

Empowering Medicaid Payment and Delivery Transformation with Claims Data

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Medicaid payment and delivery system transformation is a key strategy for states seeking to control costs, increase access, and improve quality.



Medicaid as a Driver of Health System Transformation



The Role of Data in Medicaid System Transformation



Defining Data Strategy



Four Transformation Data Disconnects



Roles for Data Agencies in Transformation

Medicaid as a Driver of System Transformation

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Bundled Payment Programs

Example states include:



Arkansas



Tennessee

Medicaid ACOs

Example states include:



Minnesota



Oregon

VBP Required in MCO Contracts

Example states include:



Arizona



South Carolina

DSRIP Waivers

Example states include:



California



New York

Multi-Payer Initiatives

State Innovation Models (SIM) Grants

CMS also awarded over \$300 million in SIM grants to States to support the development of payment and delivery system transformation initiatives across Medicaid and other payers.

Dual Eligibles Financial Alignment Initiative

CMS has approved 14 state demonstrations to promote better care coordination and cost containment for individuals who are dually eligible for Medicare and Medicaid.

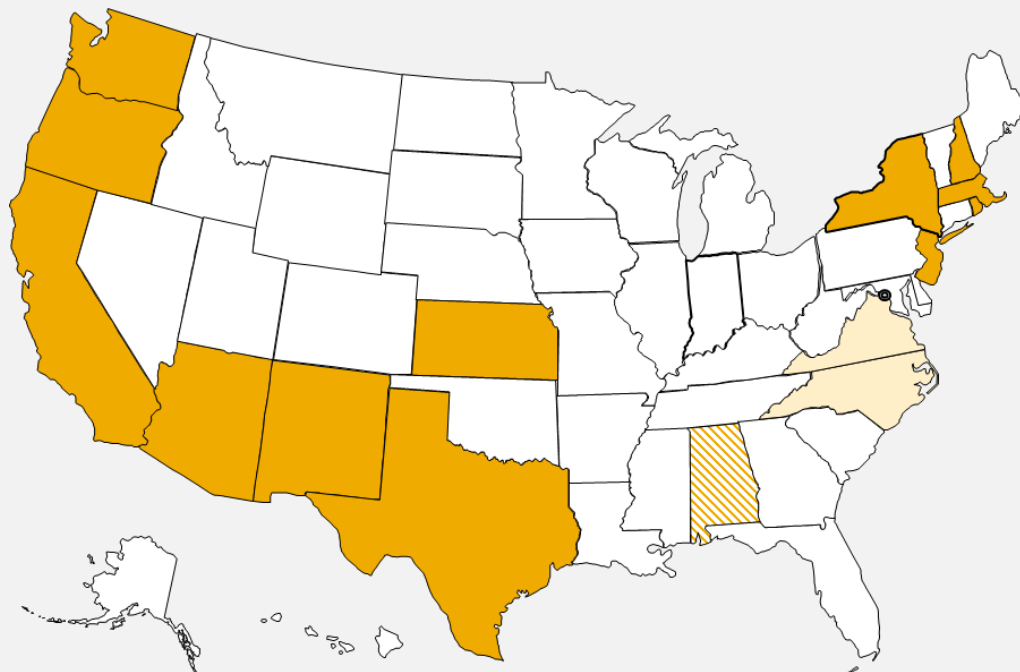
Source(s): "Medicaid Accountable Care Organizations: State Update," Center for Health Care Strategies, Inc., March 2016; "The Role of State Medicaid Programs In Improving the Value of the Health Care System," National Association of Medicaid Directors, March 2016; Manatt research on VBP requirements in MCO contracts.

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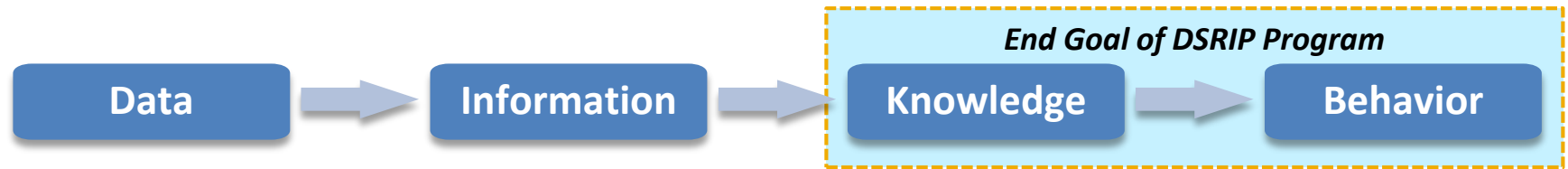
Delivery System Reform Incentive Payment (DSRIP)

Provides up-front federal funding for providers to invest in infrastructure and population health improvements

15 States Approved & Pending*



Source(s): “Implications of the Latest Round of Delivery System Reform Incentive Payment (DSRIP) Waivers for MACPAC’s Work on Value-Based Payment”, MACPAC, Sept.14, 2017. Available [here](#). “State Delivery System and Payment Reform Map”, NASHP, accessed Sept. 25, 2017. Available [here](#). Alabama will not implement its approved DSRIP.



The Pressing Need for Data Integration

- Efforts to transition from “Volume to Value” fundamentally require greater data collection, analysis, and dissemination coming from and going to more stakeholders than ever
- Particularly challenging in Medicaid transformation, as under-resourced state agencies and safety net providers are required to develop, manage, and evaluate population health initiatives

Key Data Trends

- Increased use of aggregate population data in provider network management, reporting and payment/funds flow to drive delivery system reform (across large, multi-system networks)
- Continued shift from static, retrospective analyses to dynamic predictive analyses to improve patient and sub-population decision-making (even static/retrospective analysis is often uneven)
- More systematic use of claims and clinical data to measure outcomes, improve health system performance and test clinical interventions (such as protocols, care models, care teams, etc.)

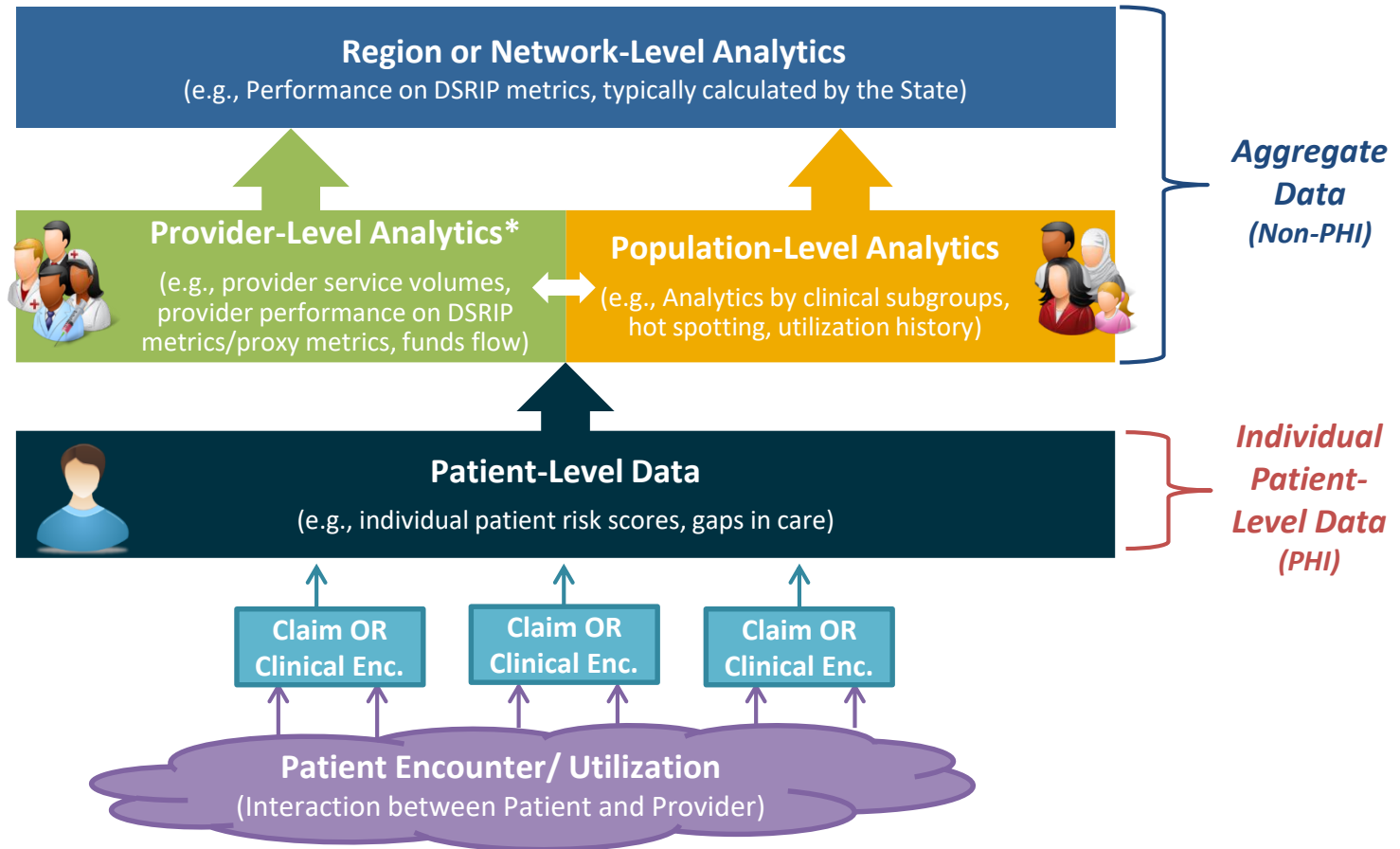
Example: Levels of Patient Data Aggregation in DSRIP

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DSRIP functions require patient encounter data to be aggregated and reported at various levels.

Typically states are responsible for performance metric calculation and reporting.

State role in patient-level and aggregate provider/population level analytics is uneven.

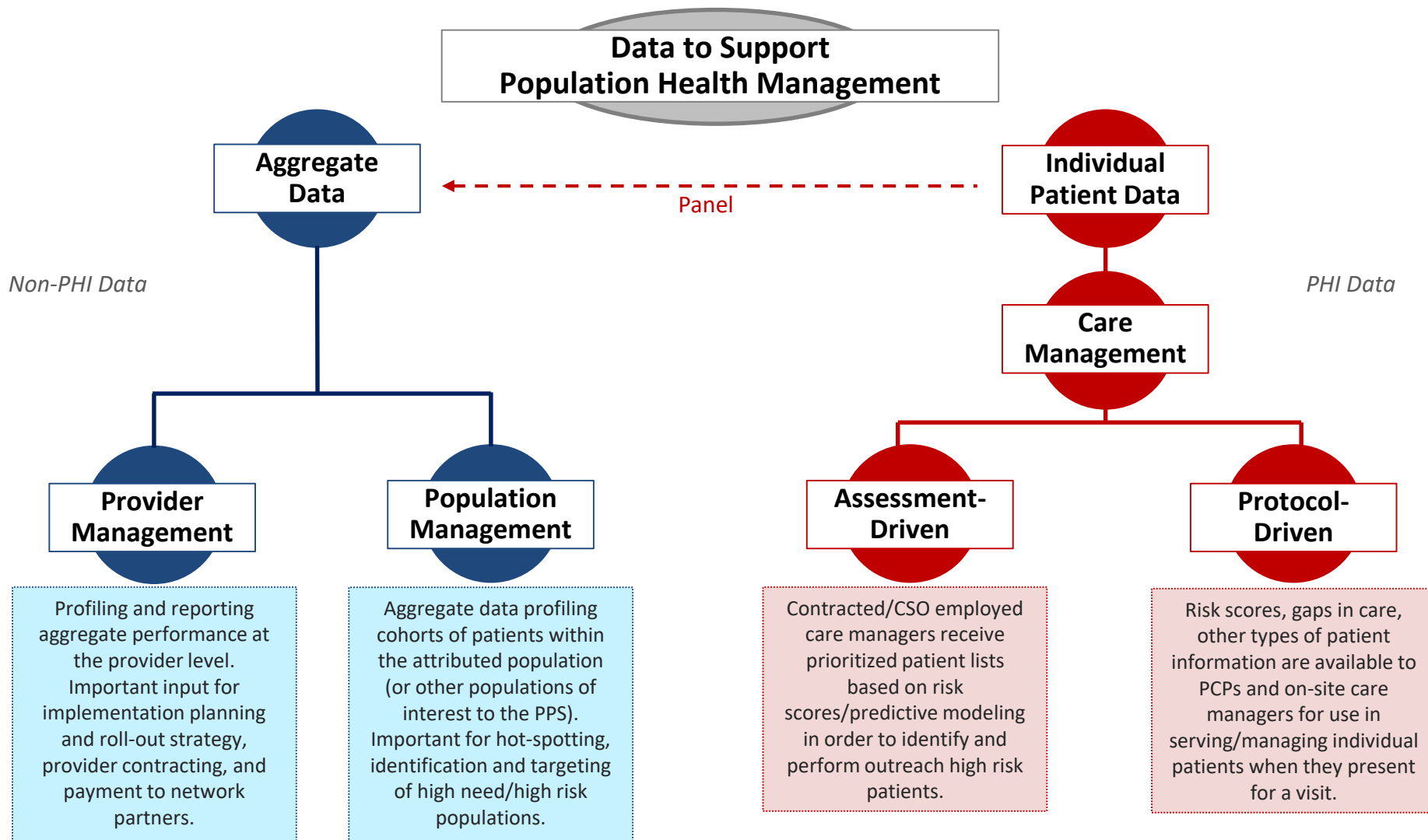


**Note: Aggregate partner analytics for management and communications purposes vary based on provider type and PPS implementation needs*

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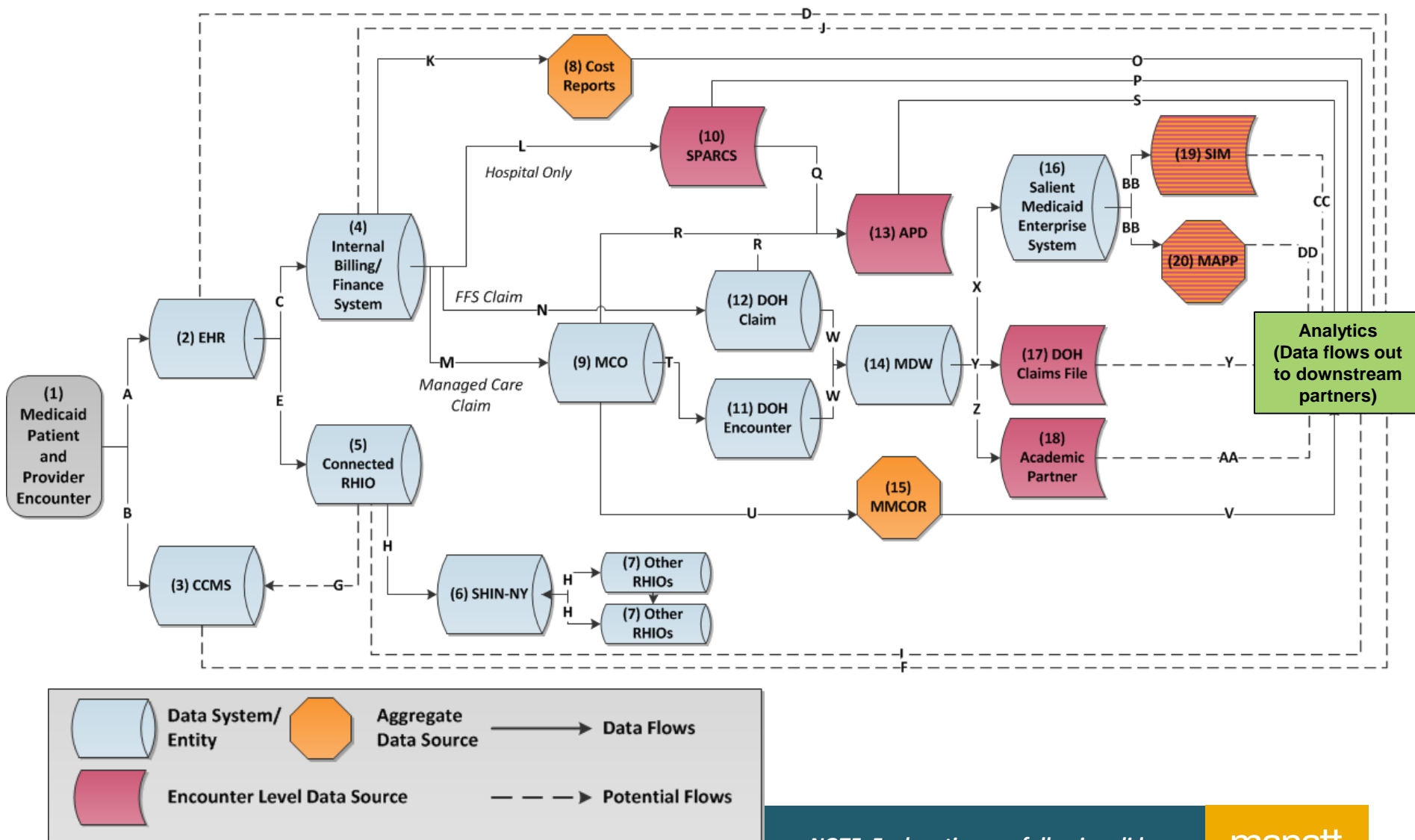
Example: Framework of Data and Analytics Needs to Support PHM

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Example: NYS Medicaid Encounter Data Flow

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NOTE: Explanations on following slides.

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Example: NYS Medicaid Encounter Data Flow

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STEP EXPLANATION

- (1) Patient meets with provider
- (2) EHR – Stores clinical data; populated by providers
- (3) CCMS – Care management system; populated by providers, care managers
- (4) Billing/Finance System – produces claim sent to DOH/MCO, encounter extract sent to SPARCS, and aggregate cost reports
- (5) Connected RHIO – Platform for exchange of clinical information from connected EHRs within sub-state regions
- (6) SHIN-NY – Statewide platform for exchange of information between RHIOs
- (7) Other RHIOs – RHIOs operating in other regions in NYS
- (8) Cost Reports – Annual provider aggregate financial and operating information reported to federal or state agencies (NYS ICR, CMS HCRIS, etc.)
- (9) MCOs receive claims from providers for their enrolled patients
- (10) SPARCS – NYS hospital reported IP/OP encounter level dataset
- (11) DOH Encounter – Medicaid encounter claims submitted by plans to DOH
- (12) DOH Claims – Fee-for-service claims submitted to DOH for payment
- (13) APD – All-Payer Database combines claims for all plans/LOBs and SPARCS
- (14) MDW – central data warehouse for NYS Medicaid claims and encounters
- (15) MMCOR – Quarterly Medicaid health plan aggregate financial and operating information submitted to NYSDOH
- (16) Salient Medicaid Enterprise System – Database populating MAPP and SIM tools
- (17) DOH Claims File – Providers may request data files from DOH containing claim and encounter records for patients with appropriate patient consent
- (18) Academic researchers may have direct access to data from the MDW
- (19) SIM – Salient Interactive Miner, a software platform allowing users limited capability to analyze comprehensive Medicaid claim and encounter data
- (20) MAPP (Performance Tool) – A dashboard based platform allowing PPS's to view and segment performance data and state-aggregated proxy metrics

PROCESS EXPLANATION

- (A) Patient meets with provider; clinical info. from visit is entered into the EHR.
- (B) Relevant information from visit may also be entered into the CCMS.
- (C) Relevant clinical data is sent to billing/finance system to produce claim.
- (D) EHR data may be accessed by the end user for patient-level analytics.
- (E) Clinical data is available for exchange through the RHIO.
- (F) End user may be able to directly access data in the CCMS.
- (G) RHIO data may be accessed by the CCMS.
- (H) RHIO data is shared through the SHIN-NY. Providers connected to other RHIOs may also access data via the SHIN-NY
- (I) RHIO data may be accessed by the end user for patient-level analytics.
- (J) Billing/finance data may be accessed by the end user for patient, encounter, or claims level analytics.
- (K) Billing/finance data is aggregated by provider to produce cost reports.
- (L) Billing/finance data is extracted to submit to DOH as SPARCS encounters.
- (M) Billing/finance system sends claims for MCO patients to MCOs.
- (N) Billing/finance system sends claims for FFS patients to DOH.
- (O) Cost Reports are publically available to end user.
- (P) Several levels of de-identified SPARCS data is publically available for end user. Patient identifiable SPARCS can be accessed with approval by SPARCS review board.
- (Q) SPARCS contributes data to ADP for encounters not paid by plans.
- (R) MCOs contribute data to ADP for encounters paid within their plans. DOH contributes data to ADP for claims.
- (S) ADP data will be publically available for end user once system is live.
- (T) MCOs submit required Medicaid encounter information to DOH.
- (U) MCOs submit aggregate quarterly MMCOR financial and operating information to DOH.
- (V) MMCOR files are publically available for end user.
- (W) DOH encounters and claims are loaded into the MDW.
- (X) Salient Medicaid Enterprise System pulls weekly data updates from MDW.
- (Y) User requested claims files are produced from MDW if approved by DOH.
- (Z) MDW data is shared with academic partners for analytic purposes.
- (AA) Academic partner could share analysis or data access with an end user.
- (BB) SIM and MAPP tools draw data from Salient Medicaid Enterprise System.
- (CC) End users can use the SIM tool for non-PHI analyses (PHI available in some cases).
- (DD) End users may be able to access performance data using the MAPP dashboards (patient-level drills will be available in future).

Defining “Data Strategy” Layer as Part of Functional Design

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Data Strategy is the key (and often missing) link in State Medicaid transformation efforts.

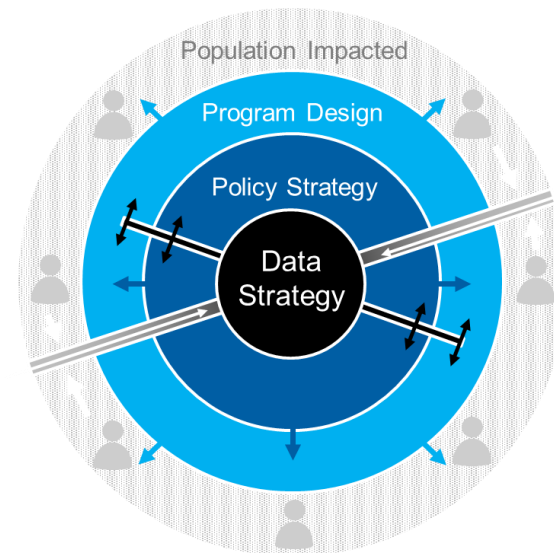
Layer	Components
Policy Strategy	<ul style="list-style-type: none">• Articulate the program goals and overall direction• Define the rules and key elements of proposed projects and activities• Establish milestones and timing
Data Strategy	<ul style="list-style-type: none">• Define the purposes for and uses of data in the context of policy and strategy goals• Establish relationships to regional project-based and population health performance metrics• Serve as the transition layer that links policy and strategy to business requirements
Business Requirements	<ul style="list-style-type: none">• Define the current and expected functionality of data systems• Identify specific actions and technical requirements
Infrastructure	<ul style="list-style-type: none">• Define the technical architecture and system design• Identify supporting systems, data repositories, and mechanisms for connections• Establish prioritization framework for technology changes• Develop technical specifications

A successful Data Strategy will define the business uses and identify the business processes that support the vision and strategies for Health Reform and guide the development of technical infrastructure.

Our Role

Manatt Health Analytics supports provider systems and state agencies engaged in payment and delivery transformation to:

- Develop a comprehensive view of the needs for, uses and sources of data and analytics in the context their policy and strategy goals;
- Define the relationships between data and analytic resources and key functional design areas, such as payment, performance management, provider network management, patient attribution, population health, quality, clinical care, oversight, and other key program areas;
- Develop actionable data strategies to leverage resources across stakeholders to link policy and strategy to business requirements.



Our State Medicaid Transformation Work

Our **Policy + Data Strategy** work with both states and providers...

Five NYS Performing Provider Systems (PPS), DSRIP Implementation

State of Washington, DSRIP Implementation

...provides us a unique perspective on reform and strategy data needs and barriers in State Medicaid transformation.



1. The “Come from Behind” Priority

Historically, data and analytics capabilities are typically under-invested by states and safety net providers. Yet, data and analytics are often central to early transformation planning (though this often is not recognized until planning activities are well underway). Jump-starting data analysis and dissemination, in the context of short timelines and limited resources, can be a big lift for all parties.

2. Leverage Existing Capabilities... But Recognize Limitations

Despite historic under-investment, states and other stakeholders typically have some existing data and analytics capabilities. However, it is unlikely that existing capabilities will meet all or even most of the data needs for transformation planning and implementation. It is critical to recognize where existing resources can be leveraged, and where new investment or restructuring of existing capacity is necessary for success.

3. “1,000 Flowers Blooming”

The combination of high stress around capacity gaps and the infusion of resources to support transformation activities may lead to precipitous and inefficient investment of resources in data and analytics infrastructure. Without effective planning and coordination, a disproportionate amount of program resources may be expended as individual agencies and entities rush to take on overlapping and/or disparate data/analytic tasks that would be better served by centralized coordination and investment.

4. Analytics Staffing/Skills Gap

States and other stakeholders often struggle to hire and retain staff who have the needed data and analytic skills, and who can also understand (and translate) results to inform policy. This gap is exacerbated by local competition for these skillsets between state agencies, regional or provider lead organizations, and other transformation stakeholders.

➤ Data Agencies as **Reform Leaders**

Agencies can be key partners in transformation, contributing their expertise and insights on data and analytics needs and opportunities in statewide transformation planning and implementation processes.

➤ Data Agencies as **Planners**

Agencies can help states and regional/provider network leaders to proactively develop short- and long-term data and infrastructure plans to ensure the right data/analytic investments are made and resourced appropriately to support program goals.

➤ Data Agencies as **Conveners**

Agencies can be conveners between providers, payers, state policy-makers, and other stakeholders, helping each to better understand data-related reform goals and limitations, resulting in stronger collaboration and reform plans.

➤ Data Agencies as **Educators**

Agencies can educate policy-makers about what data is and what it can and cannot do, and what resources and capabilities are needed to get the right data and analytics to the right place to support transformation goals.

Thank You!

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