INTEGRATED CARE WORKGROUP

Meeting #4

April 28, 2015

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:00 – 10:10	Foster Gesten, MD
2	Updates Since Last Meeting	10:10 – 10:20	Susan Stuard John Powell
3	The APC Straw-Person: Comments/Input Received	10:20 – 1:00	Foster Gesten, MD Susan Stuard
4	Break	11:50 – 12:00	
5	Working Lunch: APC Discussion	12:00 – 1:00	Foster Gesten, MD Susan Stuard
6	Measurement and APC	1:00 – 1:45	Hope Plavin Andy Cohen, Quality Institute
7	Next Steps and Discussion	1:45 – 2:00	Susan Stuard Foster Gesten, MD

Past slides posted online:
https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm

Welcome and Introductions

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Updates Since Last Meeting

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APC Straw Person: Comments and Issues

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Comments and Issues

1. Alignment: APC, NCQA, etc.

2. Recognition

3. Health Information Technology Requirements – Pre-APC

4. Bar too high?

   ▪ 75% care management threshold

   ▪ Quarterly surveys

   ▪ Board certification

5. Bar too low?

   ▪ Population Health

   ▪ Shared Decision Making

   ▪ After hours access

Who/how will practices be 'recognized' as APC?

- Currently
  - NCQA (JC/URAC) but..
    - Few payers pay on this
    - Does 'recognition' = 'transformation'?
  - Insurer requirements (plus/minus NCQA)
    - Non alignment
    - Idiosyncratic
  - CMS/CMMI requirements
    - Milestones with local 'faculty' assessments

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What are options?

- Plans
- State
- Self-attestation
- New entity
- Combination

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Suggestion

- Trust, but verify
  - Combination of self attestation with 'audit'/evaluation (CPC model)
  - Performed 'locally' by 'trusted entity'
    - Acceptable to practices and payers
    - Standardized (statewide) criteria
  - Could be dual role for 'transformation' entity/vendor
  - NCQA 2014 recognized could get 'EZ Pass' for some elements of APC
  - Use of data to confirm
  - Some health plans may elect to do some of their own verification as well (attestation to the plan, audits, etc.)

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Measurement and APC

Measure sets used in federal and state initiatives:

1. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

2. CMMI Priority Measures for Monitoring and Evaluation

3. CMS Health Home Measure Set

4. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set)

5. CMS Medicare Shared Savings Program (MSSP) ACO for 2014

6. CMS requirements for QHPs in Marketplaces

7. Comprehensive Primary Care Initiative (CPCI)

8. Meaningful Use Clinical Quality Measures (CQMs) for 2014

    1. Pediatric

    2. Adult

9. Medicare-Medicaid Plans (MMPs) Capitated Financial Alignment Model (Duals Demonstrations)

10. PQRS – EP EHR Incentive Clinical Quality Measures (eCQMs)

11. CMMI State Innovation Model (SIM) Suggested Population-Level Measures

12. Medicare Hospital Compare

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Other Measure Sets:

Measure sets used by private purchasers:
- Measures used in private purchasing initiatives
- Local or regional employers (e.g., Walmart.)

Accreditation measure sets:
- Health plan (e.g., HEDIS)
- Hospital (e.g., The Joint Commission)

Other national measure sets:
- Leapfrog
- LTSS Scorecard

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Initial SHIP scorecard: 5 categories, 18 domains, 8 composite scores, 207 individual measures

					Number of composites	Individual measures
Triple Aim	1	Health improve-ment	1.1	Behavioral risk factors	1	7
			1.2	Prevalence and Incidence	1	9
			1.3	Health outcomes	1	10
					3	**26**
	2	Care improve-ment	2.1	Patient experience of care	1	6
			2.2	Quality of care	1	51
			2.3	APC eligibility criteria	1	26
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	3	Cost reduction	3.1	Total cost of care	1	7
			3.2	Utilization	1	19
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Context	4	Landscape	4.1	Demographics	n/a	8
			4.2	Payer market structure	n/a	11
			4.3	Provider market structure	n/a	11
					--	**30**
	5	Transfor-mation	5.1	Improving access to care	n/a	5
			5.2	Ensuring integrated care for all	n/a	6
			5.3	Making healthcare transparent for all consumers	n/a	5
			5.4	Paying for value, not for volume	n/a	13
			5.5	Connecting healthcare with the community	n/a	3
			5.6	Workforce strategy	n/a	6
			5.7	Health Information Technology Adoption	n/a	4
					--	**42**

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Program	Description	Alignment of SHIP scorecard with program measures	Implications
CPCI	Federally-sponsored, multi-payor PCMH	▪ 13 of 14 measures are included[1]	▪ Push as voluntary alternative
Medicaid DSRIP	Incentive payment programs	▪ 15 of 22 Domain 2 measures included[2] ▪ 32 of 37 unique Domain 3 measures included	▪ Push as voluntary alternative with amendments
NCQA	National PCMH recognition program	▪ NCQA 2011 or 2014 recognition is included in 2.3 APC eligibility criteria	▪ Push as voluntary alternative
Medicare Shared Savings program	Federally-sponsored ACO program for Medicare FFS	▪ All 15 measures across Care Coordination/Patient safety and Preventive Care measures are included ▪ 12 At-risk population measures are addressed, but not at the metric-level	▪ Push as alternative, with MSSP-specific amendments
Meaningful Use Clinical Quality Measures (eCQMs)	CMS EHR Incentive payment	▪ 13 of 18 2014 Recommended Core Measures (Pediatric and Adult)	▪ Push as alternative, with amendments
Adirondack Medical Home	PCMH pilot in upstate New York	▪ Quality measures are addressed but not by measure ▪ Large suite of patient and provider experience surveys not included	▪ No action needed for standards to co-exist

1 Excluded measure "Use of appropriate medications for people with asthma" is scheduled to be dropped from HEDIS
2 DSRIP measures of Medicaid spending are included in SHIP scorecard but for all payers

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"Buying Value" (RWJF) Most Frequently Used State Program Measures, By Domain

The following charts list the most frequently used state program measures, by domain. The counts contained in the first column, "Number of Programs Using Measure," are based on Buying Value's 2013 study of state measure sets. Note that the counts also include measure use in a limited number of non-state programs.

The table below is organized by domain and within each domain the measures are grouped together with like measures. These groupings are differentiated by variation in shading. The measures are listed from highest to lowest frequency of use within each grouping of measures. For example, NQF #24, NQF #421 and NCQA ABA are all Body Mass Index (BMI)-related measures and therefore grouped and sorted by use frequency before listing the next group of related measures (e.g., well-care measures).

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
Cancer Screening				
30	Breast Cancer Screening	NCQA HEDIS (BCS)	0031 (no longer endorsed)[1]	All Adults (18+)
24	Cervical Cancer Screening	NCQA HEDIS (CCS)	0032[2]	All Adults (18+)
19	Colorectal Cancer Screening	NCQA HEDIS (COL)	0034	All Adults (18+)

[1] NQF 0031 endorsement was removed October 2012; however a new Breast Cancer Screening measure is being developed by steward NCQA to align with practice guidelines.

[2] NQF 0032 endorsement was updated January 2014 to align with new practice guidelines.

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
Preventive Care				
17	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	NCQA HEDIS (WCC)	0024	Pediatric (0-17)
14	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS	0421	All Adults (18+)
9	Adult BMI Assessment	NCQA HEDIS (ABA)	NA	All Adults (18+)
14	Adolescent Well-Care Visits	NCQA HEDIS (AWC)	NA	Pediatric (0-17)
12	Well-Child Visits in the First 15 Months of Life	NCQA HEDIS (W15)	1392	Pediatric (0-17)
12	Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life	NCQA HEDIS (W34)	1516	Pediatric (0-17)
7	Child and Adolescent Access to Primary Care Practitioners	NCQA HEDIS	NA	Pediatric (0-17)

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
6	Adult Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	NA	All Adults (18+)
9	Annual Dental Visits	NCQA HEDIS	1388	Pediatric (0-17)
7	Lead Screening in Children	NCQA HEDIS (LSC)	NA	Pediatric (0-17)
Women's/Maternal Health				
15	Chlamydia Screening	NCQA HEDIS (CHL)	0033	All Adults (18+)
15	Maternity Care: Postpartum Care (PPC), Prenatal Visit During 1st Trimester (PPC)	NCQA HEDIS	1517	All Adults (18+)
8	Frequency of Ongoing Prenatal Care	NCQA HEDIS	1391	All Adults (18+)

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
4	PC-01 Elective Delivery	The Joint Commission	0469	Pediatric and Adult (0-64)
Immunizations				
21	Childhood Immunization Status	NCQA HEDIS (CIS)	0038	Pediatric (0-17)
12	Immunizations for Adolescents	NCQA HEDIS (IMA)	1407	Pediatric (0-17)
9	Influenza Immunization	AMA-PCPI	0041	Pediatric and Adult (0-64)
5	Pneumococcal Vaccination Status for Older Adults	NCQA HEDIS	0043	Adult 65+
4	Flu Shots for Adults Ages 18-64	NCQA CAHPS HEDIS (FSA)	0039	Adult 65+

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
Behavioral Health				
19	Follow-Up After Hospitalization for Mental Illness (30-day only)	NCQA HEDIS (FUH)	0576	Pediatric and Adult (0-64)
17	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	AMA-PCPI	0028	All Adults (18+)
14	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Composite	NCQA HEDIS (IET)	0004	Pediatric and Adult (0-64)
14	Follow-Up Care for Children Prescribed ADHD Medication (Continuation/ Maintenance Phase only)	NCQA HEDIS (ADD)	0108	Pediatric (0-17)
13	Antidepressant Medication Management (Continuation Phase only)	NCQA HEDIS (AMM)	0105	All Adults (18+)
12	Screening for Clinical Depression	CMS	0418	All Adults (18+)

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# Programs Using Measure	Measure Name	Steward	NQF#	Age
Cardiovascular Care				
29	Controlling High Blood Pressure[3]	NCQA HEDIS (CBP)	0018	All Adults (18+)
17	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening & LDL-C Control (< 100 mg/dL))[4]	NCQA HEDIS (CMC)	NA	All Adults (18+)
6	Persistence of Beta-Blocker Treatment After a Heart Attack	NCQA HEDIS (PBH)	0071	All Adults (18+)
6	Heart Failure Admission Rate (PQI 8)	AHRQ - PQI #8	0277	All Adults (18+)
6	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 mg/dL[4]	NCQA HEDIS	0075	All Adults (18+)
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	AMA-PCPI	0081	All Adults (18+)
4	Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	NCQA	0013 (no longer endorsed)	All Adults (18+)

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State Innovation Model (SIM)
Common Measure Set Update

SIM Integrated Care Workgroup

Tuesday, April 28, 2015

United Hospital Fund

Quality Measure Alignment Overview

- SIM grant includes development of a common measure set to evaluate health care quality and performance for use in NYS

- Common measure set has several connected goals and potential uses:
  - To reduce data collection burdens on providers and payers and associated administrative cost
  - To benchmark and measure impact of the SHIP, over time and compared to other states
  - To align measures across programs for maximum focus

- Universe of measures for initial common set will come from existing measures – no new measure development in this process

- Beginning focus will be primary care

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Initial Activities

- Review Existing State and National Measure Alignment Activities
- Review initial set of measures identified during early SIM development (e.g., IOM, NCQA)
- Identify state successes in measure alignment activities and contact a sub-set
- Learn from these processes and identify an effective strategy for the NYS context

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First Phase: Aligning Primary Care Measures

- Review initial NYS measure set, including measure framework and methods for aligning measures

- Inventory other primary care measures (e.g., DSRIP) and various national measure activities to include in alignment process (e.g., meaningful use, HEDIS)

- With stakeholders, develop draft, realistic measure sets for primary care providers to review

- Goal is to create a draft menu of primary care measures, using already-existing work as the foundation

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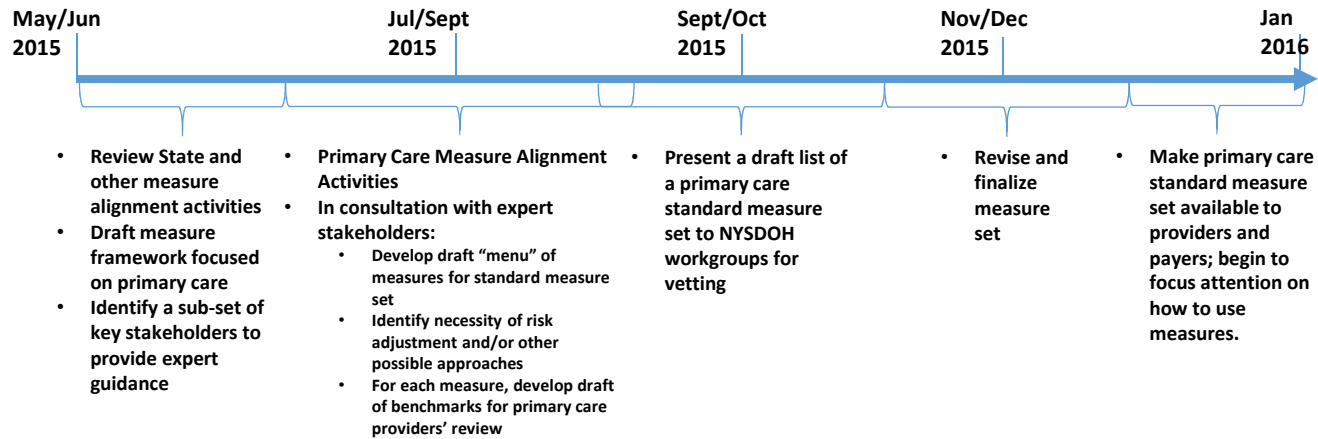
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Develop Review Process for Primary Care Measure Set

- Identify a sub-set of expert stakeholders to provide guidance during measure alignment process

- Ensure activities are aligned with other SIM activities

- Obtain summary recommendations provided by sub-set of stakeholders about measures to focus on

- Develop the draft set of measures to vet through appropriate NYSDOH workgroup

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Timeline

Draft Workplan for May 2015 through January 2016

May/Jun 2015	Jul/Sept 2015	Sept/Oct 2015	Nov/Dec 2015	Jan 2016

- Review State and other measure alignment activities
- Draft measure framework focused on primary care
- Identify a sub-set of key stakeholders to provide expert guidance

- Primary Care Measure Alignment Activities
- In consultation with expert stakeholders:
  - Develop draft "menu" of measures for standard measure set
  - Identify necessity of risk adjustment and/or other possible approaches
  - For each measure, develop draft of benchmarks for primary care providers' review

- Present a draft list of a primary care standard measure set to NYSDOH workgroups for vetting

- Revise and finalize measure set

- Make primary care standard measure set available to providers and payers; begin to focus attention on how to use measures.

Next Steps and Discussion