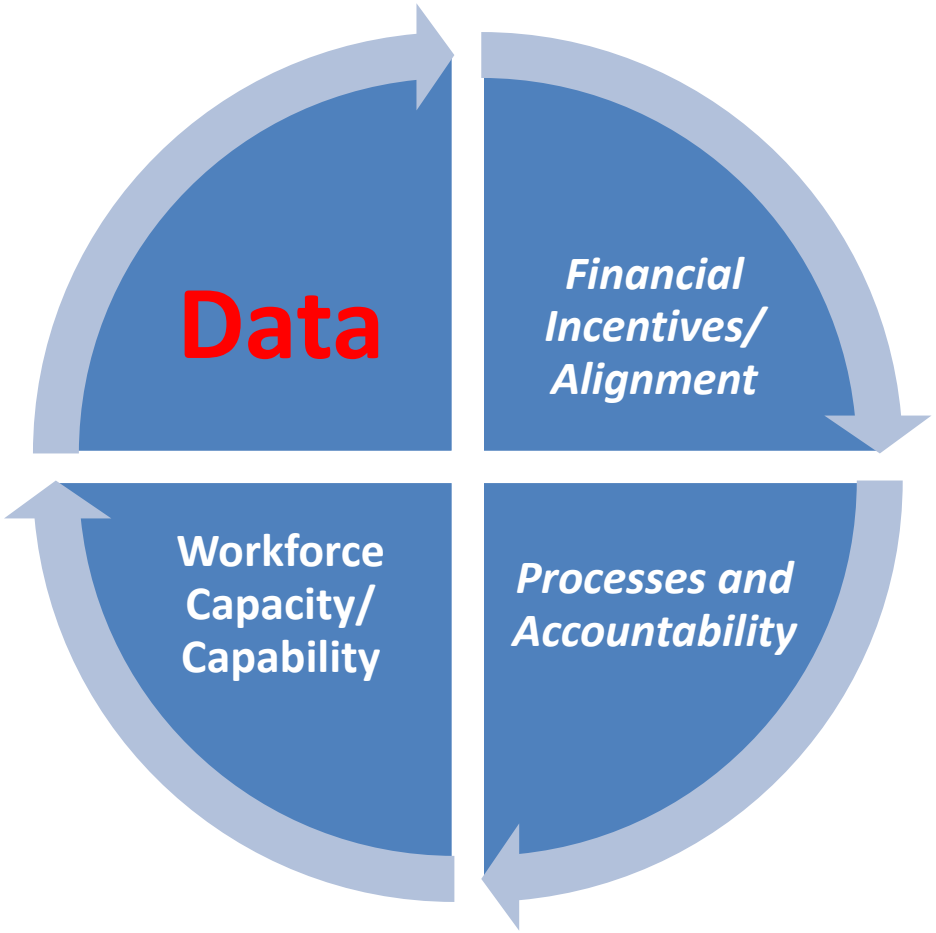
Medicare Data for High Value Care

January 23, 2015

Purpose of Today's Discussion

- Review the value of Medicare data for care coordination
- Recommend a game plan for obtaining and using Medicare data to create high value care
- Gain consensus on next steps

Building Blocks of High Value Care



Multiple types of data support high value care

Types	Examples	Uses
Claims/encounter/billing	Billing diagnosis Length of stay Insurance(s)/Payer(s) Billing provider Immunization	Attribution Risk stratification Reporting Reconciling
Pharmacy	Prescription fill data	Risk stratification (medications often strong indicator of clinical status) Identify non-adherence Monitor safety of all meds in combination Abuse monitoring
Structured clinical data (CCD, HL7)	Prescribed medications Medication list Problem list Lab values Immunizations	Dynamic risk level modification as clinical status changes Rule-based tasks Trigger episode management
Non-structured	Direct messages Patient-specific goals and action plans	Shared care plan components that are very patient specific (but need to be shared with others assisting in care of patient)

Beneficiary-specific Medicare data gives a more holistic view of the patient and more opportunities to coordinate care

- Beneficiary Information
- Professional and Institutional claims with all providers
- HCCs
- Procedure and diagnosis information
- Dates of service

The Maryland All Payer Model Agreement Allows the Demo to Request Individually-Identified Data

Data Sharing. *Over the performance period of the Model, CMS is willing to accept data requests from the State or its agents for data necessary to achieve the purposes of the Model. Such data could include de-identified (by patient or by provider) data or individually identifiable health information such as claims level data. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure. CMS will make best efforts to approve, deny or request additional information within 30 calendar days of receipt. Appropriate privacy and security protections will be required for any data disclosed under this Model*

Care Coordination is a Valid HIPAA Basis for Individually Identified Data

Request Process

Work with Demo Project Manager

- Establish continuing discussions and negotiation
- Initial communication in progress

Provide PM with solid plan and basis

- Exactly what will be done to coordinate care
- Specific data needed to support CC
- Who in the delivery system will have access to what data and for what purpose
- How the data will help the delivery system to help the patient

Amend the Demo and the DUA follows

- Request a letter amendment to the Demo
- Once the Demo is amended, the DUA applies to the new activities

If that doesn't work, consider other approaches such as Organized Health Care Arrangements (OCHAs)

An Organized Health Care Arrangement (OHCA) is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more Covered Entities (CE) who participate in joint activities to share protected health information (PHI) about their patients in order to manage and benefit their joint operations. In order to qualify as an OHCA, the legally separate CE's must be clinically or operationally integrated and share PHI for the joint management and operation of the arrangement. Also, individuals must expect that these arrangements are integrated and share information to manage their operations.

- American Medical Association

The hospitals are covered entities. A central repository such as CRISP, under a Business Associate Agreement, can handle the data on behalf of the CEs.

So what should we do?

Recommendation

Develop a detailed plan to create a collaborative care coordination initiative for fee-for-service Medicare patients. Identify, obtain, and organize the data needed to support the components of the initiative.

- **Develop detailed plans for the care coordination of high-risk patients**
- **Identify data needed to support each component of care coordination**
- **Create a detailed request to CMMI for Medicare data to support care coordination**
- **Identify implementation plan budget and resources**
- **Identify and hire a vendor to manage and distribute the data**

Develop detailed plans for the care coordination of high-risk patients

- Identify data needed to support each component of care coordination
- Create a detailed request to CMMI for Medicare data to support care coordination
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Develop detailed plans to coordinate the care of high-risk patients with the following components:

1. The capability to attribute members to providers.
2. A risk stratification process that identifies patients who should be in a care management program based on their risk level. The capability to inform providers of patients who are eligible for care management.
3. A care plan for patients in care coordination with the capability to share among providers.
4. Outcome data collection and analysis for the purpose of continuous improvement.

- Develop detailed plans for the care coordination of high-risk patients
- **Identify data needed to support each component of care coordination**
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Determine the data that is needed to support each component of care coordination

- Evaluate best practice for data needed to support the components of the care coordination mechanism
- Develop strategy for data sharing that addresses patient provider-relationships necessary for provider collaborative and care coordination
- Consider all types of data including:
  - Medicare Data including professional and institutional claims, HCCs, diagnoses and other pertinent data
  - Inpatient and Outpatient data available through HSCRC or CRISP
  - Hospital Administrative, Discharge and Transfer (ADT) and potentially other clinical data available through CRISP
  - Pharmacy data
  - Clinical data such as prescribed medications, medication list, problem list, lab values, immunization

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Create a detailed request for Medicare data to support care coordination

- **Include the following in the data request:**
  - Description of the purpose of the data
  - Specific data, data files, and timing requested
  - Description of how the data will be used and shared for the purpose of care coordination
  - Description of privacy and security protections

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Identify Implementation Plan Budget and Resources

- Develop a work plan and identify resources needed to support efforts
  - Consulting resources
  - Technical vendors
- Identify potential funding sources and strategies
- Develop a timeline for implementation activities

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Identify and hire a vendor to manage and distribute the data

- Manipulate and link Medicare, CRISP, clinical and other data for the purpose of attribution, risk stratification, care plans and analysis for continuous improvement
- Act as the central repository of Medicare data
- Have the capability to push meaningful, actionable data to the provider community
- Maintain privacy and security protections

Discussion to get to Consensus on the Recommendation…….

Potential Care Coordination Work Group Recommendation

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