



Task Force Meeting 3

Monday, February 29, 2016 – 1 p.m. to 4 p.m.
Virtual Conference via Webinar

Welcome, Overview and Introductions

Collective Impact, the contracted facilitation team, provided the welcome, overview and introductions. Since the session was being conducted via a webinar, participants were asked to be patient and courteous during the session. A roll call of participants was taken with the following Task Force members being present:

- Doug Bentz - Roane General Hospital
- Hoyt Burdick, M.D. - Cabell Huntington Hospital
- Sharon Carte - WV Children's Health Insurance Program
- Ted Cheatham - WV Public Employees Insurance Agency
- Sarah Chouinard, M.D. - Community Care of WV
- Christopher Colenda, M.D. - West Virginia United Health System
- Mitch Collins - UniCare
- Terri Giles - West Virginians for Affordable Health Care
- Tara Hulsey, Ph.D. - WVU School of Nursing
- Jeremiah Samples, WV Bureau for Medical Services
- Eric Schmitz - Humana
- Eugenie Taylor - WV Chamber of Commerce
- Kim Tieman - Claude Worthington Benedum Foundation
- Todd White - CoventryCares of WV
- Robert Whitler - CAMC and Partners in Health Network
- Karen Yost - Prestera Center

Additional participants present on the call included:

- Joshua Austin – SIM Project Management Team
- Dave Campbell – SIM Project Management Team
- Todd Crocco, M.D. – WVU School of Medicine
- Tom Gilpin – SIM Project Management Team
- Arnie Hassen, Ph.D. – SIM Project Management Team
- Garrett Moran – SIM Contractor
- Courtney Newhouse – SIM Project Management Team
- Dennis Weaver, M.D. – The Advisory Board

Bruce Decker and Denina Bautti-Cascio with Collective Impact facilitated the meeting.

An overview of the agenda and **expected meeting results** were reviewed as follows:

- Decide if the set of quality measures from the CMS Core Quality Measures Collaborative is a good starting point from which to begin aligning quality measures in West Virginia.
- Discuss how quality measures currently are set by West Virginia providers and payors.
- Determine if it is a good idea to align quality measure across all providers and payors.
- Identify West Virginia's health care value opportunities and the level at which value opportunities should be approached.
- Clarify the purpose for using quality measures in West Virginia.
- Determine if the WVQMC should be convened and, if so, how it should be structured.
- Identify criteria used to vet proposed quality measures.
- Determine how quality measures should be refreshed and updated and the frequency of such.

Denina Bautti-Cascio reviewed the following **virtual meeting ground rules** with participants:

- Log on 10 minutes before the start of the meeting, since some online products require downloads and installation.
- Refrain from discussions related to any pending or prospective procurement of services or goods.
- Do not engage in discussions or agreements that have anti-competitive objectives or results (pricing, territories, etc.).
- State your name when you speak ... every time! Try to speak one at a time so that everyone can pick up the conversation in its entirety.

- Limit your responses to no more than 30 seconds for each response to give others a chance to comment - be concise and don't beat the "dead horse."
- Stay focused and on task (use of parking lot).
- Be aware of background noise. Don't put the conference call on hold. If you leave the call to answer another line or talk to someone in your office, the hold music will play and disrupt our audio meeting.
- Be responsible for your full participation and stay focused during the meeting. Please do not multi-task (emails, calls, other work, restroom, cooking, etc.).
- Be positive and solution oriented – don't be critical, rather "build up" on what is being said to make it better.
- We will be using "roll-call consensus" – simply state thumbs up, thumbs to the side, or thumbs down.
 - ✓ Up: I support this idea
 - ✓ To the side: I can live with it while it may not met all of my needs, but I don't have strong reservations about the decision
 - ✓ Down: I cannot support this decision and have concerns and a solution that the full team must hear from me before we move forward

January Task Force Meeting Review and Update

Joshua Austin, SIM Project Coordinator, provided a PowerPoint presentation highlighting the outcomes of the January Task Force meeting and providing an overview of today's session.

NOTE: meeting notes were taken by Joshua Austin, David Campbell and the Collective Impact team. Every effort has been made to ensure accuracy. If you notice a factual error or misstatement, please contact Joshua Austin at jaustin3@hsc.wvu.edu or via phone at (304) 400-8300 to make a correction.

Discussion Point 1: Does the SIM Task Force see the Collaborative's quality measures as a good starting point or population from which to begin aligning quality measures in West Virginia? Please discuss why or why not.

- The Task Force agreed that the measures are generally good and that we do not need to reinvent the wheel; however, there were some striking gaps in the measures noted by Task Force members:
 - Only one behavioral health measure—related to depression
 - Gaps related to the geriatric population
 - Well-child measures are not included

- Needs to specify the measures to populations (e.g., children, adults, elderly, etc.)
- Using this measures set, West Virginia will need to look at target populations—avoiding measures that only affect a small portion of the population. A committee, task force or subject matter team can/should pick and choose and add other measures, prioritizing measures unique and of concern to West Virginia.
- Many of the measures (at least nine) in the CMS Core Quality Measures Collaborative measures are already tracked under Medicare Stars ratings; these ratings determine the premium for Medicare Advantage plans.
- CMS holds payors/providers to other measures currently. There will need to be flexibility to continue tracking and reporting these in addition to the CMS Core Quality Measures Collaborative measures.
- Many of these measures are already being tracked by payors, especially the Medicaid MCO that are mandated to be NCQA accredited (uses HEDIS measures). The question is how should these core measures be used? Would tracking all of them be worthwhile?

Consensus statement: We should use the CMS Core Quality Measures Collaborative measures as a starting point to begin aligning quality measures in West Virginia.

Clarification: *The Task Force’s vote did not endorse using all of these quality measures; rather, it affirmed that these measures should be used as the discussion starter from which to commence aligning quality measures. That means not all of the measures have to be used, and the measures may be tweaked, added to or taken from.*

Thumbs Up - 14
 Side Thumb - 1
 Thumb Down - 0

One Task Force member voted thumbs up but wants to make sure that the measures are prioritized to address things unique to West Virginia.

Discussion Point 2: How are quality measures currently set by West Virginia providers and payors? Please discuss the benefits and unintended consequences of aligning quality measures.

- One of the greatest challenges West Virginia Medicaid faces is accounting for various subpopulations that it serves within programs and across programs and determining measures for individual populations (e.g., pregnant mothers versus children). West Virginia Medicaid does not want to have too many measures, but there is a broad population it covers.
- Medicaid MCOs are using NCQA HEDIS measures (and national benchmarks as standards); however, by the time data are

available, it is dated. The NCQA HEDIS process is not necessarily ideal given the lag time in assessing measures.

- To be a Medicaid MCO in West Virginia, it must use HEDIS measures to be NCQA accredited. The measures must be measured anyway, but perhaps they are not the best measurement. Medicaid picks from this population to incentivize the MCOs through its quality withhold in the MCO contract.
- Measures are typically set by the payors—not providers. The challenge is if a provider must measure something outside of what is typically required; there are administrative burdens and costs incurred. Behavioral health providers, for examples, should not be measuring items outside their normal work flow.
- ICD-10 may help relieve the burden on providers in measurement tracking, if coding is done properly. Insurers will need to start incentivizing providers to report using appropriate ICD-10 codes.

Discussion Point 3: Does the SIM Task Force believe it is a good idea to align quality measures across all providers and payors, or are there circumstances that would warrant divergence in measures? Please discuss circumstances that would warrant divergence. Also, please propose potential ways to address and/or mitigate those circumstances in any quality alignment process.

- There will be different measures for different populations. Some measures may not apply based on who is served.
- Measures should undergo a cost-benefit analysis—both to the patient and payor. Additionally, less is sometimes more: need to be cognizant of how many measures are chosen to track.
- Measurement alignment is facilitated by an All-Payor Claims Database.
- What are quality standards for super-utilizers? Perhaps quality measures should follow what are applicable to the super-utilizer populations.

Decision Point 1: What are West Virginia’s health care value opportunities? On what levels should these value opportunities be approached: state, national and well / sick care?

- DHHR opinion: need to have some focus on the state’s major population health issues, while not excluding other broad-based population health goals. This is reflected in the Medicaid MCO contract measures: immunization, SHIP priorities, etc. are blended.
- Aligning with super-utilizer efforts: Two views
 - There is benefit to looking at super-utilizers as a subpopulation regarding quality measures, but that is a different task than aligning quality measures.

- The specific health care challenges of West Virginia should be addressed in quality measures. The questions is: should that be folded in with the focus on the super-utilizer population? There should be quality measures that apply population-wide and cross-walk with super-utilizer needs.
- The West Virginia Quality Measures Committee could take a population health approach and payors/providers could provide the committee with the measures that they are already tracking and compare that to the measures in the CMS Core Quality Measures Collaborative—think of it like a Venn diagram.

Consensus statement: The West Virginia Quality Measures Committee should take a population health approach to create a Venn diagram that shows where measures already collected by payors/providers and the CMS Core Quality Measures Collaborative measures overlap.

Thumbs Up - 11
 Side Thumb - 4
 Thumb Down - 0

A few Task Force members qualified their thumbs up vote by saying they wanted to make sure that West Virginia-specific measures are added based on topics that have been talked about under the auspices of SIM, e.g., smoking, diabetes, etc.

One Task Force member noted that his vote was a “weak” thumbs up because he felt the Task Force were losing sight of the super-utilizer focus.

Decision Point 2: What is the purpose of quality measures, and how will they be used? To influence behaviors of patients and providers and collectively? Disincentivize / incentive provider compensation? Allow for public / provider comparison and benchmarking?

- Patient safety and the improvement in quality should be the main goals.
- Provider-level: Use PMPM-type incentives to help drive additional premiums from CMS in shared savings arrangements with PCPs.
- All of the considerations are relevant: the purpose and goal is to influence patient, provider and collective behavior, as well as encourage public reporting of data.
- Consideration C list is okay (e.g., impact institutional performances on length of stay, readmissions, emergency department visits, access to care, etc.) but those areas are hospitalization driven—need to be revised.
- Consideration C (influencing collective behavior) is ideal, yet it requires changing both patient and provider behaviors first. Consideration E (public reporting of data/performance metrics) is worthwhile, but it might have cost and implementation

considerations

- Consideration A (influence patient behavior, e.g., weight loss, smoking cessation, quality of life measures): people hesitate because they think that providers/payors cannot penalize patients, but providers/payors can offer a “carrot” instead of a “stick”. Primarily the physician practice still operates in the mode of “I am the doctor. Do what I say.” Some patients like this. The patient engagement piece seems to be missing, and it is critical. Several Task Force members agreed with the importance of the patient engagement piece).
- Provider Task Force member noted: Most of the quality measures where I plateau are patient engagement/behavior related. Consideration E and C: need E before we can pursue C.

Consensus statement: We need quality measures that influence collective behaviors of patients, providers and payors.

Thumbs Up - 12

Side Thumb - 1

Thumb Down - 0

Decision Point 3: How is multi-stakeholder involvement structured? Who or what entities should participate (e.g., providers, payors, patients / consumer representatives)? How frequently should the WVQMC meet? Does the WVQMC include both public and commercial payors? Who oversees / houses the WVQMC?

- It was suggested that since Medicaid controls 1/3rd of the state’s insured population that it could set the quality measures and then payors and providers would need to comply with them.
- Response by Medicaid: it would be a party to any decision-making group, but it would not cede authority regarding quality measures, etc.
- Perhaps Medicaid quality withhold measures could serve as the starting point for alignment. Still, it would be helpful to have a committee/council to discuss these matters on a regular basis.
- Quality measure alignment is not simply picking the measures; it is about figuring out how to collect the data, etc.
- A Task Force member expressed that quality measure alignment within state government would take too long. Additionally, there needs to be a consumer voice and public vetting of the measures, too.
- Another Task Force member did not want to develop a new bureaucracy (e.g., WVQMC).
- CMS does not include a lot of measures for behavioral health or children’s health.
- One Task Force member’s opinion: Each day providers are working with data and are not always sure if it is impacting patient health and lowering costs. What the measures are does not really matter. Look at what we can pay attention to and measures. Let’s just get started and move and then see where we are.
- Option proposed by DHHR: distributed quality measures to and get feedback from the West Virginia Health Innovation

Collaborative (WVHIC). It is important to address three key goals:

- Want to be able to measure what is selected;
- Need to be measures that payors/providers can impact and
- Should address the three big population health issues as noted in the State Health Improvement Plan (e.g., obesity, tobacco use and behavioral health/substance abuse).
- One Task Force member requested a timeline for this quality measure alignment process. DHHR stated this could start in May/June 2016 and would need to be finished by the end of the November 2016 for the Medicaid MCO contracts.
- The 10 Medicaid MCO quality withhold measures are all process measures. The CMS Core Quality Measures Collaborative measures have some population health measures in addition to process measures. It was suggested that West Virginia stay aligned with CMS, but move towards measuring population health improvements.

Consensus statement: The WVHIC should be used to publically vet quality measures. The WVHIC will use the CMS Core Quality Measures Collaborative measures as the beginning discussion point for quality measurement alignment. The decision-making process will be as wide and as open as possible—allowing anyone to provide feedback on quality measures. This might not be the final resting place for this group if a more appropriate structure/entity is viable.

Start date/timeline for this entity: May/June 2016 (must complete work by the end of November 2016)

Thumbs Up - 4

Side Thumb - 7

Thumb Down – 0

Next Steps and Wrap Up

- Decision points four and five were not discussed during the webinar and have been tabled until the next Task Force meeting or the quality measures committee meeting.
- The next Task Force meeting is scheduled for Wednesday, March 30, 2016, from 8:00 a.m. to 4:00 p.m.

Task Force Meeting Notes Submitted by: Bruce Decker and Denina Bautti-Cascio, March 2, 2016

Task Force Meeting Notes Revised by: Joshua Austin, March 6, 2016