Data Sharing: Accelerating and Aligning Population-Based Payment Models

April 26, 2016
1:00pm – 2:15pm
WELCOME

David Muhlestein, PhD, JD
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
Member
PBP Work Group
National Medical Director
Aetna

Elizabeth Mitchell
Member
PBP Work Group
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?
Andy Baskin
Member
PBP Work Group
National Medical Director
Aetna
Frank Opelka, MS, FACS
Member
Guiding Committee
Executive VP
Louisiana State University System
Medical Director, Quality and Health Policy
American College of Surgeons
PANEL SPEAKER

Elizabeth Mitchell
Member
PBP Work Group
President and Chief Executive Officer
Network of Regional Healthcare Improvement
APM Framework

**CMS Framework for Payment Models**


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**

Category 1: Fee for Service – Link to Value
- Pure FFS

Category 2: Fee for Service – Link to Quality
- Pay for Performance
- APMs w/ downside & upside risk

Category 2a: Pay for Reporting
- APMs w/ downside & upside risk

Category 3: Alternative Payment Models Built on Fee-for-Service Architecture
- Category 3a
- Category 3b

Category 3a: Population-Based Payment
- APMs w/ downside & upside risk

Category 3b: Population-Based Payment
- APMs w/ downside & upside risk

Category 4: Population-Based Payment

**Require Aggregated Data**

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.

Expansion Regions
Implement reporting and build on community engagement.

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

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

HealthInsight Utah | Utah
Maryland Health Care Commission | Maryland

The Health Collaborative | Ohio
The University of Texas Health Science Center at Houston | Texas
Washington Health Alliance | Washington
Wisconsin Health Information Organization | Wisconsin
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.
The Clinic Risk Score represents the morbidity burden of a subset of patients in your clinic. O.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.

<table>
<thead>
<tr>
<th>Summary by Service Category</th>
<th>TCI</th>
<th>RUI</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>1.07</td>
<td>0.97</td>
<td>1.10</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>0.71</td>
<td>0.72</td>
<td>1.00</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>1.10</td>
<td>0.93</td>
<td>1.19</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0.88</td>
<td>0.89</td>
<td>0.99</td>
</tr>
<tr>
<td>Overall</td>
<td>0.95</td>
<td>0.88</td>
<td>1.07</td>
</tr>
</tbody>
</table>

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.

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

<table>
<thead>
<tr>
<th></th>
<th>Clinic</th>
<th>OR Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw PMPM</td>
<td>Adj PMPM</td>
<td>PMPM</td>
</tr>
<tr>
<td>Price</td>
<td>Price</td>
<td>Price</td>
</tr>
<tr>
<td>Professional</td>
<td>$203.02</td>
<td>$183.18</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>$69.00</td>
<td>$62.25</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$71.08</td>
<td>$64.13</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$73.92</td>
<td>$66.70</td>
</tr>
<tr>
<td>Overall</td>
<td>$417.03</td>
<td>$376.26</td>
</tr>
</tbody>
</table>

### Inpatient PMPM by Service Category

<table>
<thead>
<tr>
<th></th>
<th>Clinic</th>
<th>OR Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adj PMPM</td>
<td>PMPM</td>
<td>TCI = RUI × Index</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>$64.13</td>
<td>$71.93</td>
</tr>
<tr>
<td>Surgical</td>
<td>$46.98</td>
<td>$46.13</td>
</tr>
<tr>
<td>Medical</td>
<td>$9.55</td>
<td>$15.77</td>
</tr>
<tr>
<td>Maternity</td>
<td>$4.11</td>
<td>$8.88</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$3.49</td>
<td>$1.15</td>
</tr>
<tr>
<td>Non-Acute</td>
<td>$0.00</td>
<td>$0.27</td>
</tr>
<tr>
<td>All Admissions</td>
<td>$64.13</td>
<td>$72.21</td>
</tr>
</tbody>
</table>

### Inpatient Price vs. Resource Use Comparison by Clinic

- **High Price, Low Use**: 0.78, 1.13
- **Low Price, High Use**: 0.78, 1.13

### Resource Use Index (RUI)

- **Other Oregon Clinics**: Low Use - High Use
- **Clinic**: Low Use - High Use
NRHI

FAMILY MEDICINE INSTITUTE

Patient Demographics

<table>
<thead>
<tr>
<th>Attributed Patients</th>
<th>Practice</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,851</td>
<td>609</td>
</tr>
<tr>
<td>Average Age</td>
<td>44.5</td>
<td>38.7</td>
</tr>
<tr>
<td>% Male</td>
<td>39.1%</td>
<td>44.8%</td>
</tr>
<tr>
<td>% Female</td>
<td>60.9%</td>
<td>55.2%</td>
</tr>
<tr>
<td>% Chronic</td>
<td>39.0%</td>
<td>36.9%</td>
</tr>
<tr>
<td>% Asthma</td>
<td>7.3%</td>
<td>7.5%</td>
</tr>
<tr>
<td>% CAD</td>
<td>8.8%</td>
<td>8.7%</td>
</tr>
<tr>
<td>% COPD</td>
<td>2.1%</td>
<td>1.8%</td>
</tr>
<tr>
<td>% Diabetes</td>
<td>8.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>% Heart Failure</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>% Hypertension</td>
<td>12.4%</td>
<td>14.8%</td>
</tr>
<tr>
<td>% Hypothyroidism</td>
<td>22.4%</td>
<td>13.4%</td>
</tr>
<tr>
<td>% Obesity</td>
<td>5.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>% Back Pain</td>
<td>19.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>% Depression</td>
<td>13.2%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Retrospective Risk</td>
<td>1.07</td>
<td>1.00</td>
</tr>
<tr>
<td>Age-Gender Index</td>
<td>1.23</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Annual PMPM Trend vs. Benchmark

2 Years Prior to Reporting Period | $4421 | $4421 | $4421 | $4421
1 Year Prior to Reporting Period  | $4482 | $4482 | $4482 | $4482
Current Reporting Period          | $4470 | $4470 | $4470 | $4470

Overall Summary by Service Category

<table>
<thead>
<tr>
<th>Practice</th>
<th>BM²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw PMPM</td>
<td>Adj</td>
</tr>
<tr>
<td>PMPM</td>
<td>PMPM</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$82</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$173</td>
</tr>
<tr>
<td>Professional</td>
<td>$312</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$94</td>
</tr>
<tr>
<td>Overall</td>
<td>$503</td>
</tr>
</tbody>
</table>

Health/Partner’s Total Cost Index (TCI) & Resource Use Index (RIJ)

TCI & RIJ provide insights into overall cost, practice efficiency & price competitiveness.

TCI = Practice Adj. PMPM/Benchmark PMPM

RIJ is based on standardized cost for procedures.

The benchmark index for TCI or RIJ 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: Practice Facility TCI = 0.85 means the practice is 15% more cost-effective than the benchmark.

Practice Trends In Cost and Resource Use by Service Category

Does it cost more or require more healthcare resources to manage your panel over time?

Inpatient

Outpatient

Professional

Pharmacy

1 Benchmark practice reflects all practices receiving report, including your practice.

2 BM = Benchmark
### Compare Practice Ratings

See how your selected practices compare for Quality ratings:

- **High**
- **Good**
- **Better**
- **Best**

> Where do these ratings come from?

Adult Care ratings for your selected practices.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Location</th>
<th>Overall Rating</th>
<th>Uses Treatments Proven to be Effective</th>
<th>Uses Methods to Make Care Safer</th>
<th>How Patients Have Rated Their Experience</th>
<th>Provides Care at a Reasonable Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interomed Internal Medicine - Marginal Way</td>
<td>94 Marginal Way, Suite 206 &amp; 800 Portland, ME 04101 (207) 774-5818</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portland Internal Medicine at Baxter Boulevard</td>
<td>43 Baxter Boulevard Portland, ME 04101 (207) 771-1717</td>
<td>Did Not Report</td>
<td>Best</td>
<td>Good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falmouth Internal Medicine</td>
<td>75 Oldwater Drive Suite 106 Falmouth, ME 04105 (207) 400-6573</td>
<td>Better</td>
<td>Best</td>
<td>Better</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Low** - This practice’s cost per patient is higher than the average cost in Maine.

**Good** - This practice’s cost 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.
Value Based Pay for Performance

- $500m paid out
- 200 Medical Groups and IPAs
- 10 Plans
- 9 Million Californians
Core Program Elements

- A Common Set of Measures
- Health Plan Incentive Payments
- A Public Report Card
- Public Recognition Awards
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
You Can’t Manage Populations without Population Data

Patient Education & Engagement

Quality/Cost Analysis & Reporting

Shared All-Payer Claims and Clinical Data

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems

Patient Education & Engagement

Shared All-Payer Claims and Clinical Data

Value-Driven Payment Systems & Benefit Designs

Value-Driven Delivery Systems
NRHI Membership

Better Health Partnership
California Quality Collaborative (subsidiary of 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 Columbus
Institute for Clinical Systems Improvement
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 Improvement
Midwest Health Initiative
Minnesota Community Measurement
Mountain-Pacific Quality Health Foundation (MPQHF)
MyHealthAccess
New Jersey Health Care Quality Institute
North Coast Health Information Network
North Texas Accountable Healthcare Partnership
Oregon Q Corp
P2 Collaborative (Western NY)
Pacific Business Group on Health
Pittsburgh Regional Health Initiative (PRHI)
The Health Collaborative (includes: Health Collaborative, Greater Cincinnati Health Council and Health Bridge)
Washington Health Alliance
Wellspan (formerly South Central PA)
Wisconsin Collaborative for Healthcare Quality
Wisconsin Health Information Organization

NRHI Members
Thank You

www.nrhi.org
#healthdoers
twitter: @RegHealthImp
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)
We want to hear from you!

www.hcp-lan.org

@Payment_Network

PaymentNetwork@mitre.org

Search: Health Care Payment Learning and Action Network

Search: Health Care Payment Learning and Action Network