Milestone 6 - Data Support to Practices Greater Philadelphia
Thursday, May 3rd

DISCERN HEALTH
Data Aggregation in Greater Philadelphia for CPC+
Greater Philadelphia is focused on Milestone #6 for 2018

CPC+ Payer Partner Collaboration Roadmap

10 Aligned Milestones

“We Are Here”

1. Shared Vision of Regional Success
2. Regional Action Plan
3. CPC+ Payer Learning Agenda
4. Alternative Payment Model for Primary Care
5. Care Delivery
6. Data Support to Practices
7. Quality Measure Alignment
8. Attribution Methodology and Administrative Alignment
9. Multi-Stakeholder Engagement
10. Evaluation for Success

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Overview of CPC+ Greater Philadelphia

In Greater Philadelphia there are 215 participating primary care practices from health system-owned to small, independent groups. These are spread over a 5-county region that makes up the metropolitan area.

**Payer Partners**
- aetna
- Independence

**Payer Convener**
- Facilitates communication with/between payers
- Neutral party in decision-making
- Assist with implementation

**Data Aggregator**
- Regional HIE
- Data infrastructure and provider database
- Agreements with >85% of CPC+ practices
CPC+ - Greater Philadelphia

**Vision Statement:**
“Building better coordination across the health care continuum by supporting primary care, improving quality and clinical outcomes, and enabling population health management via data sharing that includes enhanced provider-payer coordination and communication.”

We aim to create a **culture of collaboration** in our region by:

1. Collectively addressing the challenges and opportunities of aligning payment methods and measurement standards
2. Improving care delivery and efficiency
3. Seeking ways to reduce the administrative burden on CPC+ practices
4. Working together to mobilize ideas, approaches, and resources to unlock the full potential of comprehensive primary care
Data Aggregation and Use End-to-End Process

CMS's vision for multi-payer data aggregation, sharing and alignment

- **Data Aggregation**: Compiling and standardizing data from different sources
- **Standardized Data Set**
- **Analytics**: making the data readable and useable
- **Reporting**: provides comparative measurement across settings
- **Practice Transformation**: Incorporating multi-payer information into healthcare operations for continuous improvement
- **Providers**
Data Aggregator: HealthShare Exchange

A non-profit 501(c)(3) – Member-owned entity
• Corporation formed in May 2012
• **Service area:** Delaware Valley, including southeastern Pennsylvania (Greater Philadelphia area and southern New Jersey)

• **6 million+ patients** in the HSX Clinical Data Repository
• **10,000+ physicians and other practitioners** in the HSX Provider Directory
• **150+ participating organizations:** hospitals, health plans, acute care hospitals, post-acute care facilities, behavioral health organizations, ACOs, clinically integrated networks, independent ambulatory practices and FHQC's
Regional HIE as Data Aggregator

Advantages:

- Leverages existing regional data infrastructure
- Provides a trusted, neutral location to aggregate sensitive payer data
- Strong governance model
- Established relationships (and data sharing agreements) with regional hospitals, health systems and practices
- HIE services support CPC+ goals (e.g. ENS, Direct messaging)
- Opportunities for future clinical data extraction from EMRs and/or clinical data repository (based on ADTs, CCDA, Lab feeds, etc.)
Data Aggregation Plan

- HSX was selected by IBC and Aetna as the data aggregator for the Greater Philadelphia CPC+ Program.
- HSX has contracted with CPC+ vendor - Onpoint to provide this capability.
- Reports will be based on claims data provided by IBC and Aetna for their Medicare Advantage members.
- The quarterly reports will support eight (8) claims-based CPC+ quality measures related to process, utilization and outcome requirements.
- Track 1 and Track 2 CPC+ practices and providers will be able to access quarterly performance reports through the HSX CPC+ Performance Reporting Portal (PRP).
Eight (8) claims-based measures were selected for this phase of the program.

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<th>CMS ID#</th>
<th>NQF#</th>
<th>Measure Title</th>
<th>Measure Type</th>
<th>CPC+ Group</th>
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<td>1768</td>
<td>Plan All Cause Readmission*</td>
<td>Outcome</td>
<td>Supplemental Measures</td>
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</table>

*Super protected data such as STD, HIV, Substance Abuse, Substance Abuse with Mental Disorder and Mental Disorders were not included in the generation of these measures.
The goal is to provide CPC+ Practices with access to the reporting portal in Q4 of 2018

Preliminary CPC+ Timeline

- 5/14/2018 - 6/10/2018: Obtain Practice Authorized Portal User Information
- 8/2/2018: Reporting Portal Go-Live
- 9/1/2018:
- 6/1/2018:
- 7/1/2018:
- 8/2/2018:
- 9/30/2018:
- 9/1/2018:
- 6/1/2018:
Data Aggregation Plan and Timeline

- **Practice Use Spectrum**
  - A. Data routinely used for practice transformation
  - B. Mature Learning network structure in place
  - C. Reporting back to practices
  - D. No data use or unknown

**Data Aggregation and Use Spectrum**

- **2017**
  - 1. No data sharing
- **2018**
  - 2. Claims data sharing between payers and providers (one-to-one)
- **2019**
  - 3. Aggregated claims data across payers
  - 4. Aggregated claims linked with clinical information

- In 2017 CPC+ Practices had access to payer-specific reports containing quality and utilization data
- In Q4 2018 CPC+ Practices will have access to aggregated MA claims via Onpoint reporting portal
- In 2019, we will explore “push” capability, measure expansion and FFS Medicare data inclusion
Initial Implementation Challenges

**Laborious contracting process**
- Difficult to get agreements on liability, insurance, mutual indemnification given the sensitivity of data
- Separate contracts required for each party and subcontractor

**Claims file format variation**
- Some payer require pre-formatting or reconfiguration (additional expense)
- Claims not all reportable at the same provider level (TIN, NPI, Provider ID)

**Super-protected data**
- State law requires removal of drug and alcohol abuse, mental/behavioral health data, and HIV/AIDS
- Different implications between payers (and states) for how this affects claims data loads

**Varying degrees of alignment of quality measures and value-based programs**
- Different programs: Medicare Stars vs. HEDIS vs. Medicaid measures
- Reluctance to modify existing contracts and performance reports
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