Draft SIM Workgroup Update
April 1, 2015

The following updates were drawn from information sent by CAB Liaisons and SIM Materials.

Quality Council Update
Arlene Murphy

Quality Council presented an update to Steering Committee that includes a list of those quality measures that have been provisionally approved to date and is working to resolve questions and issues that need to be resolved.

At the April 1st meeting CHARTIS will make a presentation on use of scorecards in Value Based Payments. (Link below) This will begin important discussions of how many measures will be included in scorecards and whether all payors will be using the same measure set or will a "menu approach" be recommended that includes some mandatory aligned measures and some optional choices. Work continues on quality measures relating to health care for individuals with HIV. Recommendations are still under development from the Care Experience Design Group and the Equity Design Group.

Further information can be found on links below:

Quality Council Comparison Table listing all the measures under review:
http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=335530

Practice Transformation Taskforce
Nanfi Lubogo

At the March 17th meeting, PTTF Members heard a presentation by Qualidigm and Planetree on their Practice Transformation Services. See links below

https://prezi.com/_u72gn03yh-i/march-17-sim-prezi/

http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/2015-03-17/presentation_pttf_ccip_briefing_v3-2.pdf

There was discussion of the Advanced Medical Home Pilot. PTTF members raised the importance of the AMH pilot selection process including practices/advanced networks in at least one of Connecticut's 5 largest cities (Bridgeport, New Haven, Hartford, Stamford, or Waterbury)-all with populations over 100,000 and large Medicaid populations.

The group considered the best approach for considering and developing the Community Clinical Integration Program. The Steering Committee has recommended adding additional members to PTTF and some revisions to their charter are under consideration.

CT Hospital Association submitted a letter in public comment (see link below)

http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/2015-03-17/publiccomment_pttf_cha_03172015.pdf

Equity Access Council
Alice Ferguson

The primary objective was to review the "Summary of Draft Recommendations for EAC Consideration" Document.
http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/equity_access/2015_12_03/eac_summary_of_recommendations_-_group_1_2015_0312.pdf.

A nomination was made to accept the report with revisions was agreed to.

The following suggestions for revisions/comments were made:

Area 1: Patient Attribution

Recommendation 1
This recommendation should not be a requirement; but highly encouraged. Suggested it should be regarded as one method among others.

Recommendation 2
Patients may be confused about what the notification actually mean and it should be clearly stated in the communication as well as worded at a medically literate level that is understood by recipients. There were concerns raised about consumers with literacy challenges. Various commentary regarding the clarity, quality, nature and standard used was voiced. The question was raised "Who will be responsible for the notifications?" It was suggested this effort be a part of the role of the Community Worker.

It was decided Design Work Group 3 will address these issues.

Recommendation 3
Relates to persons seeking care outside the Primary Care Provider. Question raised "Where are non-Primary Care consumer totals tracked?" It was noted the New Haven ER has a system in place that identifies "frequent ER flyers."

It was noted no model addresses the entire Attribution issue.

These recommendations are intended as innovations meant to promote their usefulness by incentivizing this model. A comment was offered that the goals as stated may be too broad to address defined goals of best fitting Attribution and Care Coordination. Further, these recommendations address a financial incentive for patients who are not in an ideal system. Physician Office settings should be promoted as opposed to ER, or other like services (i.e. urgent care, minute clinics, etc.).

It was noted Behavioral Healthcare visits are not included in this tally of service delivery.

Patients that do not meet the number of defined visits are listed as non-Attributed. Agencies providing care like the ER receives incentives to refer non Attributed patients to a Primary Care Physician.

Question posed, "Is this model rewarding quality measures alone not including accountability of care?" and "What occurs when services are not integrated?"

Additional discussion involved patients not connected to care and including matters relating to Behavioral Health as well as other medically specific concerns that steer patients to services other than Primary Care Physicians.

It was agreed this recommendation needs to be revised/enhanced to encourage Providers to be inclusive rather than exclusive of non-Attributed Patients, and must be reflected in its language.

Recommendation 4

Notification and Timing needs more attention in respect to select patients, i.e. those with no address and other under-served populations including some Medicaid Patients. In addition, systematic review of Patient Assignment and whether it is working was suggested. Safeguards must be documented and in place relative to certain populations at the end of an assignment period.

Recommendation 5

This recommendation pursues the impact of patients, that is "Where non-emergency room patients go for service" as well as "Why they are using non defined Primary Care Physicians for primary care services?" It was suggested patterns should be examined after the year end assignment. It was noted Physician relocation can have a significant impact on patients. This may also account for who is non Attributed and why in some cases.

Area 2 – Cost Target Calculation

Recommendation 1

Historical benchmark method was said to be the most useful for generating rewards at present. There are geographic concerns as well as others that affect performance. Each issue needs to be addressed to accurately determine which method is best.

It was noted more robust engagement of Providers is necessary.

Recommendation 2

Chronic Disease and associated costs have an effect on Cost Calculation by way of "unexpected development cost expenses (HIV/AIDS and Hepatitis were cited examples)" and must be somehow factored into the overall cost of utilization in order that Physicians aren't given to withhold medications.

Concerns were voiced regarding advances and suggested that safeguards be developed.

Recommendation 3-5

Will require further discussion and likely be revised in the April E&A meeting.

March 26th Equity and Access Meeting - Conference Call Update
Link to presentation below.

http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/equity_access/2015-03-26/eac_20150326_distributed.pdf

Draft Recommendations

http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/equity_access/2015-03-26/eac_summary_of_recommendations_-_group_2_2015_0326.pdf

The first objective was to discuss in detail the recommendations offered by Design Group 1: Cost Target Calculation, Design Group 2: Payment Calculation and Distribution, and Design Group 4: Retrospective and Concurrent Monitoring and Detection (E&A First Review). Note: This document and meeting agenda has not been posted to the CT Healthcare SIM Website as of the date of this report and will be emailed as an attachment.

Design Group 1: Benchmark Adjustment for New Treatment

Recommendation 2
Closing remarks regarding cost benchmarks was held. (pgs. 5, 6, 7)

Recommended revising the title as it does not adequately represent the goal of this item. It needs to more adequately speak to cases when "new" costs are involved. The question was raised does it sufficiently cover or speak to new public health issues, i.e. a bad flu season, etc.

A comment was made there were 75 new cases of HIV reported and additional federal funding should be sought after. The concern being the cost of treating any given population is considered a "cost event" affecting Providers. This issue need by addressed in clear language and across different populations, unpredicted factors have an effect on performance and need be accommodated. The comment was also offered that such matters were generally accommodated quickly in the past.

It was agreed to reverse to the "prior year" language in the recommendation.

Recommendation 3: Supplemental Payments for Complex Populations

Discussion was whether this item was specific to clinical adjustments and options.

Suggested there be a flat payment adjustment to address certain populations ensuring those populations are not selected out. Including various barriers to access to care including; socio-economic, language, homeless, rural, transportation along with other barriers to care. It was generally agreed these are factors as they apply to Supplemental Payments and are beyond the scope of this workgroup.

It was suggested this matter is a reality and should be left in the recommendations as an issue that falls under "fee-for-service" under the Community Health Worker or some other relative category.

The question was posed, "Where is the money going to come from to support this item, and other costs that are recommended?" The decision was made to include all issues and defer the monetary question to other entities, recognizing all those included are there as a matter of importance to the charge of the E&A Design Work Group.

Certain highly costly procedures will not be considered in the "Benchmarks" or "Performance" such as transplants and the like.

Design Work Group 2 - Payment Calculation and Distribution (pg. 10, 11, 12)

Various comments regarding the implications regarding the program design were made.

It was suggested this recommendation be tied to performance and quality of service overall. Generally, ACO's are not tied to any one means for payment.

This council's recommendations are advisory as they apply to the guidelines set forth for the Equity and Access Design Work Group and should be considered as such.

The Quality Work Design Group focused on measures; not necessarily quality thresholds. The question was raised "Was there a need to be more specific or defer some issue to the Quality Work Group?" and "Is E&A a part of this issue?" It was suggested E&A implications should not be left out of this matter.

It was suggested if Quality is so poor, shared savings should not be available if they do not allow for improvement as well as incentives to reach goals of quality in order to ensure consistent qualify for shared savings. It was noted within most ACO's, there are a robust range of measures that address the concerns of all patients.

The question was raised, "Should there be Underserved Measures defined beyond the general quality performance measures? It was stated all payers commit to the notion that they should adopt Underserved Populations.

Recommended the language should be adjusted to reflect wording in the Charter as it applies to E&A as a means to reinforce that focus must be on the Underserved population.

Item #2
The comment was made Medicaid payments are different in this regard; this recommendation is intended to apply to fee-for-service as an "If/then" statement rather than a "should be" directive. Lowering costs of care is a goal. This item will require further discussion.

Item #3
It was suggested Quality is a gateway or goal and should not be a penalty for Providers taking on harder populations. The components listed are general geared toward leveling service improvements.

It was stated Providers need to be encouraged to take on more difficult populations and these issues not be counted against those serving populations that typically are not progressing. This item language will be edited.

Item #4
ACO's only rewarded for savings are statistically are calculated. ACO's that do not reach set goals over time should not be eligible for shared savings.

Additional suggested for changes to this item were made.

Item #5
It was suggested ACO'S typically may not be agreeable with this guideline and would view this as an unnecessary dictate of reinvestment of savings.

Further discussion involved the various ways this option could be viewed by an ACO, regarding the contract and the Payer. This was tabled and will be revisited at a later date.

Item #6
It was commented this item not be prescriptive as to how Providers are paid but to reward Providers for reducing costs of given patent populations. Providers are paid on individual quality and performance.

It was stated ACO's should be held to task by way of recommendations.

Some meeting attendees opposed any dictates regarding payment methods, and operating principles. Recommendations will be revised and added to.

Design Group 4: Monitoring and Detection

The overall recommendation from this design group were made on the basis of made to guard against Underservice and Patient Selection.

The questions was asked, "What level of monitoring should take place?"

Second, "Are gaps in care a focus as it applies to overall Patient Costs and Quality as it relates to underservice gaps" "Should gaps be reported and addressed as they occur and are identified?"

It was recommended the Steering Council needs to determine "What is expected from Payers, Providers and that those results be made available to the public. This issue requires additional discussion and focus to determine how the "Quality of Care" matter is addressed within this context.

Adam asked for minimum recommendations for Payers to be added as a part of this overall topic as it applies to the issue of monitoring and detection. This topic will be addressed in the next meeting.

Health Information Technology Council
Pat Checko

At their March 12th meeting the HISC appointed Ludwig Johnson of Middlesex Hospital to the HIT Council. Following the March 20th meeting, the HIT Council is working toward finalizing the Charter, Conflict of interest guidelines, and pursuing the creation of an Executive Committee.
There was an intensive discussion of the request from the Quality Committee regarding the 2016 proof of solution for data collection, metric calculation, analysis and reporting. The issue of Medicaid reporting of data was also discussed at length. It was clear that there needed to be greater communication between the two councils and the Design committee was tasked with developing the questions that needed to be addressed to proceed. The Performance Measurement and Reporting and Design Group will meet the week of April 6th.

Dr. Tamin Ahmed, Executive Director of Access Health Analytics made a presentation to the council on the platform and data available from the All Payers Claims Database. He noted that PA 13-247 that created the APCD defined its purpose as "… health care information relating to safety, quality, cost effectiveness, access and efficiency for all levels of health care in Connecticut."

Dr. Ahmed had been asked if the APCD dataset had the capability to measure Diabetes A1c Poor Control Measure 1 (NCF0059) and Controlling High Blood Pressure Measure (NQF 0018), the same measures provided by the Quality Committee. He explained how the APCD through diagnosis and CPT codes could be used to created aggregate measures (i.e., percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled {{<140/190 mmHg)} during the measurement period.

The HIT Council will be hearing from the edge server contractor at the next meeting.

Medicaid Program Oversight Council – Care Management Committee
Sharon Langer

There have been no meetings since the last CAB meeting.