

Health IT & Quality Measurement for APMs Milbank Multistate Collaborative

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Contractor

Office of the National Coordinator for Health IT

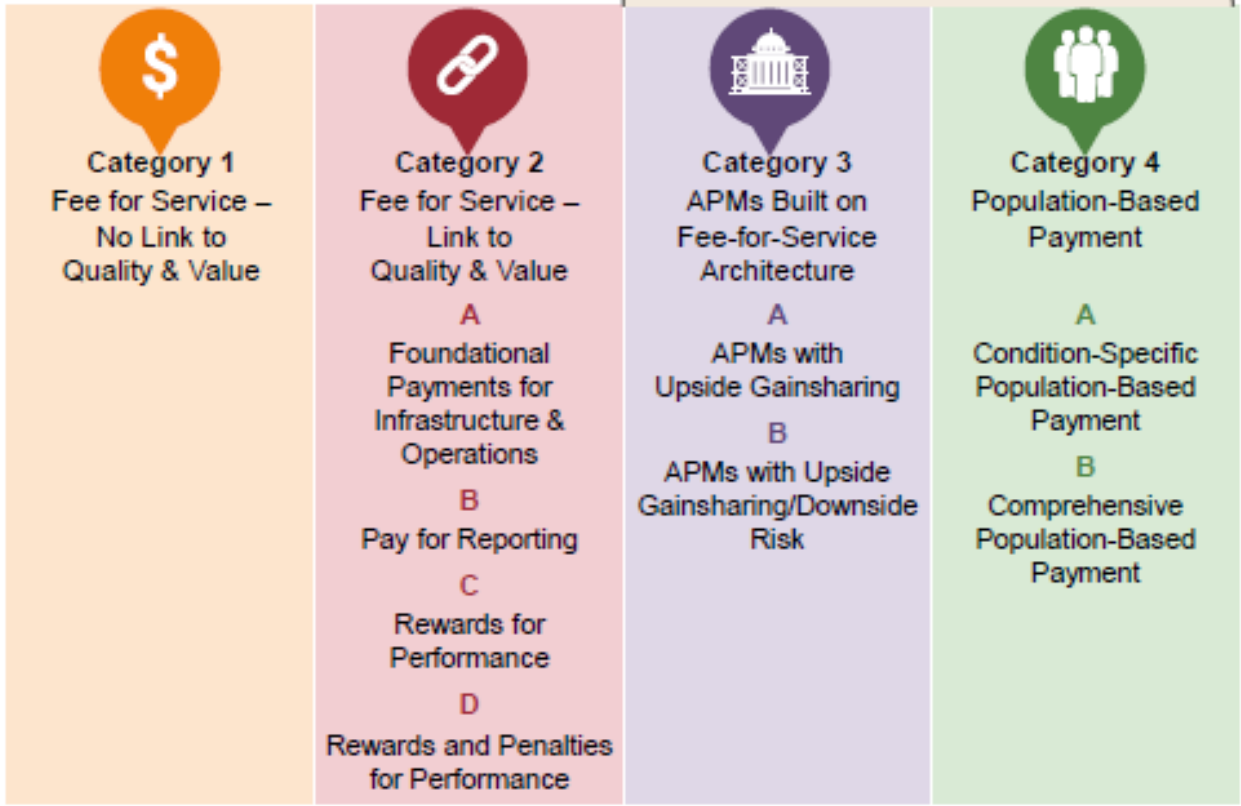
APM FRAMEWORK

At-a-Glance

The Framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

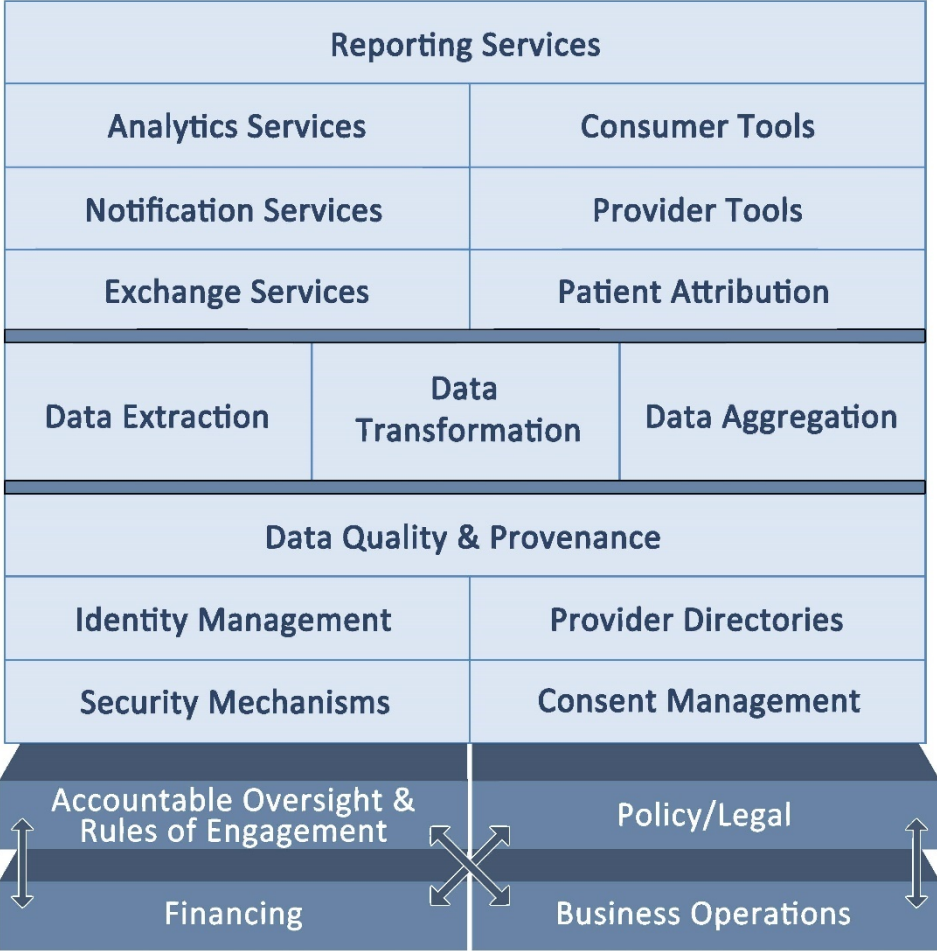
- Serves as the foundation for generating evidence about what works and lessons learned
- Provides a road map for payment reform capable of supporting the delivery of person-centered care
- Acts as a "gauge" for measuring progress toward adoption of alternative payment models
- Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities

Population-Based Accountability



The framework situates existing and potential APMs into a series of categories.

Health IT Modular Functions for APM Data Infrastructure





All-Insurer Payment Reforms

Transformation Network

Service Area & Statewide Collaboratives

Data Infrastructure

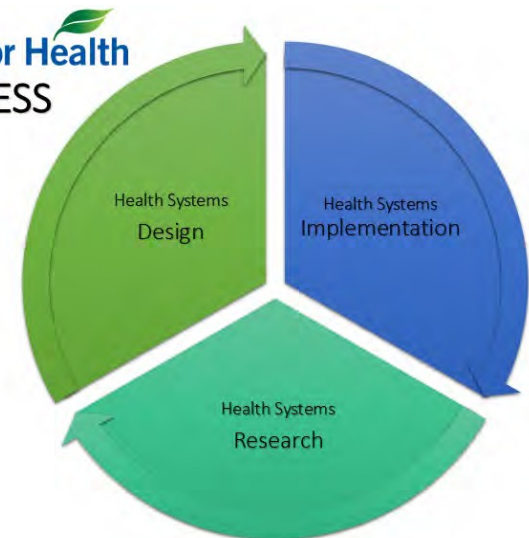
Evaluation & Comparative Reporting

Statewide Network for Comparative Learning

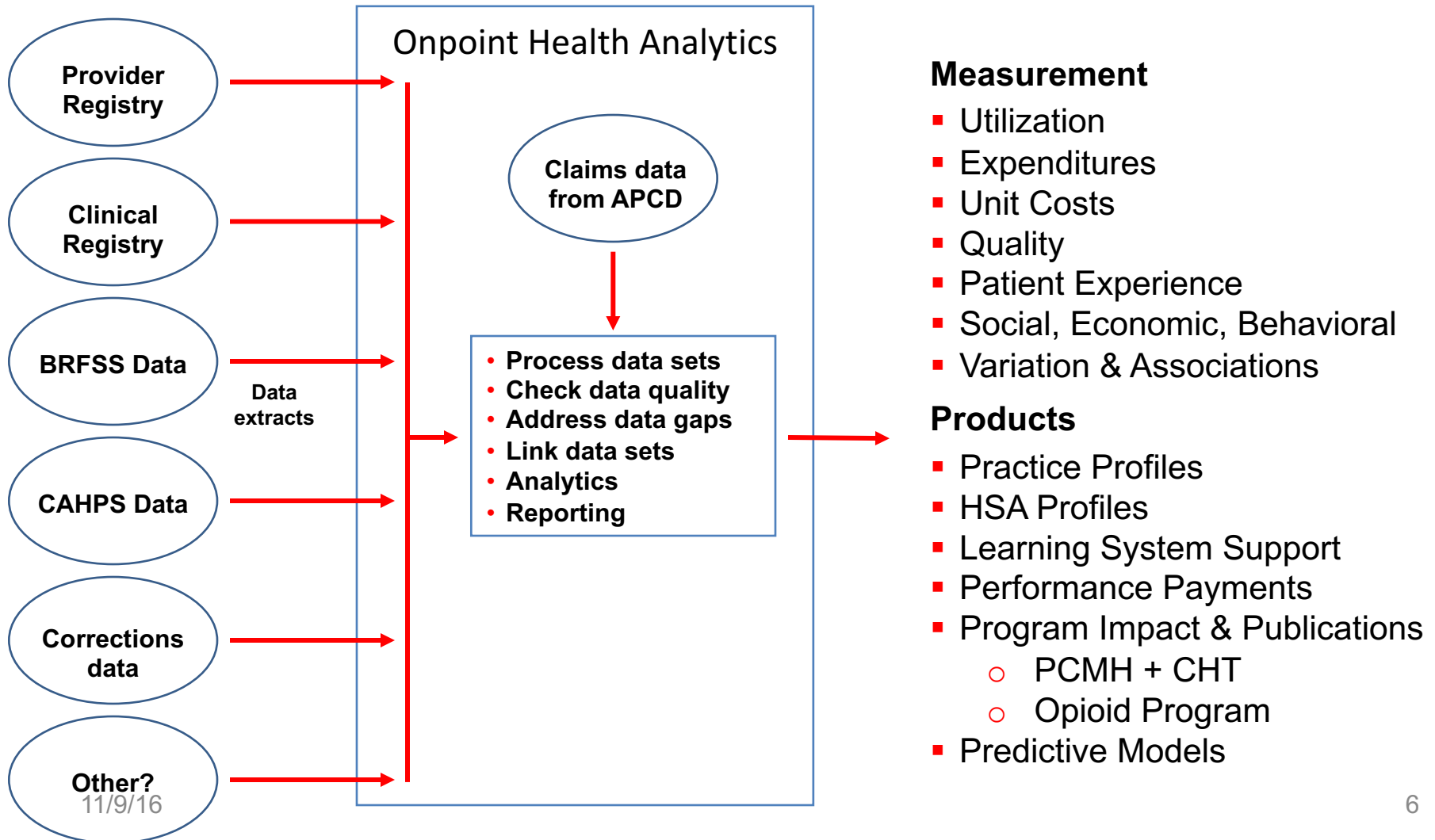


- 31 Community Health Team Leaders
- 19 Blueprint Practice Facilitators
- 14 Blueprint Project Managers
- 4 ACO Clinical Quality Leaders
- 6 ACO Clinical Consultants

VERMONT
Blueprint for Health
PROCESS



Data Use for a Learning Health System



EHR Data Quality for Quality Measurement

Core Measure Set
Defines Priority
Data Elements



- Capture elements in EHR system
- Extract elements from EHR system
- Transmit to intermediary systems
- Aggregate priority data elements
- Establish patient level records



Improve Completeness
& Utility of Data from
each Source System



Evaluate Completeness
& Utility of Data from
each Source System

Dedicated Team for Data Quality

‘EHR Capture to Aggregation to Assessment to Improvement’

Use of Federal & State Funding Streams

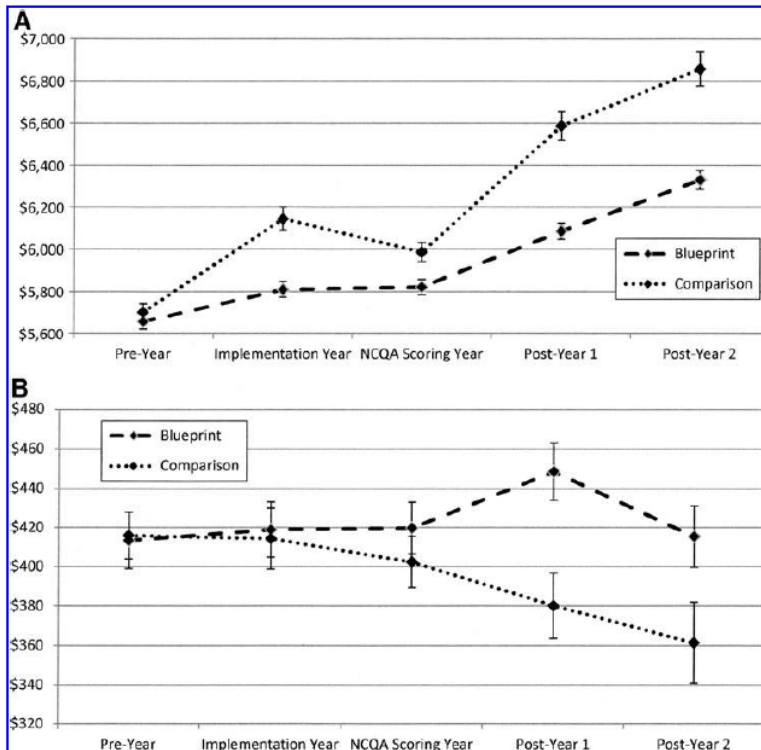
- State HIT Fund
- 1115 Waiver
- IAPD
- SIM



- HIE Infrastructure
- Clinical Registry
- Provider Registry
- All Payer Claims Database
- Patient Experience Survey
- Data Processing
- Data Quality
- Analytics
- Reporting

Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

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Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont

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Table 2
Adjusted average annual expenditures and utilization rates[†].

	MAT group	Non-MAT	Difference [‡]	P-value
Expenditures				
Total expenditures	\$14,468	\$14,880	−\$412	0.07
Total expenditures without treatment	\$ 8794	\$11,203	−\$2409	<0.01
Buprenorphine expenditures	\$2708	−\$47	\$2755	<0.01
Total prescription expenditures	\$4461	\$2166	\$2295	<0.01
Inpatient expenditures	\$2132	\$3757	−\$1625	<0.01
Outpatient expenditures	\$345	\$604	−\$259	<0.01
Professional expenditures	\$674	\$981	−\$307	<0.01
SMS expenditures [*]	\$2872	\$4160	−\$1288	<0.01
Utilization (rate/person)				
Inpatient days	1.54	3.00	−1.46	<0.01
Inpatient discharges	0.30	0.52	−0.22	<0.01
ED visits	1.44	2.48	−1.04	<0.01
Primary care physician visits	15.27	9.81	5.46	<0.01
Advanced imaging	0.29	0.54	−0.25	<0.01
Standard imaging	0.76	1.43	−0.67	<0.01
Colonoscopy	0.01	0.02	−0.01	<0.01
Echography	0.46	0.53	−0.07	0.002
Medical specialist visits	0.49	0.82	−0.33	<0.01
Surgical specialist visits	3.04	1.89	1.15	<0.01

* SMS refers to special Medicaid services and include transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services.

† Multivariable regression analysis, adjusted for gender, age, calendar year, clinical risk groups, Medicaid in the prior year, hepatitis C virus (HCV) status, and pre- and perinatal care.

‡ Difference = MAT – non-MAT.

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare



Practice Profile: ABC P
Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Welcome to the 2014 Blueprint Practice Profile from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services. Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

Demographics & Health Status

	Practice	H.S.A.	St.
Average Members	4,081	84,070	2
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.8	
Health Status (CRG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographics & health status of your practice, all Blueprint practices in your Health Service Area (HSA) as a whole. Included measures reflect the types of information used to adjust rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial enrollment during the year. In addition, special attention has been given to Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's practice, percentage of membership in Medicaid, Medicare eligibility or end-stage renal disease status, and the member's receipt of special Medicaid services that are not found in common populations (e.g. day treatment, residential treatment, case management, services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of members through the claims data as having one or more of seven selected chronic conditions: chronic obstructive pulmonary disease, congestive heart failure, co disease, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Groups (CRGs) to the year for the purpose of generating adjusted rates. Aggregated risk class includes: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic (chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (e.g., CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (e.g., dystrophy, cystic fibrosis).



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Total Expenditures per Capita

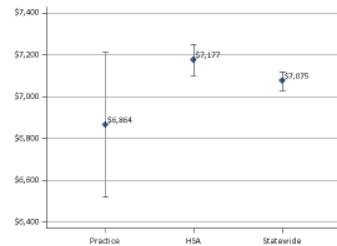


Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

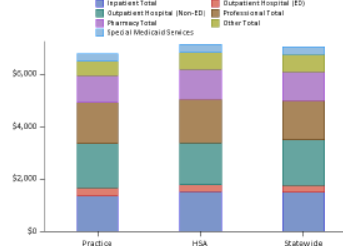


Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services.

Total Expenditures Excluding SMS

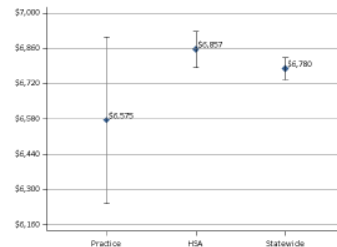


Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medicaid Services, capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

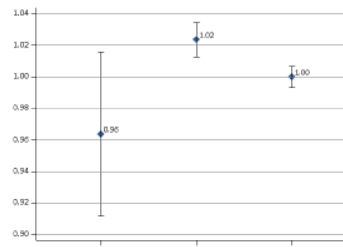


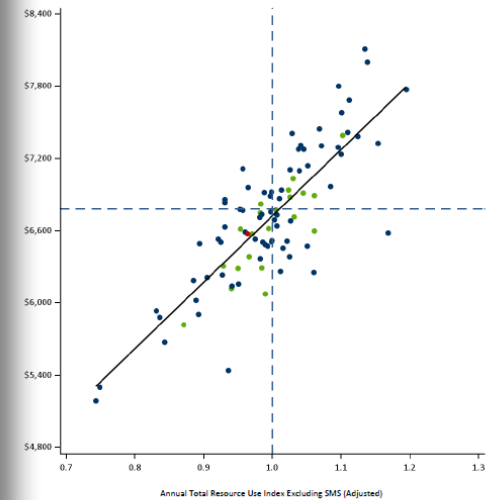
Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects on aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medicaid Services. The practice and HSA are indexed to the statewide average (1.00).



Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)



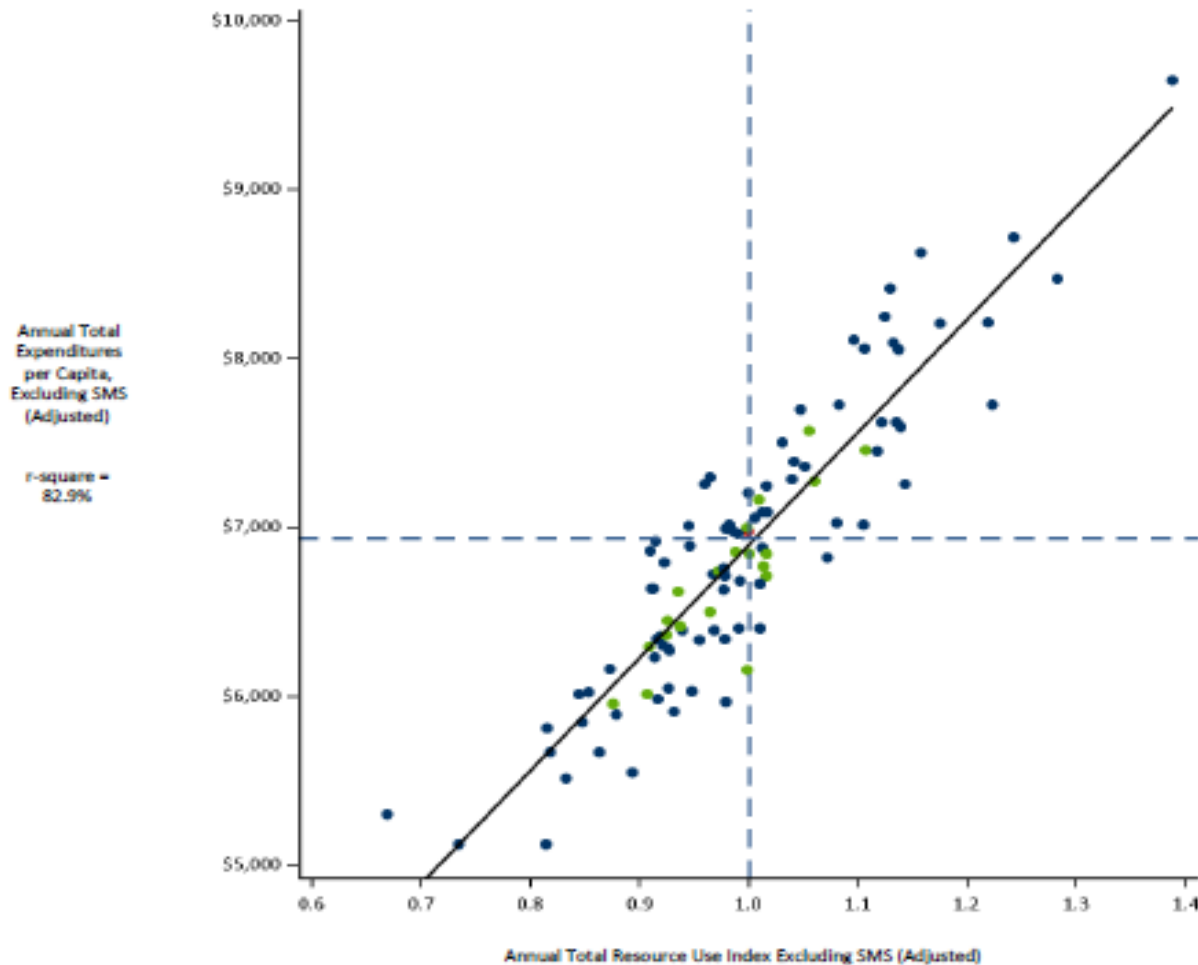
This demonstrates the relationship between risk-adjusted expenditures excluding SMS and RUI for Blueprint practices. This graphic illustrates your practice's risk-adjusted rate (i.e., the red dot) of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint practices (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI (i.e., the blue dots). The dotted lines show the average expenditures per capita and average RUI (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand corner with lower expenditures and utilization are in the lower left-hand corner. An RUI value greater than 1.00 indicates higher utilization; a value lower than 1.00 indicates lower utilization. A trend line has been included in the graphic, which demonstrates that, in general, practices with higher utilization had higher risk-adjusted expenditures.

Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

Demographics & Health Status Cost of Care Utilization Effective & Preventive Care Data Detail

Total Resource Use Index

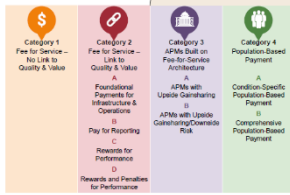
Annual Total Expenditures per Capita vs. Resource Use Index (RUI)



A 0.01 change in TRUI is associated with a \$66.80 change in expenditures per person

APM FRAMEWORK At a Glance

- The **Common** is a critical first step toward the goal of better care, smarter spending, and healthier people.
- Serves as the foundation for generating evidence about what works and lessons learned
 - Provides a road map for payment reform capable of supporting the delivery of person-centered care
 - Acts as a "passer" for measuring progress toward adoption of alternative payment models
 - Establishes a common nomenclature and a set of conventions that will facilitate discussions within and across stakeholder communities



HCP_{LAN}

The framework situates existing and potential APMs into a series of categories.

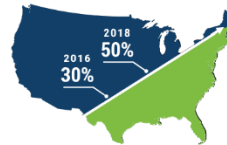
OUR GOAL Goals for U.S. Health Care

2016
30%

2018
50%

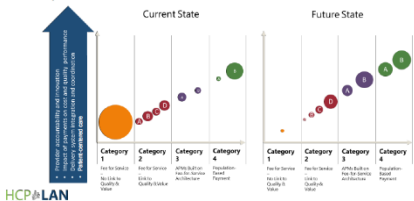
These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

Adoption of Alternative Payment Models (APMs)



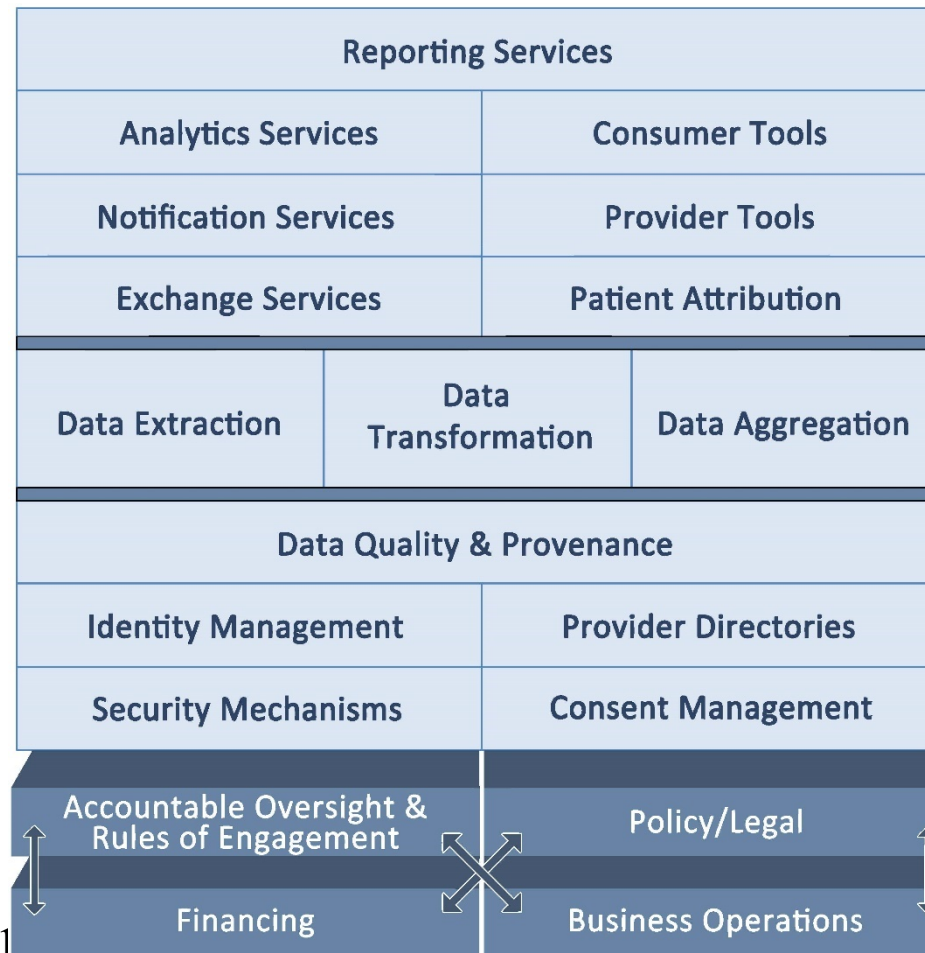
HCP_{LAN}

APM GOALS For Payment Reform



HCP_{LAN}

Health IT Modular Functions for APM Data Infrastructure



} Foundational Components

State Level Measurement Framework

Leadership Team

Include government and private sector stakeholders that have an interest in data sharing & quality measurement to guide a value based learning health system

Data Infrastructure

Data aggregation, quality, analytics, and reporting. Leverage state data systems.



Core Measures – Priority Outcomes

Limited Set – Priorities for population health & well being. Aligns system priorities and Alternative Payment Model incentive structure. Consistent across system



Driver Measures – Quality & Process

Standardized Library – Select subset to drive priority outcome. Selection may vary based on local needs and strategies used to improve core measure results.



States and the Data Infrastructure

- ***States have a vested interest to develop a data infrastructure*** that can be used to improve the health and well being of citizens, support APMs and delivery system reforms, and improve control of healthcare costs.
- ***States can function as a neutral convener***, and work across provider organizations, payers, and stakeholders to support public interests, including development of a data infrastructure as a utility.
- ***States are uniquely positioned to use matching federal dollars*** to develop a data infrastructure that supports the full continuum of providers.
- ***States maintain unique data systems*** with social, economic, and other risk factor data that could be used to fuel a more complete health system.
- ***States with APCDs have unique capabilities*** to link data that can be used for population health and a value based system.

Questions & Discussion