Welcome & Housekeeping

- All stakeholders in New Mexico’s healthcare community are welcome
- We will record today’s webinar
- Lines will be muted as we begin
- To comment or to ask a question, please ‘raise your hand’ and unmute your line, or
- Direct your question or comment (to everyone, to the presenter, or to the host) in the chat box

Agenda

- News & Information: – Michelle Bowdich, Director of Outreach & Communications and Thomas East, PhD, CEO/CIO, LCF Research and NMHIC
- Guest Presentation: How New Mexico Providers Can Use Data for Value-based Success – Presented by: Gene Hill, BBA, MA, Data Manager/Reporting Analyst, NMHIC; and Stefany Goradia, MSIE, Principal Informatics Officer, Versatile MED Analytics
- User Tip: Communicate – April Salisbury, Director of Education and Training

NMHC Outreach and Communications Update

Michelle Bowdich
Director of Outreach and Communications

NMHC Outreach and Communications

New Direct Secure Messaging User

Kindred at Home offers a variety of services from skilled nursing and rehabilitation to non-medical personal assistance, wherever you call home.

Participant List
NMHIC Outreach and Communications

New Interface from Taos: Holy Cross Medical Center, *Radiology* interface was moved into Production May 7, 2018

NMHIC Outreach and Communications

New Interfaces from Las Cruces: Memorial Medical Center, *ADT* and *Radiology* interfaces are now LIVE! June 11, 2018

NMHIC Outreach and Communications

New Interfaces are anticipated from Grants: Cibola General Hospital

NMHIC Outreach and Communications

CHRISTUS Health System, will continue using the HIE Portal in their Emergency Department and is committed to continue sharing data after their Epic transition

NMHIC Outreach and Communications

New Interfaces are anticipated from Artesia: Artesia General Hospital

NMHIC Outreach and Communications

Radiology Associates of Albuquerque, reports are in final Testing/Validation, and will be in production very soon!
“Our team has created an advanced analytic system that uses data from health plan claims and the New Mexico Health Information Exchange to identify and stratify members who are at health risk, and intervene before avoidable health issues occur.”

Dr. Mark Epstein / Chief Medical Officer, True Health New Mexico

How NM providers can use their own internal data and existing exchange data to identify value-based measures that make sense for them and facilitate conversations with local payers/MCOs.

Questions?

Providers > 10
Hospitals
Payers
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info@versatilemed.com

Providers < 10

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info@capmedcon.com
Versatile MED Analytics

USING DATA FOR VALUE-BASED CARE

How NM providers can use their own internal data and existing exchange data to identify value-based measures that make sense for them and facilitate conversations with local payers/MCOs.
ABOUT US
Versatile MED Analytics is a data-driven consulting firm headquartered in Albuquerque, NM. We are a women-owned small business.

Why we do it
We want to make lives better – and easier – with data.

What we do
We take very complex data and turn it into actions and information.
We deeply understand payer and provider operations.

Who we are
Experienced data experts and management consultants with deep roots in the NM healthcare community and Centennial Care (Medicaid) requirements:

• Presbyterian Healthcare Services
• Presbyterian Health Plan
• Molina Healthcare
• HCSC (Blue Cross Blue Shield NM)
• Various independent providers (NM & CO)

In the era of data, there is no reason lives, dollars, and efficiency should fall through the cracks. But a disparate system causes this to happen daily, disproportionately affecting vulnerable patients and the providers who serve them – resulting in disappearing access to care, rising costs, shrinking margins, and poor outcomes. We started Versatile as a way to make lives better with data, whether you’re working in the system, being served by the system, or both.

Our key wheelhouses are:
- Population Health
- Value-based care
- Medical Cost Economics
- Reporting and analytics support
- Process improvements (Lean/Six Sigma)
WHO WE ARE

Core Team

- Management Consultants
- Master Black Belts
- DBA’s / SQL Programmers
- Data Scientists

A. Dushko
Versatile CEO and Principal, Advanced Analytics

S. Gourdie
Versatile CIO and Principal, Health Informatics

T. Panoszzi, M.D.
Versatile CMO and Sr. Principal Medical Advisor

N. Kusterle
Advisor, Program Development
WHAT’S NEW?

Measures, measures, everywhere...

Centennial Care 2.0
MACRA/MIPS/APM
HQII 2.0
New CMS Star Ratings
ACO measures
Etc.
Etc.
Etc.
Providers already have various measures and requirements they are reporting, from regulatory requirements, to improvement programs, to accreditation, and more. Many of the measures you’re already reporting are starting to be looked at more closely and expanding to multiple lines of business (for instance, beyond just Medicare).

Some influencing factors of what new measures may come down the line are: what is internally important to the MCO/payer, what is being pushed down from CMS or a governing body (like the NM Human Services Department/HSD, who administers our state’s Medicaid program), what may makes sense regionally/organizationally, and what your unique organization may be able to collaborate with the payers on. And new ones might continue to crop up! Although arguing for standardization across programs makes it “easier” for everyone, it is not always feasible, and providers can find themselves with multiple measures or programs that are similar, but different enough to cause heartache for everyone involved.

These measures/requirements are increasingly being tied to payment structures, which is commonly referred to by a number of names such as: value-based care, value-based reimbursement, value-based purchasing, pay for performance, shared risk, etc. But at it’s core: payments are starting to be tied to value, outcomes, and special programs designed to bend the cost and quality curve.
As an example of how serious HSD is about incorporating value-based purchasing (VBP) structures into Medicaid, this chart is compiled from HSD proposed contract language for Centennial Care 2.0. It includes aggressive targets that MCO’s must meet for VBP initiatives. The chart shows the yearly targets of total claims that must be administered to providers under formal VBP arrangements for Levels 1-3, with the targets increasing annually for each level.

Examples of the Levels and what kind of measures might qualify for each level can be found in Appendix A.

While the ultimate goal of VBP initiative is moving more providers to risk arrangements (such as a global or capitated arrangement), there are incremental and intermediate steps that can be taken leading up to that, with some providers being more poised to move to shared risk than others. All providers vary in their ability to manage arrangements from a data, operational, and financial perspective. This is why understanding the measures, how they’re calculated, and having data to support management of them is paramount to success.
All of us have a lot to deal with right now, and that includes our MCO’s and payers.

Besides VBP requirements, MCO’s must report their performance to HSD for additional quality measures such as:
- 7/30 day follow ups for patients discharged from BH Inpatient Unit
- Comprehensive Diabetes Care
- Antidepressant Medication Management

Plus more.. some of them are similar to measures they are already reporting for HEDIS and some aren’t.

Not to mention improving and meeting HEDIS quality measures for all lines of business, not just Medicaid… (example: a new transitions-of-care measure for Medicare). And capturing chronic conditions for Medicare Advantage… And internal initiatives and strategies… And care/case management or population health efforts…
VALUE-BASED PURCHASING (VBP)

What this means:

Data is the key to success.

What this all means is: MCO’s and payers are increasing conversations on how to collaborate with providers to help them meet these targets, avoid penalties, and improve quality of care for New Mexicans. Providers may be able to help, and receive value-based or incentive dollars for doing so. This doesn’t mean that all of these areas have opportunity for your individual organization, and every MCO will vary on what they’re focusing on or is most important to them, but these areas serve as good talking points to begin a mutual dialogue.

Being able to harness data is going to be key. We take complex data and make sense of it so you can be successful. Being able to manage all of this complex data and use it to facilitate conversations, measure progress, monitor performance, and identify improvement strategies, will be key to success – not just for VBP arrangements, but operationally, financially, and clinically. And it doesn’t just apply to your own internal data, but for data provided to you by the payers and external data, as well.
HOW?

So much data, so little time…

Steps to getting started
(with an example of our work for New Mexico Hospital Association)

VBP – getting started:
1. Identify Opportunities
2. Model
3. Collaborate
4. Track
5. Improve
1. Identify opportunities based on what MCO’s are focusing on and which make sense for your facility or practice based on your organization’s unique profile and capabilities.

What you’ll need:
- An understanding of what MCO’s are focusing on (which may vary by line of business, provider type, condition, etc.)
- Data to determine what kinds of measures are feasible for your organization to bend the curve. This can be done by profiling your organization with your own internal data, performing an opportunity analysis, and even benchmarking to peers. Benchmark data to use depends on your goals/focus, but there are many sources out there (CMS, AHRQ/HCUP, published data, etc.)
- If you are a data contributor to NM HIC, some of this information can be pulled from the Exchange then augmented with additional internal data.

Example provider:
This facility sees many diabetics and hypertensives. Their patients also tend to be frequent ED utilizers.
Is there opportunity to help meet the Comprehensive Diabetes Care or target low-acuity ED utilization?
1. Identifying Opportunities (continued..)

Example provider:
This facility’s readmission rate is already very low compared to peers and is one of the best in the state. Readmission reductions may not be a feasible measure to focus effort on. We will see more on readmissions and leakage from Gene.
1. Identifying Opportunities (continued..)

Example provider:
This (mock) facility sees a large proportion of PHP members and not nearly as many Molina patients. PHP may have more interest in an arrangement due to the volume of their members this facility is seeing. Even though this facility may be seeing less Molina patients, there may be opportunities there for certain other measures, but they may not be measures that typically come with high volumes. This is part of the considerations and dialogue to think through as you prepare for conversations.
1. Identifying Opportunities (continued..)

Descriptive analysis helps providers understand the population of the patients they treat and guides an informed conversation. These are examples of how data can be sliced many different ways to identify opportunities, bottlenecks, hidden information, and story, depending on your goal. We will hear more from Gene on descriptive population profiling.
1. Identifying Opportunities (continued..) – Benchmarking

Every publicly-available data source has a pro and con, whether it’s the timeliness of the data, risk adjustment methodologies called into question, completeness of data, or relevance, etc. As with any data, the context must be understood before using it to draw a conclusion. In this way, publicized data can be used illustratively to identify high-level “pointers” or opportunities and performance comparisons. More detailed opportunity identification requires a deep-dive into more robust data and a keen eye to marry your organization’s unique data story the story being told by other various data sources.

This is just an example of the various sources of data that can be used as pointers. Specifics depend on your goal, the intricacies of what you’re measuring, and the nuances of available data. Some are free or “open source” and others require payment to access more robust, granular data.
Step 2. Baseline Modeling and “what if” scenarios

2. Financial baselines and iterative modeling – based on your actual payer mix, costs, and utilization – to identify what makes sense financially and operationally, as well as what the impact to costs and revenues will be for proposed arrangements. This is an example of a very simple cost-benefit model to evaluate a specific value-based measure and proposed payment.

After identifying baselines for specific measures or metrics of interest, it can be used to model against the proposed VBP incentive arrangement once one is identified. The difficulty here is that VBP arrangements can be structured in many different payments (pay per event, overall reimbursement rates, capitation, lump sums based on meeting thresholds, etc. etc.) and every arrangement may require modeling things differently or requiring different kinds of data inputs to get an accurate model.

This step may be iterative as you talk to payers:
1. Pull data by payer, utilization volumes, and etc.
2. Identify Baselines, feasible targets, and potential opportunity
3. Compare/model against incentives proposed
4. Determine break-even or profitable dollar value that incentive needs to be by maximizing the model based on the inputs you can control and the rate you can work with the payer to negotiate

What you’ll need:
- A clear understanding of your own organizations’ costs, reimbursements, and utilization profile to model different scenarios accurately and by payer, as well as determine feasibility of hitting particular measures.
- The need ability to obtain this data and put it into a workable model that can be used through negotiations, as well as a clear understanding of how the VBP reimbursement would be administered (upside bonus, capitated, pay per event, overall reimbursement rate adjustments, etc.)
3. Enter data-driven dialogue with payer to identify common ground, mutual definitions of measures, and data expectations for incentive or value-based arrangement.

What you’ll need
- Payer language and payer data fluency not required, but makes the conversations a lot easier.
- Expect to work iteratively with payer on data needs, data validation, data definitions, and data accuracy. You want to make sure the data is correct, accurate, and reliable, as well as representative.
- Measure definitions are KEY. This is the opportunity to make sure you understand and agree with the measures, what data is used to calculate them, and how they will be tracked and monitored as it relates to your payment. You may also work with the payer to receive supplemental data from them that helps you manage your measures or initiatives. Validate, validate, validate.
EXAMPLE WORK ONGOING WITH NMHA

Tracking helps inform progress

Step 4. Track, monitor, and validate

4. Develop tracking tools, dashboards, and an internal process for ongoing data validation with payers in order to track and manage the initiative continuously.

What you’ll need
- Ability to continually work with the payer to validate the data, measures, calculations, and detail to the patient/member-level
- Depending on arrangement and size, expect the possibility of regular performance meetings.
- On-going monitoring recommended, as with key performance indicators (KPIs) tied to strategy, finance, and operational goals/workflows.
- Strategic dashboarding or tracking reporting (this can be done in Power BI, Tableau, or even Excel depending on your budget, capabilities, capacity)
5. This diagram shows some of the reasons we tend to see drift after a new initiative is implemented. An organization may have actionable data and get off to a good start, but if there aren’t corresponding workflows and feedback loops put into place, the team may not know how their actions are supposed to change or what their new goals are.

If the new initiative requires a radical difference to what has been done in the past, it is exceptionally harder. Without a consideration to change management, it can be challenging to garner buy-in for changed mindsets. Initiatives should be coupled with mindful workflows that incorporate new initiatives rather than add them on top of what is already hard to manage.

If incentives are not aligned across the organization, it can be hard to obtain buy-in for the new initiative. Aligned incentives and committed resources may be required to regularly monitor and tie into your accountability strategy.
What we are seeing in the community:

1. Payers are starting to increase these conversations, but looking at particular measures that make sense for them
2. Providers know this is coming and are all across the board in terms of readiness
3. There is a general unease about how it all works, how it looks, and what the data definitions will be
4. Providers will need help to understand “payer” language, including how to use the payer data they may receive as part of these arrangements (such as looking for opportunities within claims)
5. Providers who can manage the data and come to the payer have more likelihood of getting involved in these conversations at this time, due to limited payer data resources
QUESTIONS?

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info@versatilemed.com

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VALUE-BASED CARE

Appendix A

Pre-Level 1: Pay for Reporting
- Bonuses payments for quality reporting
- DRGs with rewards for quality reporting
- HEDIS Data to MCO for specified measures
- Increase Preventative Preventative ED visits by 5%

Level 1: Fee Schedule with Bonus or Incentives
- Payment when outcomes/quality scores meet agreed-upon target
- All included provider requirements must exceed percentage achieved in prior year
- Bonus payments for quality performance
- DRGs with rewards for quality performance
- HEDIS with rewards for quality performance
- Decrease Preventative Preventative ED Visits by 5%

Level 2: Fee Schedule based, update only share savings
- Payment when outcomes/quality scores meet agreed-upon target
- All included provider requirements must exceed percentage achieved in prior year
- Available readmission target (5%)
- Bundled payment with higher risk info
- Total readmission
- Include patients with poor diabetes control (over is better) by 5%

Level 3: Fee schedule based or capitated payments with risk sharing
- Payment when outcomes/quality scores meet agreed-upon target
- All included provider requirements must exceed percentage achieved in prior year
- Available readmission target (5%)
- 30 Days Readmission at 1Q after discharge
- Avoidable readmission target (5%)
- Full delegation of care coordination

Contract Year 1: 10%
Contract Year 2: 10%
Contract Year 3: 10%
Contract Year 4: 13%

Contract Year 1: 3%
Contract Year 2: 3%
Contract Year 3: 3%
Contract Year 4: 3%

Contract Year 1: 3%
Contract Year 2: 3%
Contract Year 3: 3%
Contract Year 4: 3%

Contract Year 1: 3%
Contract Year 2: 3%
Contract Year 3: 3%
Contract Year 4: 3%

Source: NM Hospital Association Spring 2018 VBP Learning Summit in partnership with Patty Kehoe (Wisdom Gate Consultant Services) and Versatile MED Analytics
NMHIC Analytics Update

Gene Hill, MA / Data Analyst
New Mexico Health Information Collaborative (NMHIC)
June 2018

Bringing NMHIC Analytics to the HIE Community

Utilizing HIE data, NMHIC has made great strides in its analytics offerings in terms of content and availability.

- Customized data services (e.g., HEDIS quality analysis)
- Securely delivered HIE extracts available by subscription
- Publishing on the NMHIC website and Google Data Studio (pending)
- "Explorers"

NMHIC Analytics Offerings

Along with our original products:

- Admissions Extracts
- Risk Analysis Services
- HEDIS Quality Measures Reporting

We are engaged in new areas of study:

- Patient Migration
- Outside Utilization
- Readmission Rates
- Demographic Patterns

NMHIC Analytics: Patient Migration

NMHIC is analyzing utilization patterns statewide by county to track treatment at local versus away facilities, including:

- Utilization of local vs. out-of-county hospitals for the current period and historically
- Drilling down into diagnosis groups for patients seeking treatment away from home

NMHIC Analytics: Readmissions

NMHIC utilizes its extensive encounter data to analyze readmission rates by facility for both inpatient and emergency department visits.
### NMHIC Analytics: Outside Utilization

Similar to migration studies, NMHIC runs statistics on the share of population having treatment in multiple health systems, regardless of location.

### NMHIC HIE Demographic and Geographical Reporting

Through the use of “explorer” reports, patient age, gender and address in the HIE can be used to slice and dice clinical and Centennial Care membership data demographically and geographically.

(Subject to HIPAA “safe-harbor” limitations for smaller populations)

### NMHIC Quality Reporting (e.g., HEDIS Measures)

Explorer reports can also be utilized to display summary quality measures using BI/analytics functionality (e.g., drill-down, pivoting, advanced filtering)

### Questions, Questions ...

Please feel free to contact me with any questions about NMHIC’s reporting and analytic capabilities:

**Gene Hill, Data Manager / Data Analyst**  
New Mexico Health Information Collaborative  
ghill@lcfresearch.org  
Tel: 505 938-9946

### HIE User Tip: Communicate DSM

April Salisbury  
Director of Education & Training
NMHIC HIE User Tip: Communicate DSM

- Orion Health Communicate DIRECT Secure Messaging is half price for HIE User organizations
- You can access your Communicate DIRECT mailbox with one click from your HIE Clinical Portal account
- Communicate can help multiple users to legitimately manage a central DIRECT mailbox without sharing user IDs and passwords

The integration of HIE with Telemedicine: Opportunities and Challenges
Dr. Dale C. Alverson, M.D.
Medical Director
UNM Center for Telehealth
July 17, 2018

Next month’s webinar

Miss a webinar?
https://www.nmhic.org/events

Hyperlinks to recordings are now available!

Next Time
Not an HIE User yet?
Direct inquiries to Michelle Bowdich,
(505) 938-9909 or michelle@nmhic.org

Next date:
07/17/18, 11:30-12:30 pm