Payers and Providers Team Up to Improve Patient Outcomes

Session IS03, March 6, 2018
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Conflict of Interest

Steven Lane, MD, MPH

Consulting Fees: Member, Azuba Advisory Board
Private, not-for-profit integrated healthcare system serving more than 100 communities

- 3 million patients served annually:
  - 874,000 ED visits
  - 193,000 Discharges
  - 34,000 Births
- 5,500 physician members of Sutter Medical Network
- 24 acute care hospitals
- 35 Outpatient Surgery Centers
- 53,000 employees
- $12 billion in revenues (2016)
- Home Health and Hospice services
- Medical Research, Education and Training
Situation

• In addition to traditional **Payment** / reimbursement activities, payers desire to access or receive clinical data to support **Treatment** and **Healthcare Operations** functions:
  – Utilization Review
  – Care Coordination
  – Quality Reporting
  – Performance evaluation
  – Case Management
  – Quality Assessment and Improvement
  – Patient safety activities
  – Protocol development

• Providers must consider innovative solutions to respond to these requests while respecting patient privacy and managing costs.
Background

• Historically payers received most clinical data from providers through claims:
  – Encounter data
  – Procedure codes, modifiers
  – Diagnoses
  – Charges

• With changes in reimbursement models, service delivery, care coordination, quality measurement and reporting, etc., payers desire access to clinical data that must be carefully evaluated based on the specific purpose of use.
Required Restrictions

• Right patient(s), based on accurate Patient-Payer Attribution for specific services
• Right clinical data – Minimum Necessary for specific need
• Exclusion of data related to services for which patient has invoked a Self Pay Restriction
• Flagging of data for which patient has requested Adolescent Confidential Services
Multiple Data Sharing Technologies

- Electronic Health Record (EHR) access
  - Release of Information (ROI) applications
- Data extracts – delivered via secure Managed File Transfer
- HL7 interfaces
- Document exchange
  - Query-based
  - Direct interoperability
- Application Programming Interfaces (APIs) / Web Services
  - Fast Health Information Resources (FHIR)
- Health Information Exchanges (N)
Assuring Appropriate Restriction of Data Access and Use

• Limited access to EHR
  – View only vs. read/write access if documentation required
  – Chart access restricted by patient, encounter and data type
  – Custom use case specific reports, dashboards, registries
  – Remote vs. supervised on site access

• Filtering/specification of data released via interfaces, reports, extracts, APIs and HIEs

• Auditing and monitoring of access by individual users
Evaluating Payer Requests

• Business Case
  – Value proposition
  – Internal sponsor

• Purpose of the Request must fall within:
  – Treatment
  – Conducting quality assessment and improvement activities
  – Reviewing the competence or qualifications of health care professionals

• Protected Health Information (PHI) Requested:
  – Minimum necessary – patients, data elements, time frame
  – Special restrictions for HIV results, Psychotherapy Notes, “Part 2” data
21st Century Cures Act, Section 4003

• Trusted Exchange Framework & Common Agreement (TEFCA)
  – Priority Target Areas include:
    • Achieving a HIT infrastructure that allows for the electronic access, exchange, and use of health information
    • The promotion and protection of privacy and security of health information in health IT
  – Use Cases include: Population Level Data
    • Querying and retrieving Electronic Health Information about multiple patients in a single query to support population health services, such as quality measurement, risk analysis, and other analytics
• **Stakeholders:**
  Include Payers & Providers

  - **FEDERAL AGENCIES**
    Federal, state, tribal, and local governments

  - **INDIVIDUALS**
    Patients, caregivers, authorized representatives, and family members serving in a non-professional role

  - **PROVIDERS**
    Professional care providers who deliver care across the continuum, not limited to but including ambulatory, inpatient, long term and post-acute care (LTAC), emergency medical services (EMS), behavioral health, and home and community based services

  - **PAYERS**
    Private payers, employers, and public payers that pay for programs like Medicare, Medicaid, and TRICARE

  - **TECHNOLOGY DEVELOPERS**
    Organizations that provide health IT capabilities, including but not limited to electronic health records, health information exchange (HIE) technology, analytics products, laboratory information systems, personal health records, Qualified Clinical Data Registries (QCDRs), registries, pharmacy systems, mobile technology, and other technology that provides health IT capabilities and services

• **Permitted Purposes:**
  Include Healthcare Operations

  - **PUBLIC HEALTH**
    Public and private organizations and agencies working collectively to prevent, promote and protect the health of communities by supporting efforts around essential public health services

  - **TREATMENT**
  
  - **PAYMENT**

  - **HEALTHCARE OPERATIONS**

  - **INDIVIDUAL ACCESS**

  - **BENEFITS DETERMINATION**
Reciprocal Provider Needs

- Providers desire clinical data from payers or Delegated Entities to support:
  - Care & care management
  - Quality management and reporting
  - Population risk stratification
- Data types:
  - Clinical data embedded in claims
  - Pharmacy payment and dispense data
  - Quality / care gap information from other sources
Da Vinci Project

- Private sector initiative that addresses the needs of the Value Based Care Community by leveraging the HL7 FHIR platform
- Collaboration of payers, providers, HIT vendors, HL7, and ONC
- Identify and implement high priority use cases to support data sharing between payers and providers

The goal of the DaVinci Project is to help payers and providers to positively impact clinical, quality, cost and care management outcomes [through] the early adoption of FHIR® as a foundation for driving the critical use cases.
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Director of Pharmacy Services
BlueCross BlueShield of Minnesota
BCBSMN Introduction
Blue Cross Blue Shield of Minnesota

• Today we are the leading health plan in the state
  – We have more members, the largest network of doctors, and more products and services than any other health plan in Minnesota.
  – About one in three Minnesotans has a health plan with us.
  – Our 2.6 million members can be found in every Minnesota county, all 50 states and on four continents.
• We are a nonprofit Minnesota company
  – 90 cents of every health care dollar we collect is used to pay for our members’ health care.
  – Our administrative cost is less than 10 cents of every dollar – one of the lowest in the country.
  – Even though we are a nonprofit, we pay more than $100 million in taxes and assessments every year.
  – We provide more than $250 million in wages to our state economy each year.
  – Approximately 3,500 employees work for us throughout Minnesota. We have offices in Eagan, Virginia, Aurora, Duluth and St. Cloud, and a retail store location in Edina.
Our goal is to understand our members’ health needs and ensure high quality care is approached with four focus areas: prospective initiatives, retrospective initiatives, operational excellence and member experience.
Business Questions

How can we understand our Medicare, Medicaid, and ACA members’ needs, and deliver high quality programs when we don’t have ongoing access to key clinical information?

• How can we drive accountability for HEDIS hybrid performance for both plan and providers?
• How can we prevent duplicative or unnecessary outreach to members for interventions?
• Are there more efficient processes to request 100,000s of charts from providers than manual processing from provider to plan?
• How can we manage our Part D medication therapy management (MTM) program and easily integrate data from our clinic based providers?
Current State
Current Operations

Utilizing Epic Interoperability allows Blue Cross to advance our work in population health and improve health outcomes for our members.

- Epic Interoperability provides Blue Cross near real time clinical data that can more effectively enable proactive outreach and care coordination assistance to members, and health care quality improvement efforts.

- As a tool familiar to many providers, Blue Cross’ use of Epic’s electronic medical record (EMR) database will streamline payer-provider collaboration to improve members’ health outcomes and reduce administrative burden for providers/care systems.

- Through earlier awareness and engagement with members, Blue Cross members benefit by improved capabilities to direct them to appropriate services when needed (e.g. preventive care screenings, medication management support and care coordination).
Improved Member Experience and Outcomes

**Patient A: Meiko**
Medicare Member with Diabetes

Meiko receives the recommended diabetes screenings, however, her lab values indicate that her diabetes is uncontrolled.

**Current Process**
- **PCP Visit:** labs indicate diabetes is uncontrolled
- **Lab results:** entered into EMR
- **Patient A is eligible for a diabetes outreach program**
- **Lab results:** submitted to Blue Cross
- **Patient A receives preventative screening reminders**

**Epic Interoperability**
- **PCP Visit:** labs indicate diabetes is uncontrolled
- **Lab results:** entered into EMR
- **Blue Cross has access to lab/biometric data**
- **Claims submitted to Blue Cross**
- **BCBS outreaches to patient to address optimal diabetes management**
- **Patient A is referred to primary care for follow up of uncontrolled diabetes**
- **Patient A may also be eligible for home visits, disease management, or other supplemental benefits**
Improved Provider Experience

Patient B: Charles
Medicare Member with COPD

Charles recently visited his PCP for a respiratory infection causing an exacerbation of his COPD. However, when the claim was submitted, the PCP did not include COPD as a diagnosis on the claims, only upper respiratory infection.

Current Process

PCP Visit: Respiratory infection causing an exacerbation of COPD

Medical information entered into EMR

Claims submitted to Blue Cross, no COPD

Blue Cross must request chart records to verify COPD.

Patient B does not receive referral to Disease Management Program

Epic Interoperability

PCP Visit: Respiratory infection causing an exacerbation of COPD

Medical information entered into EMR

Blue Cross accesses medical information

Blue Cross verifies COPD diagnosis through medical information

Patient B is referred to primary care for regular COPD follow up visits

Claims submitted to Blue Cross, No COPD

Blue Cross provides training to physician group on appropriate coding practices and documenting diagnoses

Patient B may also be eligible for home visits, disease management, or other supplemental benefits
Improved Medication Management

**Patient C: Luis**
Medicare member with multiple chronic conditions and medications

**Current Process**
- Patient C refills/fills a prescription with clinic pharmacist
- Clinic pharmacist documents the prescription in EMR and documents on a spreadsheet contact attempts & appointment scheduling
- EMR Documentation is extracted and sent with copies of the required patient takeaways and documentation of member outreach is sent to BCBSMN via manual efforts

**Epic Interoperability**
- Patient C refills/fills a prescription with clinic pharmacist
- Clinical documentation from MTM visit available via Care Everywhere
- Using an automated SFTP, required CMS data elements are sent via CCDA, decreasing the pharmacy teams administrative work
Patient Awareness

Blue Cross has secured authorization to access the medical information by establishing global patient authorizations

- Members’ applications for Medicare, Medicaid, and ACA include standard language providing authorization to medical information.

- All members for these lines of business have authorized BCBSMN to have access to their medical records for care management, quality improvement activities, and other purposes.

- Includes authorization to access information prior to their enrollment with BCBSMN.

- These authorizations are being used with organizations today for the manual chart review/retrieval process.
Future State
Opportunities

• In-workflow provider alerts and coding opportunities
• Sharing medical claims data with providers
• Transitions of Care
  – Real-time care alerts
  – Enhanced program referrals and connecting members with transition benefits
• Disease Management
  – Enhanced identification and stratification
  – Targeted member engagement and referral into existing provider and plan programs
• Leveraging Epic to be a central record for the patient
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Sanjay Motwani
Staff Vice President, Population Health Platforms, Anthem
New Needs Across Entities...

**Payers**
- “Bend the Trend through Providers”, not at them
- Drive quality by influencing care closer to the point of care
- Enable bi-directional information sharing to create transparency
- Support providers in risk transition

**Providers**
- Achieve cost and quality results expected in value based contracts
- Improve patient and physician satisfaction; reduce administrative burden
- Establish population health platforms that enable network scale & growth
- Enable a roadmap to take on risk

**Employers**
- Drive down employee contribution costs
- Seek direct solutions with providers and other non-payer entities

...in an environment that’s consistently changing...

Which entities are most affected?
- Value-Based Purchasing
  - Payers
  - Providers
- Re-Admission / HAC Reduction
  - Payers
  - Providers
- Alternative Payment Models / Merit-based Incentive Program
  - Payers
  - Providers
  - Employers

...lends itself to Provider anxiety about the future.

**Question**: What is the main barrier for your organization to take on additional financial risk?

1. Lack of Enabling Capabilities for Population Health
2. Organizational readiness to adopt changes
3. Capital or cash flow
4. Local market dynamics
Enabling Success: Results That Matter

- Reduction in ER visits by frequent ER utilizers from 21% to 16% over a 4-month period.

- Significant technology adoption:
  - All 7 Founder health systems now participating in EMR data exchange.
  - 439K encounter records YTD shared across network to support collaboration.
  - 33 different EMR interfaces sending real-time patient data to the central portal.

- Delivered shared savings disbursements with system partners

Vivity is a joint venture with seven different healthcare systems and Anthem in Southern California:

- Cedars-Sinai
- Torrance Memorial Health System
- Huntington Hospital
- Memorial Care Health System
- Good Samaritan Hospital
- PIH Health
- UCLA Health
- Anthem Blue Cross of CA

Challenge: 33 different EMR interfaces

Defined needs: Technology and clinical support to drive success of Vivity joint venture by:

- Data exchange to connect clinical and claims data across multiple systems/sites of care
- Engagement of multiple systems/sites to ensure consistent Care Management approach and streamline patient experience
- Identification, prioritization and execution of clinical initiatives to reduce cost of care
- Enable visibility of 210K members through our portal (combination of Commercial and Medicare Advantage risk-sharing arrangements including Vivity)

* Vivity metrics require run-out (IBNRs) to be calculated several quarters in arrears to represent accurate performance metrics. For this reason, the YE 2016 metrics (updated in Aug 2017) represent the most accurate Vivity performance metrics to-date.
Our Platform Approach

EXECUTIVE
- 360-Degree Performance Insights
- Contract, Payment & Population Management
- ROI from VBC

Bi-Directional Data Interoperability
- Acquisition
- Normalization
- MDM
- Quality
- Terminologies
- Analytics
- Workflow
- Security
- Infrastructure

CONFIGURABLE LOGIC ENGINES
- Labs
- Pharma
- Provider Billing and Administrative
- Patient Reported Outcomes
- Psychosocial and Socio-economic

OPERATIONAL RELIABILITY
- Adjudicated Claims (All Payers)
- Administrative (All Payers)
- Provider EMRs (Clinical, ADT)

Three Unique Offerings

Value Based Care Analytics
- Mainly claims and care management data, serving Anthem VBC programs

Longitudinal Patient Record (LPR) Analytics
- Serving Anthem product partnerships with providers and employers, e.g. Vivity
- Combines clinical, claims, care management & patient data, with bi-directional integration

Integrated Population Health Management
- Integrated data, analytics and workflow solution; optional self-service tools for a physician’s patients.