

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



Quality Council

Alignment Plan Review

October 28, 2015

Meeting Agenda

Item

Welcome and public comment



Recap



Follow-up on measure review



Health equity design group recommendations for claims based measures



Health plan meetings: Lessons for alignment plan



Proposed Quality Measure Alignment Plan



Meeting schedule/ Next Steps

Re-Cap

Recap

- The Council reviewed a re-cap of recent meetings, including the recommendations of the Care Coordination Measure Design Group to refer two hospital admission measures to the development set due to possible numerator insufficiency. A Council member questioned why pediatric asthma admissions were not also moved to the development set. After discussion, the members recommended that pediatric asthma admissions be moved to the development set and also that a new measure be added to this set, which is a pediatric ambulatory care sensitive condition composite, as this measure is currently in use by Anthem. PMO also clarified that cardiac stress imaging (NQF 672) should have been moved to reporting based on 9/30 meeting.

Recap

- The Council reviewed the results of the member ranking of measures and the proposed assignment of measures to either a core, supplemental, reporting or development set. There were concerns about the labels for these categories and especially with the term “supplemental.” There was discussion as to whether 26 core measures was the right number, but no target # was identified. Payers noted that some implement a standard measure set for all ACOs and others analyze performance of an ACO on a standard measure set and apply only those with opportunity for improvement.

Recap

- The review and extensive discussion resulted in the following:
 - a. Prenatal care and post-partum care (#22) recommended Medicaid only for core set, reporting for commercial
 - b. Well child visits in 3rd, 4th, 5th and 6th years of life (#19), (drop for commercial because topped out, confer with Medicaid for core)
 - c. Adolescent well visits (#20) , (drop for commercial because topped out, confer with Medicaid for core set)
 - d. DM: Diabetes foot exam (#33) – not recommended unless DPH determines should be restored due to health equity value
 - e. Oral health: primary caries prevention (#24) – payers note no way to capture, coverage is not required for all products, refer to development set unless PMO consultation with subject matter experts suggests otherwise
 - f. Frequency of ongoing prenatal care (#23) recommended as Medicaid only for core, reporting for commercial
 - g. Adult major depressive disorder: Coordination of care of pts with co-morbid conditions (#7), move to reporting
 - h. Documentation of current medications in the medical record (#5), not recommended

Recap

- Health equity design group recommendations were discussed. The Council supported the top four recommended measures for development as health equity measures including HTN control, A1C poor control, Depression screening, and colorectal cancer screening.
- In light of the fact that most of the Health equity design group recommended claims based measures are not in the core set, Elizabeth Kraus will re-survey the Health equity design group for recommended claims based measure using the current provisional core measure set as a reference.
- Final tally, 29 recommended commercial/Medicaid measures and 5 recommended Medicaid only measures. One of the 29 is PCMH CAHPS which will ultimately be comprised of multiple measures.

Follow-up items

Diabetes Foot Exam - 0056

Research and commentary provided by Dr. Dalal

Age-Adjusted Hospital Discharge Rate for Diabetes-related non-traumatic amputations in CT (2012), per 100,00 population

Overall: 21.8

White: 16.5

Black: 65.6

Hispanic: 30.6

The amputation rate is 4 times higher in Blacks and about 2 times more likely in Hispanics

Percent of CT adults with diabetes who had an annual foot exam by a doctor in the past year (BRFSS telephone survey data 2011-2013)

Overall: 75.3%

White: 75%

Black: 78.9%

Hispanic: 76.3%

There are no major differences by race/ethnicity in adults reporting annual foot exams

Diabetes Foot Exam - 0056

Appears to be no apparent disparity in the processes of care, yet a major outcome disparity.

The ACP does recognize the value of two important components of the measure: visual inspection and sensory exam.

The questions are:

How harmful and prevalent is unnecessary ABI testing (maybe payers can weigh in) and does that outweigh the benefits of the visual inspection and sensory exam?

Can the measure drive improvements in overall amputation rate (open question, but seems plausible enough that it could)

Can the measure close equity gaps (likely not, as it appears something else besides foot exams is driving the outcome disparity)

Oral Health: Primary Caries Prevention – formerly 0419

Coverage

- Fluoride varnish application for children under the age of 6 by non-dental providers must be covered by all private and public health insurers since May 2015. The only exemptions are some grandfathered and ERISA plans.

Billing codes

- Private/Commercial payers – CPT Code 99188 - Application of topical fluoride by a physician or other qualified health care professional.
- CT Medicaid/HUSKY – D1206- Fluoride Varnish

Oral Health: Primary Caries Prevention – formerly 0419

Duplicative services

- Young children see their primary care provider far more often than they do their dentist. For children at the highest risk for disease, every opportunity for prevention should be seized.
- Dental decay is still high in young children in low income families and minority populations. 40% of all children in third grade in Connecticut had dental caries experience. The need for more active prevention is necessary.
- Multiple applications are safe and evidence from North Carolina indicates that frequent applications at the youngest age are most critical for effective decay prevention.
- With integration of oral health in the Advanced Medical Home and Clinical and Community Integration Plan, there should be communication between the medical and dental practice to prevent duplication to the extent that damage could occur.

Health Equity Measures

Health Equity Design Group Recommendations

The Health Equity Design Group reconsidered recommendations for measures that should be race/ethnic stratified and for which health equity gap reduction should be incentivized

- DM: HbA1C Screening, 5 votes
- Emergency department usage per 1,000, 5 votes
- Plan all cause readmission, 4 votes
- Asthma medication ratio, 3 votes.
- Asthma medication management, 2 votes.
- DM: Medical attention for neuropathy, 2 votes
- PCMH CAHPs, 2 votes

Health Equity Design Group Recommendations

- DM: HbA1C Screening
- Emergency department usage per 1,000
- Plan all cause readmission
- Asthma medication*



Recommended

-
- DM: Medical attention for nephropathy
 - PCMH CAHPs



Not recommended at this time

*Either Asthma Medication Ration or Asthma medication management, depending on which remains after public comment

Health Plan
Meetings: Lessons
for Alignment Plan

Health Plan Interviews Update

*Based on our discussions with the health plans and other constituents participating with the SIM Quality Council, we will propose **a multi-payer alignment process** for the quality measure set.*

Focus of the health plan meetings:

- Process and requirements for health plans to program, produce, and implement SIM measures for inclusion in value-based payment scorecards and potential risks/challenges;
- Contracting and negotiation processes including the lead time required to write measures into existing and new contracts; contract cycle timing and duration, and
- Level of health plan support for the production of a common quality scorecard for use statewide in reporting provider performance

Health Plan Interviews Update

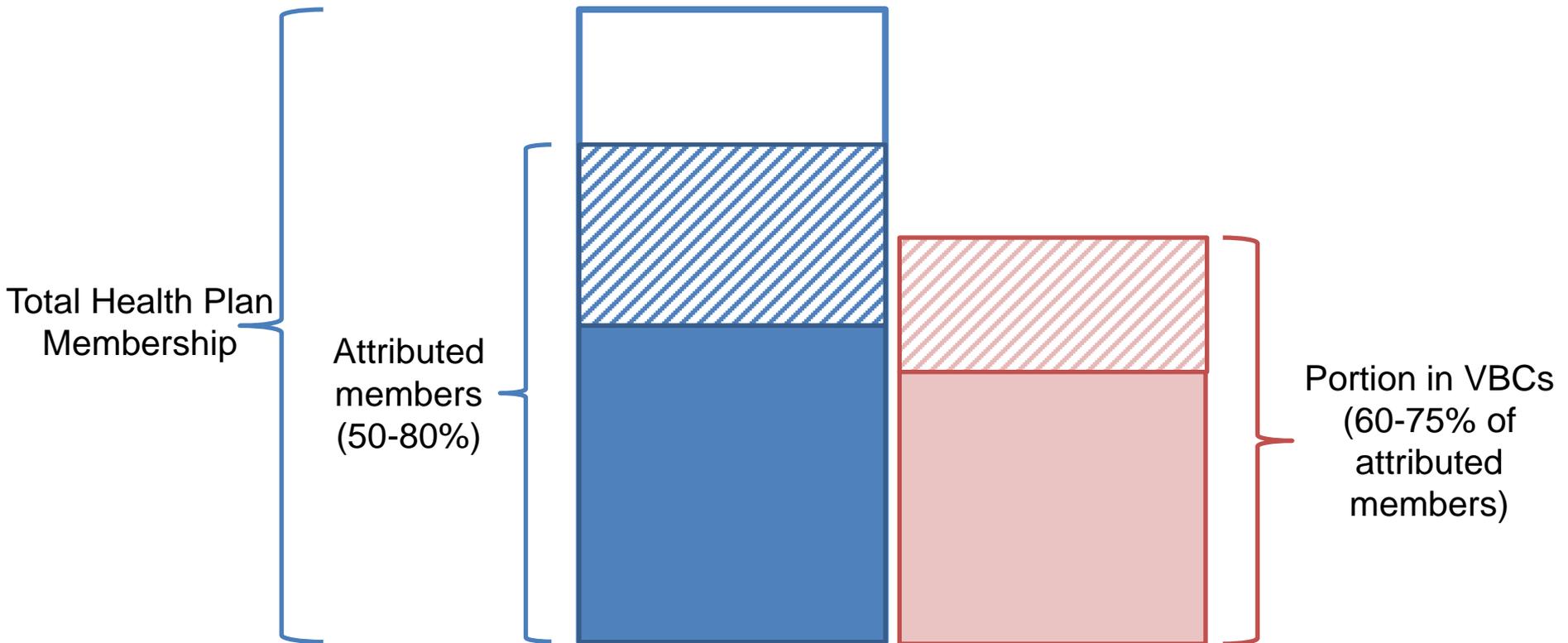
Key Figures in Connecticut:

- Number of measures in contracts: ~10-~27 plus utilization measures
- Length of contracts: typically 2-3 years (some reported outlier contracts)
- Time to program new measures: 3/6 months – 1+ year
- Most plans reported contracts with ~10-20 provider networks / ACOs with a wide range of reported number of lives
 - Reported minimum number of lives range from 1,000-3,000 under certain conditions (e.g. growth) with uniform preference for 5,000+ and one stated minimum of 10,000 lives

Health Plan Interviews Update

Key Figures in Connecticut:

- Significant % of attributed members in CT already in value-based contracts (e.g., **60-75%** of attributed membership with 50-80% of members attributed)



Denotes range among payers

Note: graphs depicts rough estimates, data not provided

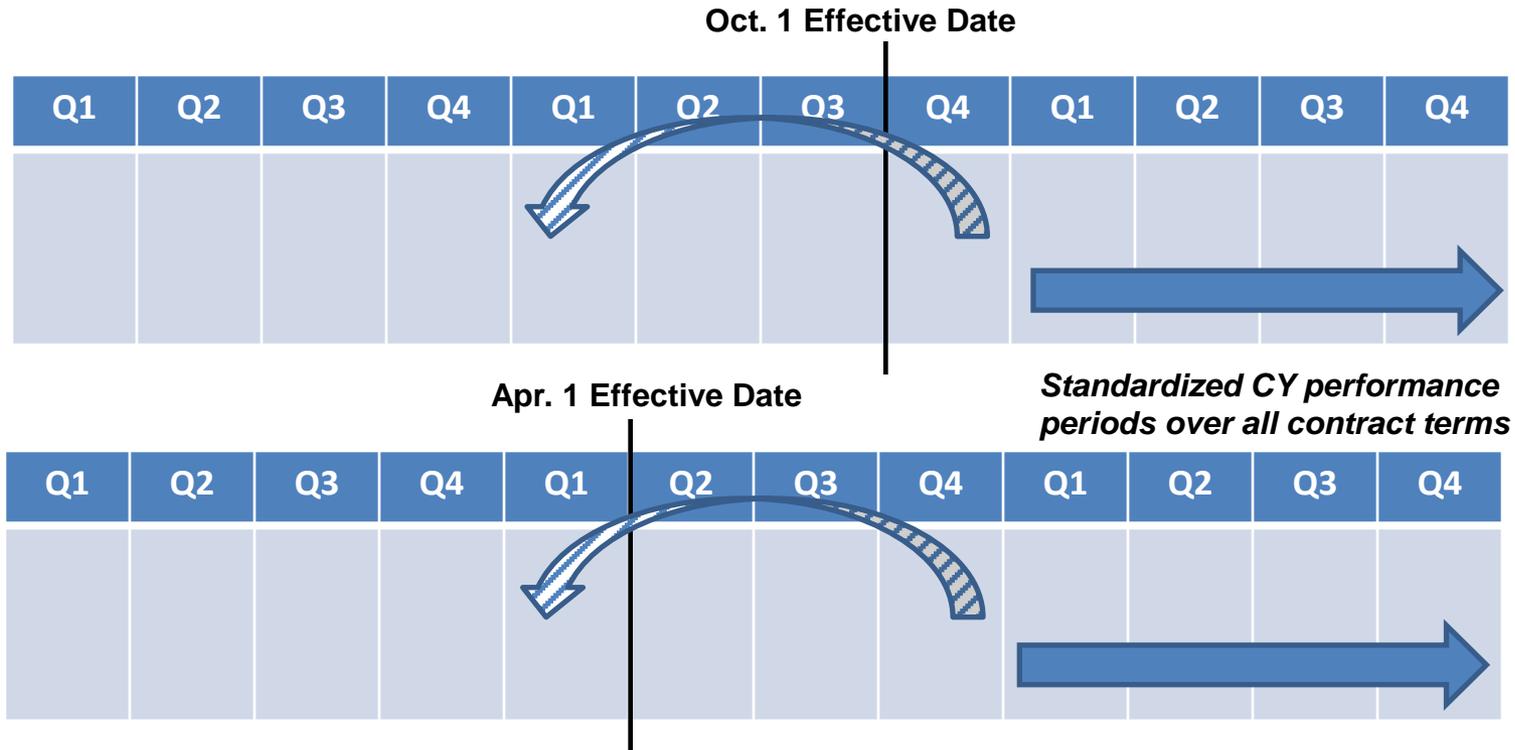
Health Plan Interviews Update

Key themes....considerable variation among the plans:

- Health plans are negotiating contracts now for 2-3 year terms with lead times generally varying from 3 months to a year;
- Performance is judged and benchmarks adjusted annually
- Contracts may have different start dates throughout the year (e.g.; some start 1/1, 4/1, 7/1, 10/1)
- Some health plans align around calendar performance year, others have rolling annual performance years based on start date of contract
- 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

Contract Timing – Example A

Health plans mix approaches of standardizing attribution lookback and performance years based off of CY and annually based off of effective date*

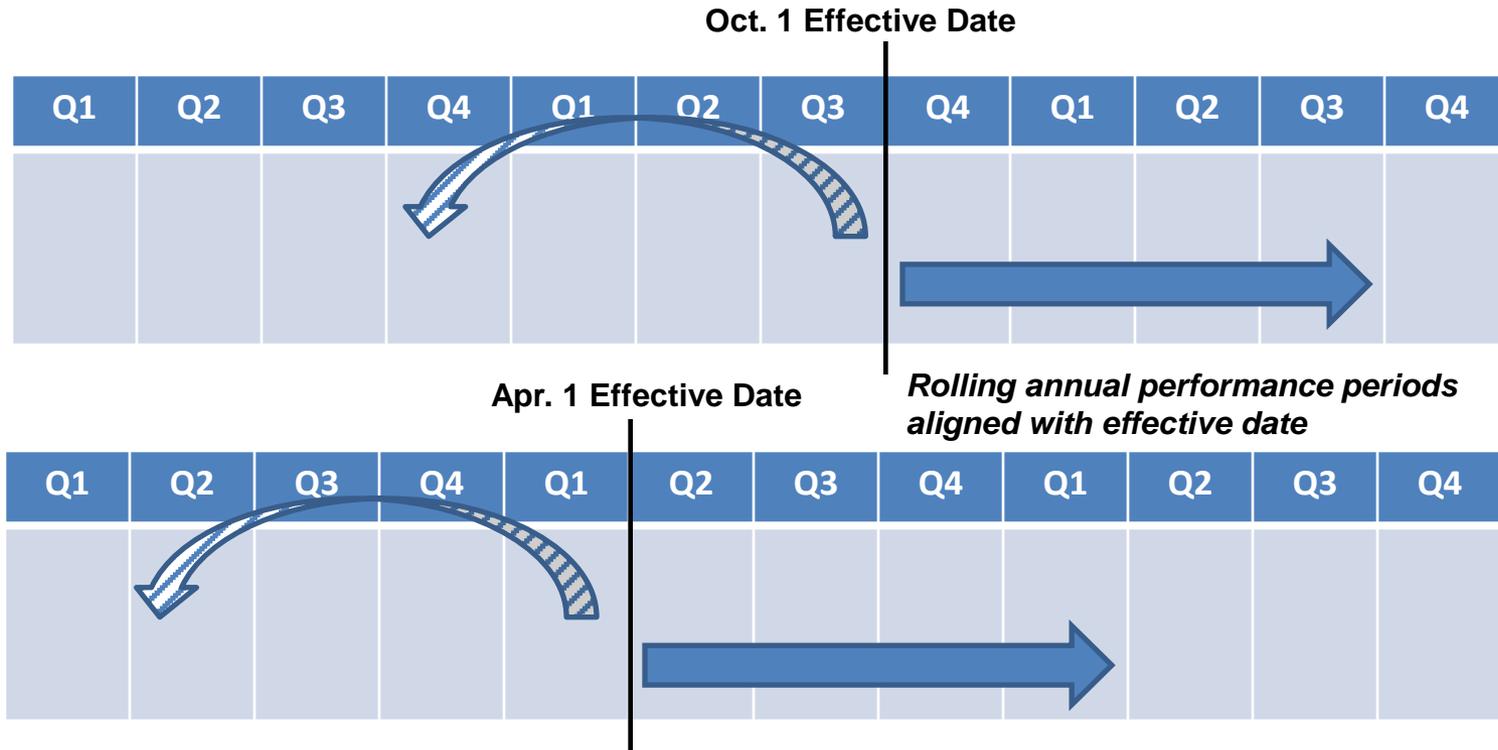


Look-back period for prospectively attributing patients*

*Look-back can go up to 24 months sometimes from the negotiation period to where patients received care (plurality of visits) among other things

Contract Timing – Example B

Health plans mix approaches of standardizing attribution lookback and performance years based off of CY and annually based off of effective date*



Look-back period for prospectively attributing patients*

*Lookback can go up to 24 months sometimes from the negotiation period to where patients received care (plurality of visits) among other things

Health Plan Interviews Update

Key themes:

- With rare exceptions, value-based contracts are exclusively claims-based
- A couple of plans have implemented small number of EHR measures by means of provider chart abstraction and data submission
- Some have pursued use of lab data to measure A1C control; however, data is incomplete
- For multi-year contracts that are being negotiated now, would be helpful for plans to signal how many measures and what type of measures they intend to add as a result of SIM
- Request that QC identify provisional core measure set, even if not final

Health Plan Interviews Update

Key themes:

- Level of commitment to state alignment is moderate to strong among most payers
- Multi-payer measure alignment offers the opportunity for some plans to introduce more measures than they would otherwise be able to do, because all payers are requesting the same measures
- With one or two exceptions, national payers expressed a commitment to alignment; while they strive for standardization and efficiency nationwide, they are making some provisions to customize for SIM states and special initiatives (e.g., CPCI)

Lessons for Quality Measure Alignment Plan

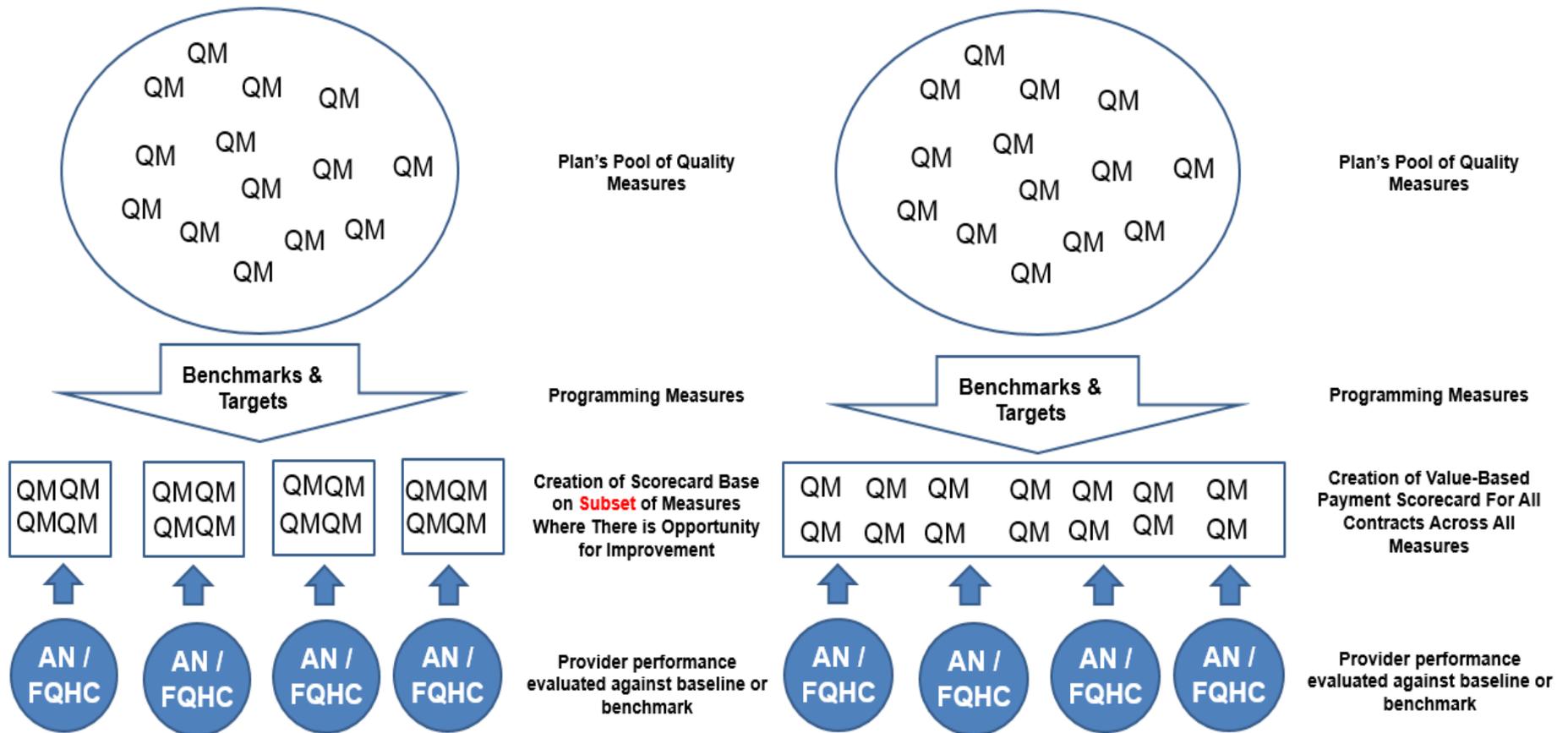
*In contrast to Medicare/Medicaid, the contracts for commercial plans are **negotiated** with providers*

Implications:

- Providers tend to prefer fewer QMs with longer contracts (3 years) and like to track their progress over time
- Some payers combine measures from a national measure set with customization to account for populations such as pediatric or geriatric
- Once executed, payers only replace measures by mutual agreement; typically when measures are replaced with updated measures or when endorsement is lost
- Wholesale changes to the measure set usually are not done until the end of the contract term

Approaches to Performance Assessment

In some instances provider performance is measured against a standardized suite of quality measures across all contracts. Others have create unique sets for each provider with some uniform measures but other selected based off of opportunity for improvement and base rate sufficiency.



Lessons for Quality Measure Alignment Plan

*Alignment with NCQA and/or NQF is important for plan consideration of a new measure, but **alignment with the payer's national strategy** also facilitates adoption*

Implications:

- Even though some measures are NQF endorsed, plans tend to modify numerator/denominator calculations to suit local needs and/or application to ACO environment, which could complicate full alignment process
- Models of patient attribution are proprietary and often nationwide and payers are not customizing for state initiatives
- Multi-state plans tend to have national strategies that may impact the ability of regional divisions to align with state reform initiatives

Lessons for Quality Measure Alignment Plan

Caution around EHR-based and care experience measures is uniform across payers and will require additional work

Implications:

- Health plans generally support care experience measures but caution against patient bias (tends to be overwhelmingly positive) and lack of variation, which may limit ability to discriminate among providers on this measure of performance
- Clinical measures require paper submission of records or manual extraction from EHRs 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

Lessons for Quality Measure Alignment Plan

Full alignment will entail a multi-year process due to extended contract terms (typically 3 years) and need to coordinate with national corporate headquarters

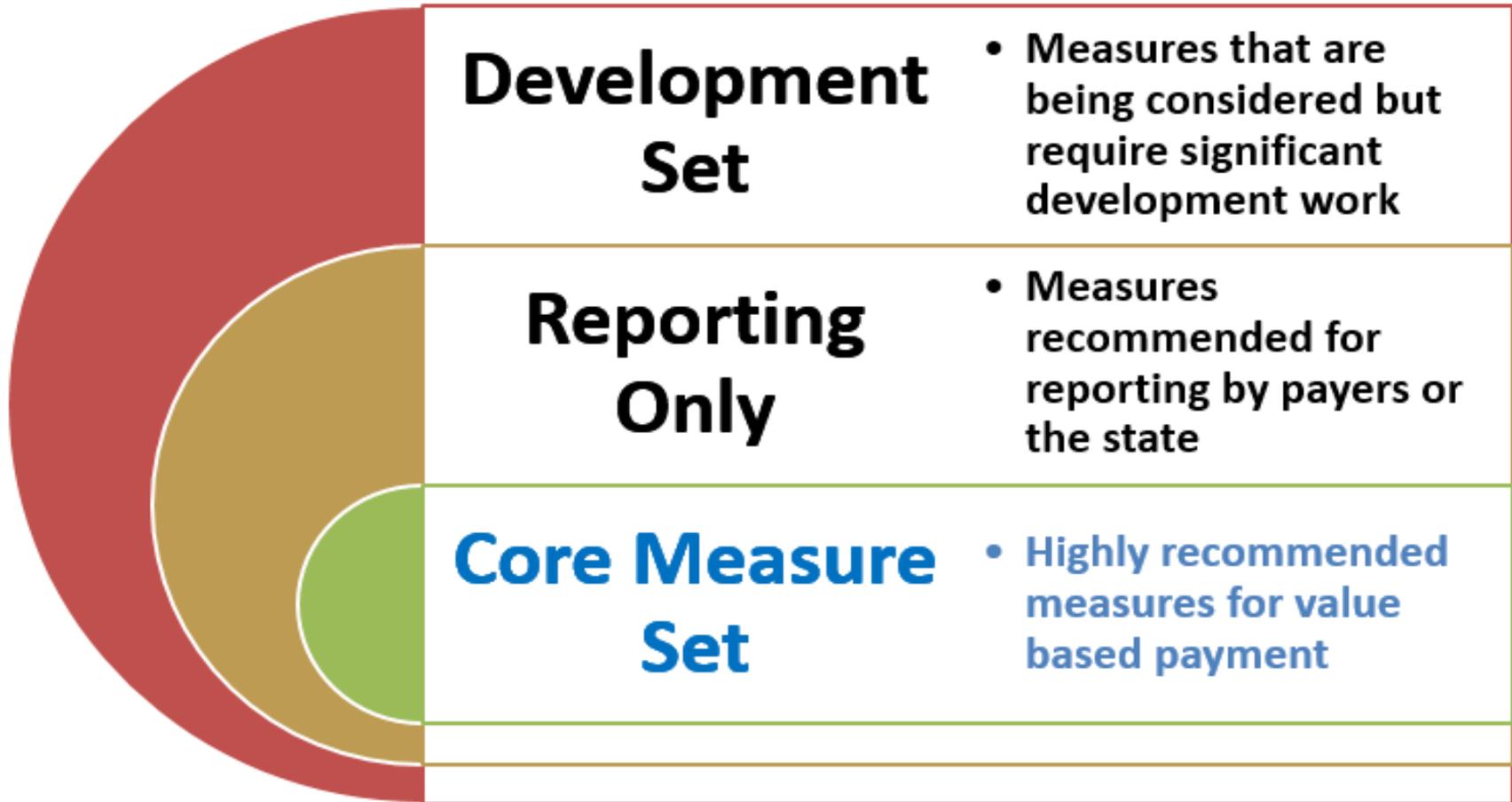
In addition:

- Health plans would value simplicity and flexibility in the alignment process in early years
- Health plans ask that alignment not focus on measure weights, benchmarking methods, or application to shared savings distribution

Proposed Quality Measure Alignment Plan

Proposed Measure Set

The Council debated the concerns over the supplemental label and moved rearranged the measures into 3 sets



Proposed Core Measure Set

Core Quality Measures (29 Commercial/Medicaid 5 Medicaid only)
Ranked within Each Category

#	Measure	Rank	NQF	ACO Category	Strongly Rec	Mod Rec	Not Rec	Avg	
Consumer Engagement									
1	PCMH - CAHPS measure	4	5	1	81.25	18.75	0	1.19	
Care Coordination									
4	Emergency Department Usage per 1000	13		2	64.71	35.29	0	1.35	
6	Annual monitoring for persistent medications	34	2371	2	35.29	41.18	23.53	1.88	
2	Plan all-cause readmission	15	1768	2	70.59	17.65	11.76	1.41	
Prevention									
18	Well-child visits in the first 15 months of life	1	1392	3	88.24	11.76	0	1.12	
10	Breast cancer screening	2	2372	20	82.35	17.65	0	1.18	
11	Cervical cancer screening	7	32	3	76.47	23.53	0	1.24	
13	Colorectal cancer screening	9	34	19	82.35	5.88	11.76	1.29	
22	Prenatal Care & Postpartum care (Medicaid)	10	1517	3	82.35	5.88	11.76	1.29	
16	Preventative care and screening: BMI screening and follow up	11	421	16	76.47	17.65	5.88	1.29	
15	Weight assessment and counseling for nutrition and physical activity for	12	24	3	70.59	23.53	5.88	1.35	
12	Chlamydia screening in women	16	33	3	58.82	35.29	5.88	1.47	
20	Adolescent well-care visits (Medicaid only)*	17		3	58.82	35.29	5.88	1.47	
17	Developmental screening in the first three	18	1448	3	64.71	17.65	17.65	1.53	
14	Adolescent female immunizations HPV	19	1959	3	58.82	29.41	11.76	1.53	
23	Frequency of Ongoing Prenatal Care (FPC)	31	1391	3	41.18	35.29	23.53	1.82	
21	Tobacco use screening and cessation	20	28	17	58.82	29.41	11.76	1.53	
27	Behavioral health screening (pediatric, Medicaid only, custom measure)			3	58.82	17.65	23.53	1.65	
25	Screening for clinical depression and follow-	23	418	18	3				
Acute & Chronic Care									
35	HTN: Controlling high blood pressure	3	18	28	4	82.35	17.65	0	1.18
31	DM: HbA1c Screening (possible interim	5	57	4	4	76.47	25.53	0	1.24
30	DM: Hemoglobin A1c Poor Control (>9%)	6	59	27	4	76.47	23.53	0	1.24
32	DM: Diabetes eye exam	8	55	41	4	52.94	41.18	5.88	1.53
38	Appr. treatment for children with upper respiratory infection	21	69	4	4	47.06	47.06	5.88	1.59
37	Avoidance of antibiotic treatment in adults with acute bronchitis	22	58	4	4	35.29	52.94	11.76	1.76
28	Medication management for people w/	28	1799	4	4	43.75	25	31.25	1.88
29	Asthma Medication Ratio	32	1800	4	4	41.18	29.41	29.41	1.88
36	Use of imaging studies for low back pain	33	52	4	4	41.18	47.06	11.76	1.71
34	DM: Diabetes: medical attention for	26	62	4	4				
Behavioral Health									
43	Child & Adolescent MDD: Suicide Risk	24	1365	5	5	35.29	58.82	5.88	1.71
40	Follow-up care for children prescribed ADHD	27	108	5	5	35.29	41.18	23.53	1.88
44	Unhealthy Alcohol Use - Screening	35		5	5	35.29	23.53	41.18	2.06
42	Depression Remission at 12 Twelve Months	39	710	40	5				
41	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric,	NR		5					
*Retained - Medicaid has prioritized as a payment measure									
Currently designated as an MQISSP Payment or Challenge Measure									
Recommended health equity measure									

29 Measures
Recommended for
Commercial/Medicaid
and 5 Measures for
Medicaid only (29
includes PCMH
CAHPS which will be
comprised of multiple
domains)

Proposed Reporting & Development Sets

Reporting Only Measures / Development Set

Ranking Number	Reporting Only	NQF	ACO	Category
	Anti-Depressant Medication Management	105		
	Initiation and Engagement of Alcohol and Opioid Drug Dependence Treatment	4		
	Follow up after hospitalization for mental illness, 7 & 30 days			
	30 day readmission (MMDLN)			
	ED Use (observed to expected) – New NCQA			
	% PCPs that meet Meaningful Use		11	
7	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions			2
14	19 Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid)	1516		3
	22 Prenatal Care & Postpartum care (commercial only)	1517		3
	23 Frequency of Ongoing Prenatal Care (FPC) (commercial only)	1391		3
	26 Oral Evaluation, Dental Services (Medicaid only)	2517		3
40	39 Cardiac stress img: Testing in asymptomatic low risk patients	672		4
Ranking Number	Development Set	NQF	ACO	Category
	Gap in HIV medical visits	2080		
	HIV/AIDS: Screening for Chlamydia, Gonorrhea, and Syphilis	409		
	HIV viral load suppression	2082		
	Annual % asthma patients (2-20) with 1 or more asthma-related ED visits			
3	Asthma admission rate (child)	728		2
	Pediatric ambulatory care sensitive condition admission composite			
	ASC admissions: Chronic obstructive pulmonary disease (COPD) or asthma	275	9	
	ASC: heart failure (HF)	277	10	
	All-cause unplanned admission for MCC		38	
	All-cause unplanned admissions for patients with heart failure		37	
33	9 All-cause unplanned admissions for patients with DM		36	2
22	8 Asthma in younger adults admission rate	283		
	24 Oral health: Primary Caries Prevention*	4419		3
	Preventable hospitalization composite (NCQA)/Ambulatory Care Sensitive Condition composite (AHRQ)			
Ranking Number	Not recommended/eliminated	NQF	ACO	Category
33	DM: Diabetes foot exam**	56		4
5	Documentation of current medications in the medical record	419	39	2
	*Pending PMO follow-up with subject matter experts			
	**Pending Dr. Dalal examination of relevance to health equity			

12 Measures
for Reporting

14 Measures
for
Development

Plan for Alignment

Asking that all payers adopt core measure set in one of two ways:

- Adopt as part of standard, state-wide scorecard
- Adopt as part of the payer's standard measurement set, against which provider performance is assessed at the start of a negotiation; subset of measures selected for scorecard where there is an opportunity for improvement

Plan for Alignment

The PMO expects alignment to increase over time as new VBP contracts are written and as existing contract terms come up for re-negotiation on a rolling basis.

Opportunities include:

- Negotiation of a new VBP contract
- Renegotiation of an existing contract after the term (2-3 years)
- Mid-cycle after annual performance review/updates at the discretion of the payer and provider

Plan for Alignment

The PMO anticipates an evolving process that takes into consideration advances in measurement science at the national level:

- Recognize that SIM Quality Council will continue to update core measure set on an annual basis
- Ask that payers use latest Quality Council recommended core measure set at the time a negotiation or re-negotiation begins
- Alignment will be an ongoing process that recognizes
 - core measure set is being updated over time, and
 - contracts are being re-negotiated on a rolling basis

Consumer Experience Measures

The PMO intends to administer the PCMH CAHPS survey on behalf of payers:

- Conduct baseline survey of all ANs/FQHCs in Q1 2016 for CY 2015 base year
 - Solicit list of attributed members in each AN during 2015 as basis for sample
 - Survey will target ANs that are in a contract with at least one commercial health plan
 - Survey will be commercial payer agnostic;
 - Random sample weighted to reflect each payers attributed membership

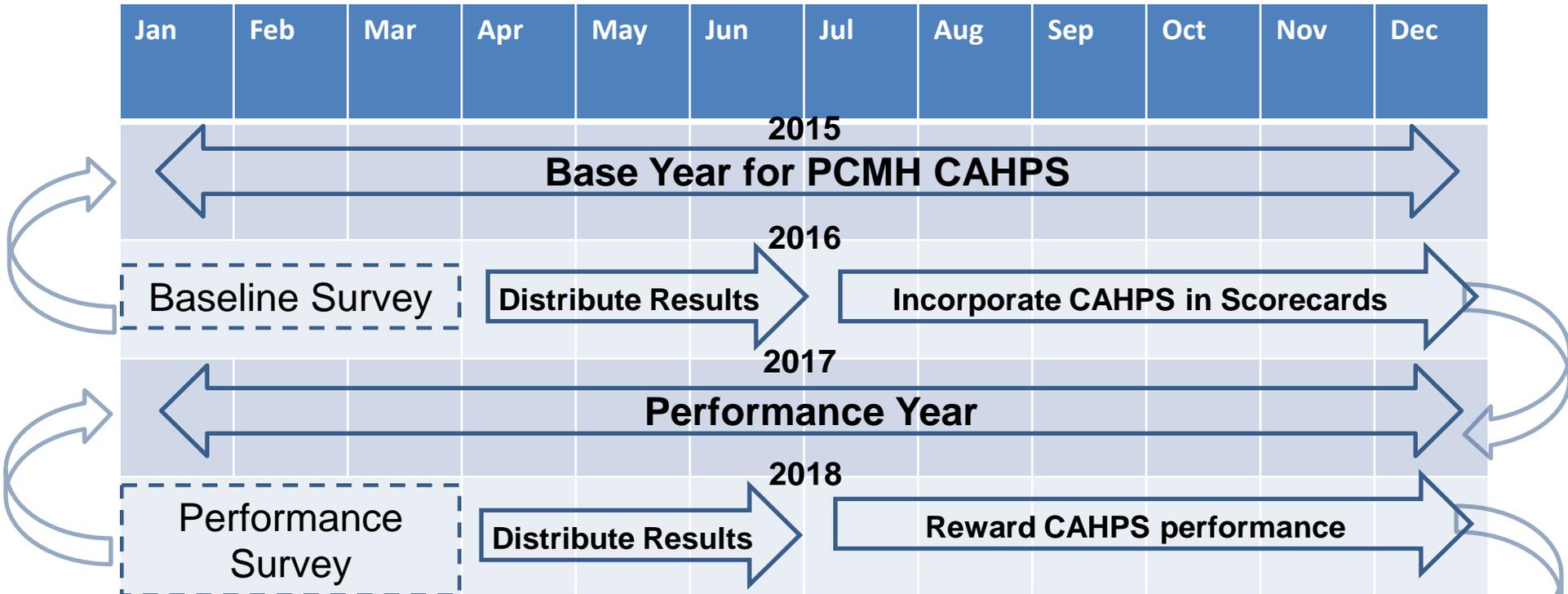
*Coordinated approach with DSS for Medicaid is under discussion; similar approach may be followed, to include FQHCs

Consumer Experience Measures

- Consider finalizing CAHPS measures for core measure set based on analysis of baseline survey data
 - Consider variation and opportunity for improvement
 - Anticipate 4-7 domains
- Conduct initial performance survey in Q1 2018 for CY 2017
- Need to consider issues associated with payers' asynchronous performance periods

Consumer Experience Timeline

The PMO is requesting that all payers begin to include CAHPS performance measures in VBP contracts beginning July 2016



**Key question – is approach oriented around CY 2017 compatible with asynchronous contract years?*

Claims-Based Measures

Assuming the core measure set is finalized in January 2016, payers are encouraged to adopt recommended claims-based measures as part of the first phase of the alignment process. The State is encouraging payers to:

- Begin programming and production of measures in Q1/Q2 2016
- Include recommended claims-based measure in new value-based payment contracts or contract renewals beginning July 1, 2016
- Continue with rolling adoption of recommended core measure set as new contracts are negotiated or existing contracts are renegotiated

EHR-Based Measures

The State, with the advice of SIM HIT Council, will be responsible for the production of EHR-based clinical measures. State will conduct a pilot followed by statewide implementation of edge server technology, dependent on successful completion of the pilot. The State is encouraging payers to:

- Contractually require providers to participate in the state-administered EHR-measure reporting process, dependent on successful completion of the pilot
- Initially tie payment to provider reporting on EHR-based measures
- Subsequently, tie payment to performance on EHR-based measures once reported measures achieve minimum standards of completeness, reliability, validity, etc.
- Target timetable to be determined in consultation with DSS/UConn HIT team

Reconciling Measure Set & Implementation Timeline

This process will involve ongoing alignment with flexibility for health plans to retain existing contract periods

	2015	2016	2017	2018
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
EHR-based*	Finalization of measure set after public comment & begin EDGE server pilot	Implementation of EDGE tech; payers include reporting requirements in VBP contracts	EHR measure reporting and testing; payers include performance requirements in VBP contracts	Core EHR measures tied to payment; continued adoption in VBP contracts

*Hypothetical timetable for EHR based measure alignment

SIM QC updates core measure set on an annual basis

Measuring Alignment

The PMO will monitor progress toward alignment on an annual basis. One option for measuring alignment is as follows:

- Assess % alignment as # of payers that have adopted each measure divided by # of payers times # of measures
- Approach does not factor in # of members or # of contracts in which a measure is being applied to avoid undue complexity

$$\% \text{ Alignment} = \frac{\text{SUM (\# of measures Payer 1: \# of measures Payer X)}}{\# \text{ of payers} * \text{ number of measures}}$$

X = # of payers of sufficient scale to do VBP (5 commercial & Medicaid), but excluding Medicare

Next Steps

Quality Council Calendar: November 2015

Monday	Tuesday	Wednesday	Thursday	Friday
2 <div data-bbox="92 311 411 454" style="border: 1px solid black; padding: 5px; background-color: #cccccc;"> Release draft Quality Council Report </div>	3	4 <div data-bbox="832 311 1151 454" style="border: 1px solid black; padding: 5px; background-color: #c1e1c1;"> <u>Quality Council Meeting</u> (possible) </div>	5 <div data-bbox="1203 311 1522 454" style="border: 1px solid black; padding: 5px; background-color: #cccccc;"> Release Report to Steering Committee </div>	6
9	10	11	12 <div data-bbox="1203 539 1522 682" style="border: 1px solid black; padding: 5px; background-color: #add8e6;"> <u>Steering Committee:</u> Present Report </div>	13
16	17 <div data-bbox="484 701 803 872" style="border: 1px solid black; padding: 5px; background-color: #cccccc;"> Release Report for public comment (due 12/15) </div>	18	19	20
23	24	25	26	27
30				

Adjourn