



Improving Care and Lowering Costs: The Use of Clinical Data by Medicaid Managed Care Organizations

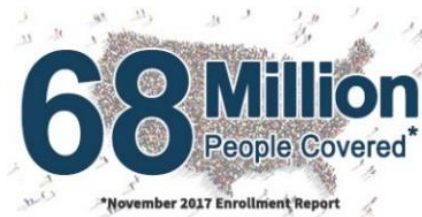


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INTRODUCTION



According to data from the Centers for Medicare & Medicaid Services, Medicaid spending grew to \$565.5 billion in 2016¹. More than 68 million Americans enrolled in Medicaid in November 2017 and an additional six million were enrolled in Medicaid’s Children’s Health Insurance Program (CHIP.)² As a cost savings measure, states are increasingly interested in contracting with managed care organizations (MCOs) to deliver healthcare services to Medicaid beneficiaries.

MCOs deliver Medicaid health benefits and additional services, while managing cost utilization and quality. In 2017, 39 states contracted with MCOs. In 2016, 75% of all Medicaid beneficiaries, in 28 states, were enrolled in MCOs³. Arrangements between MCOs and states are typically risk-based, as MCOs control healthcare expenditures by trying to improve health plan performance, healthcare quality, and outcomes. They focus on preventive care and early intervention, provide quality care coordination and care management, reduce the unnecessary use of services, and lower costs. Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

eHealth Initiative conducted six interviews with executives from leading Medicaid Managed Care Organizations to better gauge MCOs’ progress in defining and implementing their clinical data strategies. Executives were asked about their organization’s main sources of clinical data; progress related to collecting, storing, and sharing clinical data; and about leveraging clinical data for various processes. Interviews revealed the ways clinical data is used in case management systems and value-based contracts with states and provider networks. Executives also shared their biggest challenges in collecting clinical data. The challenges to implementing an effective clinical data strategy for MCOs are multifaceted, as the necessary components of a successful value-based framework include aggregation and organization of data in consolidated reporting systems, timely provision of applicable data to the necessary parties, and provider infrastructure augmentation.

“Having better access to clinical data - having it done more simply and less expensively - would remove a lot of unproductive action in the healthcare system.”
-MCO Executive

¹ NHE-Fact-Sheet. (2017, December 06). Retrieved from <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

² November 2017 Medicaid and CHIP Enrollment Data Highlights. (2017, November). Retrieved from <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

³ Paradise, J. (2017, April 24). Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion. Retrieved from <https://www.kff.org/medicaid/issue-brief/data-note-medicicaid-managed-care-growth-and-implications-of-the-medicicaid-expansion/>



The push toward value-based care has amplified the need for efficient exchange of *quality* patient information between MCOs and their provider networks. Traditionally, MCOs have worked with claims information, which describe the billable interactions between insured patients and a healthcare delivery system. MCOs are now integrating clinical data into their overall strategy to develop more comprehensive and contemporary patient snapshots. A comprehensive picture of the patient facilitates case

management, risk adjustment, and quality reporting, while simultaneously empowering MCO provider networks to effectively manage their patient populations, eventually lowering the cost of care.

CLINICAL DATA STRATEGIES

Defining a clinical data strategy is crucial for MCOs that want to manage Medicaid expenses using this information. The collection, storage, and use of clinical data requires careful planning, including considerations around data sources, the format in which data should be collected, and the infrastructure necessary to receive and store data. Consumers receiving healthcare services through Medicaid, especially those with chronic conditions and co-morbidities, will likely have their clinical information spread across multiple systems of providers and organizations in various digital and paper-based formats.



In defining a clinical data strategy, MCOs must identify the necessary infrastructure and tools for data transmission and storage, while considering sources of data, data transmission formats, and accounting for costs. The resources, skill sets, and infrastructure of provider networks are also a consideration, as these factors may limit a provider’s ability to efficiently exchange clinical data with the MCO.

Sources of data can include:

- Electronic health records (EHRs)
- State immunization and disease registries
- Labs
- Health Information Exchanges (HIEs)

Data transmission formats can include:

- Admission Transfer and Discharge (ADT) messages
- Continuity of Care Documents (CCDs)
- Flat files
- Excel spreadsheets

Sources of Clinical Data

In defining their clinical data strategy, MCOs should consider which sources of clinical data they will use to supplement their claims data. The primary clinical data collection method used by the executives is the HL7 Admission, Discharge, and Transfer (ADT) message system. Some MCOs reported collecting clinical data through flat files, CCDs, and EHRs, but to a lesser extent than ADTs. For those interviewed, ADTs are the easiest format to receive and have the most use cases.



MCOs are also utilizing their state’s immunization and disease registries to get more robust, quality data. This information has been very helpful for some in supplementing claims data. State registries act as tools for tracking the clinical care and outcomes of specific patient populations and provide information through patient reports, progress reports, and stratified population reports. Some MCOs communicate with the immunization registries of border states, where their beneficiaries may receive care. Other MCOs do not believe the immunization and disease

registries in their market are valuable because the data is fragmented.

Executives are grateful for the role of data aggregators, such as HIEs, in facilitating data exchanges and acting as secure repositories for clinical information across organizations and within community or hospital systems. The MCOs interviewed prefer to use HIEs as a source for clinical data, rather than making individual connections with each provider EHR system, a process that can be expensive and time consuming. Through government contracts, some MCOs are required to become members of their state’s HIE, and thus would like to leverage the services and data available as much as possible. One MCO co-founded a regional HIE, providing their organization with easy access to ADTs and information from immunization registries, prescription drug monitoring programs, and EHRs.

“Our last choice is to try to connect to individual provider EMRs. It’s the most expensive as you have to connect over and over.”
- MCO Executive

MCOs’ progress in collecting, storing, and sharing clinical data

Each executive indicated that their MCO has a defined clinical data strategy in place and has dedicated over one million dollars to acquiring new (or upgraded) clinical data infrastructure. MCOs ranged widely in their ability to collect, store, and share clinical data with internal teams and provider networks. Most executives described their clinical data strategy as dynamic and constantly evolving, regardless of their progress in collecting and using the information. They have employed an array of strategies, including data sharing agreements with contracted provider networks and purchases through third parties, such as HIEs, private data aggregators, pharmacies, and labs.

“Clinical data helps support better clinical decision making and is going to improve the health of a patient. If the patient is healthy, they don’t cost as much.”
-MCO Executive

MCOs in the early stages of their strategy are complementing their existing claims data with clinical data from HIEs and data vendors. Some of these MCOs reported that they have not entered data sharing agreements with their provider networks and instead encourage their providers to voluntarily share information via electronic channels. These MCOs will next

focus on building data repositories and normalization tools. Their goal is to integrate the collected information into internal platforms. In the future, these MCOs may be able to share their repository of clinical data with their provider networks.

MCOs with more advanced clinical data strategies are maximizing their plans to integrate data into provider workflows. Stronger patient data allows providers to make better clinical decisions. One MCO

is also interested in multi-payer integrations to promote data exchange between payer organizations with overlapping geographies. Providing a single connection to access this information reduces the burden on providers who connect to multiple health plan systems, while allowing for access to a wider range of information.

Augmenting Claims Data with Clinical Data

Federal law requires that MCOs develop a written quality strategy, including quality metrics for reporting. States and their contracted health plans use these strategies to assess the quality of care that Medicaid beneficiaries receive and to set measurable goals and targets for improvement. Executives expressed that claims data is not a sufficient tool in assessing quality as does not provide a full clinical picture of a patient. To provide a more comprehensive measurement for quality reporting, the MCO executives interviewed were most interested in clinical data that supported risk management predictions and case management procedures. It was less important to use the information to alert providers about clinical events, such as admission or abnormal test results.

“Claims are only as accurate as the person who completed it on the end user side. If the provider isn’t coding to the highest level of specificity, or laterality, or degree of illness, we only get what they tell us on the claim.”

- John A. Johnson, MD, MBA, FACP, Chief Medical Officer, Virginia Premier Health Plan, Inc.

Using Data to Manage Quality, Risk, and Guide Case Management



Some MCOs reported that clinical data is helpful for risk management, due to its accuracy and specificity. Risk management is a common technique in the insurance industry used to predict a member’s service utilization and related costs. Through risk adjustment, a process that assigns each member into demographic, morbidity, or disease categories, MCOs can target the unique needs of different populations, rather than treating all populations similarly.

MCOs are trying to base clinical decisions for these populations on the most accurate information available. MCOs can also reduce costs through negotiating provider reimbursements, the value of which is based on predictions made during risk management. MCOs encourage providers to deliver data at the highest level of specificity so the predictions, and resulting reimbursements, are as accurate as possible. One executive reiterated that claims data alone is not a good source to gauge potential clinical outcomes.

Having access to timely data helps to:

- Flag abnormal lab results
- Notify case managers when a member is admitted to the hospital or emergency room
- Inform case managers whether a member has received a necessary clinical service

Case management allows eligible individuals access to various services, including medical, social, and educational resources. Through the development of specific care plans, referrals, and monitoring activities, case management provides both quality and cost-saving benefits. MCOs want clinical data that will help guide the case management process and noted the importance of engaging members in the right programs and support systems from the moment they are enrolled.

MCOs stated that the historical perspectives provided by clinical data allow case management teams to complete a full assessment of members. MCOs also want providers to have access to timely clinical data at the point of care so they may better monitor and manage members.

Interviews demonstrated the MCOs' clear desire for the use of clinical data in case management, while also revealing the limited extent to which clinical data can flow through their systems, if at all. Lab data comprises a large source of clinical data in most case management systems, and some MCOs also have ADT and EHR data integrated. Other MCOs are unable to import CCDs and must rely on case managers to manually input the information.

“What do we need to know about this member right away to make sure we engage them in the right programs and connect them with the right support to create sustainable care?”

- John A. Johnson

CHALLENGES ACCESSING CLINICAL DATA

MCOs are faced with a variety of barriers in the collection and use of clinical data, including the technical immaturity of both MCO and provider networks, changing organizational cultures, chart chasing, and concerns from providers. Many respondents stated that their current infrastructure does not support their clinical data strategy and operational requirements. Clinical data needs to travel smoothly to utilize its full potential in improving care and lowering costs.

Technical Immaturity and Variability



The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 offered incentives to eligible providers who could demonstrate meaningful use of certified EHR technology. HITECH created a surge in the implementation of electronic health records and EHR technology, especially by large and mid-size provider organizations. Even as more providers are adapting EHR technology, interviews revealed that smaller provider organizations

are still using paper records and sending the information to MCOs through fax or Excel spreadsheets. One MCO admitted that this process creates so much additional work, they are tempted to disregard paper-based records and solely rely on claims data.

In general, MCOs experience challenges with the variability found in EHR systems and the sheer volume and types of data available. MCOs that rely on EHR systems as a major source of clinical information report that they have limited integration with EHR systems and that data exchange is not bidirectional. They also find it difficult to extract critical information from EHR documents. Some MCOs are so nascent in developing their clinical data strategy that they do not have the tools to store, normalize, or analyze data received from providers.

While HIEs are a key source of accessing and distributing data, some payers have been slow to use them because it is unclear whether the payer or provider should be responsible for HIE fees. Other

MCOs do not have the opportunity to exchange data through an HIE because there are none available in their states.

Changing Organizational Cultures

Technology is not the only challenge related to collecting clinical data. As MCOs are transitioning from a culture reliant on claims data to one that incorporates clinical data, many organizations are struggling to understand the value of clinical data. They are also working on acquiring the skillsets necessary to handle this kind of data. As one MCO shared, a recent change of leadership helped change their organization's attitude toward clinical data. The arrival of a new Chief Information Officer was a catalyst for their organization to define their clinical data strategy.

“As we transition from the use of administrative data to clinical, we have to build up skills, knowledge, organizational structure, and tools.”

- MCO Executive

Concerns from Providers

Providers act as barriers to the exchange of clinical data with the MCOs. Executives reported that providers have a variety of financial concerns and believe that incentives may be necessary to encourage providers to share information. Executives stressed the essential nature of trust building, especially with providers who perceive that managed care information sharing will lead to a decrease in payments and profit loss. Executives understand that building the connections necessary to exchange data with MCOs requires dedicated resources and believe that some providers are unwilling, or unable, to commit to the cost.

Chart Chasing

“Legacy business processes often rely on information that is stored in departmental databases that have limited access instead of more robust systems that make clinical data – like medical charts – available to all the departments and providers who need it for various reasons. For this reason, insurers and providers should work to advance clinical data exchange tools that improve access to information and ultimately help decrease costs.”

-Hayes Abrams, Executive Director, Enterprise Network Solutions and Provider Partnerships, Health Care Service Corporation

MCOs are also advocating for organizational changes that eliminate inefficient “chart chasing,” a practice that often occurs in silos within an MCO's business. In the past, when patient information was not as readily available, each department would individually request clinical information from providers and store the data in different databases, which were unavailable to other MCO employees. When additional departments needed the same information, they would have to “chase” the chart again, costing both the MCO and the provider excess time and money.

USING CLINICAL DATA IN VALUE-BASED CARE CONTRACTS

The American healthcare system is in the process of shifting from a fee-for-service model that reimburses providers for volume of service to one based on the value of service. Value-based

contracting involves reimbursement based on value metrics, such as health outcomes, efficiency, and quality. Some MCOs are under value-based contracts with their states, while others are bound by other kinds of contractual agreements that do not center reimbursement on quality measures. MCOs reported participation in multiple types of contracts with their provider networks that link performance measures to financial incentives. Some MCOs primarily use risk-sharing agreements to enforce value-based payment models, while others rely more on pay-for-quality (P4Q) agreements.



MCOs must proactively manage the performance risk of their networks against value-based payment goals. They are doing so by:

- Assessing quality measures
- Making data available to their providers
- Participating in information exchanges with other MCOs
- Using dashboards and benchmarks
- Sending field staff to their provider partners to observe potential drivers of low performance
- Creating “a personal dialogue” with providers about potential opportunities for improvement

Sharing Clinical Data as a Strategy for Value-Based Contracts

To implement an effective value-based contract with their providers, MCOs must have the ability to share timely performance information with providers. Providers can better understand their current performance against quality measures when they have more access to clinical data. Exchanging clinical data increases the breadth of clinical quality measures that can be brought into value-based contracting arrangements. These data exchanges help payers and providers avoid chart chasing, particularly when partnering with states that tie incentives and sanctions to performance on quality metrics.

“The need for clinical data is greater than ever as business processes mature, and the market evolves to rely on effective use of data as the basis for care delivery, analytical insight, operations, and competition.”

- Hayes Abrams

In the past, MCOs were able to manage value-based contracting without clinical data. As business processes mature, however, interviewees increasingly recognize the value proposition clinical data offers. Regardless of their level of advancement, MCOs are accepting the importance of sharing clinical data with their provider networks as a strategy for value-based contracts. MCOs with less advanced clinical data strategies are currently focusing on internal information sharing and are planning on data sharing in the future, while those with advanced data strategies recognize that clinical data sharing is a critical component of value-based contracts.

SUMMARY OF KEY TRENDS

MCOs vary in their readiness to collect, store, and share clinical data with internal teams and provider networks, but all respondents have developed clinical data strategies that will help them transition from systems that rely on claims data to those that embrace the use of clinical data. A number of key trends emerged from the interviews.

- **Common Sources of Clinical Data.** The primary clinical data collection method used by executives is the HL7 Admission, Discharge, and Transfer (ADT) message system. Some MCOs use state immunization and disease registries to collect clinical data. The MCOs interviewed prefer to use Health Information Exchanges (HIEs) as a source for clinical data, rather than making individual connections with each provider EHR system.
- **Targeting High-Risk Members Earlier for Intervention.** MCOs hope clinical data will improve risk management analysis and predictions related to service utilization and cost. Better data will help MCOs target members who can most benefit from case management and support programs earlier.
- **Sharing clinical data with their provider networks.** MCOs with a more advanced clinical data strategy reported that sharing clinical data with their provider networks is a critical component of value-based contracts. Regardless of their level of advancement, MCOs are accepting the importance of sharing clinical data with their provider networks as a strategy for value-based contracts.
- **Technical Immaturity.** Many executives stated that their current infrastructure does not support their clinical data strategy and operational requirements. Some MCOs do not have the tools to store, normalize, or analyze data received from providers, or employees with necessary skillsets. MCOs desire the use of clinical data in case management but are limited by the way clinical data flows through their case management system. Smaller provider organizations are still using paper records and sending the information to MCOs through fax or Excel spreadsheets.
- **EHR Limitations.** MCOs experience challenges with the variability found in EHR systems and the sheer volume and types of data available. Some MCOs have limited integration with EHR systems, report that data exchange is not bidirectional, and find it difficult to extract critical information from EHR documents.
- **Limited Access to HIEs.** While HIEs are a key source of accessing and distributing data, some payers have been slow to use them because of uncertainty about who is responsible for HIE fees, the payer or provider. Other MCOs do not have the opportunity to exchange data through an HIE because there are none available in their states.
- **Concerns from Providers.** Providers may be hesitant to share information with MCOs for managed care purposes due to a belief that it will lead to decreases in payments and profit loss. Additionally, executives understand that building the connections necessary to exchange data with MCOs requires dedicated resources and believe that some providers are unwilling, or unable, to commit to the cost.



Managed care offers an opportunity to improve the quality of care Medicaid beneficiaries receive, while decreasing the costs associated with that care. When managed care organizations engage in clinical data exchanges, the potential benefits of managed care are even greater. As the industry shifts toward one that rewards value over volume, the ability to collect, store, and share clinical data will continue to grow in importance. MCOs can use clinical data to develop a more comprehensive picture of the patient, which facilitates case management, risk adjustment, and quality reporting, while simultaneously empowering MCO provider networks to effectively manage their patient populations, and eventually lower the cost of care.

INTERVIEWEES		
 <p><i>Interviewee requested to remain anonymous</i></p>	 <p>Hayes Abrams <i>Executive Director, Enterprise Network Solutions and Provider Partnerships</i></p>	 <p><i>Interviewee requested to remain anonymous</i></p>
 <p><i>Interviewee requested to remain anonymous</i></p>	 <p>John A. Johnson, MD, MBA, FACP <i>Chief Medical Officer</i></p>	 <p><i>Organization & interviewee requested to remain anonymous</i></p>