

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Health Information Technology Council Meeting

November 20, 2015

Meeting Agenda

Agenda Item	Presenter	Allotted Time	Action
1. Introductions	Commissioner Bremby	5	Discuss
2. Public Comments	Commissioner Bremby	5	Discuss
3. Minutes Approval	Commissioner Bremby	5	Approve
4. HIT Relevant Updates	Michelle Moratti	30	Discuss
5. Review of Overall SIM Logic Model	Michelle Moratti	40	Discuss
6. Design Team Updates	Michelle Moratti	20	Discuss
7. Q&A	Commissioner Bremby	10	Discuss
8. Next Steps	Commissioner Bremby	5	Discuss

Objective of Discussion

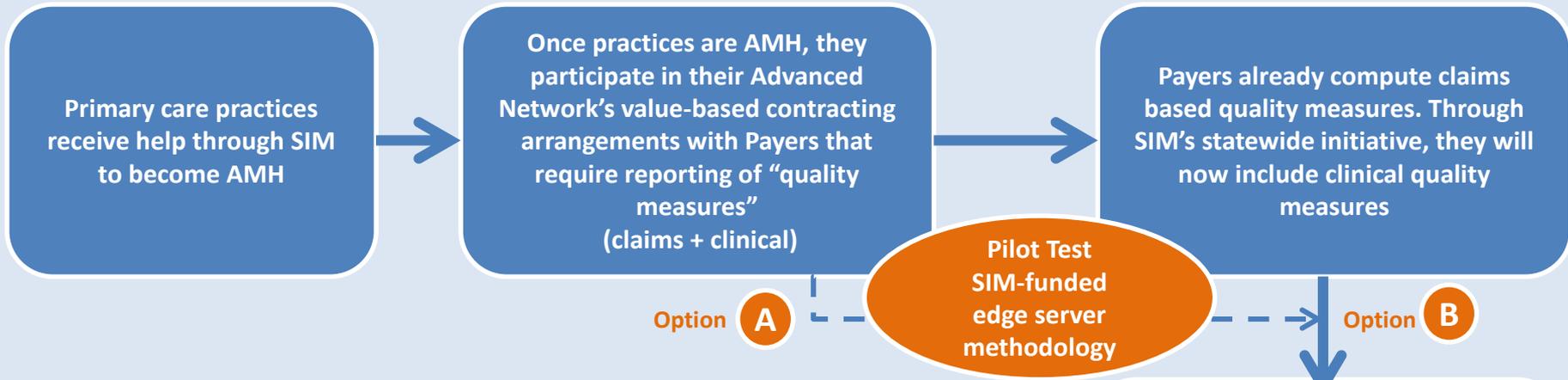
4. HIT Relevant Updates

30 min



- Update on the AMH Program
- Update on the Quality Council Work
 - Release of 1st Draft Report “A Multi-Payer Quality Measure Set for Improving Connecticut’s Healthcare Quality” (11/02/15) and “Alignment Plan Review” (10/28/15)
- Practice Transformation Task Force
 - Release of CCIP 2nd Draft Report; PMO answers to HIT Council questions in progress
- Update about the MQISSP Timeline
 - MQISSP deadline extended to go live in January 1, 2017
- PMO: SIM programmatic requirements to be 90% final by 12/31/15
- Request for extension of submission of HIT section of SIM Operational Plan – March 1, 2016

Advanced Medical Home (AMH) – Quality Measure Alignment



Prerequisites for launching a pilot test to demonstrate the ability to use "edge servers" for reporting of clinical quality measures

Step 1: Payers agree to criteria of what would prove a successful pilot test

Step 2: The PMO secures agreement in writing that Payers will use clinical quality measures and edge server methodology during the Model Test period, if the pilot test is successful

Step 3: The PMO/Payer agreement requires this methodology for all practices in VBP arrangements during the Model Test period

Step 4: The PMO/Payer agreement requires reporting to the state for clinical quality scorecard production

Assumes appropriate and adequate data sharing agreements (DURSAs) are in place

Payers report to the state so that comparative provider clinical quality scorecards can be generated

State generates cross-payer provider clinical quality score cards that report data across the system

AMH: At a Glance



Components of AMH Model

- 15-months of SIM funded transformation services from **Qualidigm** and **Planetree**
- Interactive learning collaborative, practice facilitation visits, and a variety of evidence-based Quality Improvement (QI) interventions
- Support to achieve **Advanced Medical Home Designation**: NCQA PCMH 2014 standards level II or III with additional required elements and factors
- Support to achieve **Planetree Patient-Centered Bronze Recognition** for excellence in patient-centered care (The application fee is waived for those participating in the AMH program)
- Eligibility for discounted NCQA application fees
- Facilitation for AMH participants to qualify and enroll in the Medicaid PCMH program and thereby qualify for enhanced fees and quality of care incentive payments

Participating Primary Care Practices will...

- Receive assistance in mastering evidence-based processes to improve clinical outcomes and patient care
- Be better positioned for new care delivery and payment models, such as shared savings programs and other value-based payment initiatives
- Receive free practice-specific technical support and assistance from local and national experts
- Experience enhanced clinician and staff satisfaction with care delivery by building and maintaining a supportive and team-based workplace culture
- Learn with and from peers with similar goals and challenges
- Achieve National Committee for Quality Assurance PCMH recognition, CT Advanced Medical Home designation, and Planetree's Patient-Centered Bronze recognition
- Differentiate themselves as leaders in Connecticut and in the nation

AMH Goal: 350 primary care practices will complete AMH Glide Path by 2019.

AMH Vanguard vs. AMH program

AMH Vanguard (pilot)

- **Pilot** program for 50 practices to test AMH standards (ends July 2016)
- Technical assistance to enable practices to meet NCQA PCMH Level 2 or Level 3 standards with additional required elements
- Technical assistance to enable practices to meet PlaneTree Bronze recognition

AMH Program

PTTF will advise at a later point as to whether final AMH program should be exactly as piloted or modified

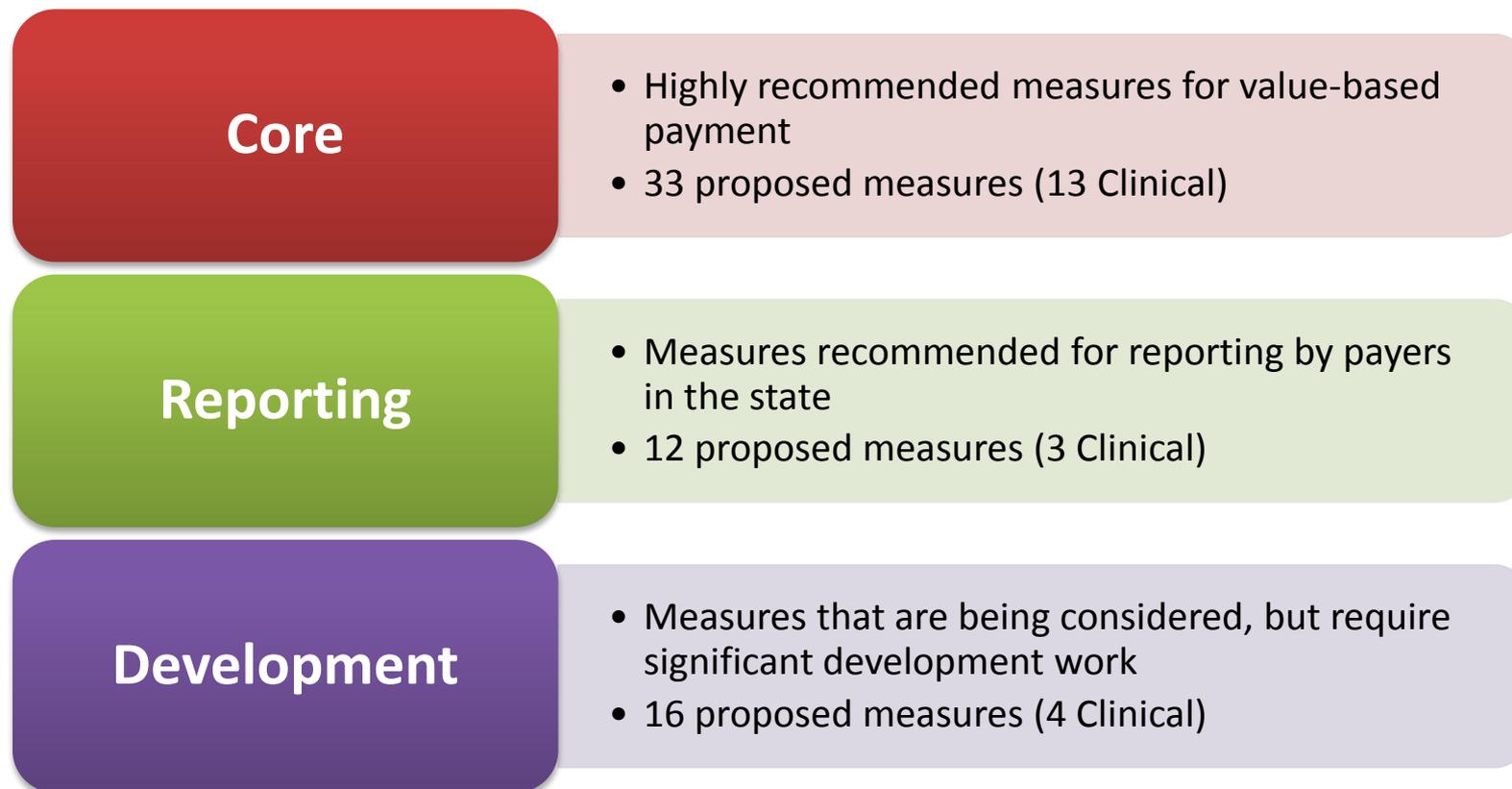
Common Questions of CCIP

The PTTF is continuing to examine in greater detail the work flows and processes of its recommended initiatives, however, there are still key questions that can be answered.

- 1. Which practices can participate in CCIP? An Advanced Network or FQHC that has been recognized as a PCMH and that is also participating in the SIM MQISSP program, but not participating in PTN?**
 - All Advanced Networks or FQHCs that meet criteria identified by the Request for Proposals (RFP) through which DSS will select MQISSP Participating Entities.
- 2. How many practices are anticipated to participate in CCIP?**
 - This will be determined by the number of FQHCs and Advanced Networks that are selected by DSS under the MQISSP RFP. Whether FQHCs are required to meet all of the CCIP standards or participate in the TA is under discussion.
- 3. For CCIP participating practices, what is the anticipated # of attributed patients that are Medicaid versus Commercial?**
 - Medicaid anticipates including 200,000 – 215,000 attributed Medicaid members in the first wave of the MQISSP initiative. By extension, that number would also be a suitable benchmark for CCIP.
 - It is not possible at this time to estimate attribution of commercial patients.
- 4. How will the level of integration between the community and primary care practices be measured and evaluated?**
 - That remains to be determined.

CT SIM Provisional Quality Measure Set

The Quality Council has currently ranked and split proposed quality metrics into three groups: Core, Reporting and Development.



Connecticut's goal of core measure health plan alignment and target date of 2018 are still under discussion.

Notes: The metric ranking is based on an average of polled results of Quality Council for all three levels of response (Strongly Recommend, Moderately Recommend, Do Not Recommend Measure for Core Measure Set). Some measures may be listed in multiple groups, but split up based on payer.

Some measures may be recommended for specific payer categories only (commercial, Medicaid, etc.)

Core measure alignment includes both commercial and Medicaid health plans.

HIT Relevant Updates – PMO Interviews with Health Plans*

- Number of measures in contracts: ~10-~27
- Length of contracts: typically 2-3 years
- Time to program new measures: 3/6 months – 1+ year
- Contracts may have different start dates throughout the year
- Too late to include measures for January 1, 2016
- May be able to begin including *claims-based* measures by 7/1/2016 but more likely by 10/1/2016 and 1/1/2017

* Quality Council Alignment Plan Review – Draft – October 28, 2015

HIT Relevant Updates – PMO Interviews with Health Plans*

- ***Caution around Clinical measures is uniform across payers***
- With rare exceptions, value-based contracts are exclusively claims-based
- A couple of plans have implemented small number of Clinical measures by means of provider chart abstraction and data submission
- Clinical measures require paper submission of records or manual extraction from Clinicals which is costly and time consuming
- Even if clinical data extraction can be automated, the ability to audit or verify is essential, e.g., by plan or credible 3rd parties

* Quality Council Alignment Plan Review – Draft – October 28, 2015

QC Alignment Process

The alignment process entails working with payers to adopt the recommended measures as they negotiate their existing and new contracts. This process will continue to be iterative as the measures continue to evolve over time

Recommended Adoption Process

- Adopt the measure set as part of a standard quality measure set for use in all VBP contracts
- Adopt the measures as part of a suite of measures that are included in VBP contracts when there is opportunity for performance improvement

Windows for Alignment

- Negotiation of new VBP contract
- Renegotiation of existing contract after the term (usually every 3 years)
- Mid-cycle after an annual performance review

QC Draft Measure Set & Implementation Timeline (1/2)

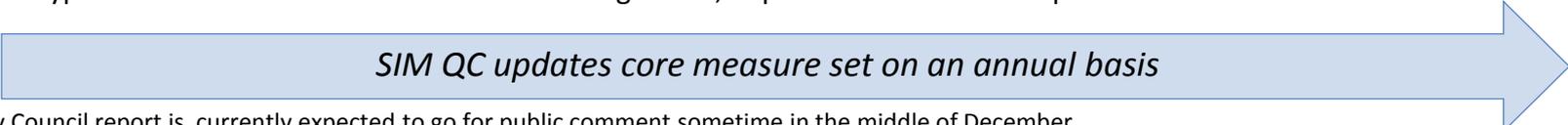
The proposed alignment process will occur over several years and will involve ongoing alignment with flexibility for health plans to retain existing contract periods.

Draft Timeline to Alignment

		2015	2016	2017	2018
Quality Measure Set	Cons. Exp.	Baseline Year	First annual survey to establish 2015 baseline	First performance year	First performance survey; 2017 performance tied to payment
	Claims	Finalization of measure set after public comment	Programming and production of measures to include in VBP contracts	Core claims measures tied to payment; continued adoption in VBP contracts	Core claims measures tied to payment; continued adoption in VBP contracts
	Clinical*	Finalization of measure set after public comment & begin edge-server pilot	Implementation of edge-server tech; payers include reporting requirements in VBP contracts	Clinical measure reporting and testing; payers include performance requirements in VBP contracts	Core Clinical measures tied to payment; continued adoption in VBP contracts

*Hypothetical timetable for Clinical measure alignment, dependent on successful pilot

SIM QC updates core measure set on an annual basis



Note: Quality Council report is currently expected to go for public comment sometime in the middle of December.

Statewide Initiatives: Quality Measure Production

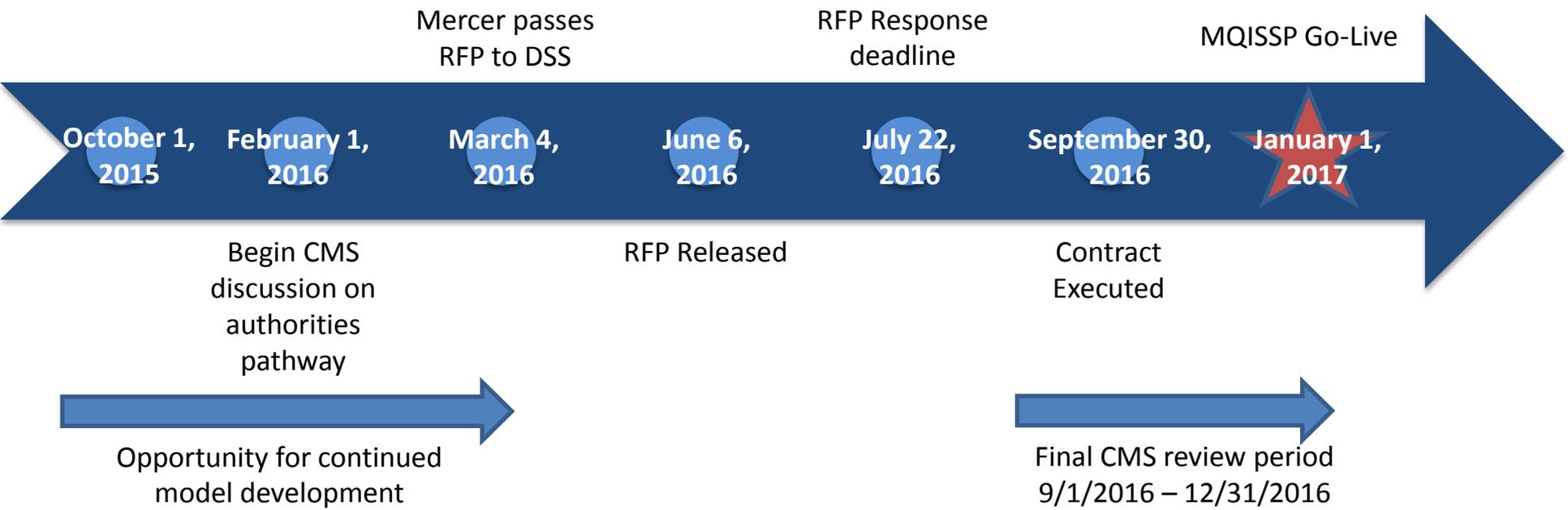
- The Model Test Grant identifies value-based payment and quality measure alignment as statewide initiatives that are supported by SIM. The SIM participating entities in value-based payment and quality measure alignment include:
 - Payers that use value-based contracting, especially commercial and Medicaid
 - Providers (advanced networks/FQHCs) that enter into value-based contracts
- The Quality Council is asking the HIT Council to determine whether edge-server or other technology could be used to produce Clinical measures as a shared utility to support value-based payment*

*Other states, such as OK have been able to set up a shared utility that facilitated the production of Clinical measures for use in value-based scorecards

Draft MQISSP Implementation Plan

The MQISSP implementation plan has been extended to go live on January 1, 2017.

Draft MQISSP Implementation Timeline



Objective of Discussion

5. Review of Overall SIM Logic Model

40 min



Discussion on overall Logic Model of SIM Initiative

Connecticut SIM Logic Model: Legend

Categories

1. Inputs: A set of defined resources that will enable the activities to be accomplished
2. Activities: Defined set of activities conducted to address the health care issues
3. Outputs: Evidence produced from the completed activities
4. Outcomes: Defined measures/changes that will occur within the next five years from the completed activities
5. Impacts: Overall changes that will occur as a result of completing the activities

Definitions

1. Section headings *I – III* represent identified SIM Impacts
2. Sub-section headings *A – D* represent SIM initiatives

Terminology

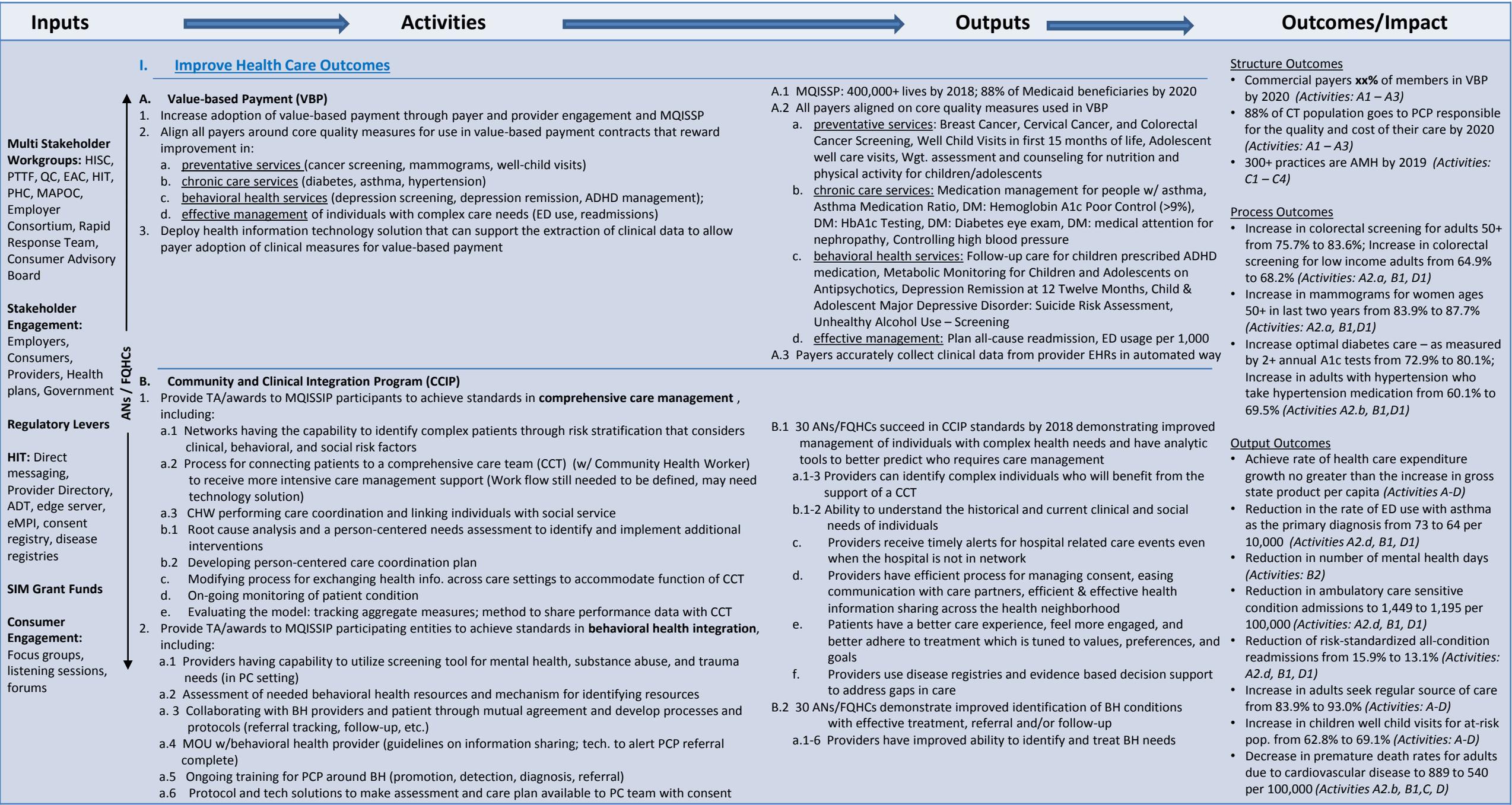
Initiatives

1. AMH: Advanced Medical Home
2. CCIP: Community and Clinical Integration Program
3. MQISSP: Medicaid Quality Improvement and Shared Savings. Program
4. VBID: Value-Based Insurance Design
5. VBP: Value-Based Payment

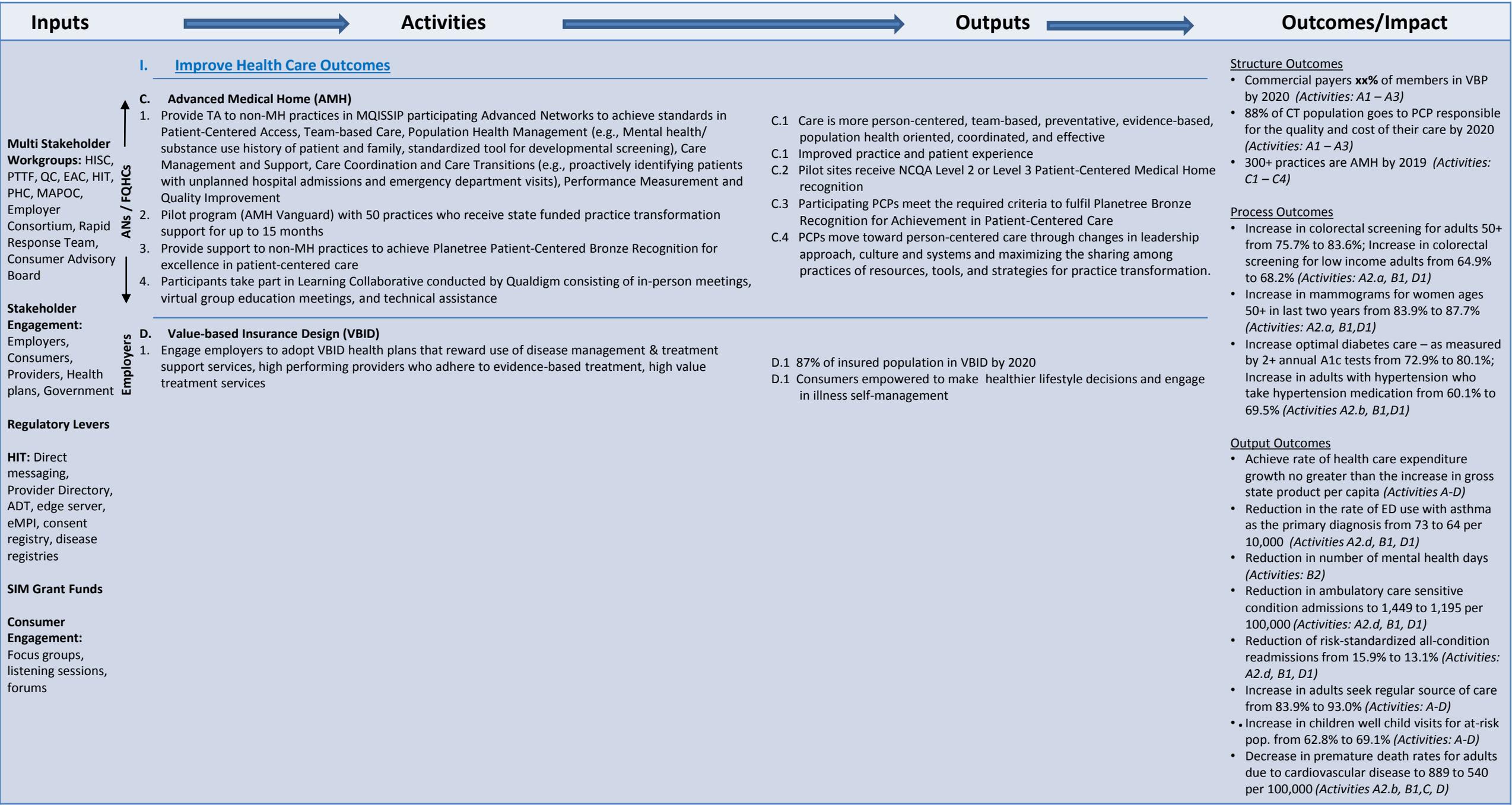
Other

1. AN: Advanced Networks
2. BH: Behavioral Health
3. CCT: Comprehensive Care Team
4. CHW: Community Health Worker
5. FQHCs: Federally Qualified Health Centers
6. HEC: Health Enhancement Community
7. PSC: Prevention Service Center
8. TA: Technical Assistance

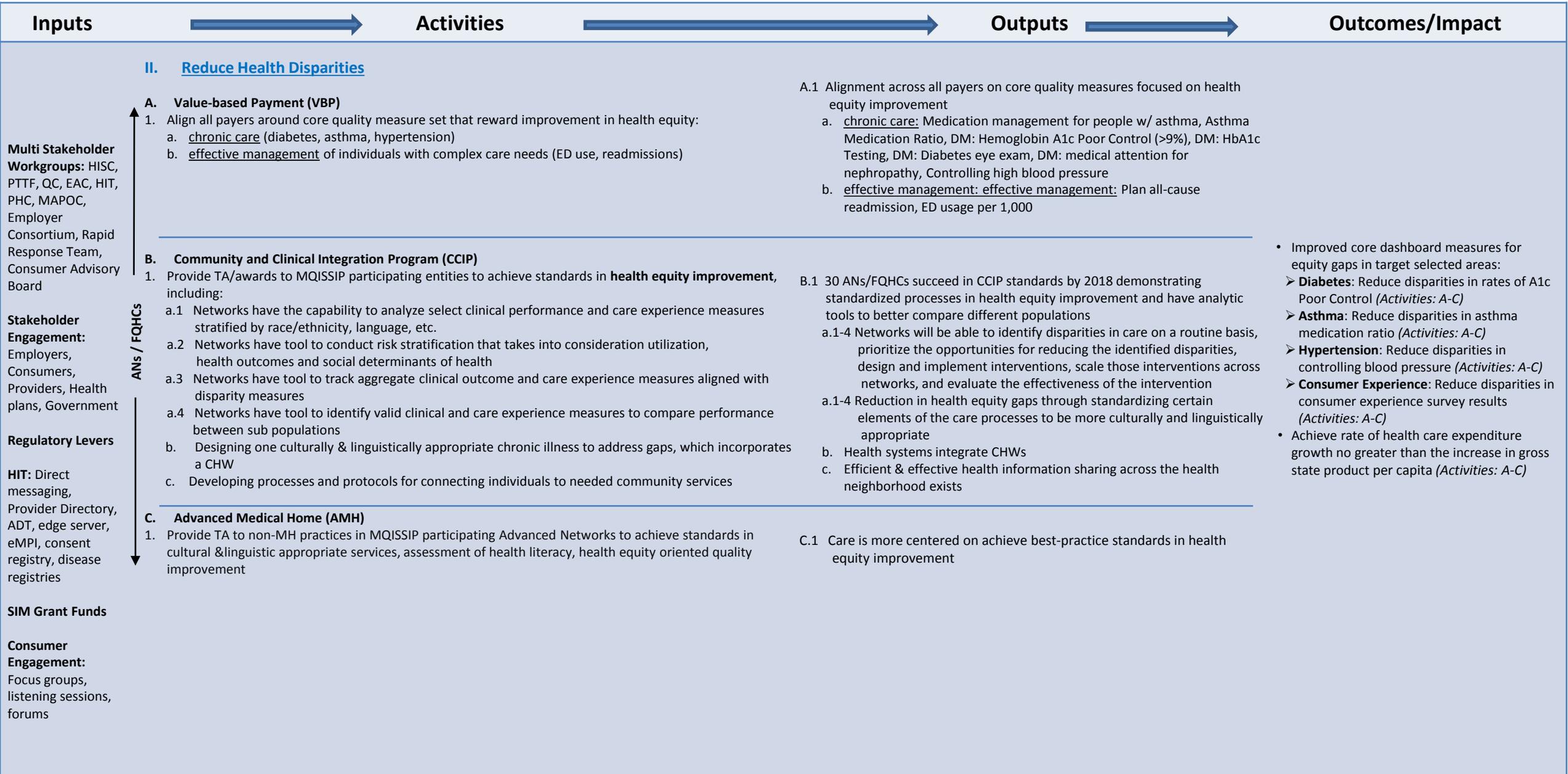
Connecticut SIM Logic Model: Detailed Information (1/4)



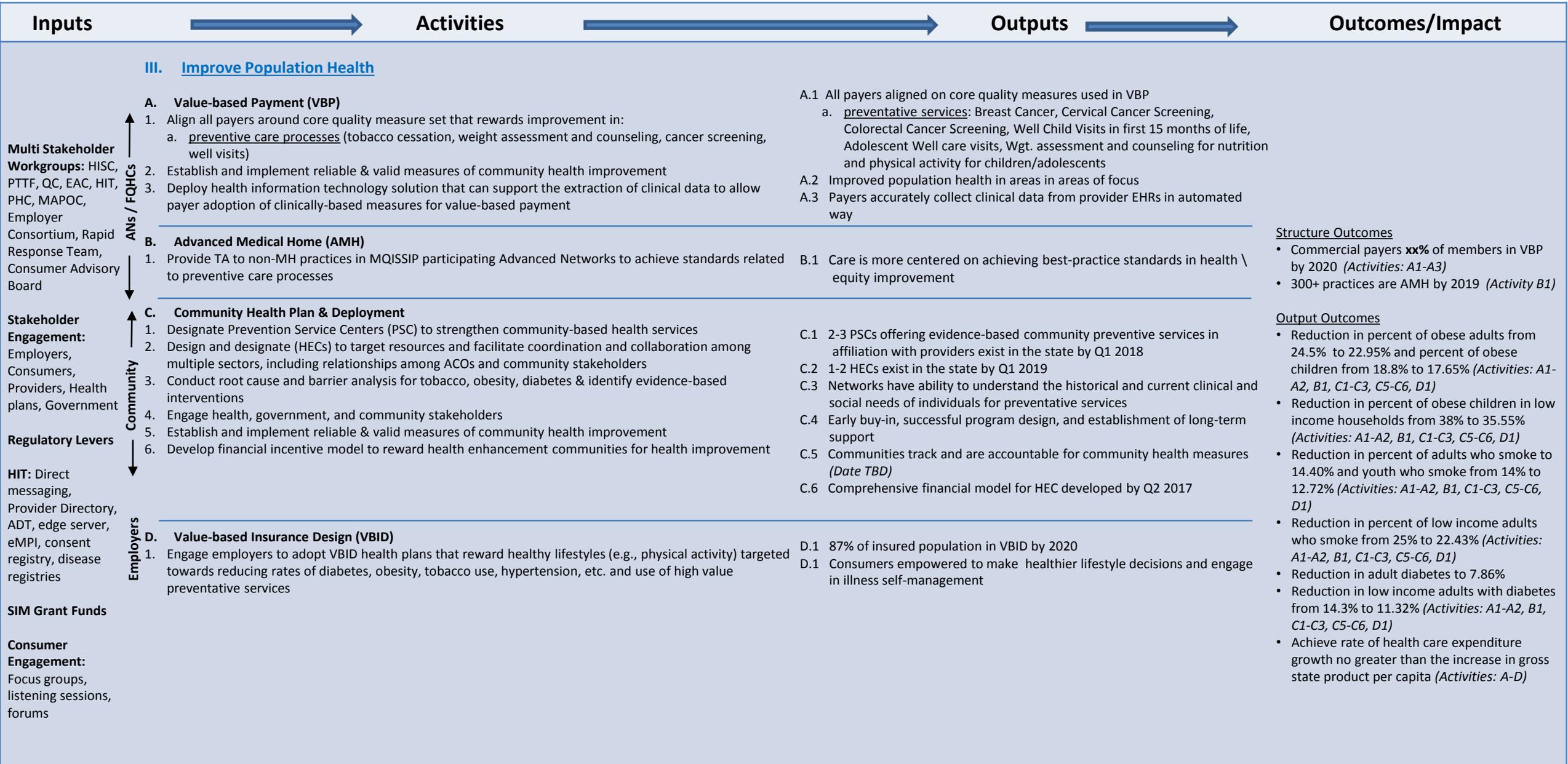
Connecticut SIM Logic Model: Detailed Information (2/4)



Connecticut SIM Logic Model: Detailed Information (3/4)



Connecticut SIM Logic Model: Detailed Information (4/4)



Objective of Discussion

6. Design Team Updates

20 min



Discussion about relevance of design teams as currently structured for pilot and long-term group meetings given the information just presented

Review proposed timeline of activities

Information Exchange Time Frame

Previously Discussed

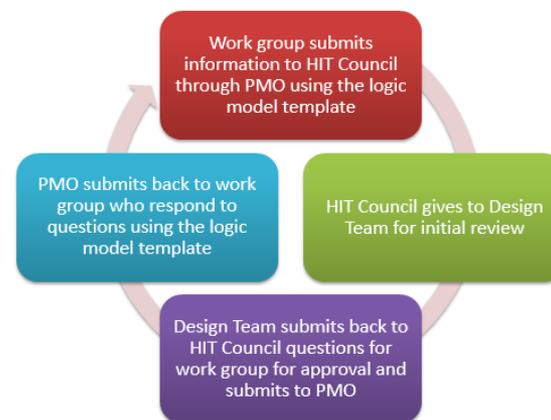
Setting dates for responses and feedback between the HIT Council and other work groups will help set expectations and drive the HIT Council's work plan.

Proposed Logic Model Template

Resources/ Inputs	Activities	Outputs	Outcomes	Impacts
In order to accomplish our set of activities we will need the following:	In order to address our problem or asset we will conduct the following activities:	We expect that once completed or under way these activities will produce the following evidence of service delivery:	We expect that if completed or ongoing these activities will lead to the following changes in 1-3 then 4-6 years:	We expect that if completed these activities will lead to the following changes in 7-10 years:
Personal Health Record	Personal Health Records/Patient portal to provide access to EHRs	Increased capacity to process data	Continuity of care or individuals released from DOC to community-based providers	Improvement in targeted HP 2020 population health indicators



Process of Design



We are here

Potential Time Frame

Work Groups submit information using template (1st iteration)

Work Groups submit responses to questions using template (2nd iteration)

Work Groups submit responses to questions using template (3rd iteration)

October 30, 2015

November 20, 2015

December 4, 2015

December 18, 2015

January 8, 2016

TBD: January 2016

HIT Council reviews and submits questions back to work groups (1st iteration)

HIT Council reviews responses and submits questions back to work groups (2nd iteration)

HIT Council begins developing high-level roadmap based on Work Group HIT solution requests

Objective of Discussion

7. Responses to Council Member Questions

10 min



Frequently Asked Questions

At the last HIT Council Meeting we discussed a new process for sharing HIT Council member questions received between Council meetings.

- 1. Can a council member serve on either design team if their employer is a technological company and may submit and RFP? What if they recuse themselves from detailed/specific discussions relating to vendor selection and/or procurement activities?** As previously discussed, it was decided by the HIT Council that due to potential conflicts of interest, it would not be appropriate for members of technology organizations to serve on the Design Teams.
***** Discussion Question: If the company is willing to recuse themselves from submitting an RFP to the potential HIT technology solutions, does the HIT Council believe it would be acceptable for the council member to participate in the design teams?**
- 2. When is it expected that the Zato demonstration will occur?** Early next year, as it gives us the time to understand better the needs of the SIM participants that are currently evolving.
- 3. Can we still meet the expected timeline of the design teams?** As discussed at the last HIT Council meeting, the overall HIT Council timeline, as well as the Design Team timeline will be revisited based on the new timing requirements from the work group information that is discussed in the Logic Model. However, based on current information, we believe that the originally discussed timeline for both design teams will have to be extended.

Objective of Discussion

8. Next Steps

5 min



- PMO is in the process of refining Logic Model and getting input from other SIM work groups