whom, not how.

1. *Data Follows the Patient*
   a. *Promote efforts to ensure that patient records can be securely matched to the right patient, regardless of payer*
   b. *Work toward maturing data along "Information to Knowledge" continuum*
2. *Standardized Data*
   a. *Support efforts to standardize data as an investment that will strengthen the value of the analytics*
3. *Data is Timely and Actionable*
   a. *Ensure patient discharge and transfer data is shared with providers and is more timely*
4. *Removing Data Sharing Barriers*
   a. *Remove or minimize legislative restrictions to data sharing*
   b. *Identify ways to minimize financial and technical barriers*
5. *Data Governance and Accountability*

DATA SHARING QUESTIONS

- What are the major concerns that you see with the current state of data sharing?
- What are the biggest barriers to implementing effective data sharing in population based payments?
- Are any important types of data sharing not included?

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PANEL SPEAKER

Elizabeth Mitchell
Member
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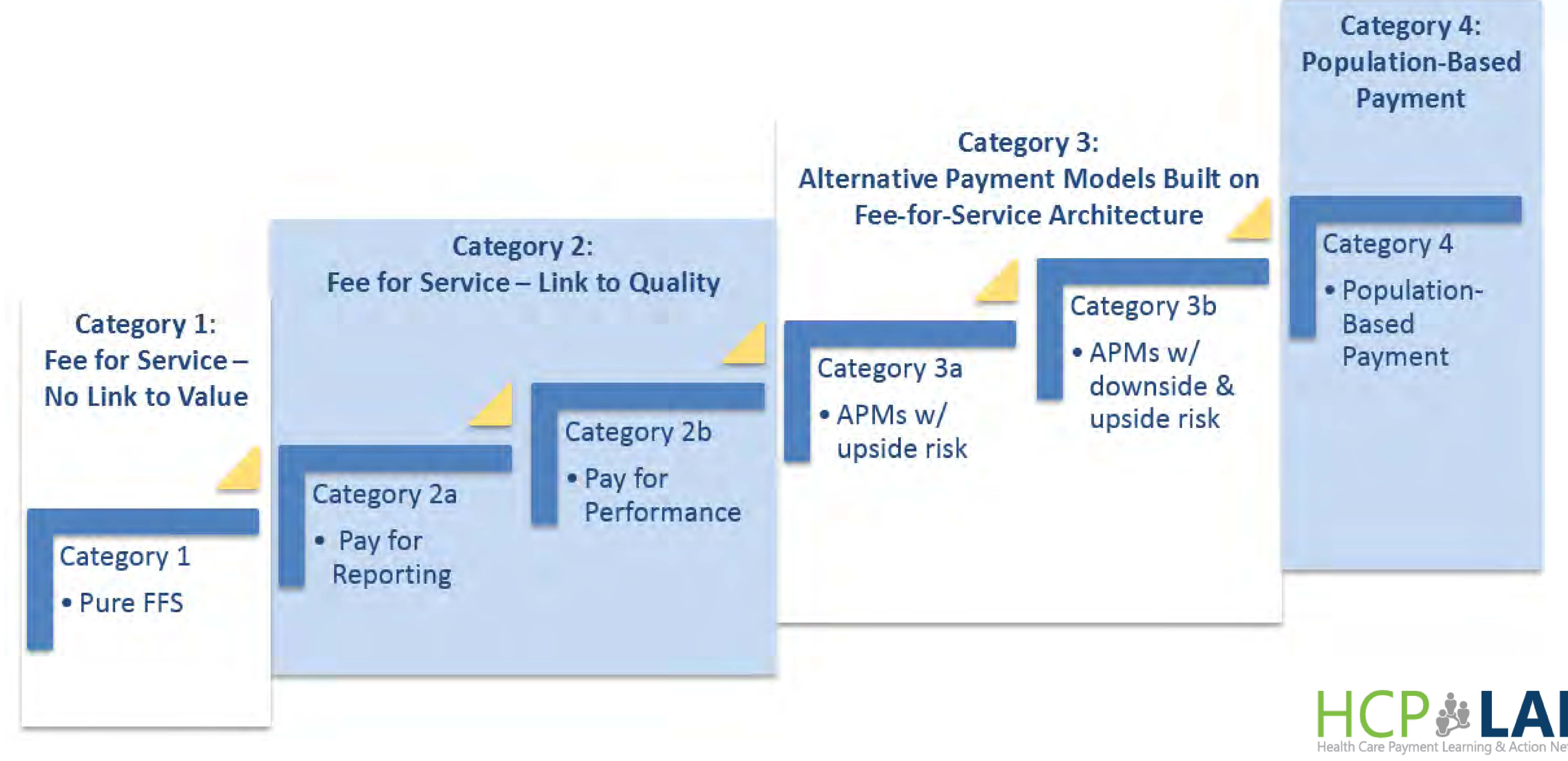
APM Framework

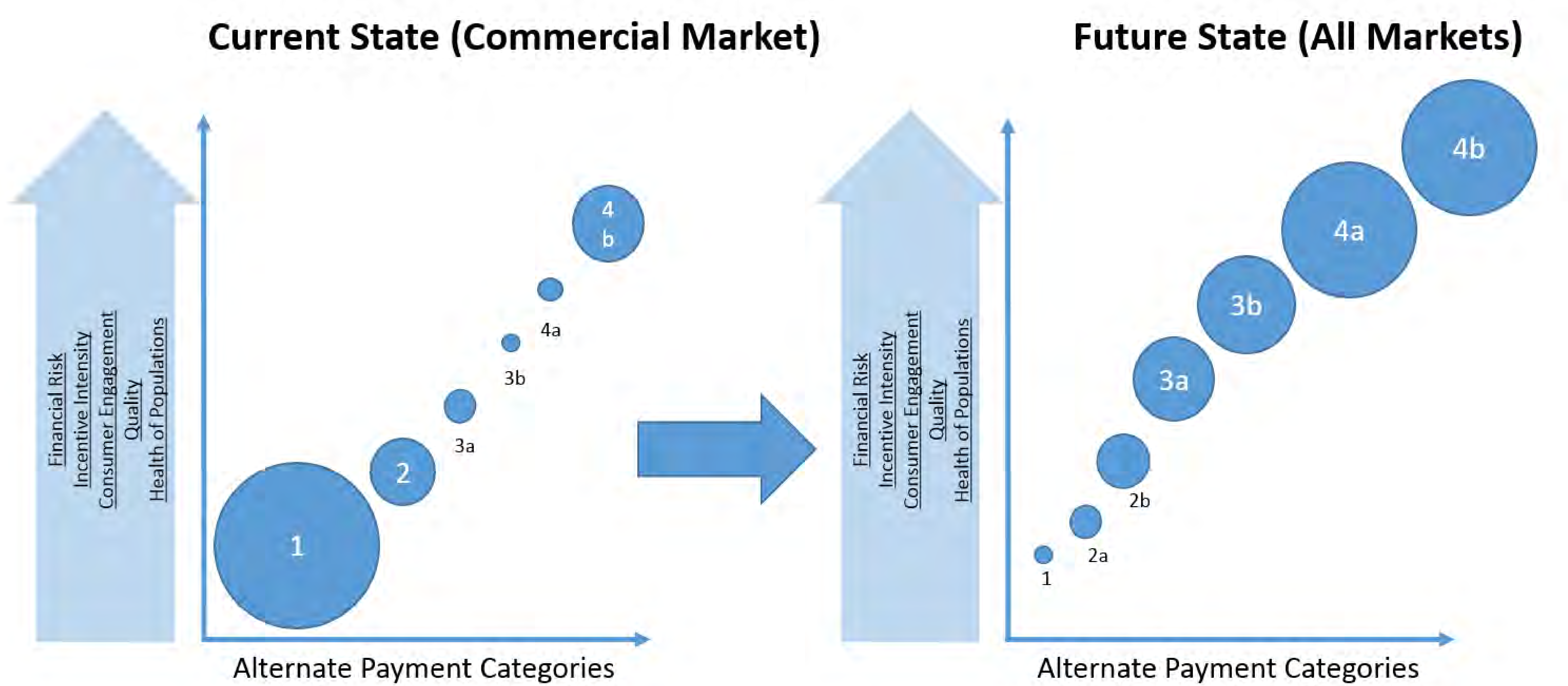
CMS Framework for Payment Models



Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.
For limited release (LAN CMS Participants and GC Members Only)

Over time, the desire is to influence a shift in payment models to Categories 3 and 4

Conceptual diagram of the desired shift in payment model application given the current state of the commercial market*



Note:

- Size of "bubble" indicates overall investment in each category of APM
- Over time, APMs will move up the Y-axis and there will be more investment in the higher categories

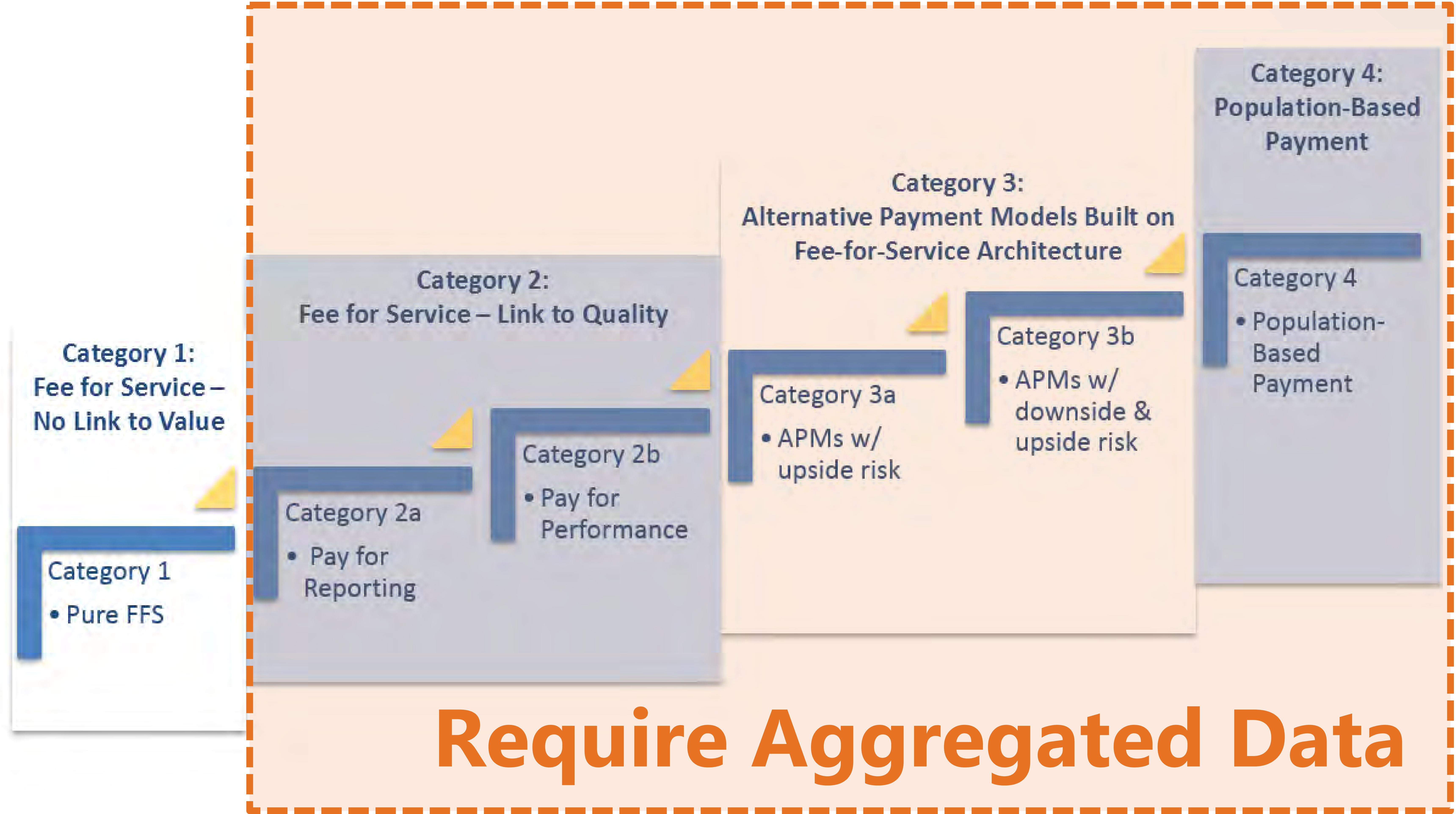
Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.

How Do We Get There?
From FFS → Performance-Based Payment

- **New measures – quality and cost**
- New shared data infrastructure
- New incentives
- Transparency
- Alignment across payers
- New care models
- New community partners
- New relationships

APM Framework

CMS Framework for Payment Models



Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

Background on MACRA Medicare data provisions

- Section 105(a) of MACRA expands how QEs will be allowed to use and disclose analyses and combined data. Starting July 1, 2016:
  - QEs can provide or sell **non-public analyses** to "authorized users"
  - QEs can provide or sell **combined data** to providers, suppliers, medical societies and hospital associations
  - QEs can provide at no cost **Medicare claims data** to providers, suppliers, medical societies and hospital associations
- Section 105(b) requires CMS to give QCDRs access to Medicare claims data "for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety…"

Multi-payer Patient Centered Medical Homes

- Eastern Maine Health System
  - 76% reduction in ED visits
  - 86% reduction in hospital admissions
- Martin's Point (a PCMH pilot site)
  - Readmissions rate dropped from 24% to 17%
- Enhanced payments to primary care practices: $12.8 million

Comprehensive Primary Care Initiative -Tulsa, Oklahoma

MyHealth Access Network

The Centers for Medicaid & Medicare, Blue Cross and Blue Shield of Oklahoma, Community Care of Oklahoma, and the Oklahoma HealthCare Authority (Oklahoma Medicaid) worked with a network of 68 primary care practices, caring for 200,000 patients.

- Clinical data and claims were used to risk-stratify patients, identify gaps in care, and engage employers, insurers, and providers to work together to review the quality and cost of care.
- All practices shared their cost and performance data, which created a culture of collaboration and a focus on outcomes.
- As a result of improved care coordination,
  - all-cause hospital **admissions dropped** significantly
  - **cost of care for Medicare patients dropped** 7 percent in Year 1 and 5 percent in Year 2. Saved Medicare $10.8 million over two years.
  - A participating **Medicare Advantage plan saved 15 percent over two years**
  - Savings triggered **incentive payments to providers** who met quality targets.

What Made it Work?

- Shared population data
- Common priorities and common measures
- Aligned incentives
- Direct multi-stakeholder relationships
- Local engagement
- A neutral convener

Getting to Affordability:
A Total Cost of Care Initiative

REGIONAL COMMITMENT. NATIONAL IMPACT.

The initiative was piloted by NRHI and RHICs in five regions. Their success led to the Phase II expansion, with six new regions joining the team.

Pilot RHICs

Continue analysis and reporting, increase engagement, and provide mentorship.

Center for Improving Value in Health Care | Colorado
Maine Health Management Coalition | Maine
Midwest Health Initiative | St. Louis, Missouri
Minnesota Community Measurement | Minnesota
Oregon Health Care Quality Corporation | Oregon

Expansion Regions

Implement reporting and build on community engagement.

HealthInsight Utah | Utah
Maryland Health Care Commission | Maryland

Development Regions

Test methods to advance organizational readiness, and resolve barriers for future reporting.

The Health Collaborative | Ohio
The University of Texas Health Science Center at Houston | Texas
Washington Health Alliance | Washington
Wisconsin Health Information Organization | Wisconsin

MINNESOTA HealthScores
When Health Care Improves, Everyone Wins.

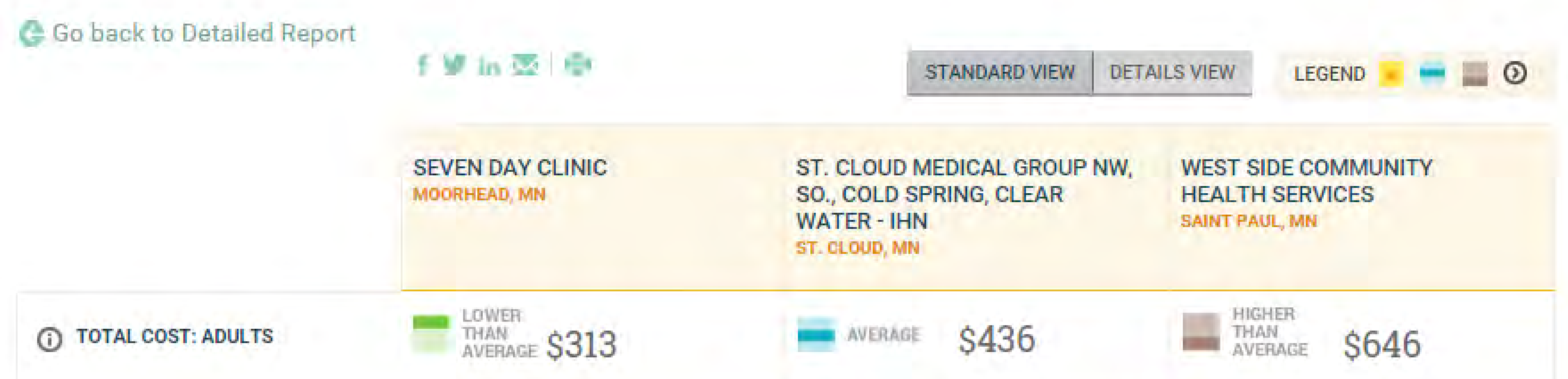
TRANSFORMING HEALTH | MEASURING QUALITY | MANAGING COST | ADVANCING THE FUTURE

Detailed Report – Total Cost: Adults

This display helps you compare the care quality and cost of care ratings for up to three medical groups. If a medical group has no HealthScore rating for a specific measure, it has no reportable information. This could be due to not offering that type of care; having too few patients who received that care; not submitting information; or recently being renamed or closed.

Use the back button in your browser to return to the full list of medical groups and change your selections to compare.

Don't see a health topic you're looking for? It may be a clinic or hospital measure.



Risk Score

	Score
Clinic	1.13
OR Average	1.00

The Clinic Risk Score represents the morbidity burden of a subset of patients in your clinic. Q Corp uses the Johns Hopkins Adjusted Clinical Groupers (ACG) System which measures morbidity burden based on disease patterns, age and gender using diagnoses found in claims data.

Summary by Service Category

	TCI	= RUI	x Price Index
Professional	**1.07**	0.97	1.10
Outpatient Facility	**0.71**	0.72	1.00
Inpatient Facility	**1.10**	0.93	1.19
Pharmacy	**0.88**	0.89	0.99
Overall	**0.95**	0.88	1.07

A Total Cost Index, Price Index or Resource Use Index value greater than 1.00 means the clinic's score is higher than the Oregon average score for the measure.

For more information see the Total Cost of Care Definitions page.

Price vs. Resource Use Comparison

This chart shows your clinic's price and resource use compared to other clinics across Oregon. Clinics that are lower in price and resource use appear in the lower left quadrant.

Q Corp Clinic Comparison Reports Cost Detail

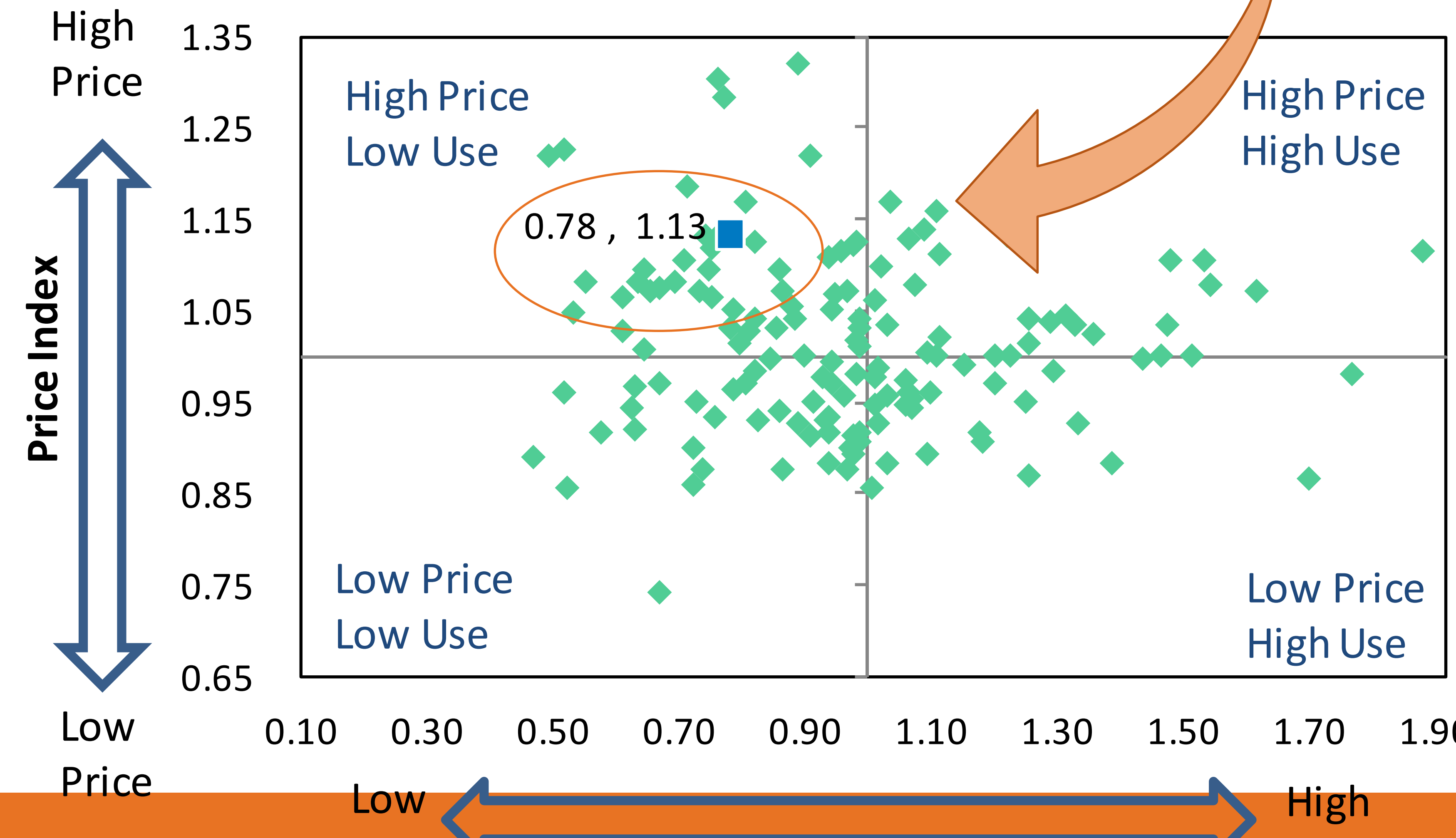
Overall Summary by Service Category

	Clinic Raw PMPM	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	x Price Index
Professional	**$203.02**	**$183.18**	$167.12	**1.10**	0.99	1.11
Outpatient Facility	**$69.00**	**$62.25**	$115.53	**0.54**	0.60	0.90
Inpatient Facility	**$71.08**	**$64.13**	$72.21	**0.89**	0.78	1.13
Pharmacy	**$73.92**	**$66.70**	$69.20	**0.96**	0.98	0.98
Overall	**$417.03**	**$376.26**	$424.06	**0.89**	0.85	1.05

Inpatient PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	x Price Index
Acute Admissions	**$64.13**	$71.93	**0.89**	0.79	1.13
Surgical	**$46.98**	$46.13	**1.02**	0.83	1.22
Medical	**$9.55**	$15.77	**0.61**	0.70	0.87
Maternity	**$4.11**	$8.88	**0.46**	0.40	1.17
Mental Health	**$3.49**	$1.15	**3.04**	3.03	1.00
Non-Acute	**$0.00**	$0.27	**0.00**	0.00	1.00
All Admisssions	**$64.13**	$72.21	**0.89**	0.78	1.13

Inpatient Price vs. Resource Use Comparison by Clinic

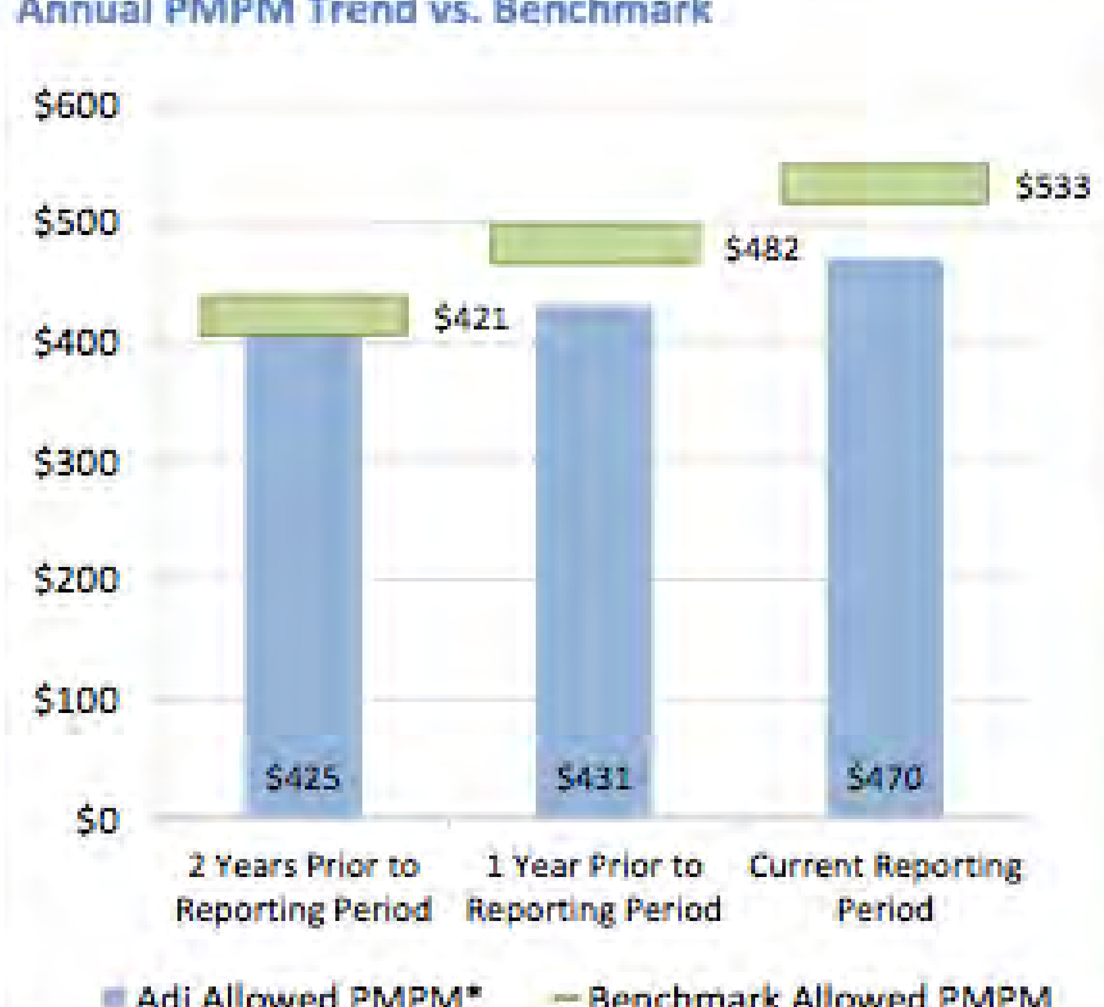


Pr

FAMILY MEDICINE INSTITUTE

Patient Demographics

	Practice	Benchmark Practice[1]
Attributed Patients	1,351	609
Average Age	44.5	38.2
% Male	39.1%	44.8%
% Female	60.9%	55.2%
% Chronic	39.0%	36.9%
% Asthma	7.3%	7.5%
% CAD	3.8%	2.7%
% COPD	2.1%	1.3%
% Diabetes	8.9%	6.8%
% Heart Failure	0.5%	0.5%
% Hyperlipidemia	12.4%	14.8%
% Hypertension	22.4%	19.4%
% Obesity	5.7%	5.5%
% Back Pain	19.2%	15.4%
% Depression	13.2%	12.7%
Retrospective Risk Score*	1.07	1.00
Age-Gender Index	1.13	1.00



*Adj. allowed PMPM and Adj. PMPM indicate retrospective risk adjusted allowed amount, normalized to the Benchmark

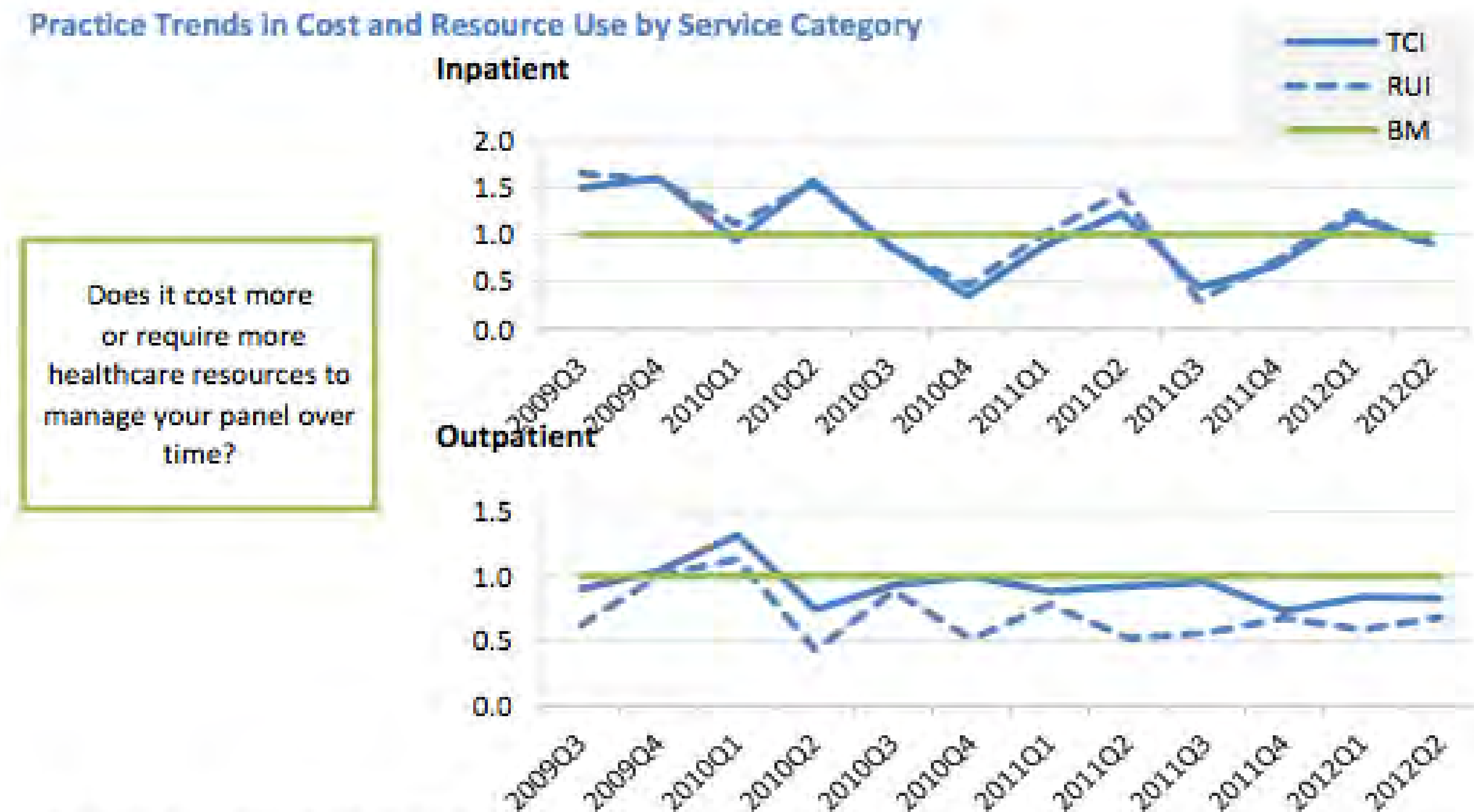
Overall Summary by Service Category

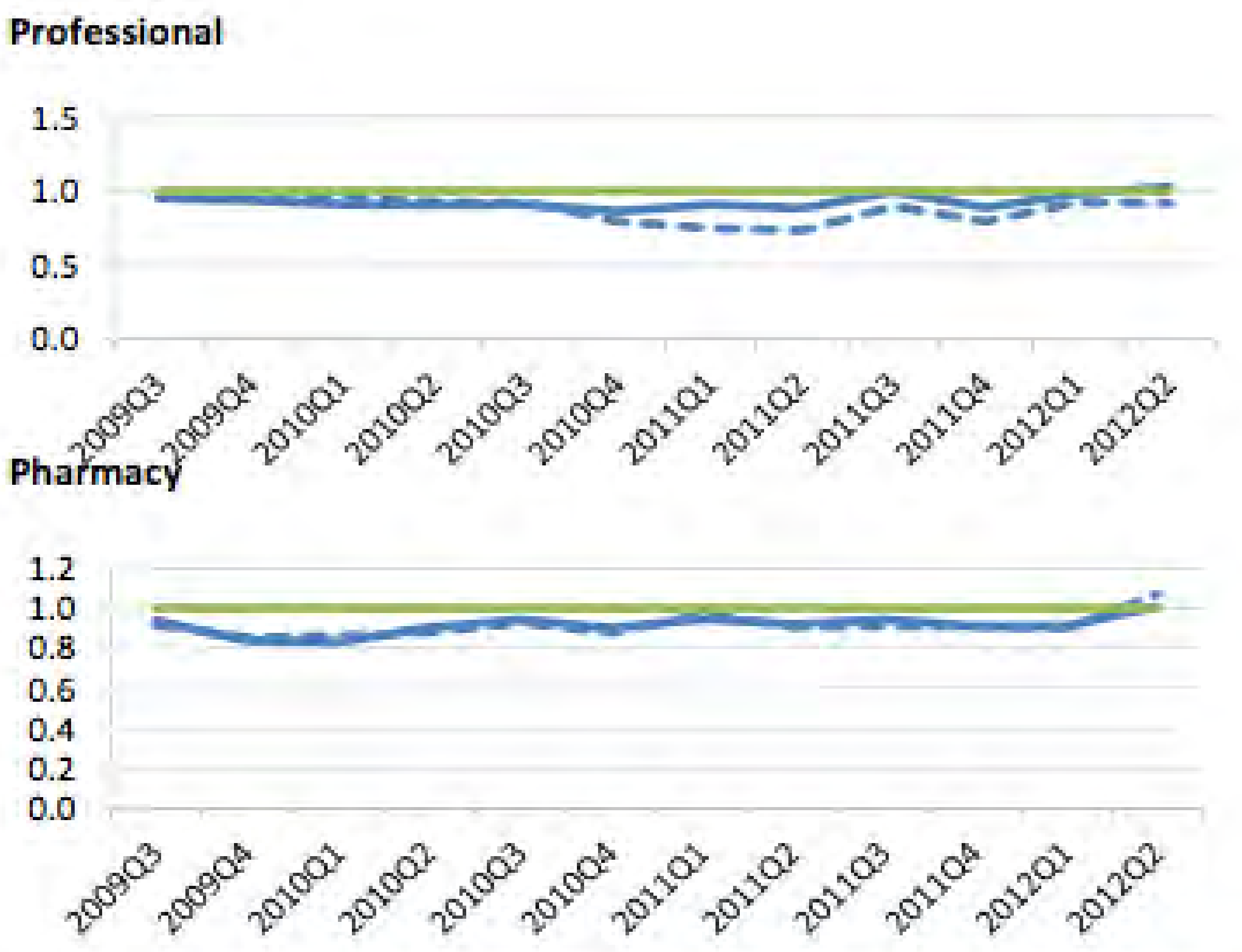
	Practice Raw PMPM	Practice Adj PMPM*	BM[2] PMPM	TCI	RUI
Inpatient Fac.	$82	$77	$98	0.78	0.74
Outpatient Fac.	$175	$164	$196	0.84	0.62
Professional	$152	$142	$146	0.97	0.88
Pharmacy	$94	$88	$93	0.94	0.95
Overall	*$503*	*$470*	*$533*	*0.88*	*0.79*

HealthPartner's Total Cost Index (TCI) & Resource Use Index (RUI): TCI & RUI provide insight into overall cost, practice efficiency & price competiveness.

TCI = Practice Adj. PMPM/Benchmark PMPM
RUI is based on standardized cost for procedures

The benchmark index for TCI or RUI is 1.0. Index values below 1.0 indicate a practice that is delivering services in a more cost or resource-efficient manner than the benchmark. Example: Inpatient Facility TCI = .85 means the practice is 15% more cost-effective than the benchmark.





[1] Benchmark practice reflects all practices receiving report, including your practice.
[2] BM = Benchmark

Please see glossary on Page 7 for details on terminology and calculations

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SEARCH

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Compare Practice Ratings

View on map

Change My Selections

See how your selected Practices compare for Quality ratings:

Low | Good | Better | Best

> Where do these ratings come from?

Adult Care ratings for your selected practices
(Last updated on Wed, 03/09/2016 - 15:26)

Practice	Uses Treatments Proven to be Effective (Overall Rating)	Uses Methods to Make Care Safer	How Patients Have Rated Their Experience	Provides Care at a Reasonable Cost
	What This Rating Means	What This Rating Means	What This Rating Means	What This R
InterMed Internal Medicine - Marginal Way 84 Marginal Way Suite 700 & 800 Portland, ME 04101 (207) 774-5816 > See Rating Detail and Practice Info	Best	Best	Best	Go
Portland Internal Medicine at Baxter Boulevard 43 Baxter Boulevard Portland, ME 04101 (207) 771-1717 > See Rating Detail and Practice Info Integrated Behavioral Health	Did Not Report	Best	Good	Unable to
Falmouth Internal Medicine 75 Clearwater Drive Suite 106 Falmouth, ME 04105 (207) 400-8570 > See Rating Detail and Practice Info	Better	Best	Better	Go

CLOSE

Low - This practice's cost per patient are higher than the average cost in Maine.
Good - This practice's cost per per patient is about the same as they are in most practices in Maine.
Best - This practice's cost per patient are below the average cost for practices in Maine.
Unable to Determine - There is not enough consistent data on this practice to assign a rating.
No Quality Rating - The value of health care services cannot be understood unless patients have both quality and cost information. Since this practice does not report the minimal amount of quality information requested, we do not provide a cost score for them.

Public Reporting

- IHA partners with the California Office of the Patient Advocate to publicly report program results
- As of March 2016, Report card release includes, for the first time, physician organization:
    - Total Cost of Care
    - Medicare Advantage star ratings
- Results are based on MY 2014 performance that was reviewed and finalized last summer

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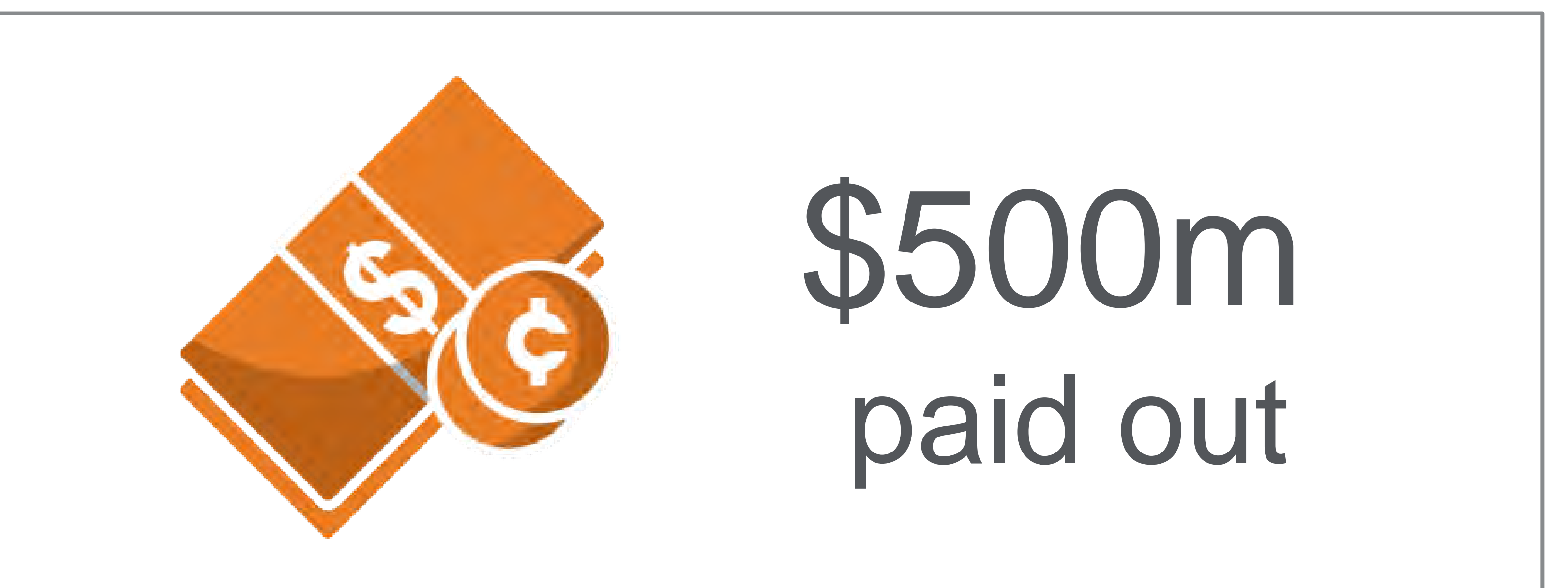
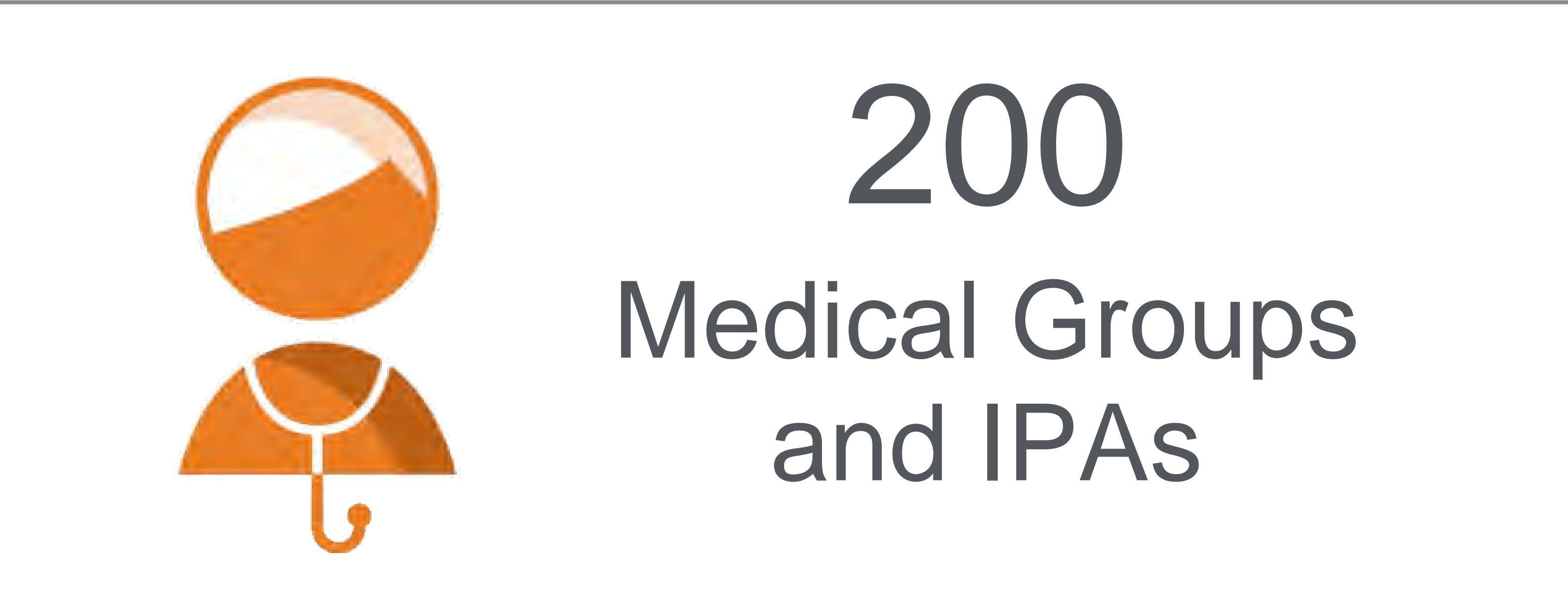
Value Based Pay for Performance





10
Plans

Anthem
BlueCross

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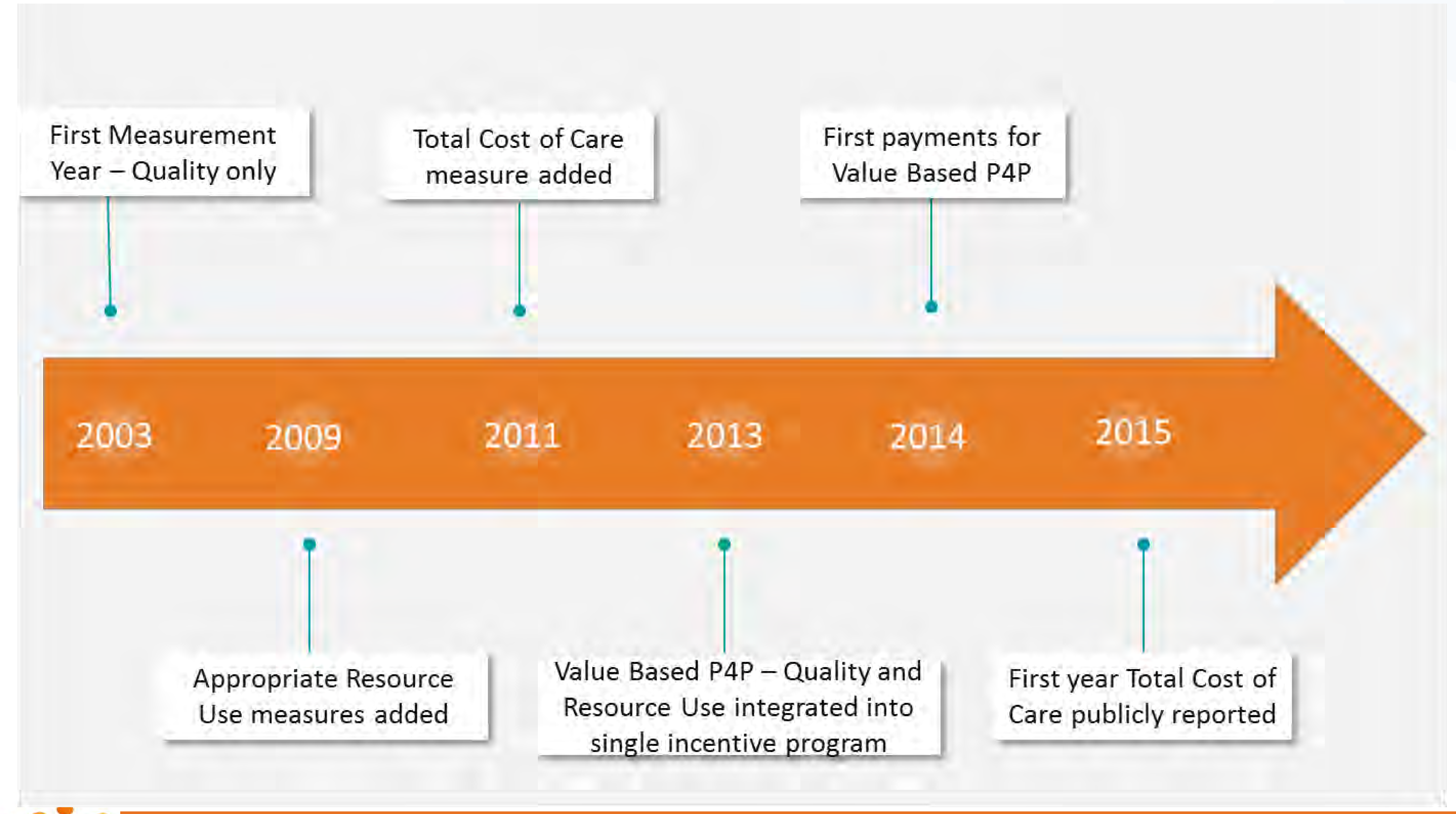
Program Evolution



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Core Program Elements

A Common Set of Measures

Health Plan Incentive Payments

A Public Report Card

Public Recognition Awards

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Value Based P4P Measurement

Clinical (50%)

Process and outcomes measures focused on six priority clinical areas

- Cardiovascular (2)
- Diabetes (7)
- Maternity (0)
- Musculoskeletal (1)
- Prevention (8)
- Respiratory (3)

Patient Experience (20%)

Patient ratings of six components, including care overall:

- Communicating with Patients
- Coordinating Care
- Health Promotion
- Helpful Office Staff
- Overall Rating of Care
- Timely Care and Service

Meaningful Use of Health IT (30%)

- Percent of providers meeting intent of CMS Meaningful Use core requirements
- Ability to report selected e-measures (2)

Appropriate Resource Use

Utilization metrics spanning:

- Inpatient stays
- Readmissions
- ED visits
- Outpatient procedures
- Generic prescribing

Total Cost of Care

Average health plan and member payments associated with care for a member for the year, adjusted for risk and geography

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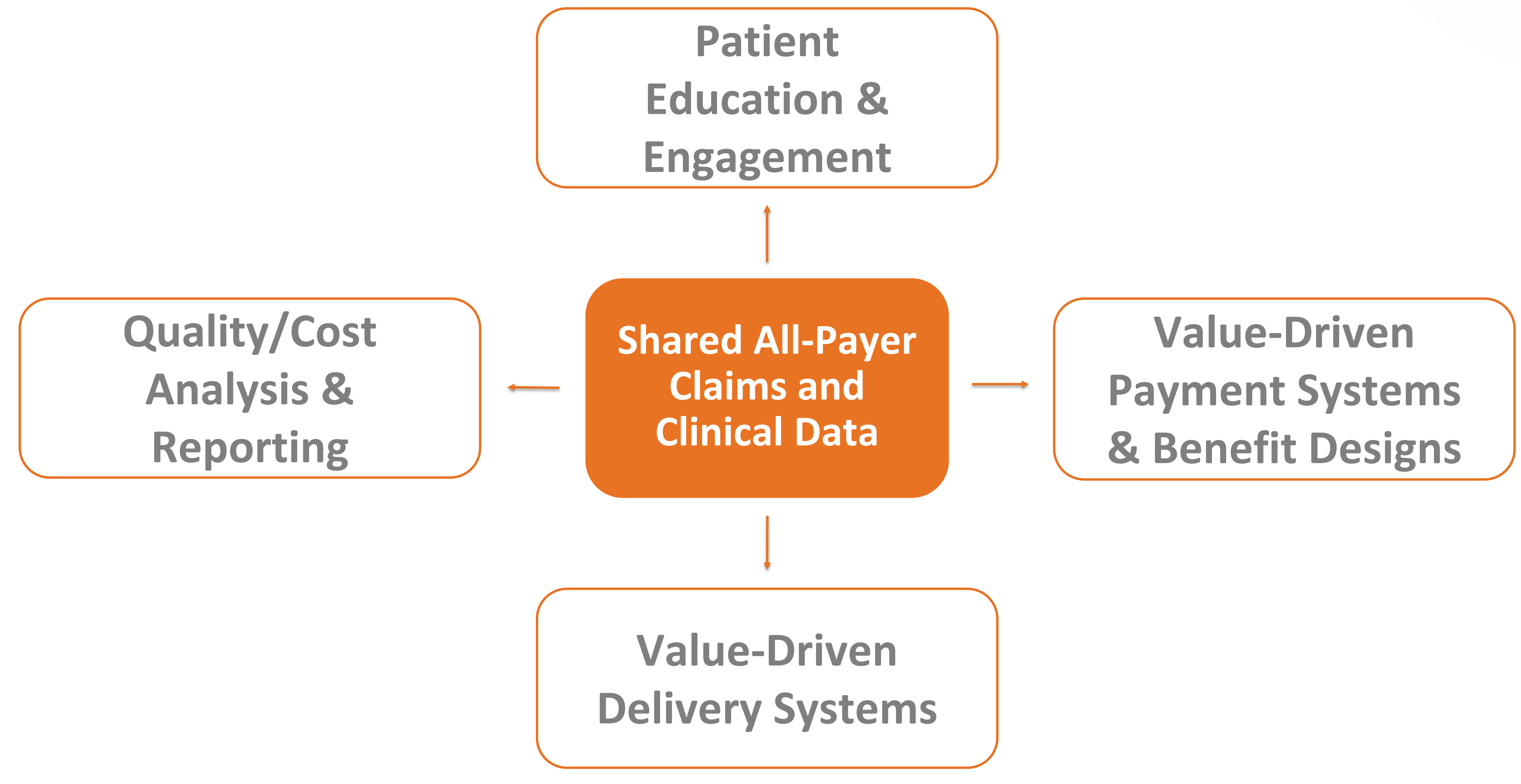
You Can't Manage Populations without Population Data



NRHI Membership

Better Health Partnership
California Quality Collaborative (subsidiar
PBGH)
Center for Improving Value in Healthcare
Community First, Inc.
Finger Lakes Health Systems Agency
Great Detroit Area Health Council (GDAH
Health Insight - Nevada
Health Insight - New Mexico
Health Insight - Utah
Healthcare Collaborative of Greater Colur
Institute for Clinical Systems Improvemer
Integrated Healthcare Association (IHA)
Iowa Healthcare Collaborative
Kentuckiana Health Collaborative
Louisiana Health Care Quality Forum
Maine Health Management Coalition
Maine Quality Counts
Massachusetts Health Quality Partners
Michigan Center for Clinical Systems Impr
Midwest Health Initiative
Minnesota Community Measurement
Mountain-Pacific Quality Health Foundati
(MPQHF)
MyHealthAccess
New Jersey Health Care Quality Institute
North Coast Health Information Network
North Texas Accountable Healthcare Part
Oregon Q Corp
P2 Collaborative (Western NY)
Pacific Business Group on Health
Pittsburgh Regional Health Initiative (PRH
The Health Collaborative (includes: Healt
Collaborative, Greater Cincinnati Health C
and Health Bridge)
Washington Health Alliance
Wellspan (formerly South Central PA)
Wisconsin Collaborative for Healthcare Q
Wisconsin Health Information Organizatio

Thank You

www.nrhi.org

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Q&A?

What questions do you have about the [Data Sharing recommendations]?

What changes or additions to these recommendations would you suggest that would help you implement PBPs in your market?

What value will such recommendations add to the field?

How would you tackle the challenges of data sharing?

What do you see as the most significant barriers to adopting these recommendations?

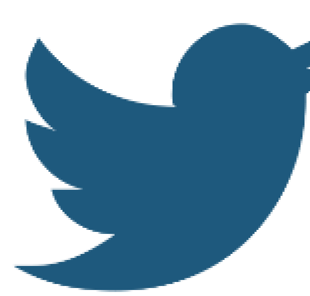
Access the white paper:

(link)

CONTACT US

We want to hear from you!

www.hcp-lan.org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