Your ACO Guide to Targeting Costs With Data-Driven Strategies

Part 2: Strategies Supported by Claims + Quality Data

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Educational Webinar Series

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About Roji Health Intelligence

- We provide Value-Based Care technology and services to providers.
- Our powerful tools identify patients at risk and target health interventions.
- Roji Health Intelligence is a CMS-qualified ONC-certified registry for QPP reporting, and we report eCQMs and CQMs.
- Roji Episodes reveal cost variations and drivers to generate strategies to address Total Cost of Care.

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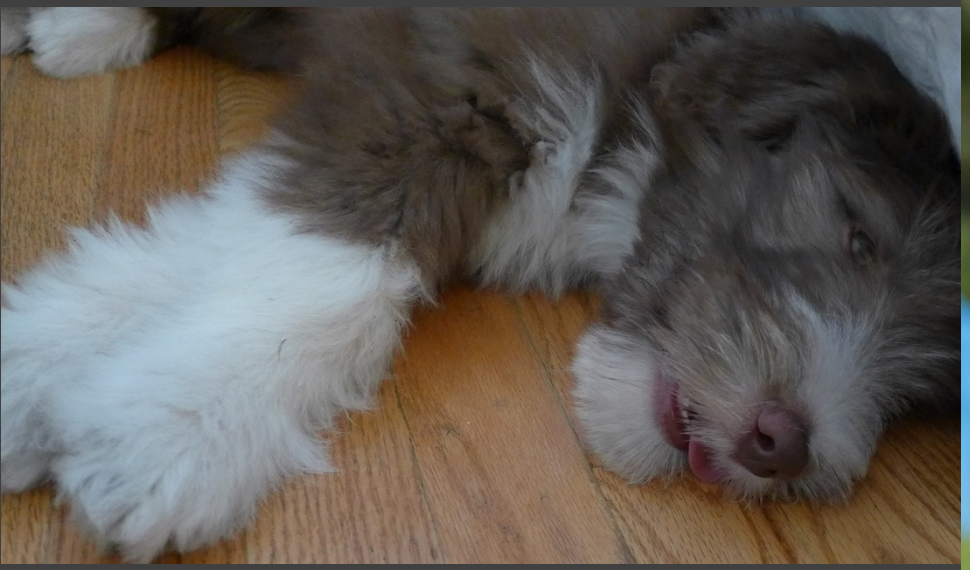
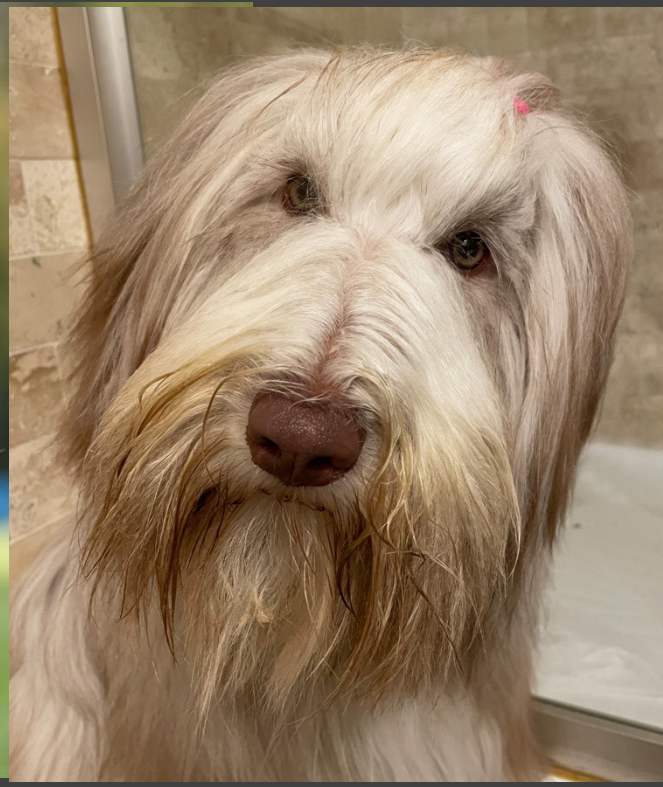
POLLING QUESTION: How do you use quality data?



A. We use quality data just for quality reporting.

B. We use quality data for improving outcomes *and* costs.



C. What quality data?

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Don’t Eclipse Your Vision!

Today we will explore the boundaries of your data power.

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Total Cost of Care (TCoC) or Total Per Capita Cost (TPCC)

- How payers and patients measure affordability
- TPCC = $TCOC\ divided\ by\ number\ of\ patients$ – basis for capitation

- All billed and covered services paid to eligible providers
- Physician services including those outside your network
- Hospital-based provider services, facility inpatient, outpatient, ER
- Behavioral health
- Prescription drugs (excluded or included in payment models)
- Ancillary services like DME, SNF, hospice (excluded or included)
- Value-based care payment model will vary the components

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Why can’t your cost action plan be as simple as: Reduce TCOC?

At the TCOC or TPCC level, your only tools to lower costs are:

- Cuts in services via preauth or referrals
- Enforcing benchmark cuts to physician payments

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TCOC or TPCC is not actionable.
It provides no detail on what is driving cost.

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Creating Interventions for Cost Control

1. Understand your available data
2. Target projects to reduce TCOC through focused projects and patients identified by data.
3. Claims + APP measure data provide some clinical data
4. Data will need special tools for use in cost: Episodes

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What are Easily-Available Data Sources for ACOs?

- Claims data
- APP Measure Response Data
- Unfortunately, almost 1/3 of ACOs don’t use it to its full extent.

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What's "Easy" About that Data?

- You get it as part of other activities.
- Claims data identifies patients with Dx
- APP Measures provide values for risk, depending on source type
- QRDA 1s, flat files, or input APP numerators provide clinical outcome values
  - Trend in control values over the year
  - Patients with most problematic values
  - Claims (hospital/ER events with Dx) show comorbidities that increase risk
  - If no electronic data aggregation, input values can be retrieved for use

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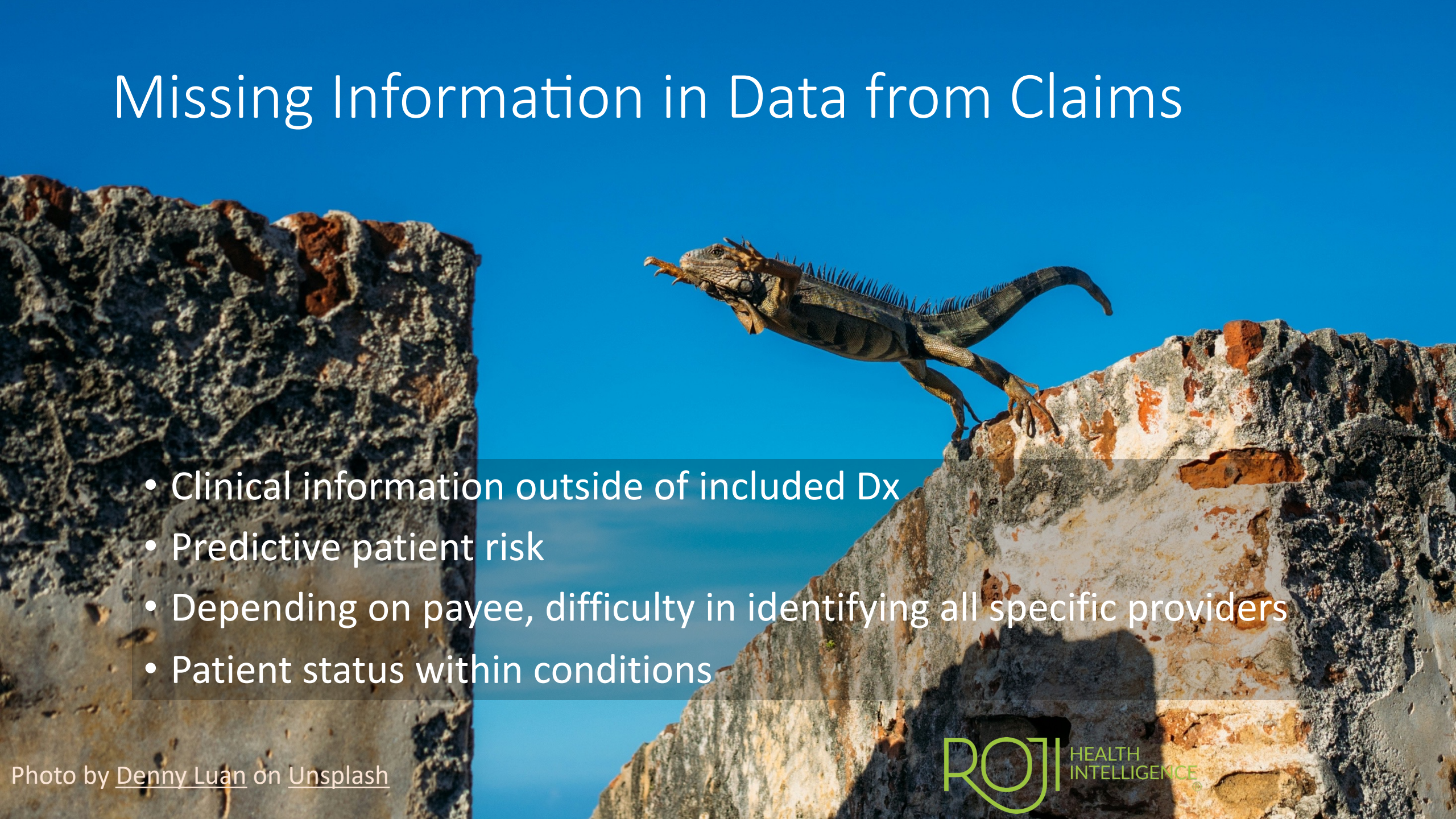
Missing Information in Data from Claims



- Clinical information outside of included Dx
- Predictive patient risk
- Depending on payee, difficulty in identifying all specific providers
- Patient status within conditions

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Missing Information in APP Data

- APP Reporting using eCQMs: QRDA 1s limit data
  - Other risk data not captured, only specific measure
- APP Reporting using Medicare CQMs, ACO may only input values
- Questionable amount of longitudinal values

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Data Limitations Degrade Opportunities

- Speed – how old the data is
- Content – dependent type of source data
- Distance – trended data over time
- Old or poor data content reduces data value:
  - patient risk information
  - Interrelationships of clinical data

Pippi in agility trial. Photo by Lisa Urbaniak.

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Meaningful cost performance improvement requires more data to feed strategies.

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More Opportunities with Quality Data

- Many more risks and conditions
- More effective patient-focus
- Stronger clinician engagement
- Greater impact on cost
- High-efficiency data aggregation

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What Quality Data?

Quality: You know it when you see the data.

- Patient health status
- Clinical indicators of disease
- Laboratory and diagnostic tests
- Diagnoses
- Problem lists (show old problems)
- Prescribed drugs
- Treatments / referrals

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Targeting Costs: 2 Paths

Clinical / Quality Path

- Current cost drivers: Patients with chronic disease at high risk / persistent poor control
- Future cost drivers: Patients with hidden Dx (e.g. CKD) based on values and/or other Dx
- Current health equity: Patients with poor control and no referrals or advanced meds

Cost Variation Path

- Compare costs for procedures on an episodic basis
- Current cost drivers: What do higher cost procedures contain, after exclusions for trauma or other expected variations

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Data Required to Pursue

Clinical / Quality Path

- Claims data
- All patient Dx whether or not there was claim
- Vitals and clinical values for all quality measures
- Prescribed medications
- Referred services

Cost Variation Path

- Claims data
- Patient diagnoses and clinical status
- Infections, complications
- Anesthesia type and cost
- Rehab, home or SNF costs
- PT
- Related procedures for patients

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Reasons Why Practice EMR Data is Essential

- Outcome, Prescription & Risk data enable targeting interventions
- Ability to create clinically rich pathways to savings with physician collaboration
- Reveals factors driving cost
- Enables APP Reporting for all patients
- Provides detail for validating costs and outcomes

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Getting Best Value from Your Data Aggregation

- Avoid single-use data pulls from participating practices – aggregate everything you need for ACO initiatives
- For APP, do not use limited data formats such as QRDA
- Survey practices on their EHRs and identify issues in advance
- Make data transparent – show validation fields for every patient for diagnoses, etc.
- Consider offering central EHR for purchase by practices with archaic systems

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3 Essential Data Types Essential for Interventions

Time-based lab & other values and treatments to show trended patient status

Clinical Events like exacerbations, do-overs, utilization events, complications show opportunities

Prescribed meds, referrals to programs and services point to issues of stagnation and health equity

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Best Quality Data Aggregation Options

Highest content:

- FHIR
- Flat files

Supplemental:

- QRDAs

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Data Collected, Now What?
Episodes of Care for Inquiry

- Compare costs per patient
- Target interventions for patients with chronic disease
- Examine cost variation among specialty procedures
- Identify patient economic vulnerabilities limiting treatment

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Go Higher With Quality Data in 5 Focus Areas

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- Big 3 metabolic conditions
- Heart failure
- Patients with static outcomes
- Prescription drugs on lower or older tier
- Both high and low procedure costs

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Key Steps to Clinically-Driven Savings: Conditions

- Create core patient population with Episodes
- Use outcomes to focus on patients with highest risk
- Apply clinical interventions to patients not on expected clinical path
  - Population Health
  - Visit profile
  - Prescription meds
  - Referrals
  - Self-management programs
  - Clinical review – share data with physicians and groups
- Measure and share results with clinicians

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Key Steps to Lower Cost Variation: Specialty Procedures

- For highest diagnoses/procedures, create procedural Episodes
- Plot costs on curve by episodes and by proceduralist
- Identify common attributes of higher and lower cost cases
- Show clinically notable observations associated with procedures
- Share cost variation data with specialists
- Provide mechanism for clinicians to provide feedback on data
- Where appropriate, create collaboratives to improve pathways, reduce complications, and improve patient results

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No one path to data-driven cost performance exists.

Use tools to help data reveal your cost vulnerabilities / variations, and focus on patient improvement.

From that point, the human change process requires politics and persuasion to create results.

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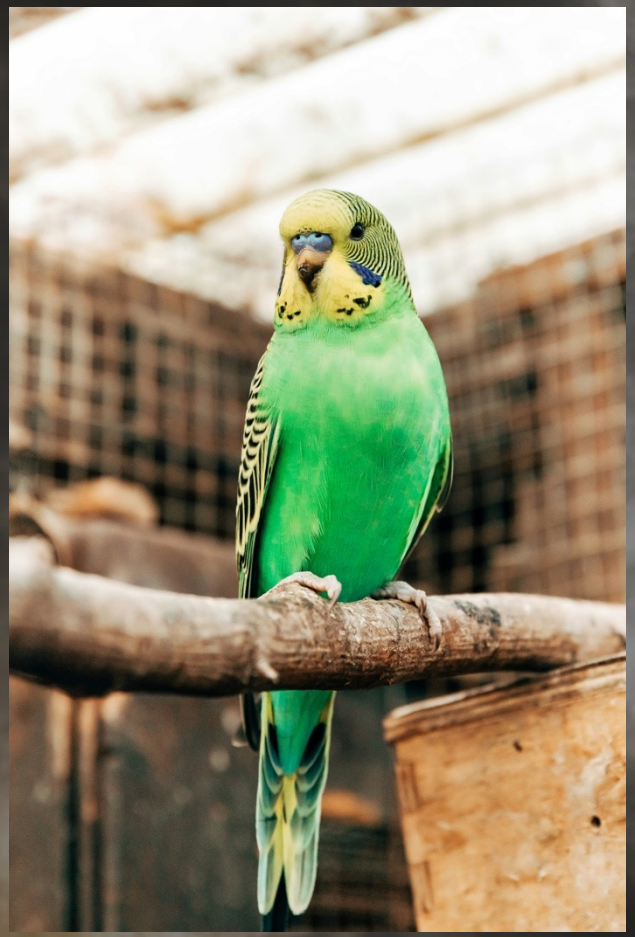
Polling Question
What is your 3-year Plan for data?

1. Use mainly Claims Data



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2. Aggregate EHR data

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3. Neither, too expensive!

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The Future of Managing Costs

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New Value-Based Payment Models: Not FFS, all Risk-based TPCC or PC-PCC

- ACO Reach
- ACO Primary Care Flex
- Specialty Care Models, e.g. Enhancing Oncology

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CMS applies both TCOC and TPCC in MIPS

- Two total cost of care measures
  - Total Per Capita Cost (primary services)
  - Medicare Spending Per Beneficiary

  PLUS
- 27 additional episode-based measures for selected Dx and Px
- Foretell what will be happening in specialty care and potentially ACOs

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CMS MIPS Cost Measures

1	Total Per Capita Cost	15	Lower Gastrointestinal Hemorrhage
2	Medicare Spending Per Beneficiary Clinician	16	Lumbar Spine Fusion for Degenerative Disease, 1-3
3	Elective Outpatient Percutaneous Coronary Intervention	17	Lumpectomy, Partial Mastectomy, Simple Mastectomy
4	Intracranial Hemorrhage or Cerebral Infarction	18	Non-Emergent Coronary Artery Bypass Graft (CABG)
5	Knee Arthroplasty	19	Renal or Ureteral Stone Surgical Treatment
6	Revascularization for Lower Extremity Chronic Critical	20	Asthma/Chronic Obstructive Pulmonary Disease (COPD)
7	Routine Cataract Removal with Intraocular Lens (IOL)	21	Colon and Rectal Resection
8	Screening/Surveillance Colonoscopy	22	Diabetes
9	STEMI with PCI	23	Melanoma Resection
10	Acute Kidney Injury Requiring New Inpatient Dialysis	24	Sepsis
11	Elective Primary Hip Arthroplasty	25	Depression
12	Femoral or Inguinal Hernia Repair	26	Emergency Medicine
13	Hemodialysis Access Creation	27	Heart Failure
14	Inpatient COPD Exacerbation	28	Low Back Pain
15	Lower Gastrointestinal Hemorrhage (at group level only)	29	Psychoses and Related Conditions

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As Accountable Care Grows… Cost Measures Will Expand

- Cost Measures will expand
- CMS is driving consistency across program, so will likely apply some cost measures to ACOs over time
- Likelihood of more activity around specialty cost measures
  - For use by ACOs in negotiating global cap
  - Or become part of algorithms for measuring total cost of care
- Focus on cost of specialty services will increase
- The more ACOs are in global cap, the more they will also want data to guide distribution of $

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ACOs Must Grow Data Expertise and Data-Driven Solutions

- Help participating providers move to common or better & fewer EHRs
- Help improve integrity and completeness of data
- As NLP grows within EHRs, it will unleash huge data surge
- Genomic data will become available
- The more ACOs are in global cap, the more they will also want data to guide distribution of $ to other providers, and add to their resources

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ACOs will have a choice on data aggregation

for a while. Then there will be financial consequences.

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Questions and Answers
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