NATIONAL ASSOCIATION OF Community Health Centers®

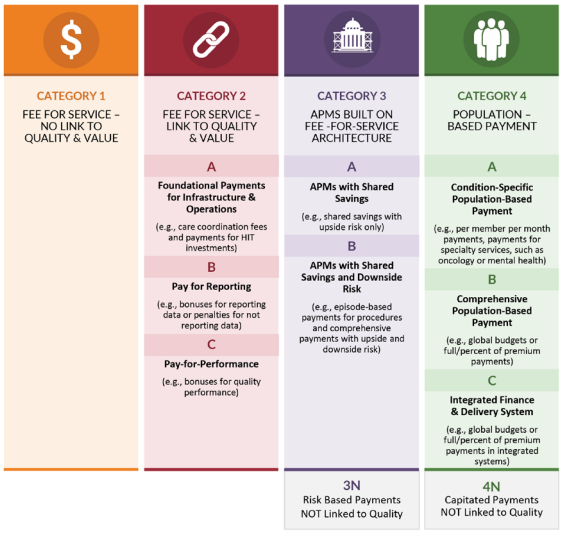
VALUE TRANSFORMATION FRAMEWORK

Action Brief

PAYOR DATA

WHY

is Payor Data Important?



Health Care Payment Learning and Action Network (LAN) Framework

Appropriate and timely patient data is key to effective population health management and performance in value-based payment models. Health insurance plans (i.e., Payors) often have access to patient health information that health centers may not, since payors receive claims (requests for payment for services rendered) submitted by various health care providers including hospitals, emergency departments (ED), urgent care centers, clinicians, and others. Health center access to payor data offers a view into the care and services patients may receive outside the health center. Providers can better understand changes in health status they may not have been informed of, where care is being received, utilization patterns, and in some instances, the cost of the care provided. Given the complex nature of health center populations, having a broader perspective on what is happening outside the clinic walls can be invaluable. While data from payors is often delayed (due to the time it takes to be processed before it can be shared) and often does not include robust social drivers of health information, it is still an essential data source for health centers engaged in value-based payment models. Payor data can be integrated with a health center's data within the electronic health record (EHR) and population health management systems.

As health centers advance through their value-based care and payment journey and take on increasing accountability for their patient populations (see the Health Care Payment Learning and Action Network [LAN] Framework that offers a national vocabulary for categorizing payment models), it becomes essential for health centers to understand how payor data can be leveraged, how payor data is received by the health center (and at what frequency), and the health information technology (HIT) infrastructure necessary to integrate and transform payor data into actionable population health management solutions.

WHAT

Data Do Health Centers Receive from Payors, and What Does It Look Like?

The volume of data and the specific metrics that a health center receives from a payor will depend on the type of value-based arrangements in which the health center participates. In pay-for-performance or quality arrangements, payors may share less data than in a shared savings arrangement that looks at the total cost of care for a population.

Payors will share additional data as health centers advance along the accountability continuum (i.e., progress along the LAN continuum). Once health centers enter LAN Category 3A and above, payors will share more than quality measures/gaps in care reports with providers. This additional payor data may include information on a patient population's cost of care, trends over time, and where opportunities exist

to manage or reduce medical or pharmacy costs. The below table outlines the type of reports a health center could expect from a payor when participating in each type of value-based payment arrangement along the LAN categories.

HCP LAN Category	Types of Data and Reporting Typically Provided by the Payor Partner
2A and 2B – Pay for Infrastructure and Reporting	• In these categories of value-based care arrangements, information and data usually flow from the provider to the payer. A provider may be reporting on how they are using the infrastructure dollars or outcomes or activity from their investment of funds from a payor. • Payors will provide attribution reports and potential gaps in care reports. • Providers in pay-for-reporting arrangements may send payors their performance on quality metrics they pull and calculate from their EHR.
2C - Pay-for-Performance	• Attribution Report - It may only show attributed patients that fall into the performance metrics within the contract • Gaps in Care Report (at the patient and provider level) - Show which quality metrics a patient has met or any open clinical gaps
3A – Total Cost of Care Shared Savings Model (Upside only/Shared Savings)	• Reports from the 2C category above, plus… • Attribution Report - Attributed patients, typically by month • Medical (and sometimes pharmacy) claims - Some payors may include claim payment amounts others may only provide encounters • Population health reports, such as: - Risk-stratified patient lists - Patients who frequently utilize the Emergency Department - High-cost patients - Site of care use or high-value specialist use - Care management engagement - Generic prescribing - Cost category trends • Financial reporting on performance against target/benchmark - May occur monthly, quarterly, and at a minimum, annually
3B – Total Cost of Care Shared Savings/Losses Model (downside risk)	• Reports from the 3A category, plus… • Diagnosis and Risk Score reporting • Monthly financial reporting - May include cost estimates for services performed but not reported to the payor (Incurred But Not Reported [IBNR]) and other actuarial estimates or projections)
4 A – C, and N - Population-based Payments	• While health centers are not widely represented in this category, there are relevant models to point out. Health centers may be involved in 4N models, such as a primary care capitation (that may or may not be linked to quality). Additionally, a health center may participate in a network that is taking on global capitation. In these instances, health centers may see data and reports from the 3B category, plus… - Capitation reports ▪ Include the capitation amount, risk score, and eligibility at the patient level every month

It is important to note that health centers participating in an independent practice association (IPA) or clinically integrated network (CIN) may receive data and reports from their IPA or CIN partner instead of directly from the payor. The IPA or CIN may combine data across payors, transform the data received into different reports for health centers, or only provide specific data and reporting downstream to health centers in the network.

While the volume of data, the specific values/metrics, and the reports that a health center or network receives from a payor partner will vary across LAN category types, different payors may also have different delivery methods for the data and reports. The complexity of managing data across multiple payors increases as the number of value-based contracts a health center is engaged in increases. In addition, payors may provide data that needs to be transformed before it can be analyzed. Payors may provide data or reports in Excel files via a provider portal where all data and reports must be viewed or downloaded from an online site or through a

health information exchange (HIE). Health centers need to ensure appropriate staffing and systems are in place to manage the variation in data and how reports are delivered. For example, it is not uncommon to see a network with multiple value-based arrangements, with each payor providing data differently. It takes considerable time and resources to gather the data, synthesize or normalize the data into a consistent format or database, and produce reports and scorecards downstream within the network.

HOW

Considerations for Payor Negotiations and Payor Data Implementation

Health centers have multiple data, financial, and infrastructure considerations when contracting with payors for value-based arrangements. Care should be taken to review these considerations when engaging in total cost of care arrangements (as health centers move into LAN categories 3A, 3B, and above).

STEP 1 **REVIEW YOUR HEALTH CENTER'S INFRASTRUCTURE AND ASSESS DATA INTEGRATION AND ANALYTICS NEEDS.** Does the health center currently have the HIT infrastructure (including systems and trained staff) available to receive and integrate payor data and to produce meaningful reports that are actionable to care teams and providers? If not, health centers should work with the payor to provide actionable reports for total cost-of-care breakdowns, patient-level utilization, and risk stratification data while the health center develops competencies in this area.

STEP 2 **UNDERSTAND HOW THE FREQUENCY OF DATA AND REPORTING IMPACT THE HEALTH CENTER.** Different data and reports from payors may inherently have different delivery cadences. Consideration should be given to whether your health center can process or analyze monthly data or if quarterly reporting may make more sense. Reports that outline financial performance or break down the total cost of care for the population can come with limitations as the frequency increases. For example, monthly reporting of medical expenditures should be accompanied by an IBNR estimate (claims that have occurred but have yet to be sent to the payor or paid) unless the monthly reporting is lagged to only show fully complete months of claims.

STEP 3 **DETERMINE HOW THE HEALTH CENTER TRANSPARENTLY RECONCILES FINANCIAL INFORMATION.** While this would not apply to health centers with pay-for-performance arrangements, this becomes especially important in LAN category 3A and above, where there are more complicated processes for calculating shared savings or losses. There should be a high level of transparency in the calculation, both in the contract and what is provided to the health center from a reporting perspective when savings or loss determinations occur. Health centers should work with payors to receive detailed financial reconciliations at least every quarter to understand how contract performance is trending. Additionally, health centers should work with payors for reconciliations to be delivered as line-by-line calculation developments so that the health center can tie the reconciliation to what was agreed to in the contract, such as how benchmarks or targets would be set, what cost categories would be included, how risk adjustment would be handled, etc.

STEP 4 **DETERMINE HOW TO PARTNER WITH THE PAYORS TO LEVERAGE BENCHMARKING DATA.** It is common for payors to have networks that span across a state or region and providers participating in various value-based arrangements from pay-for-performance (LAN category 2C) to downside total cost of care risk (LAN category 3B). Health centers can request benchmarking data to help gauge performance and the level of opportunity they may have in a cost category (e.g., acute inpatient medical) or segment of utilization (ED visits). Consider requesting peer performance in the same level of value-based arrangement. Payors may also share details on providers with similar risk profiles of patients. These reports can help a health center understand where to allocate limited population health resources in the clinical setting.

PAYOR DATA

STEP 5 DETERMINE WHAT DATA AND REPORTING IS MOST VALUABLE TO THE HEALTH CENTER.

Payor data and reports of most value to health centers will vary by the types of value-based arrangements the health centers are engaged in and how experienced a health center is in value-based care arrangements. Typically, the data and reporting of greatest value will be the data and reporting that allows for the quickest *improvement* in their value-based arrangements. For many health centers, this will include:

- **Attributed Patient Report.** Timely and accurate reporting on the patients that health centers are accountable for is paramount to value-based arrangement success.
- **Risk Score or Suspected Diagnosis Lists.** Shared savings and loss contracts almost always incorporate a component related to the "risk score" of the attributed patients. The risk score is determined based on the diagnoses submitted to the payor on claims within a certain period of time (such as a calendar year). Generally, improvements in the accuracy and completeness of diagnosis coding for patients will improve performance in most value-based arrangements. Improving medical coding practices and risk scores is often seen as the "lowest-hanging fruit" in value-based arrangements (instead of reducing medical spending). The risk score and suspect diagnosis lists (i.e., conditions that may be present with a patient but have not been coded by a provider) will help identify which of your patients likely have diagnoses and conditions that are not yet reflected in their risk score.
- **High-risk patient reports.** It is well-known that a small percentage of a population accounts for a much more significant proportion of the total medical spending. Reports that identify the highest-risk individuals in your attributed population (either based on total spend, high ED usage, or multiple comorbidities, including behavioral health) will allow your health center to more efficiently allocate resources toward patients that have the most opportunity for cost mitigation and improved health outcomes.

STEP 6 DEVELOP A STRATEGY FOR HOW THE HEALTH CENTER WILL IMPLEMENT NEW DATA SOURCES AFTER A NEW CONTRACT IS SIGNED.

While a few individuals or teams within a health center may initially handle data, there is a broad array of end users for the various data types and reporting that payor partners may provide within a value-based arrangement. Depending on the size and infrastructure of the health center, a quality manager or specialist within the health center, or a combination of the quality and data and analytics functions, would generally be responsible for handling this data and disseminating it to the key stakeholders or end users in the organization. Much of the time, these same individuals or teams are also the ones meeting with payors regularly to understand the data that is being provided and the potential use cases. Note that if health centers are working to integrate specific data into their EHRs, the area or individuals responsible for the EHR will sometimes be involved.

The table below outlines some of these situations and end users.

Types of Data and Reporting	Who Manages the Data Once Received?	Who Uses the Transformed Data and Reports to Inform Action?
Attributed and Eligibility	• Quality team • Data and Analytics • HIT/EHR specialists (to integrate data into EHR or population health platform)	• Clinical staff (e.g., nursing, medical assistants (MAs), providers) • Care coordinators or staff performing outreach to patients for appointment scheduling (e.g., for the "assigned but not yet seen population")
Care Gap Reports at the patient and provider-level	• Quality team • Data and Analytics • HIT/EHR specialists (to integrate data into EHR or population health platform)	• Care coordinators or staff performing outreach to patients • Care managers • Medical Director responsible for overseeing value-based contract performance • Clinicians and nursing staff (potentially through the EHR, in daily pre-visit planning huddles, or pre-visit planning chart notes)

Claims reports (medical and pharmacy)	• Data and Analytics	• Ideally, raw claims are fed into EHRs or other population health platforms for point-of-care information or additional reporting and dashboarding purposes • Data and Analytic teams may work with clinical leadership on analyses to help understand utilization or cost patterns in the population
Population health reports such as: • Risk-stratified patient lists • Frequent utilizers of the -Emergency Department • High-cost patients • Site of care use or high-value specialist use • Generic prescribing • Cost category trends	• Data and Analytics • Quality team	• Medical Director responsible for overseeing value-based contract performance • Clinical staff • Finance Director • Care Managers • The clinical committee responsible for reviewing value-based arrangement performance and deriving the clinical interventions and operations to support improved population health (committee could include finance, operations, clinical, and care management roles)
Diagnosis and Risk Score reports	• Quality team • Data and Analytics • HIT/EHR specialists (to integrate data into EHR or population health platform)	• Medical Director responsible for overseeing value-based contract performance • Quality team • Clinical staff • Frontline physicians (potentially through the EHR, in daily pre-visit planning huddles, or pre-visit planning chart notes)
Financial reports on performance against target/ benchmark and monthly financial reports (may include IBNR and other estimates or projections)	• Finance - while the other reports are more operational, these reports will likely be handled by the finance team.	• Finance team - to help inform financial forecasting, budgeting, and other financial planning exercises • Clinical committee – to understand how clinical operations and interventions are impacting the economics of their value-based arrangements

Note: a health center may only have some of the roles/resources described in this section.

Access to accurate and timely patient data is crucial for successful population health management and achieving positive results in value-based payment models. It drives positive outcomes and improves the quality of care by informing decision-making, facilitating performance measurement, enabling population health management, and driving continuous improvement. Data supports care coordination, identifies high-risk patients, and promotes cost-effective practices. While there is a plethora of data available, it is a challenge to use it in a way that is effective. By implementing the steps above and starting with the most impactful data, health centers can enhance patient care, optimize resource allocation, and achieve better health outcomes for individuals and populations.

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