Health Information Technology Oversight Council and HIT/HIE Community and Organizational Panel

October 12, 2017

This public meeting is being recorded
Agenda

• Welcome, Introductions, Feedback from OHPB Meeting
• HCOP Roundtable on Challenges/Opportunities
• Alternative Payment Models – Landscape and Implications for HIT
  – APM Overview
  – Oregon APM Landscape
  – HPQMC and Measure Alignment Work
  – HIT for APM Framework and Discussion
HIT/ HIE Community and Organizational Panel

- Your organization's greatest challenges
- Your organization's most significant opportunities
- The value of coming together as the HCOP to you and your organization
An alliance of 100+ private pediatric providers caring for ~150,000 children in Oregon and Washington

Focused on health management of all pediatric patients including comprehensive needs-based care of children and youth with special health care needs

The Alliance and the Foundation work together to:

• Develop and implement transformational quality improvement programs
• Drive quality care delivery, care experience and cost management
• Offer clinical and strategic expertise about meaningful pediatric measures and actionable workflow solutions

CHA Pediatric Practices – Adding PHM Value

• Care Management
  – Outreach management, patient stratification, comprehensive patient care summary, shared care plans, extended care teams, etc.
• Panel Management
  – Care gap alerts/action lists, pre-visit planning, disease registries, performance reports
• Care guidance
  – Pediatric protocol prompts, comprehensive patient care summary
• Population analytics
  – Patient stratification, agile data drilling, registry analytics, data aggregation
• Performance Reporting
  – Detailed measures with clinical data sources, agile custom reporting, uniform standard reporting, direct/interface reporting
• HIE
  – Aggregation with claims/registries/hospitals for 360° view of patient, practice comparisons and benchmarking, single hub connection to external data partners
• QI & Analytics leadership
  – Centralized CHA management and support of data sharing, analytics, collaborations, strategies and innovations to help practices perform as top tier pediatric medical homes
Challenges

- Desire for health plans/others to connect to providers individually for clinical data places significant burden on individual practices.
  - Cost, Resources, IT capabilities
- Health plans not yet willing/able to share claims data with small group providers
  - Barriers include HIPAA, technology, attribution
- Not all EMRs have standard CCDAs/data sharing capabilities despite regulations.
  - Data is not always vetted by large HIEs

Opportunities

- Actionable data in the hands of the provider can lead to improvement in care and drive action
  - Data can be used to proactively prevent care gaps
  - Pharmaceutical data would be of significant value
- Incorporating 360° view of patient can lead to coordination previously unavailable
  - Specialists, behavioral health, ED, DHS, Juvenile Justice, Education, etc.

Value - HCOP

- Provide the provider perspective for HIE
- Provide an understanding of the nuances of clinical data and how to make it actionable for providers.

Inserting a Clinical PHM Solution for Provider Practices – Care Management, Reporting & Analytics Tool (CMART)
Regional Health Information Collaborative (RHIC)
HIE Challenges

Interoperability
• Time, cost and resources to implement/customize
• Legacy technology investments (or new)
  – Existing workflows
  – Ease of use and requiring another login
  – Multiple initiatives – what makes the most sense for providers/partners/agencies
    • Vendor EHR integrations, bypassing HIE systems
    • Sequoia/Carequality/PDMP
    • Pre-Manage

Financial sustainability model
• Services to an industry moving away from fee-for-service care delivery
• Developing high value analytic capabilities
• Lab/Imaging/Pharmacy – efficiencies actually drive down revenue

Complicated HIE landscape
• Some CCO’s unable to catch up and join the HIE model financially
• Vendor capabilities are rapidly changing
• Rapid growth in HIE capabilities causes a wait and see environment in community partner conversations

HIPAA/FERPA
• Behavioral Health
• Educational/Social Agencies
HIE Opportunities

Social Determinant of Health attributes
• Community/medical need & desire to collaborate through HIE

Early Intervention/Educational/Family/ Partners
• Biggest population with the most potential to impact long term health metrics

90/10 Grant Monies
• Big factor in bringing in data partners to build financial sustainability models

Secure messaging and intercommunity referrals
Central Oregon Health Connect

Michael Thomas, PhD

Mission: to improve the health and well-being of the individuals, families and communities we serve
Update On Opportunities

• COHIE and Reliance
  • COHIE is actively supporting Reliance in Central Oregon to build a community health record
  • Referral management tools are also being evaluated.

• Carequality
  • Universal protocol for EMR to EMR data sharing
  • In Epic, utilizes Care Everywhere functionality

• OHA HIT Commons
  • Looking forward to it
Opportunity

• Currently housing community health records for Southern, Central Oregon and the Gorge.

• Single sign on capability currently live in Epic for Mosaic and Central Oregon clinic staff to view community health record

• List of contributors can be found:
  • [http://reliancehie.org/participating-clinicspractices/](http://reliancehie.org/participating-clinicspractices/)
  • Includes all of the Central Oregon OCHIN clinics, all of the Adageo clinics and St. Charles

• Separate product available for data analytics. Currently being utilized by AllCare in Southern Oregon

• New technical support/trainer hired for Central Oregon support.
Opportunity

Display outside data where its most useful

• The goal is to present a complete picture of the patient using both internal and external data, directly within the EHR and not require the clinician to toggle to external systems.

• For patients with schedule appointments the Clinical Summaries should be pulled from all sources of care (Hospital, Clinic, VA, CVS, Surescripts, etc.) and presented directly to the provider at the point of care.
Challenges

• Local specialist and urgent care partner faces uncertain future with new owner.
• Lack of resources available in the local hospital system since they are converting to a new EMR.
• Keeping the community momentum around an HIE.
• No radiology groups are connected in Central Oregon.
• Uncertain funding future.
• Need to implement before analytics can be completed. Then data will need to be validated.
• Behavioral health integration
• Social determinants of health standards
- GrapeVine hosted by Engage/INHS
- Hospitals: OHSU, Legacy, Mercy Roseburg, St. Anthony Pendleton
- Sequoia Project (EPIC, VA-in progress)
- Providers
  - Athena
  - eCw
  - Greenway
  - GE Centricity

SUCCESS
- Clinics/FQHCS
- CCOs
- Other Labs/Diagnostics
- First Responders
- Pharmacies
- Registries
- Other Health Plans

FUTURE
- Mental Health Services
  - Transfers
  - Coordinating Care
- Dental/Medical Services
EDIE/PreManage Successes

- EDIE and PreManage users consistently report real time information has greatly improved the efficiency and effectiveness of their care
- Increased ability to know who is involved with the patient and to coordinate care
- Visit information (number of visits, visit location) and patient specific care recommendations are seen as most valuable
- Community collaboration has reduced duplication of efforts and enhanced ability to streamline and standardize processes
EDIE/PreManage Challenges

- Identifying opportunities to leverage the use of the tools while focusing on reducing ED utilization
- Limited technical assistance for practices to optimize use of tools
- As adoption of PreManage increased, focus shifted from ED utilization efforts to implementation
- Rapid spread of PreManage made development and dissemination of aligned workflows and processes difficult
- Coordinating and sustaining efforts to reduce ED utilization
EDIE/PreManage Opportunities

- Continue to focus on community collaborative efforts
- Broadly disseminate promising practices and resources
- Use data to identify opportunities to focus in specific areas or with specific populations (e.g. SPMI)
- Leverage use of tools to support transformation efforts (e.g. opioid prescribing reduction)
- Implement EDIE/PDMP Integration
Value of HCOP

- Stay connected to other HIT/HIE efforts in Oregon
- Increase understanding of broader transformation efforts enabled by HIT/HIE
- Learn about strategies for successful adoption of health information technologies that improve the efficiency and effectiveness of care
Advantage Dental – ADIN (Advanced Dental Information Network)

• Biggest Challenges
  • Connections
    • Working on this with Reliance and IHN
    • Immediate leverage of connection with MORE care study hosted by Dentaquest Institute
  • Dentists
    • Hasn’t been a big push to bring additional providers on yet
  • Resources
    • Currently using contractors to augment in-house team which are slower and less efficient
    • All costs are paid for by Advantage Dental so budget is always a concern
Advantage Dental – ADIN (Advanced Dental Information Network)

• Biggest Opportunities
  • Expand Provider Network
    • Become de-facto standard for Dental-HIEs in Oregon
  • Expand Connection Partners
    • Connect with Behavioral health as we share a lot of the same Medicaid patients
    • Getting consents to/from parents for EPDHs in the school based settings
  • Continue Developing Features
    • Analytics and Community Reporting
    • Screenings and enhanced Community Care Coordination
    • Increase supported Practice Management software to remove roadblocks to adoption
Advantage Dental – ADIN (Advanced Dental Information Network)

• The landscape of interoperability is rapidly changing in Oregon and HCOP provides a venue of collaboration allowing stakeholders the unique chance to have their voice heard and synchronize efforts across the spectrum of care.
Formal opportunity to interact and learn from others in the Oregon Health Information Exchange space
Venue to further explore and understand what is on the horizon from OHA and state sponsored initiatives in Oregon
Opportunity with our peers to share thoughts concerns and support for OHA initiatives
Opportunities

- Behavioral Health Exchange Support
  - Consent Administration Support for Substance Use Treatment Information
  - Integration of BH & SUTI data with Physical and Social Determinant Data

- Dental Health Exchange Support

- Population Health Metrics Support
  - Claims Data integration
  - Support for CCBHC, CPC+, STARs, PQRS, HEDIS, etc.
Challenges

Boil the Ocean

- Competing Priorities
  - EHR and Technology Vendors
  - IPAs and IDNs
  - State of Oregon & CCOs

- Data Quality
  - Workflow change in small care settings
Alternative Payment Model Landscape and Implications for HIT

Sean Carey
Lead Policy Analyst
Goal 2 and Work Ahead

Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

• Proposed process:
  – Baseline understanding and framework introduction (now)
  – Gaps and opportunities, strategy development (Spring 2018)
  – Update to strategic plan in August 2018

• Key question for strategy development: What is the right HIT needed to support APM efforts?
Alternative Payment Models (APMs)

Health system transformation

Better care
Lower costs
Better outcomes

Payment reform (APMs)

Reward value
Value = care/ cost
and/or
Value = outcomes/ cost
### Broad Framework – HCP-LAN

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE FOR SERVICE – NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE – LINK TO QUALITY &amp; VALUE</td>
<td>APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION – BASED PAYMENT</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>B</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td></td>
<td>Integrated Finance &amp; Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</td>
<td></td>
</tr>
</tbody>
</table>

3N Risk Based Payments NOT Linked to Quality

4N Capitated Payments NOT Linked to Quality

This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.
MACRA: MIPS and Advanced APMs

The Quality Payment Program has two tracks you can choose from:

- **Advanced Alternative Payment Models (APMs)**
  
  If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

- **The Merit-based Incentive Payment System (MIPS)**
  
  If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

- Replaces Medicare Meaningful Use, Physician Quality Reporting System and Value-Based Payment Modifier

- Advanced APMs are a subset of APMs that:
  - Require certified EHR technology
  - Base payments on measures comparable to those in MIPS
  - Be a medical home model or involve more than nominal financial risk for losses
Every layer is a little more complex (and tomatoes are fruit!)

Key Influences:
Size of practice/panel, # of payer contracts, competition, practice type
APM needs with implications for HIT

- Metric reporting (care provided or outcomes)
- Ability to coordinate care
- Accurate information and alignment with payer
  Ability to stratify population based on risk
- Ability to identify care improvement opportunities
- Specific HIT requirements
<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service - No Link to Quality &amp; Value</td>
<td>Fee for Service - Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
<tr>
<td>A: Fee for Service</td>
<td>B: Fee for Reporting</td>
<td>A: APMs with Upside Geiching</td>
<td>A: Condition-Specific Population-Based Payment</td>
</tr>
<tr>
<td>for Infrastructure &amp; Operations</td>
<td>C: (Rewards for Performance)</td>
<td>B: APMs with Upside Geiching/Downside Risk</td>
<td>B: Comprehensive Population-Based Payment</td>
</tr>
<tr>
<td>D: (Rewards for Performance)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Health IT Infrastructure**

- Organizational EHR
- Event notifications (e.g., ADF: fax, spreadsheet, Direct)
- Query for clinical data from another organization or system
- Separate care coordination system with manual data entry to create care plans
- EHR CQMs
- Manual chart review & claims-based CQMs
- Manual submission of CQMs to payers

**Ideal Health IT Infrastructure**

- Organizational EHR with interoperable summary clinical data
- Organizational EHR with all clinical data interoperable
- EHR & Community-based social service systems with all clinical data interoperable

- Closed referral loop
- Shared care plan integrated with EHR and available to entire clinical care team, patient, & their caregivers
- Event notifications integrated into workflow
- Limited claims data sent from payer to provider organization
- Organization data warehouse to combine clinical & claims data
- Linking of organizations’ patient data to limited data set from payers
- Near real-time, provider-based eCQMs
- Majority of CQMs are eCQMs & can be reported to multiple payers
- Real-time risk scores from claims & clinical data
- Real-time disease specific risk scores from claims & clinical data
- Aggregate multi-payer claims data & multi-organization clinical data that’s available to all participants in APGs
- Interoperable provider directory – hierarchical & relational
- Linking of all claims & clinical data from multiple organizations
- Real-time patient-centric eCQMs calculated across systems or contracts
- Near-real-time benefit eligibility information & evidence-based CDS available at time of order
- Provider value score available at time of order – cost & quality

**Key**

- EHR System
- Care Coordination/Management
- Quality Measurement
- Data Aggregation & Attribution
- Risk Scoring
MIPS – Key HIT Components

Advancing Care Information

In 2017, there are two measure set options for reporting. The option you use to submit your data is based on your electronic health record edition.

- **Option 1**: Advancing Care Information Objectives and Measures
- **Option 2**: 2017 Advancing Care Information Transition Objectives and Measures

You can report the Advancing Care Information Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions that support these measures.

You can report the 2017 Advancing Care Information Transition Objectives and Measures:

- If you have technology certified to the 2015 Edition; or
- If you have technology certified to the 2014 Edition; or
- If you have a combination of technologies from 2014 and 2015 Editions.

CMS Quality Payment Program website (includes list of advanced APMS and tools for clinician participation in MIPS): [https://qpp.cms.gov](https://qpp.cms.gov)
Payment Impacts of MIPS to Medicare Part B

- Maximum Adjustments:
  - 4% increase
  - 5% increase
  - 7% increase
  - 9% increase
  - 4% decrease
  - 5% decrease
  - 7% decrease
  - 9% decrease

*Potential for 3X adjustment

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System (MIPS)
Summary

• The APM landscape is complicated but there are some frameworks to organize and understand categories of models
• The implications for HIT are diverse and sometimes nebulous, but some common themes emerge
• Increasingly, providers and payers can expect to fall into APM models of some kind
• MIPS has a broad reach, and may be a model for other programs, private initiatives moving forward
• APMs are driving collaboration between payers and providers, including around data and HIT
Other APM Resources

- **HCP-LAN Whitepaper on APMs:**

- **Oregon FQHC APM Pilot:**
  http://orpca.org/initiatives/alternative-care-model

- **Oregon Certified Community Behavioral Health Clinic (CCHBC) Program:**

- **CMS Center for Medicare and Medicaid Innovation Map:**
  https://innovation.cms.gov/initiatives/map/index.html

- **Center for Healthcare Quality and Payment Reform APM Glossary:**
  http://www.chqpr.org/downloads/PaymentReformGlossary.pdf
Value-Based Payment Landscape

October 12, 2017

Chris DeMars, MPH
Transformation Center Administrator
Value–Based Payments

• Value-based payments (VBPs) give providers flexibility to deliver the care patients need, and don’t link payments to individual services.
  – VBPs are in contrast to fee-for-service, a payment model where individual health care services are paid for separately.

• VBPs hold providers accountable for the cost and quality of the care they provide, not just quantity of services.
CCO VBP Efforts
Findings from CCO interviews (Bailit Health, May 2017)

- Significant variation across CCOs reflecting different organizational and market history, network composition, geographic reach and size
- CCOs are integrating quality performance into payment
  - Opportunities exist for further development in number and type of measures used
- VBPs beyond primary care capitation and full capitation for behavioral health and dental care are limited
- Slow to adopt VBPs for specialists and hospitals.
  - Some use of risk pools for referral and hospital services
- CCOs planning for incremental change
- Challenge in rural areas where provider networks comprised of few providers large enough to contract using VBPs
- CCO non-claims spending 29% for both 2014 and 2015
CCO VBP EXAMPLES
Shared Savings

• CCO provides primary care, pediatric, specialty and behavioral health clinicians with an opportunity to share in savings based on cost performance

• Savings are also linked to clinicians’:
  – Performance on a set of utilization and access metrics, and
  – Ability to meet a set of clinically focused quality benchmarks

• Ensures accountability of the triple aim

• Provides contracted providers incentive to move from volume-based care to value-based care
Risk Payments

- CCO shares risk on overall CCO performance with voluntarily participating hospitals, Patient-Centered Primary Care Home clinics, primary care physicians (PCPs) and independent physician associations (IPAs)
- If the CCO performs better than budgeted, the CCO distributes 77% of the surplus using an agreed-upon formula, some of which is reserved for quality performance bonuses
- If the CCO exceeds its budget, the participating providers are responsible for 60% of the total losses (maxed at 5% of total reimbursement for each participant)
Case Rates

• Three behavioral health plans affiliated with Health Share of Oregon have implemented case rates for most outpatient behavioral health services.
• There are eight different case rates based on Level of Care – 4 for adults and 4 for children:
  – Lowest Level of Care contains payment for individual and family therapy, group therapy, medication management, case management.
  – Higher Levels of Care include everything in lowest Levels of Care, plus skills training, peer and family support, telephonic crisis support, relapse prevention, etc.
• Case rates cover either 6 or 12 months of services.
• Financial incentives given for providers that use evidence-based/outcomes-based care (maxed at 5% of total reimbursement for each participant).
MULTI-PAYER ALIGNMENT EFFORTS
Comprehensive Primary Care Plus (CPC+)

Centers for Medicare and Medicaid Services (CMS) model to improve quality, access, and efficiency of primary care:

• Payment redesign gives practices greater flexibility to provide the care patients needs
• Two practice tracks based on practice readiness for transformation
• Five-year program (2017 to 2021)
• Oregon is one of 18 CPC+ regions nationally
CPC+ Oregon Region

**Payer Partners**
- AllCare Health, Inc.
- CareOregon
- Columbia Pacific CCO
- Eastern Oregon CCO
- FamilyCare Health
- InterCommunity Health Network
- Jackson Care Connect
- Moda Health Plan
- Oregon Health Authority (Medicaid)
- PacificSource
- PrimaryHealth
- Trillium CCO
- Providence Health Plan (PHP) and Providence Health Assurance (PHA)
- Umpqua Health Alliance
- United Healthcare
- Western Oregon Advanced Health
- Willamette Valley Community Health
- Yamhill Community Care Organization

**Total Number of Practices Starting in 2017**
- **156** Practices

**Track Breakdown**
- Track 1: 71
- Track 2: 85

**Organizational Structure**
- **46** independent practices
- **30** rural practices
- **23** small practices
- **100,549** Medicare FFS beneficiaries served
CPC+: Advancing Care Delivery and Payment

Fee-for-Service Primary Care

- Focus on volume
- High-cost services
- In-person encounters
- Fragmented care
- Provider burnout
- Little attention to social determinants of health

Practice Transformation

- Actionable milestones to deliver high quality, whole-person, patient-centered care
- Effective use of health information technology (HIT) and data analytics
- Practice learning networks

Payment Redesign

- Non-visit based care management fees
- Regional shared savings opportunity

Comprehensive Primary Care

- Focus on efficient, high quality care
- High-value utilization
- Population-based care delivery
- Engaged patients, caregivers, and families
- Multi-payer support
- Coordination across the medical neighborhood and community services
## CPC+ Multi-Payer Payment Reform

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Objective</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care management fee</td>
<td>Support increased staffing and training for delivery comprehensive primary care</td>
<td>Per-member, per-month payment (PMPM)</td>
</tr>
<tr>
<td>Performance-based incentive payment</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>PMPM</td>
</tr>
<tr>
<td>Payment structure redesign for Track 2 practices</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting (e.g. email, phone, etc.)</td>
<td>Upfront payment with reduced FFS payment</td>
</tr>
</tbody>
</table>
CPC+ Oregon Payer Partner Roadmap

1. Shared vision of regional success
2. Multi-stakeholder alignment
3. CPC+ Payer learning and information sharing
4. Alternative payment model for primary care
5. Practice support
6. Data aggregation/data support to practices
7. Quality measure alignment
8. Evaluation for success
Primary Care Payment Reform Collaborative
Purpose

SB 231 (2015) and SB 934 (2017) require development of a Collaborative to implement a Primary Care Transformation Initiative to:

• Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care)
• Improve reimbursement methods, including by investing in the social determinants of health
• Align primary care reimbursement across purchasers of care
Primary Care Payment Reform Collaborative

Strategies

- Use of value-based payment methods
- Provision of technical assistance to clinics and payers in implementing the initiative
- Aggregation of data across payers and providers
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee
- Facilitation of the integration of primary care behavioral and physical health care
Primary Care Payment Reform Collaborative
Senate Bill 934 (2017)

- Requires the Collaborative to report annually to the Oregon Health Policy Board and the Oregon Legislature on:
  - Implementation of the Primary Care Transformation Initiative
  - Progress towards meeting primary care spending target of at least 12%

- Requires that CCOs and insurers participating in a CMMI program (such as CPC+) “offer similar alternative payment methodologies to all patient centered primary care homes…”
VBP Roadmap for CCOs
Oregon’s Medicaid 1115 Waiver: 2017-2022

- Requires transition to a payment system that rewards health outcomes improvement and not volume of services
- Requires development of a plan describing how the State, CCOs and network providers will achieve a set target of VBP use by the end of the demonstration period
- Process: Develop in partnership with CCOs
- Timeline: Finalize Q2 2018
Thank you!
Questions?

Chris DeMars, MPH
Administrator
Transformation Center
chris.demars@state.or.us
www.health.oregon.gov
Metrics Alignment

Metrics Team:
Jennifer Davis
Sara Kleinschmit
Kate Lonborg
Milena Malone
Kristin Tehrani
Frank Wu

Valerie T Stewart, Ph.D. Manager-Metrics and Evaluation
METRICS ALIGNMENT

Challenges
Balancing Act of Needs
National-State Level Alignments
Example of Metrics Alignment
Challenges--Metrics Proliferate Over Time

• In 1991, HEDIS was a fledgling organization with a few standardized metrics
• In 2017 we are overpopulated with metrics!
  – 1,367 measures in use across 48 measure sets and of these 509 are DISTINCT, non-duplicated. Only 20% of the 509 metrics were used in two or more measure sets
  – As of November, 2016 there were 650 NQF-endorsed measures
Challenges--Practices Spend Over $15.4 Billion every year to report quality measures*

Balancing Competing Needs

- Development of new measures
- Alignment of existing measures

- Shift to more outcomes measures
- Decrease reporting burdens

- Respond to new concerns and new evidence…
- Improve data quality with experience…

- But increase reporting burdens
- But decrease outcome measure options
National Efforts on Alignment - Examples

• Agency for Healthcare Research and Quality (AHRQ) National Quality Strategy
• National Academy of Medicine Vital Signs – Core Metrics
• CMS Core Quality Measures Collaborative to identify core sets for clinical areas such as ACOs and primary care, cardiology, pediatrics
  – Measures Management System to standardize development and maintenance of measures used in CMS programs
• National Quality Forum (NQF) evaluation process includes consideration of competing or related measures
Oregon Metric Alignment Efforts for Conceptual – Big Picture Alignment

- Inter-agencies-DHS for social determinants of health, Department of Education for access and others
- Parts of the same agency-Public Health, Quality Improvement Transformation Center, Health Service Delivery and Health Information Technology and others
- Community-based committees representing providers—Health Plan Quality Metrics Committee, CCO Metrics and Scoring, Federally Qualified Health Clinics, Hospitals and others
- Specific Program and Projects for Metrics
Oregon Measure Alignment Efforts for Specifications and Metrics

- Health Plan Quality Metrics Committee – measure selection will affect nearly 1.5 million Oregonians

<table>
<thead>
<tr>
<th>Coordinated Care Organizations</th>
<th>Nearly 1.0 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEBB-Public Employees</td>
<td>139,000</td>
</tr>
<tr>
<td>OEBB-Educators</td>
<td>153,000</td>
</tr>
<tr>
<td>Exchange Plans</td>
<td>155,000</td>
</tr>
</tbody>
</table>

- Comprehensive Primary Care Plus (CPC+) – data aggregation discussion

- Clinical Quality Metrics Registry – collection point for clinical/ EHR-based measures
2017 Measure Set Alignment Example

271 MIPS quality measures (CQMs, claims, CAHPs)

53 MU CQMs

14 CPC+ CQMs

3 CCO incentive

* Diabetes
* Hypertension
* Depression
* Screening

1 CCO incentive

* Tobacco
* Prevalence

MIPS=Merit-based Incentive Payment System
MU=Meaningful Use
CPC+=Comprehensive Primary Care Plus—CMS program to strengthen primary care clinics
Strategies for Health IT to Support APMs
APM needs with implications for HIT

- Metric reporting (care provided or outcomes)
- Ability to coordinate care
- Accurate information and alignment with payer
  Ability to stratify population based on risk
- Ability to identify care improvement opportunities
- Specific HIT requirements
ONC Health IT Modular Functions for APMs

Data Use Capabilities

Core Technical Capabilities

Foundational Components
Discussion

• Is the ONC model useful for framing discussion of HIT to support APMs? If not, is there another model to consider?

• What do you see as key focus areas for HITOC’s work?
  – Within your organization, what do you hear about how HIT is successfully being used to support APMs? About HIT gaps?

• Feedback on proposed process:
  – Staff work on investments and gaps
  – Future HITOC meeting with panel presentation from provider, payer, cross-organization support (e.g., data intermediary)
  – Incorporate strategies into August 2018 strategic plan review/update
Public Comment
Next Meeting

• December 7th, 2017
  12:30 pm – 3:45 pm

• Transformation Center Training Room
  Lincoln Building, Suite 775
  421 SW Oak Street
  Portland, OR