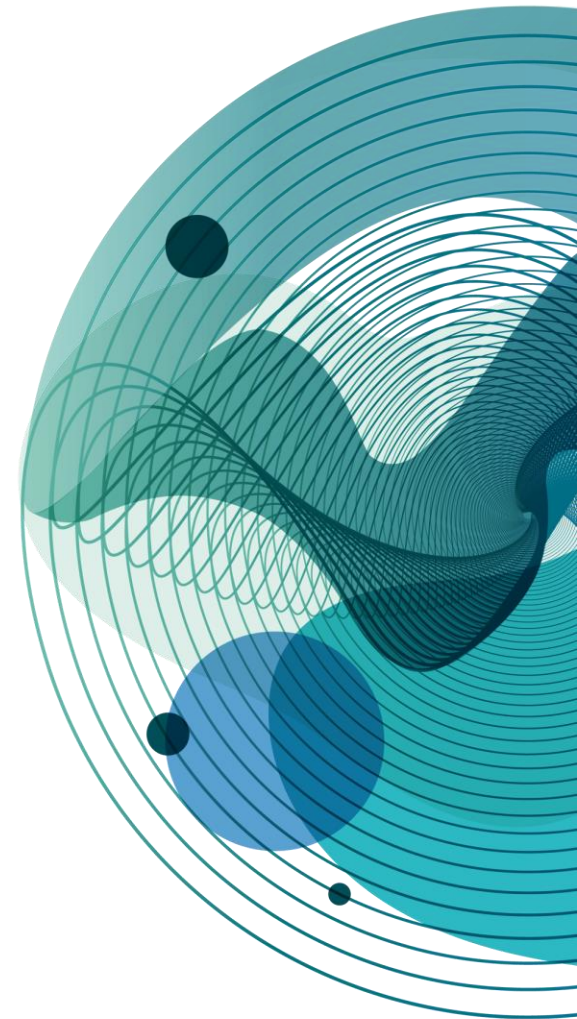# Civitas Annual Conference

"CMS & HIE Partnerships for Data-Driven Value-Based Care Transformation"

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Center for Medicare & Medicaid Innovation

CMS & HIE Partnerships to Drive Value Based Care Transformation

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*Data Aggregation
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This session will highlight how CMS has partnered with Health Information Exchanges to deliver meaningful, actionable data insights to practices to drive primary care transformation. Explore CMS' future vision for data aggregation and partnerships with HIEs to advance quality and cost outcomes.

The Challenge

To optimize value-based care, providers need to track **more and more** population and patient-level metrics.

These data live across **numerous portals**, platforms, and reports and often **lack actionable, comprehensive insights**.

Providers need **consistent, consolidated, and understandable** data to track performance, improve **population health**, and **transition** to value-based payment.

Data Aggregation Overview

Data Aggregation

Partnering with aggregators (e.g. Health Information Exchanges) to provide aggregated, multi-source data insights to **support practices in improving quality and reducing cost of care.**

Unified reports and data products from across care settings…
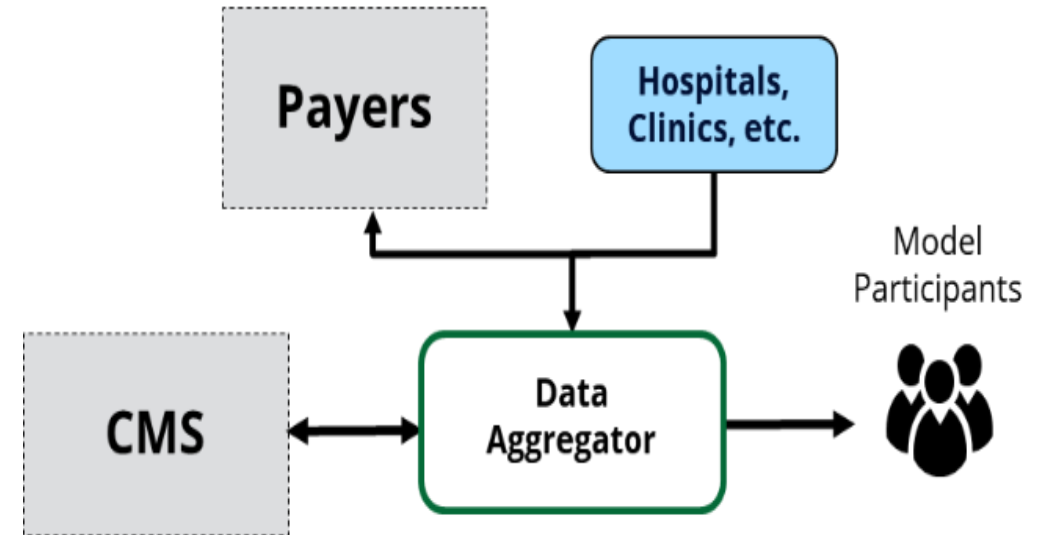
Reduce practice burden

Support practice goal setting, root-cause analyses, and planning efforts to support organization level changes

Improve care coordination, reduce unnecessary services, and improve the quality and value of care provided to patients

Data Aggregation – Conceptual Data Flow

Payers

Hospitals, Clinics, etc.

Model Participants

CMS

Data Aggregator

Data Aggregation – CPC+ & PCF

CMS leveraged HIE partnerships to support practices in **improving quality and cost outcomes** through its Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF) Models

- ✓ Partnered with **16** aggregators

- ✓ Delivered aggregated insights to **1,930 +** practices

- ✓ Covering **1.8M +** patients

- ✓ Across **44** payer partners

Current & Past DA Use Cases

Encounter Notification Services (ENS)

Focused Clinical Reports – HbA1c Reporting

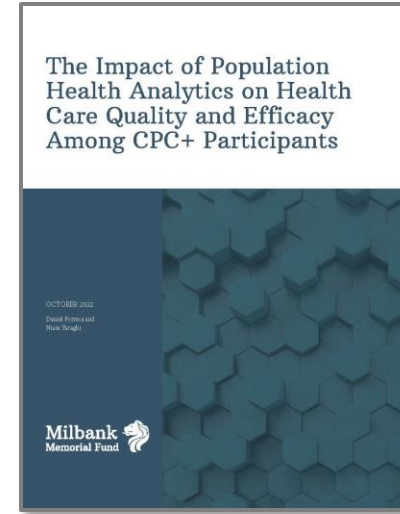Medication Management Improvement Reports

Gaps in Care Reporting

Multi-payer Utilization & Expenditure Reports

Data Aggregation & HEALTHeLINK

Multi-payer reports with aligned measures provide practices with population insights to enhance data-driven care transformation

- Payers have **different value-based care models** with their **own sets of performance metrics**.

- CMMI's partnership with HEALTHeLINK in the CPC+ Model provided practices with aggregated multi-payer claims reports, to **improve utilization, expenditures, and gaps in care**

The Impact of Population Health Analytics on Health Care Quality and Efficacy Among CPC+ Participants

OCTOBER 2022
Daniel Ferrara and Nina Tenaglia

Milbank Memorial Fund

A 2022 study by the Milbank Memorial Fund found that practices who participated in CPC+ and received multi-payer DA reports **outperformed peers** *who did not receive the reports.*

✓ Overall, practices saw a 24.1% **reduction in hospital admission rates** and a 30.4% **reduction in readmission rates**
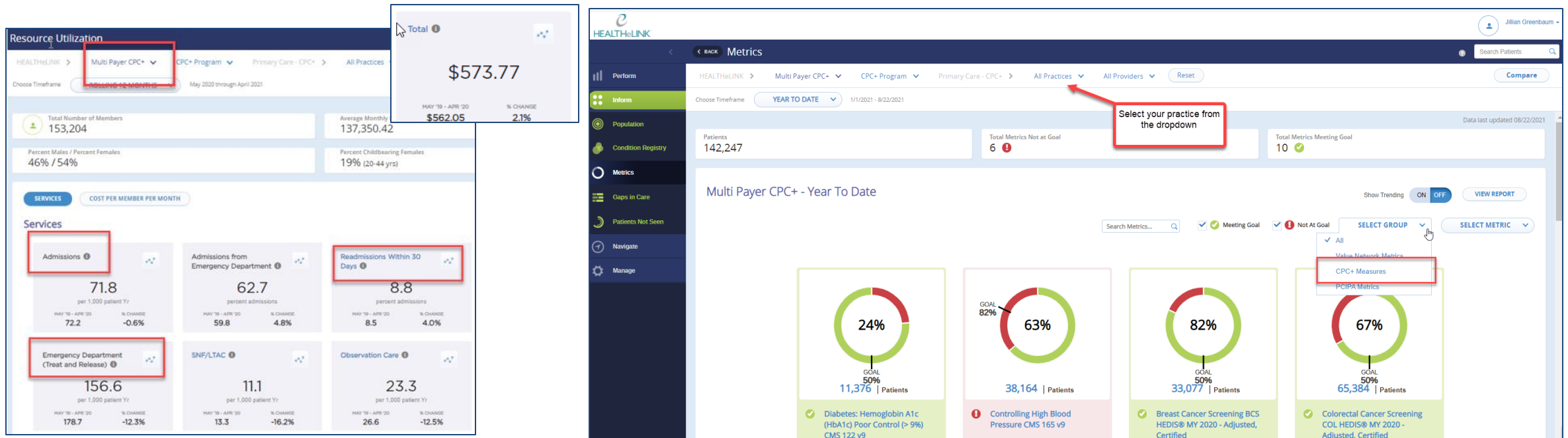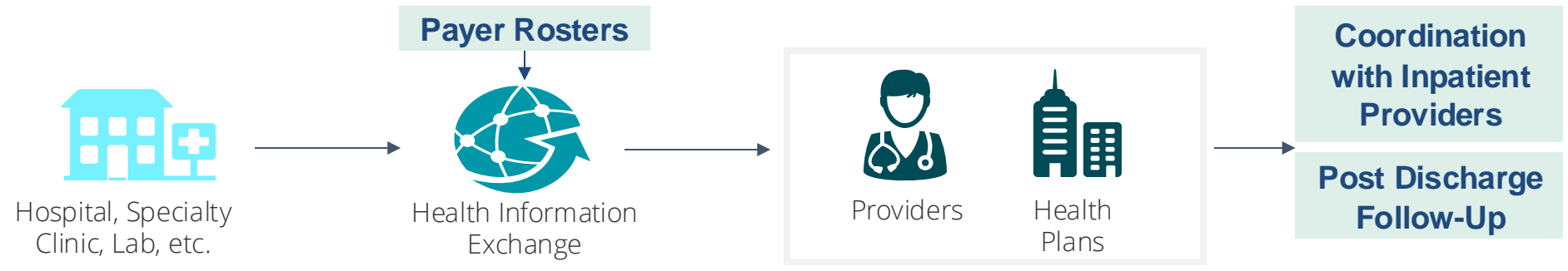
Data Aggregation & SHARE – Encounter Notification Services

Payer-derived attribution for ENS provides real-time alerts to providers on their accountable patient population to improve care coordination and reduce avoidable utilization

Last Name	First Name	DOB	Patient's Phone	Payer Relationship	Name of Hospital	Attending Provider	Primary Diagnosis	Description of Visit	T
Sharetest	James	1/1/1986		Medicaid	Drew Memorial	Brian Beans	Crohn's disease, unspecified, with unspeci	Discharge/End Visit	Emergen
Taylor	Tim F	3/30/1965	(501) 555-6655		Drew Memorial	Charlie Russ	Major depressive disorder, recurrent, uns	Discharge/End Visit	Inpatient
Smith	John	9/1/2017	(479) 555-5555		Magnolia Hospital	Mary Moon	Type 2 diabetes with ketoacidosis	Outpatient to Inpatient	Outpatie
Duck	Donald	2/4/1982			UAMS	John Smith	Back pain	Admssion	Emergen
Mouse	Minnie	3/15/1942	(870) 555-5555	Medicare PCF	UAMS	John Smith	Contact with exposure to covid-19	Discharge/End Visit	Emergen
Mouse	Mickie	5/18/1942	(870) 123-4567		Drew Memorial	Jane Doe	Strain of unspecified muscle	Discharge/End Visit	Inpatien
Gilmore	Lorelai	4/11/1935	(479) 123-4567		ACH	Ricky Ball	Shortness of Breath	Admssion	Emergen
Glitter	Poppy	9/19/1967			Baptist Health	Bill Silver	Acute viral hepatitis	Discharge/End Visit	Emergen
VonSweet	Penelope	9/19/1937		Ark Health and Wellness	Drew Memorial	John Taylor	Unspecified pain	Admssion	Emergen
Wreck	Ralph	7/1/1962		Blue Cross	Mercy Health	Steve Emdee	COVID 19	Outpatient to Inpatient	Outpatie
VonSweet	Penelope	9/19/1937		Ark Health and Wellness	Drew Memorial	John Taylor	abdominal pain	Discharge/End Visit	Emergen
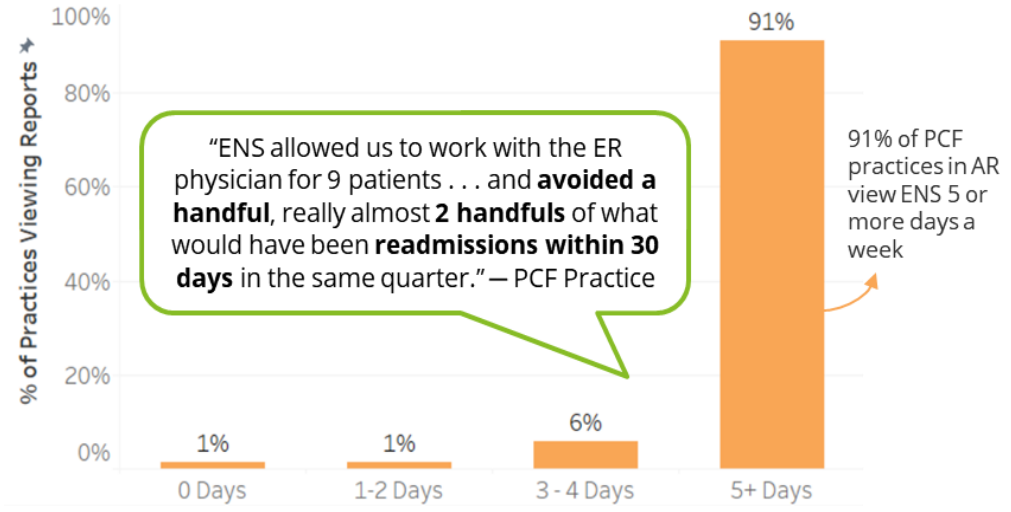
Through SHARE's payer partnerships, practices receive ENS on ALL of their patients covered by Medicare FFS or other PCF payers.

"ENS allowed us to work with the ER physician for 9 patients . . . and **avoided a handful**, really almost **2 handfuls** of what would have been **readmissions within 30 days** in the same quarter." — PCF Practice

91% of PCF practices in AR view ENS 5 or more days a week

Chart: % of Practices Viewing Reports — 0 Days: 1%, 1-2 Days: 1%, 3-4 Days: 6%, 5+ Days: 91%

Payer Rosters

Hospital, Specialty Clinic, Lab, etc. → Health Information Exchange → Providers / Health Plans → **Coordination with Inpatient Providers** / **Post Discharge Follow-Up**

Data Aggregation & SHARE – HbA1c Reporting

Focused clinical reports enable targeted care management outreach based on a comprehensive view of patient lab results across care settings

PATIENT ID	PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT MIDDLE NAME	PATIENT DATE OF BIRTH	DATE OF SERVICE	LOINC CODE	LAB DESCRIPTION	LAB RESULT	UNITS	ORDERING PROVIDER NPI	ORDERING PROVIDER	VISIT TYPE
PCF ID	GEORGE	WASHING	S	1/27/1949	1/27/2023	4548-4	HBA1C MFR BLD	6 %		1234567891	JOHN DOE	OUTPATIENT
PCF ID	JOHN	ADAMS		9/20/1935	2/1/2023	4548-4	HEMOGLOBIN A1C	8.1 %		NULL	JANE DOE	I
PCF ID	THOMAS	JEFFERSO		9/20/1935	2/2/2023	4548-4	HEMOGLOBIN A1C	8.3 %		NULL	JANE DOE	I
PCF ID	JAMES	MADISON		9/20/1935	3/16/2023	4548-4	HBA1C MFR BLD	7.8 %		1234567891	JOHN DOE	OUTPATIENT
PCF ID	JAMES	MONROE	E	8/14/1937	2/27/2023	4548-4	HBA1C MFR BLD	6.9 %		1234567891	JOHN DOE	OUTPATIENT
PCF ID	JOHN QUI	ADAMS	W	4/20/1944	3/6/2023	4548-4	HBA1C MFR BLD	11.5 %		1234567891	JANE DOE	OUTPATIENT
PCF ID	ANDREW	JACKSON		3/23/1976	1/5/2023	4548-4	HBA1C MFR BLD	5.7 %		1234567891	JANE DOE	OUTPATIENT
PCF ID	MARTIN	VAN BUR	D	7/18/1956	1/9/2023	4548-4	HBA1C MFR BLD	5.4 %		1234567891	JANE DOE	OUTPARTIENT

*CMMI partnered with SHARE to deliver HbA1c reports to PCF practices to support **more targeted and timely care management** and **improve HbA1c control and reduce avoidable utilization***.

Ongoing monitoring of regional trends, revealed a positive association between HbA1c (Poor Control) and increased acute inpatient discharges.

*"**Patients receive better care with fewer gaps in diabetes care management.**"*

- PCF Practice

85% of responding practices indicated the reports showed patients with **high HbA1c results they were <u>not</u> aware of.**

Future of Data Aggregation

Future of Data Aggregation

- ✓ CMS is **expanding Data Aggregation** to further **enhance data exchange** and **support value-based care transformation**

- ✓ Continued partnerships with aggregators will enable CMS to provide a suite of Data Aggregation use cases and solutions to **support model participants and CMS model teams in monitoring and improving care**

- ✓ With a cross-model approach, CMS aims to demonstrate the **art of the possible with data exchange** and **uncover innovative approaches** to maximize the impact of data aggregation

Additional models & model types

Expanded DA services & monitoring capabilities

Increased payer participation & alignment

Panel Discussion