Quality Council

September 3, 2014

Agenda

- Introductions/Public Comments
- House rules/executive team
- CT State Innovation Model Test Application
- Quality Council Charter
- Guiding principles
- Next steps

Welcome to the Quality Council

Gregory Barbiero
CHNCT/DSS

Rohit Bhalla
Stamford Hospital

Aileen Broderick
Anthem Blue Cross Blue Shield

Mehul Dalal
Department of Public Health

Mark DeFrancesco
Westwood Women's Health

Deb Dauser Forrest
ConnectiCare

Daniela Giordano
NAMI Connecticut

Karin Haberlin
Dept. of Mental Health & Addition Services

Kathleen Harding
Community Health Center, Inc.

Gigi Hunt
Cigna

Elizabeth Krause
Connecticut Health Foundation

Kathy Lavorgna
General Surgeon

Steve Levine
ENT and Allergy Associates, LLC

Robert Nardino
American College of Physicians – CT Chapter

Donna Laliberte O'Shea
United Healthcare

Arlene Murphy
Consumer Advisory Board

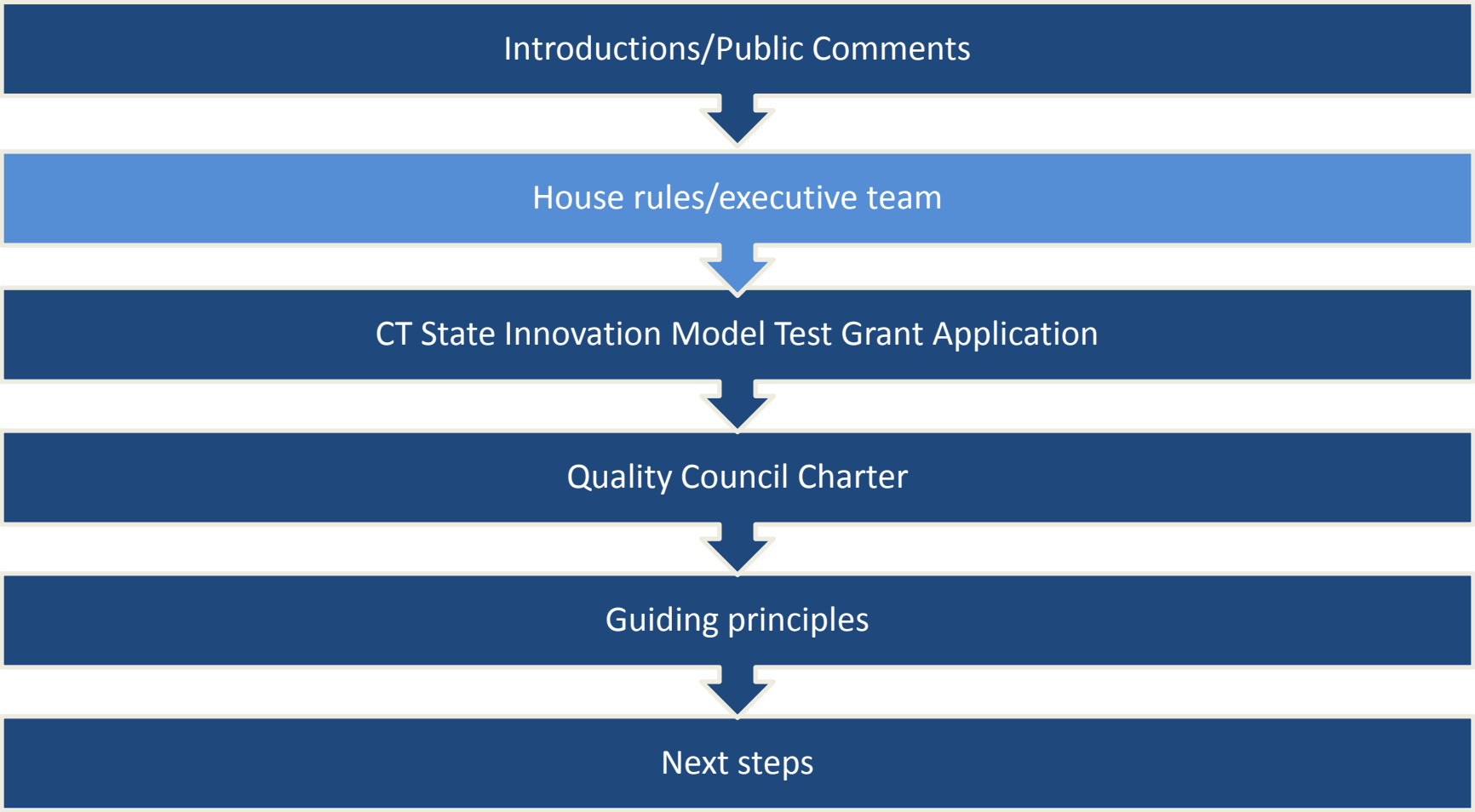
Welcome to the Quality Council

Meryl Price *Health Policy Matters*	
Jean Rexford *CT Center for Patient Safety*	
Rebecca Santiago *Saint Francis Center for Health Equity*	
Andrew Selinger *ProHealth Physicians*	
Todd Varricchio *Aetna*	
Steve Wolfson *Cardiology Associates of New Haven PC*	
Thomas Woodruff *Office of the State Comptroller*	

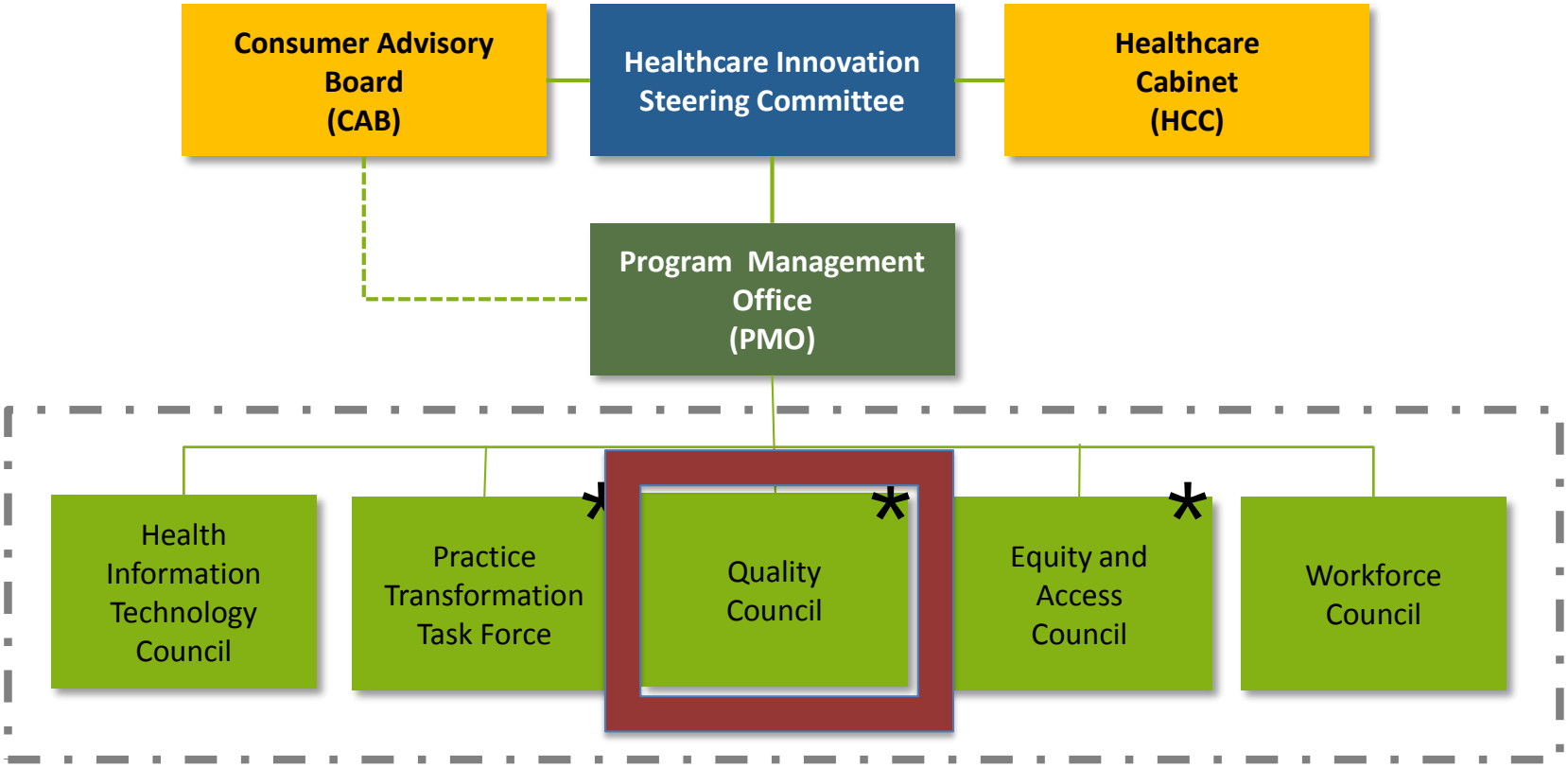
Public Comments

2 minutes per comment

Agenda


Introductions/Public Comments
House rules/executive team
CT State Innovation Model Test Grant Application
Quality Council Charter
Guiding principles
Next steps

SIM Governance Structure



House Rules

- Expectations of taskforce members:
  - Presence
    - Attend meetings
    - Prepare and participate between meetings as needed to move issues along
  - Outlook
    - Leave jobs and titles at the door; focus on best interest of CT citizens
    - Look for consensus to make recommendations to the Program Management Office (PMO)
  - Action
    - Find solutions for proposed questions
    - Build ideas and be proponent of change and transformation
    - Be vocal and share the importance of our mission

Executive Team

- One individual from each of the four major categories of representation (consumer advocate, health plan, provider, state agency)
- Role of the executive committee:
  - Provide guidance to the SIM Program Management Office and contracted work group facilitator in between meetings (e.g., pre-screen proposed meeting process, presentation, other materials).
  - Ensure that one or two members of the executive committee are designated to play the role of chair for each meeting.
- We anticipate one phone meeting with the executive committee between each meeting of the full Council.

Agenda

- Introductions/Public Comments
- House rules/executive team
- CT State Innovation Model Test Grant Application
- Quality Council Charter
- Guiding principles
- Next steps

State Innovation Model
Test Grant Application

- Submitted on July 19, 2014
- Selected states may be invited to present in Washington DC
- Awards will be announced on *or after* 10/31/14

State Innovation Model
Test Grant Application

Vision: Connecticut is seeking to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs.

State Innovation Model
Test Grant Application

- Our Model Test drives accountability, consumer engagement and high quality of care through
  - development of a comprehensive evidence-based plan for improving population health;
  - initiatives to strengthen primary care and integrate community and clinical care;
  - value-based payment and insurance design; and
  - multi-payer alignment on quality, health equity, and care experience measures.

State Innovation Model
Test Grant Application

Statewide Interventions	Targeted Interventions
Plan for Improving Population Health	Medicaid Quality Improvement and Shared Savings Program (QISSP)
Quality Measure Alignment	Primary Care Transformation
Shared Savings Program (SSP) tied to care experience, quality and health equity	• Advanced Medical Home Program
Value Based Insurance Design	• Community & Clinical Integration Program (CCIP)
Workforce Development	+ Innovation Awards
HIT / Analytics / Performance Transparency	+ Learning Collaboratives

State Innovation Model
Targeted Interventions

Focus on:

- *Federally Qualified Health Centers (FQHCs)*
- *Advanced Networks*
  - defined as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into SSP arrangements with at least one payer. Advanced networks sometimes include one or more anchor hospitals.

State Innovation Model

Medicaid QISSP

- DSS will procure FQHCs and Advanced Networks to participate in Medicaid QISSP
- To improve access, quality, health equity, and care experience
- Two waves – 1/1/16; 1/1/18
- Estimated 200 to 215,000 Medicaid beneficiaries in the first wave

State Innovation Model

Primary Care Transformation

- Advanced Medical Home Glide Path
  - Glide Path practice transformation support
  - Modeled after existing Medicaid PCMH Glide Path program
  - Targeted to practices affiliated with Advanced Networks
    - Offered more widely within available resources
  - NCQA standards w/possible modifications
  - NCQA recognition required

State Innovation Model

Primary Care Transformation

- Community and Clinical Integration Program (CCIP)
  1) integrating behavioral health and oral health,
  2) providing medication therapy management services,
  3) building dynamic clinical teams,
  4) expanding e-consults between PCPs and specialists,
  5) incorporating community health workers,
  6) closing health equity gaps,
  7) improving the care experience for vulnerable populations,
  8) establishing community linkages
  9) identifying “super utilizers” for community care teams

Community and Clinical Integration Program (CCIP) Description

- **Community and Clinical Integration Program (CCIP):** The CCIP will offer Targeted Technical Assistance and Innovation Awards to Advanced Networks and FQHCs, selected to participate in Medicaid QISSP. CCIP will accelerate advancement and spur investment in transformation. The PMO will contract with vendors to provide the Targeted Technical Assistance on the 11 focus areas.
- The PMO will establish two **Learning Collaboratives (LCs)** to support providers participating in the CCIP. The first LC will be tailored to the needs of FQHCs and the second will be tailored to Advanced Networks. The LCs will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Participants will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.
- The PMO will offer **Innovation Awards** to competitively selected providers participating in the CCIP. Innovation awards will support transformational demonstration pilots that align with CCIP priorities. The PMO will establish an Innovation Awards advisory committee to establish award criteria and processes.

State Innovation Model
Value-based payment

- Broadly aligned around the Medicare SSP
- Responsible for overall cost of care for their patients
- Rewarded with a share of any savings *if they meet quality and care experience targets*
- Quality Council was established to recommend performance measures and targets for all payers
- Goal is to create a practice culture that is organized around increasing value

$$\text{Value} = \frac{\text{Quality + Care Experience}}{\text{Cost}}$$

State Innovation Model

Shared Savings Program

- Project how much it should cost for provider to serve their patients for one year
- Similar to establishing an annual budget--actually a *virtual* budget, because provider *continues to be paid fee-for-service*
- Projected budget higher for consumers with chronic illnesses
- This is called risk adjustment

State Innovation Model
Shared Savings Program

- Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget
- Budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care.
- Provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer.

State Innovation Model
Under-service

- Shared savings programs create an incentive to provide only those services that are necessary and effective
- However, there are concerns that they might also create incentives to provide *fewer* necessary services
- Setting quality targets reduces the risk of under-service for target conditions

State Innovation Model
Under-service

- However, they may not reduce the risk of under-service in the treatment of other conditions
- It could also lead to avoiding patients who are going to be harder than usual to treat…this is called "patient selection"
- This concern about under-service is the primary reason that Equity and Access Council was established

State Innovation Model
Focus on Value

- Benefits outweigh the risks
- *Flexibility* in service and a *culture* of value
- Safeguards – our unique contribution
- Reduce costs so that healthcare remains accessible and affordable

Agenda

- Introductions/Public Comments
- House rules/executive team
- CT State Innovation Model Test Application
- Quality Council Charter
- Guiding principles
- Next steps

Why align on measures of quality?

- Clinicians and healthcare organizations feel burdened by the number of measures they have to report, and oftentimes report multiple metrics assessing the same concept.
- For example, Massachusetts General Hospital and Massachusetts General Physicians Organization report over 120 measures to different external entities, and this reporting costs over 1 percent of its net patient service revenue

Why align on measures of quality?

- Too many measures
  - burdensome and costly to collect and report
  - undermines quality improvement by diffusing organizational focus and resources

SIM Quality Council

- SIM Quality Council:
  - Is the work group responsible for aligning all payers around a common set of performance measures
  - Provides for multi-stakeholder input to support the creation of a measurement set that serves the interests of Connecticut and its citizens

SIM Quality Council

- Payers include:
  - Medicare
  - Medicaid
  - Commercial health plans (Aetna, Anthem, Cigna, ConnectiCare, United, HealthyCT, Harvard Pilgrim)

SIM Quality Council

- Payer participants include Medicaid, Aetna, Anthem, Cigna, ConnectiCare, United
- Alignment with Medicare will be a challenge…either they need to customize to us, or we need to align with them

Quality Council Charter

Introduction

- This work group will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for a core set of measures for use in the assessment of primary care, specialty, and hospital provider performance.
- This workgroup will develop a common provider scorecard format for use by all payers and reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice.

Quality Council Charter

Introduction

- SIM aims to achieve top-quintile performance among all states for key measures of quality of care, and increase the proportion of providers meeting quality scorecard targets.
- The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input.
- The Council will convene ad hoc design teams to resolve technical issues that arise in its work

Quality Council Charter

Measures

1. What are the structure, process, patient engagement and experience, efficiency, disparities-sensitive, outcome, and cost measures that are in use today by national quality bodies and CT's health plans? (e.g. NQF, AHRQ, NCQA, CAHPS)
2. Which of these measures should be adopted to measure provider performance, taking into consideration the target conditions identified in the Innovation Plan?
3. Which of these measures should be adopted to measure provider performance, taking into consideration the prevention goals identified in the Innovation Plan?

Quality Council Charter
Measures

4. What other measures could be used as indicators for whole-person-centered care, enhanced access, and coordinated care (e.g. behavioral health, oral health)?
5. What measures could be used as indicators of workforce productivity/timely return to work?

Quality Council Charter

Metrics

1. What are the metrics for each of the measures and how will they be calculated?
2. What methods will be used for risk adjustment and exclusions?

Quality Council Charter
Common Performance Scorecard

1. What are the best examples of performance scorecards currently in use?
2. What will Connecticut's common scorecard across all health plans look like?
3. What is the process for all health plans to implement the common scorecard?
4. How will cross-payer analytics be integrated for a given practice profile, including commercial and public payers?

Quality Council Charter
Common Performance Scorecard

5. Is there a recommended frequency and schedule that could be adopted across payers?
6. How will the common performance scorecard be integrated with value-based payment calculations?
7. How will the scorecards be made available to the public?

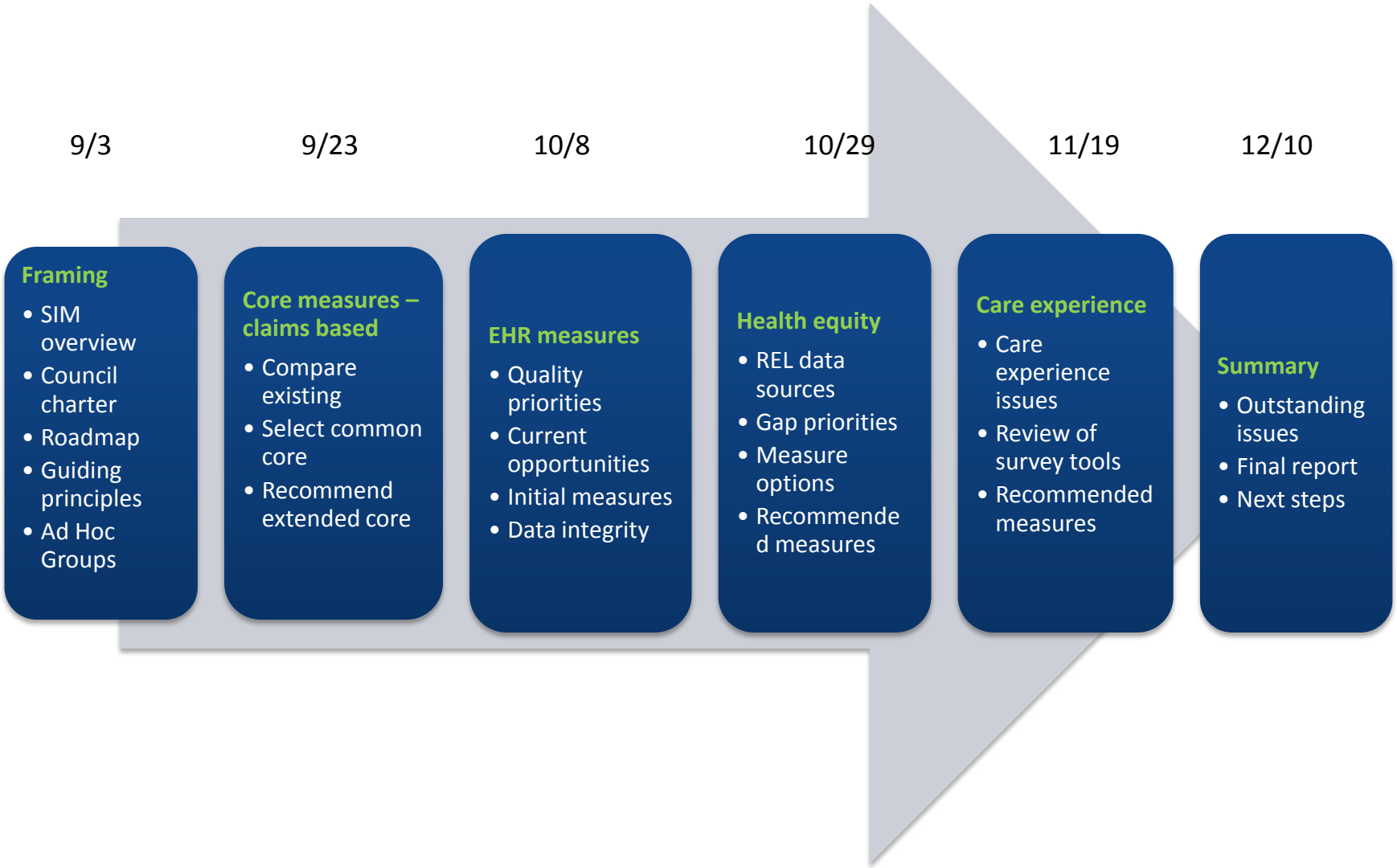
Quality Council Charter
Common Care Experience Survey

1. What are the best examples of care experience surveys currently in use?
2. Is there one survey that would best align with the goals of the Innovation Plan? Are there supplemental questions that should be considered?3.What is the process for all health plans to implement the common care experience survey?

Quality Council Charter
Common Care Experience Survey

3. One what schedule should the common care experience survey be administered?
4. How will the common care experience survey be integrated with value-based payment calculations?
5. How will the results of care experience surveys be made available to the public?

Quality Council Roadmap



Agenda

- Introductions/Public Comments
- House rules/executive team
- CT State Innovation Model Test Application
- Round Table – Your thoughts on under-service
- Equity and Access Charter
- Guiding principles
- Next steps

Guiding Principles
Considerations for measure selection

1. Our payment reform is modeled after the Medicare SSP
2. CMMI prefers that we maximize alignment with Medicare SSP measures…also called ACO measures
3. There are 33 ACO quality measures, and will soon be 37

Guiding Principles
Considerations for measure selection

1. The 33 ACO quality measures fall into four categories
   - Care experience
   - Care coordination/patient safety
   - Preventive Health
   - At-risk populations
     - Diabetes
     - Hypertension
     - Ischemic vascular disease (IVD)
     - Heart failure
     - Coronary artery disease (CAD)

Guiding Principles
Considerations for measure selection

1. Medicare is retiring process measures in favor of outcome measures
2. Approximately 1/3 of these measures are self-reported by providers from their electronic health records and many are outcomes based (e.g., blood pressure control)
3. In contrast, the measures used by commercial payers and Medicaid are almost entirely claims based

Guiding Principles
Advantages

1. Medicare ACO measures are the most widely used measures in Shared Savings Programs
2. High # of outcome and EHR based measures
3. Many CT providers have already invested a great deal in generating ACO clinical outcomes measures—so building on Medicare measures would reduce burden

Guiding Principles
Disadvantages

1. Medicare ACO measures are focused on the top problems for older adults (so they do not necessarily reflect the top concerns for commercial and Medicaid populations)
2. Unknown methods for ensuring data integrity
3. No pediatric specific measures
4. Few behavioral health measures
5. No health equity measures
6. No pregnancy management measures

Guiding Principles
Other Measure References

1. National Quality Foundation Endorsed Measures
2. Medicaid Adult and Pediatric Core Measurement Sets
3. Medicare Physician Quality Reporting System (PQRS)
4. Medicare/Medicaid EHR Meaningful Use 2
5. Measures in use today by a majority of payers

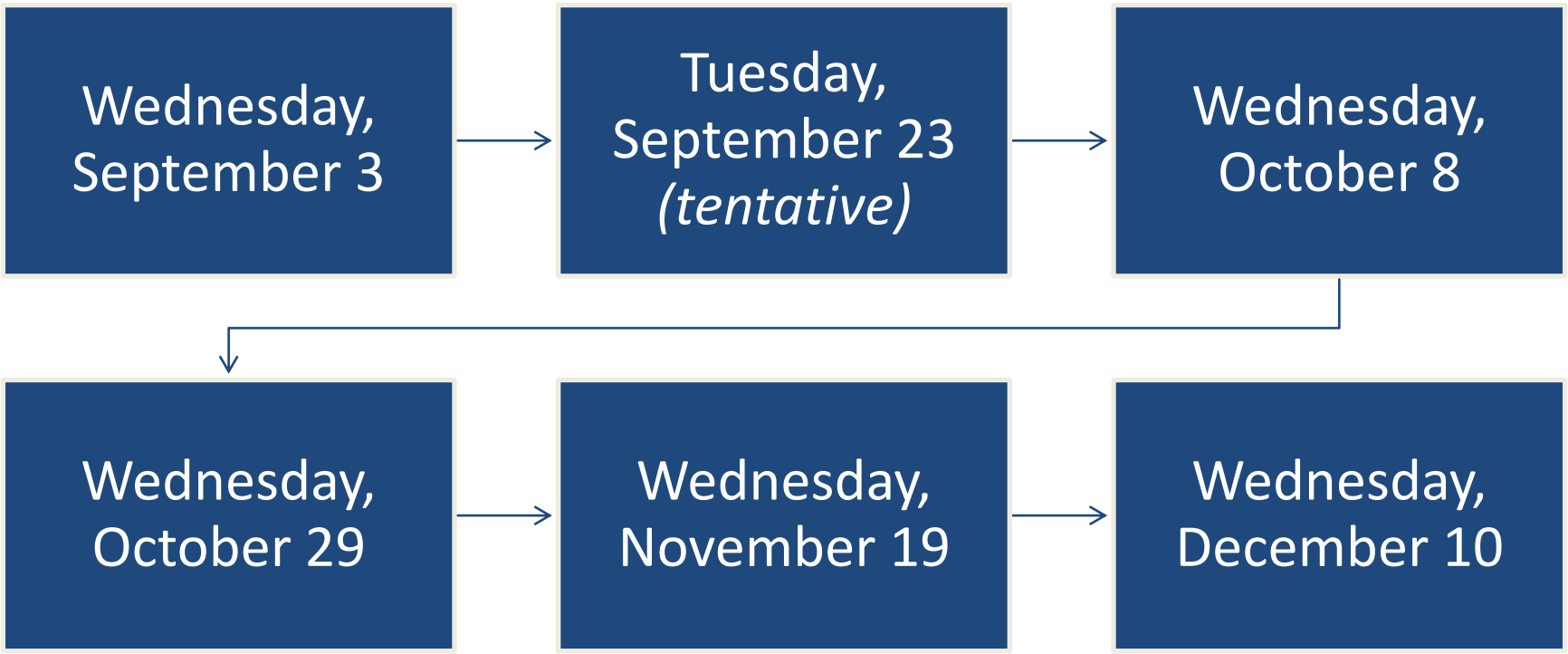
Guiding Principles

1. Decisively move from measuring process to outcomes
2. Use quality measures strategically, using other approaches where quality measures fall short
3. Measure quality at the level of the organization, not the clinician
4. Measure patient reported experience with care and patient reported outcomes as ends in themselves

From Robert A. Berenson, Peter J. Pronovost, and Harlan M. Krumholz (2013)

Guiding Principles

1. Use measurement to promote the concept of the rapidly learning health system

From Robert A. Berenson, Peter J. Pronovost, and Harlan M. Krumholz (2013)

Quality Council Meeting Schedule