Virtual Meeting Track 2: Data Sharing and Infrastructure

Maternity Multi-Stakeholder Action Collaborative

July 7, 2017

1:00-2:00pm ET

Highlights and Key Takeaways

MAC members participated in the virtual meeting for Track 2: Data Sharing and Infrastructure. Below are highlights and key takeaways from the interactive meeting, which included live interviews with Jack Feltz, MD, CEO, and Karen Ryer, COO, both from Lifeline Medical Associates which is a provider practice that participates with Horizon Blue Cross Blue Shield of New Jersey's maternity episode model. Both discussants shared their experiences with data sharing between providers and health plans, to provide MAC participants with a better understanding of how payers can support practices, not just in providing reports but in providing assistance in understanding the information that is being transmitted.

Useful Data for Providers

Providers need access to the following data to be able to successful:

- **Overall cost performance** information to assess how they are performing relative to a budget or threshold. There needs to be some means for a practice to determine how they are doing financially relative to the expectations that have been established for them to be financially rewarded.
- **Overall quality performance**, to the extent that quality is integrated into the payment model. There needs to be information on how the practice is performing on the quality measures being utilized, and a comparison of their performance relative to the benchmarks that have been established for those quality measures.
- **Detailed cost performance** information to allow providers to understand their performance on a per-episode basis and across episodes in terms of the profile of care delivery and medical expense within the practice and relative to other practices. This is an essential utility and probably where practices need to have the most sophistication, either in doing data analysis and manipulation themselves, or in understanding the manipulated data that is provided to the practice by the payer or third party.
- **Calculations** on whether the practice will receive any shared savings payment or will have financial liability. That calculation can be made available over the course of the year as episodes end and at the end of the contractual performance period to summarize the provider's performance.

Sharing data is important, but it is also important that providers know how to use the data. There needs to be education for providers on how to read reports and interpret data so providers can better use the information to inform action and make changes in care delivery patterns.

Sample Cost Reports

The State of Tennessee distributes an annual report produced at the end of the performance period to providers participating in any of their episode programs, not just their maternity care program. In Figure 1 below, the *Overview* relates the total number of episodes for the performance period, as well as the number of episodes included and excluded based on the episode definition. The *Cost of Care Comparison* section allows the provider to see what it's average cost looks like and what that is relative to the threshold which Tennessee is using. During the previous virtual session on *Setting the Episode Budget*, we discussed how Tennessee's model is able to share in savings if the providers fall below a certain threshold. In this particular example, the threshold is $5,000 and this practice has an average cost of $4,298, so they fall in the commendable range meaning they are able to share in any savings as long as they also

perform well on certain quality measures. On this report, the calculation of money that is eligible for gain sharing is shown in the right corner as $81,783.

Figure 1

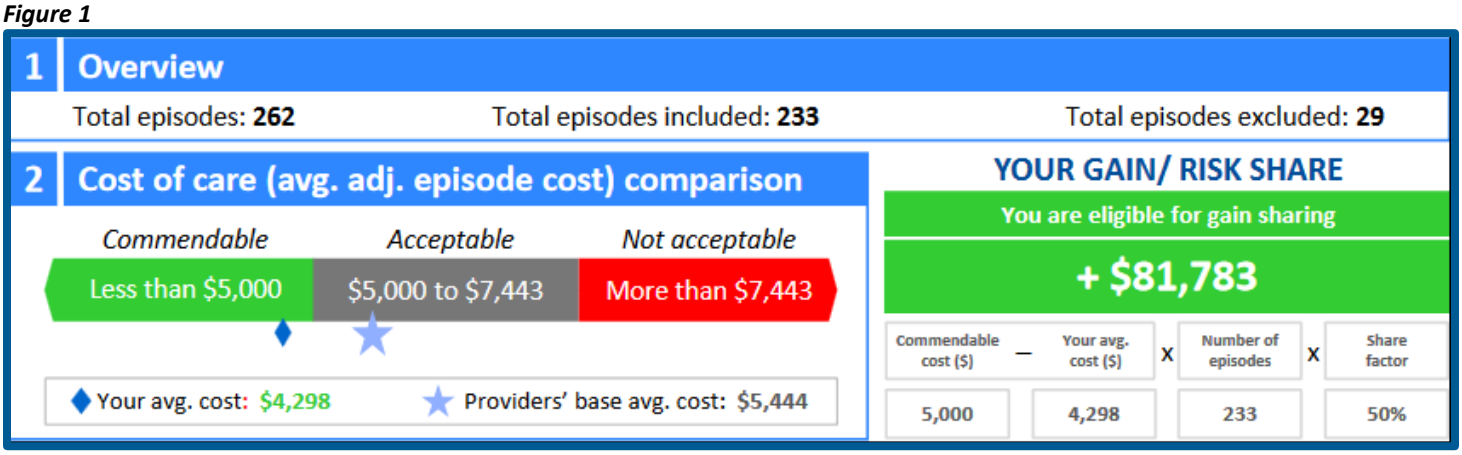


Figure 2 shows how the State of Tennessee reports cost distribution. The risk adjusted episode cost distribution chart for a provider shows a frequency distribution from a range starting below $4,000 to above $6,500. From this report, a provider is able to dig deeper into what is happening in episodes at certain price points. For example, they can analyze all episodes costing more than $6,000 to determine who those patients are, what services they received, and if there are any opportunities for improvement within those individual cases. Figure 3 shows where the individual provider stands relative to all of the other providers that might be participating in the episode program. In Tennessee's model, providers are grouped into three categories: Commendable, Acceptable, and Not Acceptable. Those in the Commendable range share in savings, and those in the Not Acceptable range have to share financial responsibility for going above the acceptable range.

Figure 2

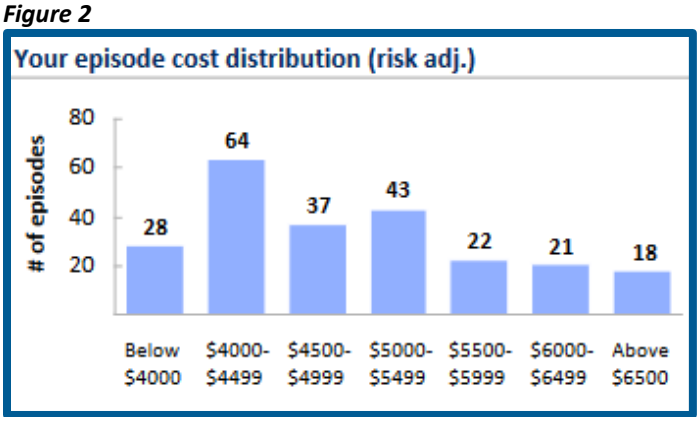


Figure 3

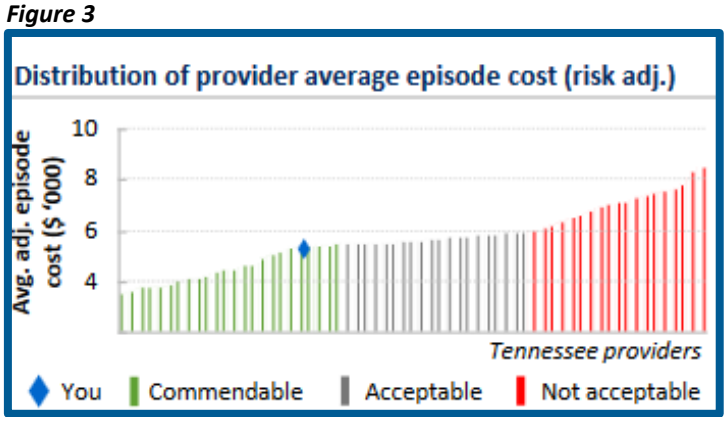
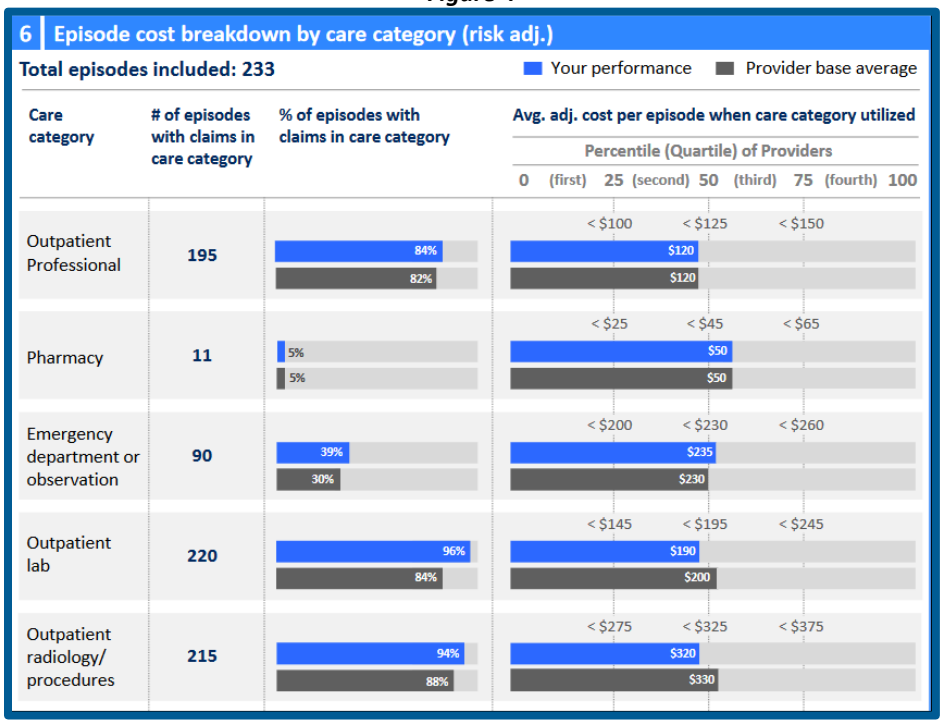


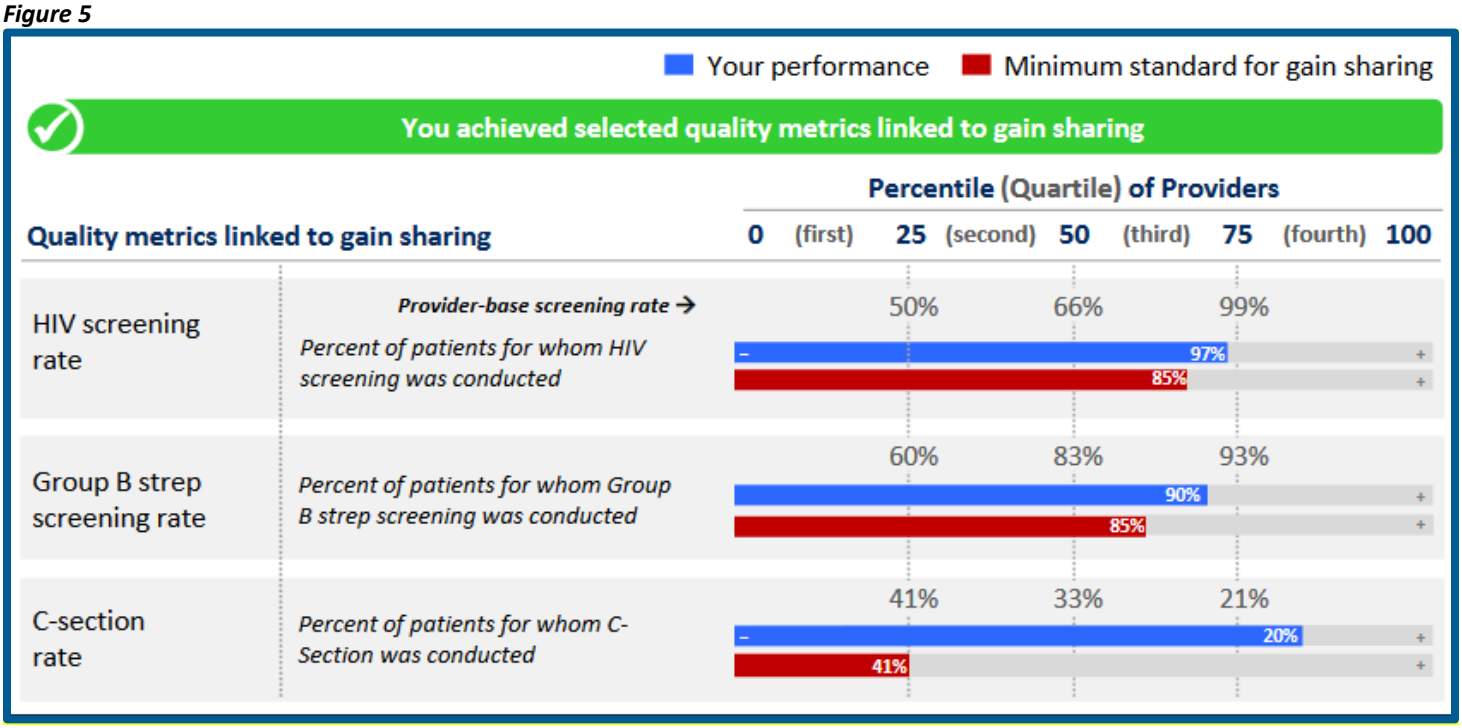
Figure 4 shows the risk adjusted cost breakdown by care category for different services that help make up the episodes. Reading from left to right you can see the care category (e.g. outpatient professional), how many episodes with claims the provider had in that category, the percentage of episodes with claims in that care category, and comparisons to other providers. Providers who notice that their performance varies greatly from the provider base average can use this report to identify, in a focused manner, where there are potential opportunities for improvement in performance.

Figure 4



The State of Tennessee also has a report which looks at quality instead of cost. Figure 5 below shows how providers receive information on their performance on three maternity quality measures in comparison to other providers. The red bar indicates minimum expected performance for a provider to retain any financial gains that are generated. Relating this information to Figure 1, we saw that this provider would potentially earn $81,783 if the provider's quality performance met or exceeded minimum standards for gain sharing. According to the blue bar performance, the provider's performance exceeded the minimum expectation for gainsharing for the measures.

Figure 5



Another example of provider reports comes from Community Health Choice, a Medicaid Managed Care Organization in Houston, Texas. Community Health Choice includes the newborn in their episode model and defined three component parts within their episode model: pregnancy, delivery, and newborn care. The sample report shown in Figure 6 provides individual patient level information such as patient name, episode start and end date, and risk adjusted and non-risk adjusted costs. These reports also have color coded information, with green indicating where costs for individual episodes are below the average and orange indicating where costs are above the average.

Figure 6

Total episodes included: 233

Less than provider base average cost | More than provider base average cost

Episode ID	Patient Name	Episode start date	Episode end date	Date of birth	Total risk adjusted cost	Episode risk factor	Non-adjusted cost	Outpatient Professional Cost	Outpatient Professiona # claims
AVG_B	Provider Base Average				$5,444.25	1.13	$6,152	$136	
AVG_Y	Your Average				$4,298.36	1.22	$5,244	$146	
NPI:	1000000002	Provider Name:	HCFALast, HCFAFirst		$3,919	0.99	$3,893	$139	
3000000	Juniper Pink	02/13/2012	10/02/2012	11/29/79	$3,807	1.03	$3,921	$137	2
4000000	Green Forest	03/07/2012	10/07/2012	01/21/88	$4,105	1.00	$4,105	$161	2
1000000	Jeaux Health	02/21/2012	10/11/2012	08/21/77	$3,569	1.01	$3,605	$125	2
2000000	Jazmyn Care	02/14/2012	10/03/2012	11/13/81	$3,776	0.98	$3,700	$114	2
6000000	Lara Croft	02/15/2012	11/04/2012	04/20/90	$3,882	1.01	$3,921	$137	2
5000000	Joley Foley	03/19/2012	11/10/2012	07/07/93	$4,064	1.01	$4,105	$161	2

Finally, Figure 7 shows another version of Community Health Choice's reports. The information provided in this report is patient level information, including both the mother and the newborn. For the first episode listed on this report, the budget was $11,252 and the actual spend was $70,261, so this episode was way above budget. On the next two rows, the actual episode costs were below budget. As mentioned before, the budgets for this health plan are summed up into

a total budget, but there are the three component elements of the newborn budget, the delivery budget, and the pregnancy budget. The report allows a provider to determine where they may be going over budget among those three component budgets and identify opportunities for improvement.

Figure 7

Member #	Member Id	Newborn ID	Facility ID	Newborn 1 Nursery Level	Sum of Total_Budget	Total Spend	Newborn Budget	Newborn 1 Costs	Newborn 2 Costs
11111	321145	123456789	1	4	$ 11,252.0	$ 70,261	$ 3,109	$ 49,176	
11112	456654	987654321	2	1	$ 11,322.3	$ 8,685	$ 3,109	$ 879	
11113	789987	654987312	2		$ 7,094.5	$ 7,355	$ 2,018	$ 174	
Grand Total					$ 29,668.8	$ 86,301.4	$ 8,236.0	$ 50,228.8	$ -

Delivery Budget	Delivery Total	Pregnancy Budget	Pregn Total	Difference (Actual-Budget)	Number of Records
$ 5,148	$ 13,211	$ 2,995	$ 7,874	$ 59,009	1
$ 5,865	$ 5,334	$ 2,348	$ 2,472	-$ 2,637	1
$ 4,470	$ 6,823	$ 607	$ 358	$ 261	1
$ 15,482.5	$ 25,368.1	$ 5,950.3	$ 10,704.5	$ 56,632.6	3

Useful Data for Payers

The approach a payer might take when distributing this information might vary based on whether the payer has implemented many different episodes, or whether the payer is implementing just the maternity episode alone. Community Health Choice is an example of a payer who implemented just the maternity episode, and they are using a less complicated software program. Tennessee is an example of a payer with many different clinical episodes, and therefore it makes sense for them to invest in and engage with external vendors that have specialty software that helps support this type of analysis. However, it is not necessary to create sophisticated analytics using specialty software in order to share data with providers and determine where opportunities for improvement exist.

Interview: Experience Sharing Data and Building Infrastructure (Lifeline Medical Associates)

The expert discussants joining this session, Dr. Jack Feltz and Karen Ryer, both work for Lifeline Medical Associates, an integrated women's health care practice in New Jersey that is operating under a maternity episode-based payment contract with Horizon Blue Cross Blue Shield of New Jersey. The discussion for this session will focus on what data is important to providers, and how they use the data to track progress and improve care.

- **Question 1:** Why did Lifeline Medical Associates decide to implement maternity episode bundles?
    - About 3 years ago, our practice began looking for opportunities to migrate away from the fee-for-service model toward value-based payment models. Episodes of care seemed like a practice-friendly way of accomplishing this, so when Horizon BCBS invited us to participate, we saw that as an opportunity to provide our patients with better, more cost-effective care.
    - The reason this approach was more "practice-friendly" was because there was equal partnership. We worked together to develop the contracts and discuss the analytics of the model to ensure it would be successful and provide our patients better, more affordable care. Horizon BCBS did not present a pre-defined episode, rather it was developed based on practice experience and health plan experience.
- **Question 2:** Now that you have been operating in this model for a few years, how would you describe your overall experience?
    - Working with Horizon BCBS has been a great experience for Lifeline Medical Associates. We have learned a lot working together with the health plan.
    - From a shared-savings perspective, I would describe the experience so far as moderately successful. One of the currently limitations is that we don't have granular data for each provider's performance, but

we are working together with Horizon BCBS and believe we will have data that allows us to better measure performance at a practitioner level and practice level by the end of next quarter.

- **Question 3:** Have you considered entering similar episode-based payment arrangements with other payers?
    - We are currently discussing this option with various other payers. Lifeline Medical Associates is a part of the U.S. Women's Health Alliance, which is an organization working with national payers to encourage maternity episodes of care at a national level. We believe that having a comprehensive, homogenous program, where all providers and patients use the same model, will reduce the discrepancies that develop from providers using a variety of payers' models.
- **Question 4:** What type of data are you receiving from Horizon BCBS today, and how will that change as you begin being able to look at practitioner level data?
    - Episodes of care are about symphony of care on how pregnancy is truly managed. We began by creating a clinical pathway that provides a basic path to follow to succeed with providing patients with better care and reducing costs. We don't use individual data points as much as overall clinical guidelines to determine who is an outlier in different areas of care so we know where best to direct education. We use data we created ourselves for this analysis since health plans don't have the ability to provide this data, and we analyze how we are practicing against clinical guidelines and care guidelines, not just quality and cost metrics.
    - We developed our clinical pathways concurrently while entering into the Horizon BCBS agreement. We used guidelines from the Society for Maternal-Fetal Medicine (SMFM) and the American Congress of Obstetricians and Gynecologists (ACOG), that we distilled into manageable clinical pathways so all participating clinicians are providing pregnancy care in the same way in order to reduce variation to quality and cost. This includes clinical pathways for the care of comorbidities such as managing diabetes and hypertension during pregnancy. We are in the process of marrying the developed clinical pathways data with the claims data provided by the health plan, which is high level data for the entire practice. Data from the health plan includes the number of patients in the episode, cesarean rates, and the number of ultrasounds to name a few areas. This data does not currently provide individual practitioner performance data within the episode. Once we have the whole program in place, we will be able to use the care pathway data, quality metrics, cost data, and use all of that to educate providers.
    - The output of the data they have provided to us has also evolved over the past three years. For example, the first quarter of data was in a PDF format, one page per patient. They quickly realized that we couldn't manipulate and use data provided in that format, so we worked together to develop spreadsheets for the data. Horizon BCBS has been very open to changes, their partnership has been key in this process.
- **Question 5:** What is the process you used to develop clinical pathways to standardize care delivery for your large volume of providers?
    - With 150 providers, it is challenging and is still a work in progress, but most of our partners believe they can become better doctors by using these clinical pathways.
    - Our partners provide feedback on the clinical pathways, including what they would like to see added or removed, and we have an open discussion at the committee level, board level, and our partnership level, so everyone feels empowered to improve care. We learn from each other and are able to provide more consistent, cost-effective care. We believe the actual practice of medicine, not just watching the specific metrics, is what drives improvement.
- **Question 6:** Has Horizon BCBS helped you understand and use the data they provide to you?

- Horizon BCBS provides us with the claims data they have access to, and we are working with a separate project to build in the quality piece, which is not easy data for a health plan to gather. We have been asking Horizon BCBS for very specific data points which they may not have out of the box. They are trying to put together a tool with that information so we can look at more than just five or six metrics and actually look at every point along the care continuum of the patient to understand if there is appropriate utilization and cost-effective care at every single point from the beginning of pregnancy until postpartum.
- We also receive data from a multitude of hospital systems, specialties, and sub-specialties to allow us to analyze costs at the provider level. From this data, we can further determine hospital and utilization costs.

- **Question 7:** What resources do you need to be able to analyze either the data that you receive or the data that you generate on your own?
  - We currently use in-house resources. It can be burdensome work, especially tying in the quality metrics. We are working with the US Women's Health Alliance as well, and we are aggregating data from our EHR, not our claims data, and running that data through the same quality metrics. This is being done with multiple EHRs throughout our alliance, and we are trying to normalize and aggregate the data through this strenuous process, so as we enter into additional programs with other carriers, there will be the need for additional resources.
  - Horizon has been very willing to work with us and help with some of the analytical work. They benefit from this work as well because they can use what they learn from us to assist their other groups they want to bring into the program.
- **Question 8:** Does Horizon BCBS provide dedicated staff to work with you?
  - They do. We are currently working with them on a project where they are having a difficult time accurately identifying the estimated date of delivery for a patient. This information is in the patient's chart, but not in a claim, so we are determining how to exchange this data because it makes a difference for the quality metrics.
- **Question 9 [Question from MAC Participant Annette Pounders]:** It is challenging to gather information from hospitals. To what extent is this an issue or not an issue for you?
  - This is a big issue for us right now. We are receiving the claims data, but the EHR data is the challenge because it is so difficult to pull data out. Our EHRs do not record the information from a hospital system, so through our ACO, we've been discussing a few of these issues with our main hospital system.
  - We are working on a project now that will eventually allow us to see the whole picture of care rendered to patients. This will be accomplished through EHR interoperability which allows us to have point-to-point exchanges and the bi-directional ability to look at hospital information as well as allowing the hospital to look at office information. The big challenge with this project is that a lot of the information we are asking for from hospitals is proprietary.
- **Question 10:** Some ACOs view episodes as "taking savings" from the ACO, explain how your ACO views episode-based contracts.
  - ACOs do sometimes view it that way, however, I am the Medical Director of the specialist engagement project at the ACO and I have had a few discussions with the finance team about this topic. The explanation I give is that this is a whole transition and you have to learn how to get a little smaller before you can grow. They are beginning to recognize that episodes aren't intended to strip mine a hospital of services, but they are intended to create appropriate utilization, and with that appropriate utilization we will be creating cost-effective, high quality institutions which provide more value to

employers and health plans. Also, the beds will be filled with the appropriate patients receiving the appropriate services.

- **Question 11**: Based on your experience over the last three years, what recommendations would you make to provider organizations, states, and health plans considering pursuing episodes?
    - First, keep it simple. From the corporate level, there needs to be detail and an understanding of the sense of gravity of this work to show that we are creating models that are fair for the providers and also sustainable for the employers and health plans. But when you start making the message that complex to providers on an individual level, it becomes overwhelming. Providers already have the complexity of practicing medicine, and adding in this next level of detail will make the episode fail. Create the simplest model you can, where a clinician can continue to provide great care to patients without needing to understand the data analytics piece.
    - For provider organizations, make it all about patient care, not the shared savings or the bonuses. The money discussion can be helpful because you will expend resources in this process, but for providers, it all comes back to providing the best care to patients. By developing care guidelines and clinical pathways that provide the best care, while being conscious of where you are spending money, in the end the data is only going to show how well you did.
    - From a health plan point of view, emphasize the importance of partnership, this is not a top-down or bottom-up approach, this is a partnership. Also, be creative. When migrating toward APMs and episodes, health plans need support financially, and support with thinking outside of the box. They tend to believe either "we're not ready for this model", or "we're concentrating on this other project", and this frustrates providers who are being told they need to move away from fee-for-service models, but then there are no other models for them to work within. Health plans should be open to the idea of working together with providers to design these models.
- **Question 12 [Question from MAC Participant Annette Pounders]:** Did you redesign your physician compensation model in order to get better cooperation or did you struggle getting physician cooperation?
    - In the beginning, we did struggle with physician cooperation because most physicians, including myself, work hard and believe we are doing the best we can. These models tend to make you look deep inside yourself and say maybe I'm not doing the best I can, maybe there is another way, so the initial reaction is "what else do you want of me?".
    - A few years ago, the initial reaction was that this process was only about creating a system where health plans are given more of a burden of the responsibility. That viewpoint has changed. Our board and committees have seen the interaction and partnership with the health plans we are working with, and many of the original fears and predicted challenges didn't occur. Providers at Lifeline Medical Associates and across the alliance now share the enthusiasm for what is possible.

Appendix: Interactive Poll Results

Data Sharing and Infrastructure Poll Questions

Data Sharing and Infrastructure Poll Question	Participant Response	Total Percent
What is the greatest data sharing challenge that you experience or foresee?	Lack of infrastructure	44%
	Delayed receipt of reports	11%
	Too little information	11%
	Too much information	0%
	Confusing analysis/Not intuitive	0%
	Unsure how to use data	33%
	Other	0%
What data are most critical to supporting a maternity episode model?*	Overall cost (per episode)	30%
	Overall cost (specific codes)	50%
	Quality metrics	60%
	Comparison to other providers	40%
	Analysis of areas for improvement	50%
	Other	0%

* Participants had the option to choose more than one response for these questions, therefore results do not equal 100%