

ROSTER

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Updated December 18, 2017

HCP LAN: Data Sharing



Principles

- Data sharing is foundational for the successful operation of PBP models
- Data sharing in PBP will need to be different than it is in FFS models
- Data sharing for PBP models requires multi-stakeholder relationship built on trust, cooperation and transparency
- Identifiable, patient-level data should follow the patient
- Population-level data should be treated as a public good
- Widespread data sharing may necessitate third-party intermediaries

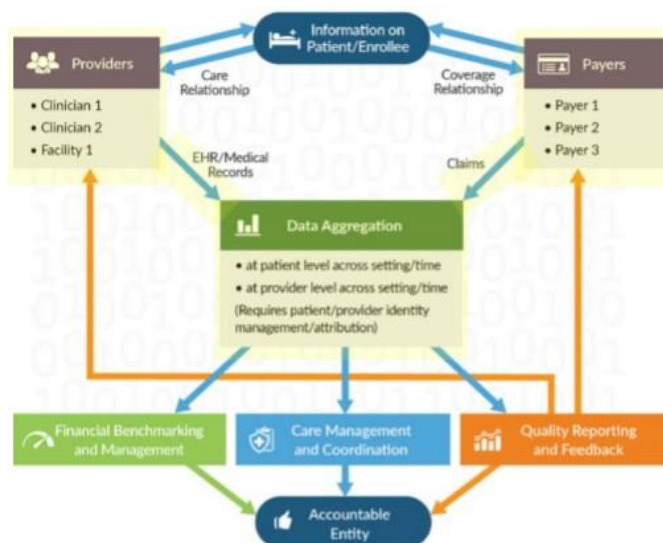
Chief Obstacles

- Proprietary approaches to data
- Establishment and dissemination of meaningful standards
- Lack of funding to develop and maintain data-sharing initiatives
- Legislative and policy barriers to the sharing of specific data sets
- Privacy and security concerns
- Technical and infrastructural gaps that limit the collection and transmission of rich clinical and patient-reported data

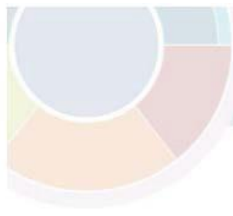
Value-Based Data Sharing Requirements Initiative



- Essential role of collaboration, shared goals and shared solutions to develop data sharing capacity
- APMs require view of data across settings and providers
- Need both claims and clinical data at the patient level, data should be aggregated at the provider or other accountable entity level



Source: [Data Sharing Requirements Initiative White Paper](#)



CMS's Data Aggregation Overview for CPC+ (same idea in Classic)



Data Aggregation in CPC Classic

- In 3 of 7 regions (Colorado, Ohio, and Oklahoma), payers collaborated to provide aggregated reports to practices on their patients' utilization, costs, and quality of care
- Potential game-changer in improving the usefulness of performance feedback to practices
 - Reflects performance across larger number of patients and common metrics
 - Increases reliability of data and provides a more complete picture of a practice's improvement opportunities
 - Reduces burden of accessing multiple reports
- Some differences in approach across regions (e.g., unit of data, financing approach)

Key Decisions When Aggregating Data

- **Figuring out the management infrastructure**
 - Select a vendor
 - Develop a governance structure
 - Decide how to finance
- **Deciding on content and structure**
 - Level of claims information to share (patient versus practice)
 - Performance benchmark
 - Platform for viewing report
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- **Other decisions**
 - Training practices in use of report
 - Whether to continue payer-specific reports

Challenges and Facilitators of Data Aggregation

- **Challenges in payers agreeing/continuing to collaborate**
 - Cost to payers, uncertain return on investment; substantial time investment to contract with aggregator; initial uncertainty about Medicare's participation in data aggregation; and concerns about sharing cost data, division of costs
- **Factors promoting collaboration**
 - Strong, independent facilitators guiding negotiations; payer acceptance that progress would be incremental; operating in market with multiple payers, each with substantial market share

Challenges of Making Aggregated Data Useful

- Time lag in claims data
- Effectively educating practices on how to use reports
- Constraints in reporting health care costs limit ability to inform clinicians' referral choices
- Issues of data validity and comparability

Key Takeaways on Data Aggregation

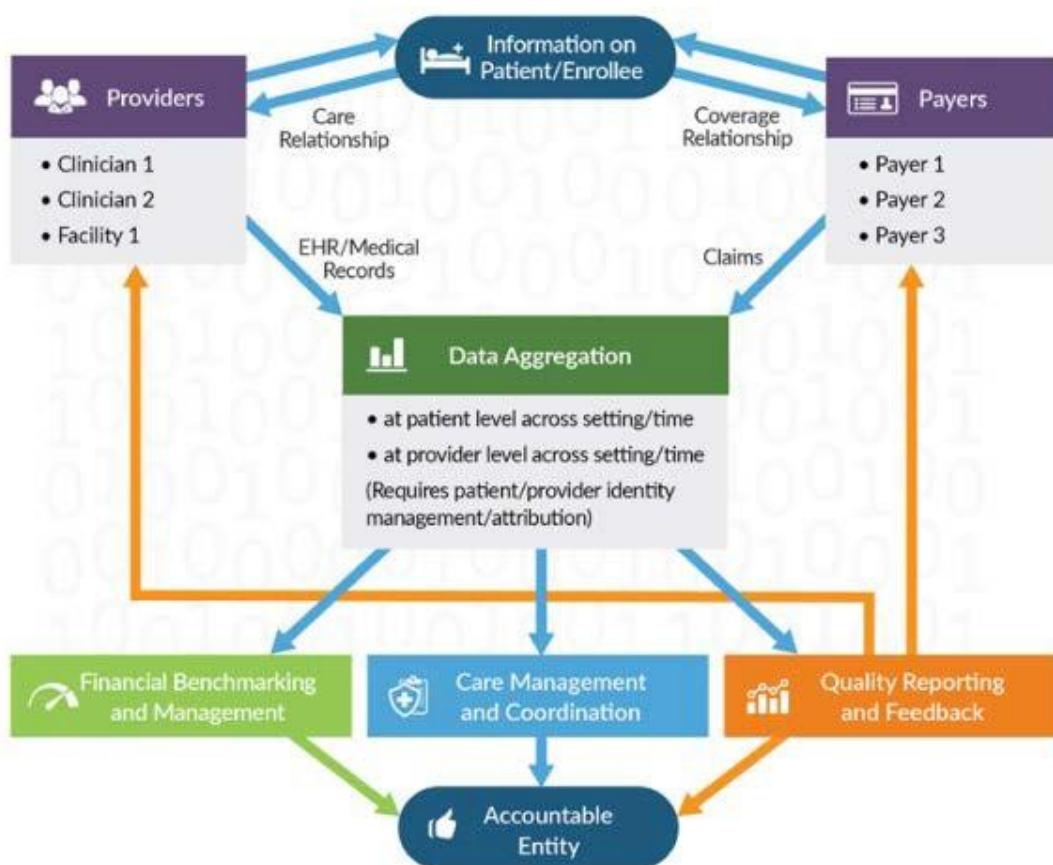
- Consider using an independent facilitator to guide payer and vendor negotiations and for ongoing governance.
- Secure a critical mass of payer participation so that the report is valuable to practices, and costs are spread across payers.
- Obtain input on the design and content of the aggregated report from practices and make any tools easy to use.
- Divide aggregation costs among payers in proportion to number of patients; consider having practices share in the costs.
- Allow ample time to work toward data aggregation and adjust expectations regarding its costs and time horizon for ROI.
- Specify roles and responsibilities for training practices in how to use aggregated feedback reports and patient-level data.

Oregon CPC+ Payer Group Data Aggregation Vision, Agreements and Scope

Beginning in October 2017, the Oregon CPC+ Payer group has been exploring options related to data aggregation, including the following activities:

- Presentation from CMS to understand their expectations for payer data aggregation, including the role of CMS as a participant in a shared solution
- Collection and review of national resources from the Health Care Payment Learning and Action Network (HCP LAN), including the [Data Sharing Requirements Initiative white paper](#) and [Accelerating and Aligning Population-Based Payment Models: Data Sharing](#).
- Presentations from existing Oregon data aggregation solutions – Oregon Health Authority’s Clinical Quality Metrics Registry and Q Corp Data Collaborative and Reporting Portal
- Gathered practice feedback at in-person learning session and through practice presentations
- Follow up exploratory meetings between OHA and Q Corp
- Survey of payers to understand their priorities and concerns related to data aggregation
- Ongoing Payer Group discussion about vision, scope and next steps

The CPC+ Payer Group agreed that the following diagram outlined the Group’s vision for and approach to data aggregation.



Source: Data Sharing Requirements Initiative: Collaborative Approaches to Advance Data Sharing produced by the Health Care Payment Learning and Action Network (2017), <http://hcp-lan.org/workproducts/dsri-report.pdf>

CPC+ Payer Group Data Aggregation Agreements

- Practices should be involved to ensure data aggregation solution meets their needs
- Prioritize the scope of CPC+ Payer commitment outlined in MOU with CMS
 - Payers will share data with practices: utilization of service and/or total cost of care data and lists of attributed members
 - Make a reasonable effort to support an appropriately structured multi-payer claims data system for a common approach for sharing data with participating practices
- Leverage existing solutions and investments, specifically the Q Corp Data Collaborative and Reporting Portal and Oregon Health Authority Clinical Quality Metrics Registry (CQMR)
 - Existing solutions from Q Corp (Reporting Portal) and OHA (Clinical Quality Metrics Registry) are in place or planned, but CPC+ payer adoption or support of these existing solutions is important to reduce duplicative efforts and streamline data exchanged with practices
- Payers have already or may be planning to adopt other solutions for collecting clinical data from EHRs and reporting claims data to practices; those need to be reconciled with next steps
- Progress is reliant on payer commitment and active leadership – CPC+ Payer Group members should be clear about what they need to bring this discussion back to their organization
- The more participation in a shared solution, the more comprehensive it will be, which increases its value
- Clinical data from EHRs and administrative data from claims each offer advantages and disadvantages; a combination is optimal for both parties involved in value-based contracts
- Any CPC+ data aggregation solution should support payer evaluation of the CPC+ model and whether/how to sustain and spread it

Scope

In Scope	Out of Scope
<ul style="list-style-type: none">• Data aggregation specific to data generated by payers and reported to practices (e.g. performance reports using claims data), or data requested from practices by payers for CPC+ and other value-based contracts (e.g. clinical quality metrics)• Aggregated data to help practices understand performance, guide quality improvement and manage costs, especially as it relates to CPC+ and other value-based contracts• Streamlining and optimizing claims-based performance reporting from payers to practices to make it more timely and actionable for quality improvement and reducing costs• Reducing administrative burden and duplicative effort, especially related to data sharing for value-based contracts (e.g. managing care gap lists, submitting clinical quality measures to multiple plans, etc.)	<ul style="list-style-type: none">• Health IT unrelated to data aggregation purposes outlined by CMS; although care coordination and care management are essential functions of CPC+ practices, tools that support these functions, but are not specific to aggregated data are out of scope (e.g. PreManage)• “From scratch” solutions

CPC+ Payer Group Data Aggregation Next Steps

Next Steps for Conveners	Next Steps for Payer Group Members
<ul style="list-style-type: none">• Interview additional practices to understand how potential solutions reflect their needs – e.g. rural practices, small and independent practices, health systems, etc.• Engage CMS to understand the financial and data contributions they could make to a shared solution• Individual meetings with payers to understand how shared solutions relate to existing individual payer solutions• Arrange for presentation of OHA CQMR to ensure payers understand capabilities and timeline• Further define costs based on Payer Group feedback on appropriate scope• Suggest how shared solution might be financed• Ongoing review of proposal	<ul style="list-style-type: none">• Engage other stakeholders within organization, consider whether they should attend February and March Payer Group meetings• Understand existing payer-operated solutions that may be duplicative of a shared resource; define what is needed to weigh those options• Understand organizational commitment to a shared solution, including contributing data, financial support, staff planning time• Consider separate data aggregation subgroup to guide next steps

CPC+ Data Aggregation Background Information

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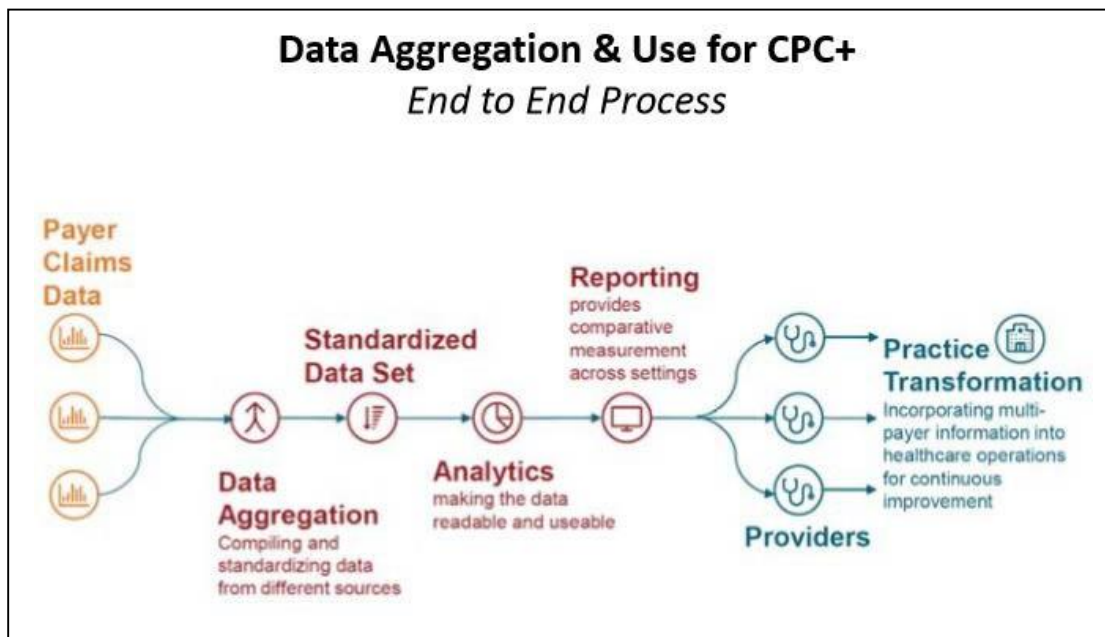
CMS and National Resources

Memorandum of Understanding

Section V: Commitment to Data Sharing with Participating Practices

1. [PAYER] will share utilization of service and/or total cost of care data with respect to its attributed members with participating practices in [MARKET] at least quarterly. [PAYER] will send the first such data report to these participating practices no later than [DATE].
2. [PAYER] will provide participating practices in [MARKET] with lists of its attributed members at the beginning of each attribution look back period.
3. If an appropriately structured multi-payer claims data system exists or can be created in [MARKET] to support a common approach for sharing data with participating primary care practices, [PAYER] will make a reasonable effort to contribute the data described in paragraph IV.1. to this system. If an appropriately structured multi-payer claims data system does not exist or cannot be created in a timely fashion, [PAYER] will develop a mechanism to enable participating primary care practices to review relevant claims data and analyses with respect to [PAYER]'s attributed members.
4. If there is no appropriately structured multi-payer claims data system available in [MARKET] and, despite the best efforts of CMS and other payer partners one cannot be created in [MARKET], [PAYER] will work with other payer partners in [MARKET] and CMS to produce a written plan by [DATE] that outlines how these payers will develop a common approach for sharing data with participating primary care practices in [MARKET]. [PAYER] will also work with CMS and other payer partners in [MARKET] to implement the approach described in this written plan by the end of the second performance year of the model.

CMS Presentation to Oregon Payers (September 2017)



Data Aggregation & Use for CPC+

Use Cases & Advantages

Objectives

- Improve care management for individuals, particularly those with complex needs
- Improve outreach and preventive services for key population groups
- Improve use of comparative performance measurement (variation, drivers)
- Improve use of data and information to guide continuous improvement cycles
- Reduce clinician burden in accessing & using data

Data Aggregation & Use for CPC+

Support for Transformation

CMS Strategies

- Share Medicare data with regional aggregators that are up & running (Part A, B, D)
- Assist with funding to support regional data aggregation & reporting
- Use Medicare CPC+ reporting to support regions without data reporting infrastructure
- Work to align with related CMS programs such as SIM and Medicaid (measures, IAPDs, waivers)
- Practice support and sharing networks at the local, regional, and national levels
- Pilots to develop and test new capabilities and models for data aggregation and use
- Meet regions where they are and assist based on regional strategies

Data Aggregation & Use for CPC+ *Framework for Assessments*

Technical Capabilities

Analytics Services	Reporting Services
Expenditure Reporting	Utilization Reporting
Data Quality & Risk Adjustment	Quality Measure Reporting
Data Extraction	Data Aggregation & Transformation
Patient Identity Management	Provider Directory & Attribution
Security & Privacy	Consent Management

Foundational Elements

Business Reason	Governance
Policy	Financing
Legal Agreements	User Support / Learning Network

Adapted from ONC Health IT-Enabled Quality Measurement Strategic Implementation Guide 2017

Health Care Payment Learning and Action Network (HCP LAN) White Papers

[Data Sharing Requirements Initiative Report \(May 2017\)](#): “The report is designed to help leaders of organizations, including providers, payers, and employers, who are working or wish to work in alternative payment models (APMs) to understand what information they will need from outside their organization and the processes involved in obtaining that information. Secondarily, this report will aid organizations, including third party entities, vendors, and policymakers, that support the data sources and data sharing processes to understand how best to enable their efforts. While the report is not a “how to” guide, as the specifics for each organization and region differ, it will be helpful in the strategic planning process to identify the APM functions that require data sharing, to assess current capacity and barriers, and to consider strategies within and across organizations to fill gaps in necessary data sharing functionality.”

[Data Sharing White Paper \(August 2016\)](#): “The Work Group [that produced this white paper] believes that data sharing is foundational for operationalizing the components of PBP models (i.e., patient attribution, financial benchmarking, and performance measurement) because these activities cannot take place in the absence of data. The White Paper documents principles and recommendations that should guide approaches to data sharing in PBP models. The aim is to share important patient data to inform clinical decision making, allow payers to assess provider performance, and support increased alignment across public and private payers. Data sharing currently faces multiple challenges, including proprietary approaches to data collection and reporting, inconsistent and underdeveloped data architecture, a lack of funding and standards, and technical limitations to

the collection of rich clinical and patient-reported data. In order to overcome these challenges, this White Paper describes the key characteristics of data sharing that can help sustain PBP models that meet the triple aim of health care.”

Mathematica Data Aggregation Slides

Key Decisions When Aggregating Data

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-

Existing Solutions – Q Corp and Oregon Health Authority

Q Corp Data Collaborative – Brief Summary

Since 2008, Q Corp has aggregated claims data from multiple payers to produce quality reports for consumers, providers, health plans, policymakers and employers. Ten data suppliers, including commercial, OHA and Medicare Advantage, contributed administrative medical and pharmacy claims data containing more than 600 million claim records from more than 3.8 million unique members:

- Oregon Health Authority (Medicaid)
- Regence BlueCross BlueShield of Oregon
- Providence Health Plan
- Moda Health
- Kaiser Permanente Northwest
- PacificSource Health Plans
- Health Net
- CareOregon
- Tuality Health Alliance
- Center for Medicare and Medicaid Services Qualified Entity (Medicare Fee-For-Service)

Q Corp's data includes patient-level detail and the ability to link individuals across plans and years. The database contains 95% of Oregonians, including:

- 100 percent of the Medicaid population
- 79 percent of the state's fully-insured commercial population
- 24 percent of the state's self-insured commercial population
- 89 percent of the Medicare population

Read More: <http://www.q-corp.org/portal>

OHA Clinical Quality Metrics Registry Overview

The Oregon Health Authority (OHA) is implementing a Clinical Quality Metrics Registry (CQMR). The CQMR will collect, aggregate, and provide clinical quality metrics data to support quality reporting programs in the state of Oregon. The ability for health care providers and organizations, as well as OHA, to gather and analyze data is a key component to evaluating system performance, improving patient outcomes and reducing costs for Oregonians.

The CQMR will:

- Improve data transparency and availability
- Decrease administrative burden of data collection and reporting
- Enable a 'report once' strategy to streamline reporting requirements among multiple quality programs
- Support Oregon's Medicaid providers in meeting federal requirements for Meaningful Use incentive payments

Why the CQMR is needed

Clinical quality measures are a way to assess the care that patients receive. With the increasing adoption of electronic health records (EHRs), Oregon has new opportunities to measure and improve the quality of care. Using EHR data supports measuring outcomes—for example, measuring whether a diabetic patient’s blood sugar levels are controlled rather than simply measuring whether the patient’s blood sugar levels were tested. The CQMR will enable more efficient collection and use of this important quality data.

Today, however, Oregon has no standard, automated capacity for the collection, storage, or aggregation of clinical quality metrics. The CQMR will fill this gap. It will align with national standards for the collection and calculation of quality measures. To support providers with different levels of technical capacity, the CQMR will offer several secure options for data submission.

How the CQMR will be used

The CQMR will be used for collecting and validating data, calculating measure results for comparison to established benchmarks, and supplying data for analytics. It will comply with privacy and security standards and best practices. The registry will allow health care organizations to review local, regional, and state data to help inform decision-making and measure how they and others are doing to help improve patient care and reduce system costs. It will provide information that can be used to evaluate systems and processes to determine if changes can be made to help meet goals.

Initially, the CQMR will support two programs:

1. Coordinated care organization (CCO) [incentive measures](#)
2. Oregon [Medicaid EHR Incentive Program](#)

OHA’s incentive-based model pays CCOs for improved health outcomes and accountability, not for the number of services provided. CCOs receive incentives for meeting benchmarks and improvement targets on certain metrics, including a subset of EHR-based clinical measures. Medicaid providers who participate in the EHR Incentive Program (also known as Meaningful Use) report annually on quality measures.

With the CQMR, OHA will be able to collect a more robust and meaningful data set for these programs. Over time, other programs may also use the CQMR. This “report once” approach would reduce administrative burdens for providers by allowing them to submit quality data once in order to meet multiple reporting requirements.

Timeline for development

Implementation started in late 2017. OHA expects the CQMR to be live in late 2018. Updates will be posted to the status page.

Read more: <http://www.oregon.gov/oha/HPA/OHIT/Pages/CQMR.aspx>

OHA and Q Corp Follow-Up Meeting #1 (11/20/17)

- The OHA’s CQMR is intended to reduce practice reporting burden by enabling efficient collection of clinical quality metrics data for multiple programs, and will be a resource for all CPC+ payers and practices. The CQMR currently is in the implementation phase, with go-live expected in late 2018. OHA is starting with collection of [Medicaid Meaningful Use measures](#) and CCO incentive metrics, which is an important consideration when the CPC+ Payer Group explores measure alignment.

- A large percentage of CPC+ practices already report Medicaid measures for CCO incentive metrics, so there is an opportunity to align use of the CQMR for that purpose with collection of measures for CPC+ and other alternative payment programs.
- The claims reporting infrastructure Q Corp has built and maintains could be leveraged to receive clinical quality measures from OHA to achieve integration of clinical and claims data for performance reporting to practices.
- The Q Corp Data Collaborative and Reporting Portal are already in place, and include information across payers and reported to practices at the clinic, provider and patient-level. This is the kind of reporting solution other CPC+ regions have developed as a starting place (e.g. Colorado).
- Q Corp and OHA have committed to greater exploration of integration of clinical and claims data, including the cost associated with Q Corp accepting and integrating clinical data with existing claims data, and potential changes in the reporting portal to optimize claims-only reporting in the interim.
- Because clinical quality measures are reported on a calendar year basis, there is potential to pilot collection of some CPC+ practices' 2018 clinical quality measure data in the CQMR in early 2019, to explore combining that data with Q Corp claims data.

OHA and Q Corp Follow-Up Meeting #2 (12/20/17)

<<Summary under OHA review>>

Practice Feedback

Summary of Practice Feedback from Learning Session 3 (September 2017)

Discussion Questions

1. What outstanding questions do you have about the work of the Payer Group?
2. Looking at the areas of the Roadmap, are there areas where payers could align that would be especially beneficial for your practice?
3. Are there areas or topics not on the Roadmap that you would expect or hope to be there?

Responses – Data Aggregation

- Report back utilization data collectively (from payers to practices) (bigger data set = more valuable)
- Alignment of reporting and data from payers to practices (x3)
- Consolidated data in one portal – uniformly measured – so we can compare across
- Roster of patients with claims data as opposed to a roster with names and dollar amounts
- Practices need data support

Responses – Submitting Data

- Eliminate duplication/extra time practices spend sending data to multiple people at the same payer for different reasons (CPC+, CCO, Stars, Quality)
- Align how payers ingest data; CMS accepts eQMs, some payers want hand-reviewed spreadsheets and that is a challenge
- Find alignment and consistency among payers on reporting and targets
- Data capture for metric reporting

Practice Presentations (November Payer Group meeting)

Representatives from two practices presented to the Payer Group on their priorities for data aggregation:

- Aggregated quality measurement reporting. The current state of measures by provider by payer are too granular and inconsistent. As a result, providers do not trust the data or results.
- Payer gap reports are frustrating and time consuming. Often times, a patient listed on the report received the relevant test or screening, but was with a different insurer at the time. An ideal solution would be for an aggregator to review the information then share it with practices
- Actionable data around total cost of care is critical. Primary care providers are held accountable for total cost of care but have no knowledge about unit pricing.
- Have a clear understanding of why payers may ask for additional data. It takes substantial staff time and knowledge to build out data feeds for each specific payer request.
- Clinics receive many duplicative requests from different departments of the same payer for different things, like quality, care management and HEDIS. It would be faster and more efficient if a request could be made once.

Presenters: Northwest Primary Care (Michael Whitbeck, Mike Salvey) and Portland Clinic (Paige Frederick)

Payer Group Input

Roadmap – Section #6. Data Aggregation

Problem Statement: Practices can't get current quality, utilization and cost data sufficient to take action. Practices receive performance reports from each health plan, and it is not representative of their full population; aggregated data may make performance reports more actionable.

Milestones:

- A. Consider how to identify and prioritize ways to align on the delivery of cost, utilization and quality data for practices, including data analytics.**
- B. Review existing data aggregator efforts
- C. Discuss and decide whether group will pursue a data aggregator
- D. Begin sharing unified or aligned data with practices, or share planned (to begin in a subsequent year) multi-payer approach for data sharing with CMS by July 1, 2017.**

Bold indicates items from payer MOU with CMS

Survey (November 2017)

Responses: 7

From your organization's perspective as you participate in CPC+ and other efforts to innovate in primary care payment, what are your organization's goals for data aggregation?

- Provide actionable data for providers using existing community resources, if possible.
- Ensure that data aggregation product/efforts are synergistic with our current plan reporting and not duplicative.
- Ease the burden on physician practices.
- Allow for the accurate measurement of performance on non-claims based measures.
- Consistent and comparable reporting (data, metrics and measures) across payers and providers that: reduce current system inefficiencies and frustrations; provide actionable information; lead to improved member health; and lead to reduced member disparities.
- Open to exploring data aggregation as part of the CPC+ initiative.
- To provide the practices with as much useful information as possible that helps them provide high-quality, cost-saving care.
- To gather sufficient data for a robust evaluation on the CPC+ program.
- Providing data that is most useful to CPC+ practices and that allows for a robust evaluation.

Is there anything else you would like us to know?

- Ideally, we would be able to use the data aggregation efforts/products for purposes outside of just CPC+ (ie for all provider reporting needs) and this could replace current reports we send.

- We are striving to keep the CPC+ initiative revenue neutral and have no additional funding allocated for data aggregation work. Cost may be a barrier.
- OHA's restrictions around contributing funds (which have already been shared with the group).

What might be some first steps we can take as a payer group on data aggregation?

- 1. Identify what the group's resource constraints are in order to "right-size" our discussion/efforts. 2. Given available resources, prioritize group's needs and align accordingly. 3. Given #2 and available community resources (ie QCorp), develop straw proposal of what could be done immediately and/or within the next year. (Give detailed info - ie what would be required of each payer, what would product look like, etc).
- I like the environmental evaluation we are doing. After that, it would appear that we need to 1) clearly agree on what the data aggregator needs to do (and prioritize if necessary) and 2) compare the requirements to what is currently available in the market to identify the gaps.
- Take an incremental approach; pick specific actionable area(s) to focus on and align efforts.
- It will be important to determine what data we are aggregating, how are we aggregating and what are we hoping to accomplish with this data aggregation solution.
- In addition to hearing what would be most helpful to practices related to data aggregation, we'd like to hear from payers what would be most helpful to them.
- Hearing from providers will be very helpful. I would also like to hear from payers about the data they are using (their own, Q corp, etc.) and what needs to be changed/added to that to meet payer/evaluation needs.

What do you see as the greatest potential?

- Leveraging what already exists instead of creating a new solution. Using this as a platform to influence future required provider reporting (i.e. ensuring that requirements align with available reporting).
- Avoiding duplicative effort, thereby lowering costs.
- Providing insight to care delivery and facilitating improved outcomes.
- Believe we should involve providers in this discussion/selection.
- An evaluation of the CPC+ program is so positive that it convinces (a) non-CPC+ payers to voluntarily adopt the model; (b) current CPC+ payers to continue the model beyond CPC+; and (c) payers to spread the model to their non-CPC+ practices.
- We're able to identify what specific components of the CPC+ payer model are more effective than others, thereby allowing for continued evolution of the model.
- Providing the data that helps practices deliver the care that will increase quality and maximize utilization.

What are your greatest concerns?

- Inability to make a group decision and therefore no progress is made (ie no data aggregation again). Also, having to continue sending plan-level reports/analysis if aggregated reports don't meet our needs.
- Picking something "too big."
- Being able to develop a solution that all are in agreement with due of the number of payers.

- The cost of the solution.
- Not having a clear definition of what we are trying to achieve with the data aggregation solution.
- That not all CPC+ payers will be willing or able to equitably contribute the funds necessary to purchase a robust data aggregation solution.
- OHA's restrictions around procurement prevent OHA from being able to participate/contribute to the data aggregation project.
- That the perfect will be the enemy of the good.
- Lack of funding will prevent action.

CPC+ Data Aggregation Solutions Based on Existing Q Corp and Oregon Health Authority Programs

Presented by Q Corp, January 9, 2018

The following options are based on Q Corp and OHA's current infrastructure and initiatives, and how they might be leveraged based on CPC+ Payer Group discussions to date. The four options are separated into two categories.

- ❑ In **blue** are existing initiatives the CPC+ Payer Group can elect to align with and support. Although these initiatives will proceed regardless of specific action from the CPC+ Payer Group, support from the CPC+ Payer Group could further the aims of each initiative, and help bring about specific aims and the further the spirit of the CPC+ program
- ❑ In **green** are pilot projects the CPC+ Payer Group could initiate to enhance the Q Corp Reporting Portal and leverage the OHA CQMR. These would require specific investment from CPC+ Payers.

The options are not mutually exclusive; in fact the most robust solution would be to pursue all the options over time. For each item, in addition to describing the problem, potential solution and next steps; a table indicates notable features, benefits to practices and health plans, the difficulty and time required to achieve it, specific non-financial resource requirements, estimated costs and any known constraints.

Existing initiatives and CPC+

- 1. Q Corp Reporting Portal and Health Plan Portal
- 2. Oregon Health Authority Clinical Quality Metrics Registry(CQMR)

Pilot projects to enhance existing initiatives

- 3. Pilot Use of Aggregated Data to Improve Measure Results and Reduce Burden of Care Gap Lists
- 4. Pilot and Implement Clinical and Claims Data Integration

1. Q Corp Reporting Portal and Health Plan Portal

Problem: Primary care practices routinely receive claims-based reports from health plans indicating their performance on quality, utilization and cost measures. These reports are of limited use because they reflect only a fraction of the practice's population, are at a level (provider versus clinic) that doesn't relate to the way a clinic organizes quality improvement, or because the information conflicts with that from other payers making it hard to narrow quality improvement priorities. For payers, there is little visibility into their members' claims history and they have little data about how they perform compared to other plans.

Solution: All Oregon primary care practices can access the Q Corp Reporting Portal, which contains more than 50 quality and utilization measures based on data from multiple health plans available in both pre-set and customizable dashboards and reports. In 2018 Q Corp will release a corresponding Health Plan Portal, where health plans participating in the Q Corp Collaborative can see their members and view data down to the provider level for other payers.

Key Message for CPC+ Payer Group: CPC+ Payers who are not submitting data to Q Corp could do so, which makes the data more valuable to all. In addition, those already submitting data could support this work by ensuring their organization submits data on time, and works proactively with Q Corp staff to address missing data, errors or other troubleshooting. The utility of the existing Reporting Portal could be enhanced through payer outreach to practices, through CPC+ and other programs. The majority of CPC+ practices are already represented in the Reporting Portal.

Features	Benefits to practices	Benefits to health plans	Difficulty	Time	Resource requirements	Estimated costs	Constraints
Aggregated quality, utilization and cost measure reports and trends over time, available down to patient level.*	Aggregated, uniform quality data is actionable for practices to evaluate performance and direct quality improvement efforts	Long-term view of quality and cost information to evaluate CPC+ Compare quality and utilization performance to that of other (blinded) plans	Currently available		Need timely data submissions and support when data issues arise Increased investment in outreach to practices to make them aware of this resource, and support them to use the data Health Plan portal roll out and onboarding	Existing Data Collaborative operating costs Need to scale up a small amount to accommodate more users (practices or payers) Additional resources to support CPC+-specific outreach to practices and health plans	Depends on existing infrastructure and partners supplying data and funding Not all CPC+ payers are members of Collaborative

Next Steps

- *Review more features of the Q Corp Reporting Portal: <http://www.q-corp.org/portal>
- Join the Data Collaborative (if data is not already included)
- Identify ways to improve utility of the portal for clinics and medical groups; actively engage in Health Plan Portal roll out
- Partner with Q Corp to ensure timely data submissions from your organization
- Participate in discussion and planning on strategies to financially sustain Q Corp Data Collaborative

2. Oregon Health Authority Clinical Quality Metrics Registry (CQMR)

Problem: Using EHR data (i.e. clinical quality measures) supports measuring outcomes—for example, measuring whether a diabetic patient’s blood sugar levels are controlled rather than simply measuring whether the patient’s blood sugar levels were tested. Today, however, Oregon has no standard, automated capacity for the collection, storage, or aggregation of clinical quality metrics.

Solution: The CQMR will fill a critical gap in enabling more efficient collection and aggregating clinical quality metrics. The CQMR will align with national standards for the collection and calculation of quality measures. To support providers with different levels of technical capacity, the CQMR will offer several secure options for data submission.

Key Message for CPC+ Payer Group: The OHA’s CQMR is intended to reduce practice reporting burden by enabling efficient collection of clinical quality metrics for multiple programs, and will be a resource for all CPC+ payers and practices. It will be used to support the CCO incentive metrics and Medicaid Meaningful Use program. A large percentage of CPC+ practices already report Medicaid measures for CCO incentive metrics, so there is an opportunity to align use of the CQMR for that purpose with collection of measures for CPC+ and other alternative payment programs.

Features	Benefits to practices	Benefits to health plans	Difficulty	Time	Resource requirements	Estimated costs	Constraints
Central registry of clinical quality metric data, standardized	Reduce practice reporting burden – report once, and many will be reporting already for CCO metrics.	Reduce burden of collecting clinical quality metrics from each practice	High	Estimated to be available 2020, potential to pilot in 2019	Health plans utilize OHA CQMR instead of or in addition to their own clinical metric collection from practices	Developed and paid for by OHA; if payers want to collect measures that aren’t part of the CMS CPC+ measure set there may be additional cost to do so through the CQMR	Timeline of project is set; fully operation will be in the fourth year of the CPC+ program

Next Steps

- OHA will have more specific timeline information in early 2018 after initial meetings with their data vendor
- CPC+ Payer Group demo of CQMR from OHA when one is available
- Payer Group members should understand CQMR to evaluate whether they will use it for collecting clinical quality metrics for CPC+ and other value-based programs, or how their existing solutions will interact with CQMR

Note: This section is based on other documents approved by OHA, but this specific iteration is under review by OHA for accuracy/completeness.

3. Pilot Use of Aggregated Data to Improve Measure Results and Reduce Burden of CareGap Lists

Problem: CPC+ is a program to encourage the transition to value-based contracts and alternative payment methodologies. These contracts depend on accurate measure results that demonstrate care quality. Health plans may also be evaluated based on measure results, and thus partner with practices to ensure measure results are as accurate as possible. The current approach to ensuring measure results are correct includes health plans sending clinics lengthy care gap lists so they may provide corrected or supplemental information. Often times the “gaps” on these list are not true care gaps, but actually gaps in information. Both payers and clinics are looking for a process that could reduce this administrative burden, and leave time for addressing actual gaps that improve patient care.

Solution: Pilot whether Q Corp’s aggregated multi-payer data could address this challenge by developing a report or process to scrub gap lists to improve measure results and reduce the administrative burden of value-based contracts. Historical claims at the patient level can ensure that screenings are reflected accurately; e.g., a patient who had a colonoscopy in 2015 and subsequently changed insurers, who would appear in his/her new payer’s gap list, will not show up in an aggregated gap list that includes all the payers.

Key Message for CPC+ Payer Group: This issue has intensified as value-based contracts become more common. Piloting a solution would address a key issue for both health plans and practices. A successful pilot would yield a measurable reduction in care gap list errors and less time spent correcting gap list errors.

Features	Benefits to practices	Benefits to health plans	Difficulty	Time	Resource requirements	Estimated costs	Constraints
Care gap report or process using the Q Corp Reporting Portal and/or Health Plan portal	Aggregated gap reports reduce administrative burden of correcting reports from each payer	Improved measure performance	Medium/TBD – explore way to leverage existing data and portals		Build care gap report and process into existing portal(s)	TBD, additional cost to update Portal(s)	Data use agreements allowing PHI to be shared between payers
More timely claims reporting	Increase utility of care gap reporting with more current data	Increase timeliness of data in health plan portal	High – work required to ingest data monthly	Must explore with Q Corp data vendor	Need timely and more frequent data submissions from all data suppliers ideally monthly; resource intensive for Q Corp data vendor	TBD, but there would be additional costs, potentially substantial, of analyzing and reporting measures each month.	Depends on data suppliers’ ability to submit data monthly and on time.

Next Steps

- Additional meetings with practices and payers to understand the care gap list process, and how it could be streamlined
- Review data use agreements with health plans to assess feasibility, especially of impact on measure results
- Need to further investigate HEDIS and other program requirements to determine acceptable data sources for measures
- Scope technological changes required and get cost estimates from Q Corp data vendor
- Identify health plans and/or practices to pilot

4. Pilot and Implement Clinical and Claims Data Integration

Problem: On their own, clinical and claims data offer unique value and drawbacks. Claims data is standardized and useful for process measures, but timeliness is a challenge. Clinical data is useful for measuring outcomes, and useful in preventive care, and care coordination and management; however, the unstructured nature of clinical data poses challenges for aggregation, and many practices still struggle to optimize their use of EHR data.

Solution: As OHA's Clinical Quality Metrics Registry (CQMR) is developed and comes online in 2019-2020, there is an opportunity for the clinical data contained there to be integrated into the claims data currently in the Q Corp Data Collaborative. This integration could include all the clinical data in the CQMR and be a robust solution for data aggregation, making performance data reported to practices more actionable and comprehensive. In other regions, both CPC+ and non-CPC+, this kind of data aggregation is being piloted to determine how it can support both practices and payers in the transition to value-based payment.

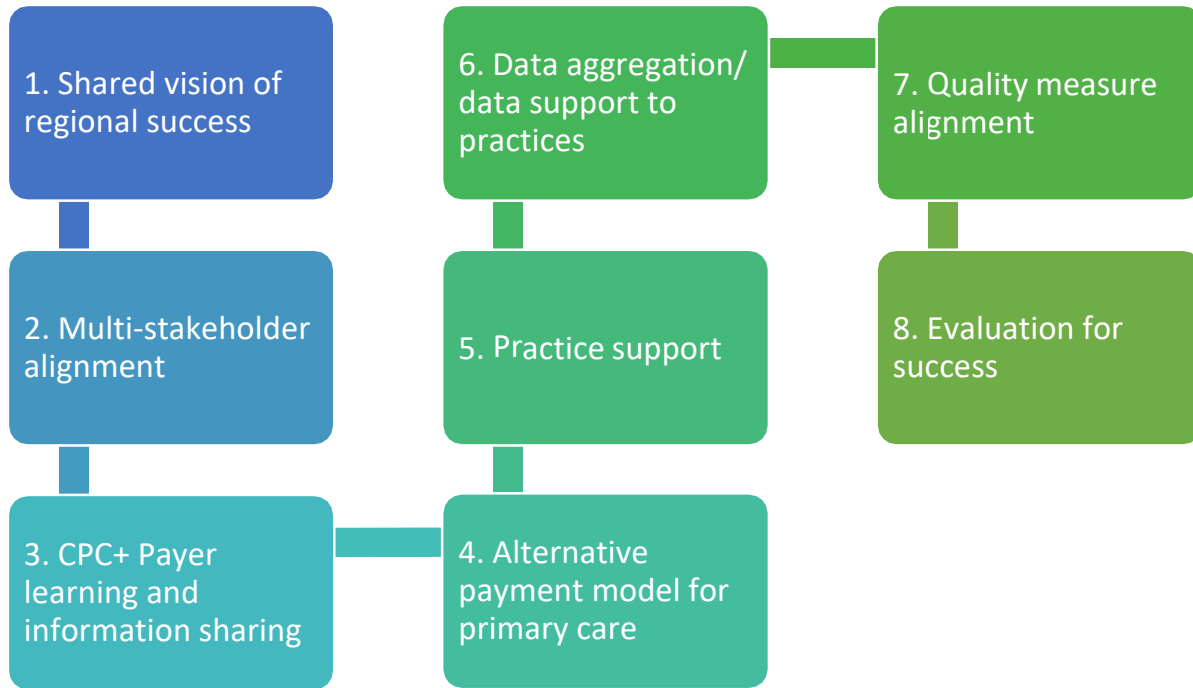
Key Message for CPC+ Payer Group: Aggregated claims and clinical data enables clinically-driven quality improvement efforts and a more comprehensive view of utilization, cost and quality measures and their impact on clinical outcomes. The CPC+ Payer Group could pilot such integration to maximize and align two distinct initiatives – the Q Corp Reporting Portal and OHA Clinical Quality Metrics Registry.

Features	Benefits to practices	Benefits to health plans	Difficulty	Time	Resource requirements	Estimated costs	Constraints
Claims and clinical data integrated into one dataset – increases accuracy of quality metrics and provides a more comprehensive view of performance	Enable accurate measurement of performance on non-claims based measures, or hybrid measures (e.g., CRC history, lab values including A1C)		High	2020 at the earliest, depends on OHA launch of CQMR	CQMR built and functioning, with standardized and reliable output	CQMR developed and paid for by OHA, would be additional costs for OHA vendor sharing data with Q Corp vendor; significant development required to expand Q Corp Reporting Portal	Practices may report data in QRDA III format (clinic-level), and QRDA I (patient-level) is optimal for integrating with claims data
	Set QI priorities based on clinical outcomes				Q Corp data vendor builds integration / import tool		
	Evaluate impact of QI activities on clinical outcomes				Practices reporting clinical quality metrics in QRDA I		
	Compare quality and utilization patterns to clinical outcomes						

Next Steps

- Continue meetings between OHA and Q Corp, eventually connect each organization's vendors to clarify scope and associated costs

CPC+ OREGON PAYER GROUP ROADMAP



PURPOSE

The CPC+ Payer Group Roadmap will:

- Define the desired outcomes of the CPC+ Payer Group in Oregon
- Identify how the participating payers will collaborate with one another and other key stakeholders, governing bodies or initiatives
- Use the lens of reducing burden of duplicative reporting and other administrative requirements on participating practices to allow them the freedom to focus on care transformation
- Contextualize program requirements from the CPC+ Payer Partner MOU (indicated in **bold**)

1. SHARED VISION OF REGIONAL SUCCESS

Problem Statement: CPC+ Payer Group needs a shared understanding of its purpose, how it will accomplish that purpose, and how to describe this purpose to interested stakeholders and partners.

Milestones:

- ✓ A. Finalize and adopt group charter to identify logistics, ground rules, priorities and decision-making models for the payer group
- ✓ B. Finalize and adopt roadmap
- ✓ C. Track progress to roadmap milestones
- ✓ D. Revisit roadmap regularly to make additions or changes to ensure aims are being met

Key Resources

- [CPC+ Payer Partner Memorandum of Understanding](#) and [other CMS payer materials](#)
- Letter of Agreement between Payer Partners and Convener

2. MULTI-STAKEHOLDER ALIGNMENT

Problem Statement: There are multiple initiatives that overlap with or complement CPC+, and the payers represented in the CPC+ Payer Group participate in or seek to align with these initiatives.

Milestones:

- ✓ A. Identify other stakeholders who are necessary for the success of CPC+
- ✓ B. Develop communication and engagement process
- ✓ C. Align when possible, communicate “why” when not possible

Key Resources

- [Primary Care Payment Reform Collaborative](#)
- [Oregon Health Policy Board](#)
- [Oregon Health Leadership Council](#)
- Oregon Health Authority [Health Plan Quality Metrics Committee](#) and [Metrics and Scoring Committee](#)
- CPC+ Practice Technical Assistance

3. CPC+ PAYER LEARNING AND INFORMATION SHARING

Problem Statement: Payers want to learn from one another, and coordinate and align where possible.

Milestones:

- ✓ A. Identify representatives who will connect group to related initiatives (see charter)
- ✓ B. Participate in CMS and Milbank learning opportunities
- ✓ C. Participate in practice learning events
- D. Create sub-workgroups as needed to delve further into particular issues (e.g. Track 2, evaluation strategy)
- E. Respond in writing to FAQs from practices posed at face to face meeting (re: attribution, measures, etc.).

Key Resources

- [CMS CPC+ Connect](#)
- [Milbank Memorial Fund Multi-State Collaborative](#)
- [Healthcare Payment Learning and Action Network \(HCP LAN\) Primary Care Payer Action Collaborative \(PAC\)](#)

4. ALTERNATIVE PAYMENT MODEL FOR PRIMARY CARE

Problem Statements: Attribution methodology is not clear to practices and causes confusion and administrative burden. Payers need to learn from one another and discuss strategies for meeting APM requirements in the CPC+ Payer MOU.

Milestones:

- A. Identify opportunities to align attribution methodologies and administration to improve accuracy and timeliness and reduce burden on participating practices; recognize the differences between CCOs and other payers
- B. Communicate attribution methodology messages to practices to clarify where there is alignment and appropriate context when there is not.
- ✓ **C. Identify opportunities for region to streamline non-visit-based financial support for practices**
- ✓ **D. Consider opportunities for the region to streamline and align on the hybrid FFS payments to Track 2 practices**
- E. **Begin paying a Track 2 hybrid FFS payment to practices January 1, 2018**

Key Resources

- [CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment and Payment Under the Medicare Physician Fee Schedule, Version 2 \(February 17, 2017\)](#)
- [CPC+ Payment Brief](#)
- [CPC+ Payer Partner Memorandum of Understanding](#)
- [Primary Care Payment Reform Collaborative Recommendations](#)

5. PRACTICE SUPPORT

Problem Statement: Payers need to collaborate and coordinate to reduce duplicative effort and burden on practices; CPC+ Payer Group should be clear on what can be streamlined to proactively address practice concerns, and be responsive to challenges as they arise.

Milestones:

- A. **Support practices in five comprehensive primary care functions: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, planned care and population health**
- B. **Minimize additional care delivery transformation requirements in region**
- ✓ **C. Collaborate with CPC+ Technical Assistance leads to streamline practice communication and interactions, promote information and knowledge sharing between payers and practices, and better inform payer participation in CPC+**

Key Resources

- [CMS CPC+ Practice Materials](#)
- Practice learning opportunities

6. DATA AGGREGATION/DATA SUPPORT TO PRACTICES

Problem Statements: Practices can't get current quality, utilization and cost data sufficient to take action. Practices receive performance reports from each health plan, and it is not representative of their full population; aggregated data may make performance reports more actionable.

Milestones:

- ✓ **A. Consider how to identify and prioritize ways to align on the delivery of cost, utilization and quality data for practices, including data analytics.**
- ✓ **B. Review existing data aggregator efforts**
- C. Discuss and decide whether group will pursue a data aggregator**
- D. Begin sharing unified or aligned data with practices, or share planned (to begin in a subsequent year) multi-payer approach for data sharing with CMS by July 1, 2017.**

Key Resources:

- Data aggregation arrangements in other CPC+ regions
- [Q Corp Data Collaborative](#)
- National Health Care Payment Learning and Action Network [Data Sharing Requirements Initiative: Collaborative Approaches to Advance Data Sharing](#) and [Accelerating and Aligning Population-Based Payment Models: Data Sharing](#)

7. QUALITY MEASURE ALIGNMENT

Problem Statement: “With a growing emphasis on improving the quality of health care, public and private payers are increasingly measuring the performance of providers on a variety of quality metrics...The result of many payers individually selecting or developing their own quality measures has been a proliferation of many diverse measures. A related issue is that multiple payers may use the same or similar quality measures, but these individual payers may have different reporting requirements (e.g., time period for reporting). The large number of quality measures, with reporting requirements that may vary by payer, can create substantial administrative burden and make it difficult for providers to focus improvement efforts.” - *Aligning Quality Measures across Payers*, prepared by SHADAC for the State Innovation Models (SIM) program under contract with NORC at the University of Chicago (May 2015).

Milestones:

- A. Consider how to align with the CMS CPC+ quality measure set and other common, prioritized regional measures as appropriate, including eQMs, CAHPS survey measures and the planned Patient-Reported Outcome Measure.**
- B. Create recommendations for Health Plan Quality Metrics Committee on aligned set of primary care metrics**
- C. Create strong advocacy to OHA Metrics and Scoring Committee to align metrics**
- D. Create strong advocacy to CMS re: stars and alignment**
- E. Create one Internal Medicine and Family Practice Measure List aligned with above that all will use and build from**

Key Resources

- Oregon Health Authority [Health Plan Quality Metrics Committee](#) and [Metrics and Scoring Committee](#)
- White paper (authored by Q Corp and OHLC): [Aligning Health Measurement in Oregon](#)
- Report [Aligning Quality Measures across Payers](#), prepared by SHADAC for the State Innovation Models (SIM) program under contract with NORC at the University of Chicago (May 2015).

8. EVALUATION FOR SUCCESS

Problem Statement: CMS evaluation is focused on Medicare and Medicaid only and CPC+ Payer Group wants to evaluate the impact of the initiative on cost, quality and utilization, for payer's population and the region as a whole.

Milestones:

- A. Establish evaluation sub-workgroup to craft evaluation strategy
- B. Share evaluation plan with Payer Group and key stakeholders
- C. Disseminate evaluation results to key stakeholders and interested parties

Key Resources

- [Assessing the Effects of Primary Care Transformation: Emerging Themes and Practical Strategies to Strengthen the Evidence](#)

CPC+ Care Delivery Requirements Program Year 1 and 2 Crosswalk

Track 1 Requirements

*Red denotes PY2 update

Function	Program Year 1 Requirements	Program Year 2 Requirements
1 Access and Continuity	1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the electronic health record (EHR). 1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.	1.1 Maintain at least 95% empanelment to practitioner and/or care teams. 1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. 1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.
2 Care Management	2.1 Risk stratify all empaneled patients. 2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management, along with medication reconciliation, to a high and increasing percentage of empaneled patients who have an emergency department (ED) visit or hospital admission/discharge/transfer and who are likely to benefit from care management. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days.	2.1 Use a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed. 2.2 Based on your risk stratification process , provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management. 2.3 Provide short-term (episodic) care management, including medication reconciliation, to patients following hospital admission/discharge/transfer,* and, as appropriate, following an ED discharge. 2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge. 2.5 Contact at least 75% of patients who were hospitalized in target hospital(s),* within two business days. *including observation stays

Function	Program Year 1 Requirements	Program Year 2 Requirements
3 Comprehensiveness and Coordination	<p>3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data.</p> <p>3.2 Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payers' data.</p>	<p>3.1 Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports.</p> <p>3.2 Using CMS/other payers' data, track timeliness of notification and information transfer from hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits.</p> <p>3.3 Develop a plan for implementation of at least one option from a menu of options for integrating behavioral health into care, based on an assessment of practice capability and population need.</p>
4 Patient and Caregiver Engagement	<p>4.1 Convene a patient and family advisory council (PFAC) at least once in Program Year (PY) 2017, and integrate recommendations into care, as appropriate.</p> <p>4.2 Assess practice capability and plan for support of patients' self-management.</p>	<p>4.1 Convene a PFAC at least three times in Program Year 2, and integrate recommendations into care and quality improvement activities, as appropriate.</p> <p>4.2 Implement self-management support for at least three high-risk conditions.</p>
5 Planned Care and Population Health	<p>5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (eCQMs) (derived from the EHR) at both the practice- and panel-level to improve population health management.</p>	<p>5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management.</p>

Track 2 Requirements

*Red denotes PY2 update

Function	Program Year 1 Requirements	Program Year 2 Requirements
1 Access and Continuity	<p>1.1 Achieve and maintain at least 95% empanelment to practitioner and/or care teams.</p> <p>1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.</p> <p>1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.</p> <p>1.4 Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living facilities), and/or expanded hours in early mornings, evenings, and weekends.</p>	<p>1.1 Maintain at least 95% empanelment to practitioner and/or care teams.</p> <p>1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.</p> <p>1.3 Measure continuity of care for empaneled patients by practitioners and/or care teams in the practice.</p> <p>1.4 Regularly deliver care in at least one way that is an alternative to traditional office visit-based care, meets the needs of your patient population, and increases access to the care team/practitioner, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits (e.g., senior centers and assisted living facilities).</p>
2 Care Management	<p>2.1 Use a two-step risk stratification process for all empaneled patients that meets the following standards: <u>Step 1.</u> Is based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition); and <u>Step 2.</u> Adds the care team's perception of risk to adjust the risk stratification of patients, as needed.</p> <p>2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk-stratification process and who are likely to benefit from intensive care management.</p> <p>2.3 Provide short-term (episodic) care management, along with medication reconciliation, to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/</p>	<p>2.1 Maintain and review a two-step risk stratification process for all empaneled patients, addressing medical needs, behavioral diagnoses, and health-related social needs: <u>Step 1.</u> Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and <u>Step 2.</u> Add the care team's perception of risk to adjust the risk stratification of patients, as needed.</p> <p>2.2 Based on your risk stratification process, provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, and likely to benefit from intensive care management.</p> <p>2.3 For patients receiving longitudinal care management, use a plan of care containing at least patients' goals, needs, and self-management activities that can be routinely accessed and updated by the care team.</p> <p>2.4 Provide short-term (episodic) care management, including medication reconciliation to patients following hospital</p>

Function	Program Year 1 Requirements	Program Year 2 Requirements
	<p>transfer and who are likely to benefit from care management.</p> <p>2.4 Ensure patients with ED visits receive a follow-up interaction within one week of discharge.</p> <p>2.5 Contact at least 75% of patients who are hospitalized in target hospital(s), within two business days.</p> <p>2.6 Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.</p>	<p>admission/discharge/transfer,* and, as appropriate, following an ED discharge.</p> <p>2.5 Ensure patients with ED visits receive a follow-up interaction within one week of discharge.</p> <p>2.6 Contact at least 75% of patients who were hospitalized in target hospital(s)*, within two business days. <i>*including observation stays</i></p>
3 Comprehensiveness and Coordination	<p>3.1 Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data.</p> <p>3.2 Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve the timeliness of notification and information transfer using CMS/other payers' data.</p> <p>3.3 Enact collaborative care agreements with at least two groups of specialists, identified based on analysis of CMS/other payer reports.</p> <p>3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care.</p> <p>3.5 Systematically assess patients' psychosocial needs using evidence-based tools.</p> <p>3.6 Conduct an inventory of resources and supports to meet patients' psychosocial needs.</p> <p>3.7 Characterize important needs of subpopulations of high-risk patients, and identify a practice capability to develop that will meet those needs and can be tracked over time.</p>	<p>3.1 Maintain collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports.</p> <p>3.2 Using CMS/other payers' data, track and improve, as needed, the timeliness of notification and information transfer from hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits.</p> <p>3.3 Develop a plan to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management.</p> <p>3.4 Advance implementation of at least one option from a menu of options for integrating behavioral health into care.</p> <p>3.5 Address common psychosocial needs for at least your high-risk patients:</p> <ul style="list-style-type: none"> • Routinely assess patients' psychosocial needs. • Prioritize common needs in your practice population, and maintain an inventory of resources and supports available to address those needs. • Establish relationships with at least two resources and supports that meet patients' most significant psychosocial needs. <p>3.6 Define at least one subpopulation of patients with specific complex needs, develop capabilities necessary to better address those needs, and measure and improve the quality of care and utilization of this subpopulation.</p>

Function	Program Year 1 Requirements	Program Year 2 Requirements
4 Patient and Caregiver Engagement	<p>4.1 Convene a PFAC in at least two quarters in PY 2017 and integrate recommendations into care, as appropriate.</p> <p>4.2 Implement self-management support for at least three high-risk conditions.</p>	<p>4.1 Convene a PFAC at least quarterly in Program Year 2, and integrate recommendations into care and quality improvement activities, as appropriate.</p> <p>4.2 Implement self-management support for at least three high-risk conditions.</p> <p>4.3 Identify and engage a subpopulation of patients and caregivers in advance care planning.</p>
5 Planned Care and Population Health	<p>5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three eCQMs (derived from the EHR) at both the practice- and panel-level to improve population health management.</p> <p>5.2 Conduct care team meets at least weekly to review practice- and panel-level data from payers and internal monitoring, and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.</p>	<p>5.1 Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three electronic clinical quality measures (derived from the EHR) at both the practice- and panel-level to set goals to improve population health management.</p> <p>5.2 Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.</p>