District of Columbia State Innovation Model
Quality Metrics Work Group: Meeting Summary

March 28, 2016
3:00 p.m. – 4:30 p.m.

TOPIC	DISCUSSION
Progress Report	**DaShawn Groves reviewed the work group's progress and unfinished business.** November and December: Discussed current quality reporting activities in the District include Medicaid MCOs, Dept. of Health, FQHCs, Meaningful Use, CareFirst PCMH and Medicare Quality Initiatives. The work group has been able to catalog over 100 quality measures that are in use in the District and identified the ones that are most frequently used in programs. January and February: Discussed recommending to the Advisory Committee the Health Home Measures Core Set and three additional measures (All-cause 30-day Readmission, Potentially Preventable Hospital Admissions and Low Acuity Non-Emergent Emergency Department Visits). The work group considered two additional clinical measures: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence and Hospital-based Inpatient Psychiatric Setting Admission Screening. February and Beyond: Will discuss measures needed to be included or removed in the core sets aligning with other District priorities in order to evaluate and monitor future interventions. They will also discuss the infrastructure needed to promote more coordinated and streamline reporting. DaShawn asked if any additional topics the District and the work group should consider. If so, to please contact him.

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Quality Performance Reporting and Payment Reform Environment	**DaShawn highlighted that payers and the industry are using quality reporting, not only for quality improvement purposes, but also for payment reform.** In 2019, Medicare will: • Change the way that Medicare rewards clinicians for value over volume; • Streamlines multiple quality programs under the new Merit-Based Incentive Payments System (MIPS); and • Provides bonus payments for participation in eligible alternative payment models (APMs) He pointed out that CMS quality measures impact patients beyond the Medicare population. Over 40 percent of the measures used in CMS quality reporting programs include individuals whose healthcare is supported by Medicaid, and over 30 percent include individuals whose healthcare is supported by other payer sources.
Discussion on Steps to Implement	**DaShawn and Chris Botts lead a discussion regarding the steps the District should take in over the next 5 years. Chris provided an overview of the electronic clinical measures and the proposed HIE quality measurement reporting tool.** • Participants discussed the amount of time it takes for providers to report measures. First generation EHRs where designed to mirror paper health records. It is not always a user friendly process. • For providers, charts are meant to be used to talk with other providers, but quality improvement needs to be able to access structured data. This is not a perfect system, but it is the direction payers are going. • Discussed the different models of eCQM and the path the District plans to incorporate eCQM and other quality reporting through a state HIE. o Are the models were mutually exclusive? State could take State Level Registry data and

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	send to HIE to aggregate with other clinical data. o Which state models are working best? Depends on the state priorities and needs. o What is the different between Model 1 utilizing SLR or MMIS as data source for state quality measures and Model 2 utilizing HIE? The biggest difference is Model 1 is largely used for Meaningful Use Attestation. o Has any state implemented these models? It still early stages. It is largely depended the states IAPD process and the ability to build the infrastructure. • Participants discussed that the next IAPD will propose implementing an eCQM reporting tool. This will create the infrastructure to allow providers to submit claims data or CCDA to be analyzed and reported to the appropriate entity. o Is it too late to provide input? Chris explained that is what we are doing now. While the District is about to submit the IAPD, the District can submit updates but needs to ensure that there are local funds. DHCF always wants feedback from stakeholder. o Who would control the tool? Part of the IAPD discussion, there are multiple possibilities. DHCF or OCTO could house it or CRISP could just like they do in Maryland. • Part of the discussion is looking at where we are today in terms of quality data and reporting as well as looking at the government and industry trends. In terms of reporting elements as it relates to payment reform. Does it make sense to align the District with these trends? o It makes sense to move towards the trends instead of being a system that is an outlier. There are gaps of expectations of where providers and payers need to be. We want to make sure that the roadmap is can be implemented. o Actionable data needs to be available to providers, and we need to have population health data to make informed decisions on where to focus resources.

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	○ eCQMs are more of a proxy for quality. It is good for organizations, payers, MCOs, but not provider. We would need to couple it with other tools that empower providers to analyze their structure data.
Next Steps	• **Next Steps:** 1. The next meeting is scheduled for **Monday, April 18th from 3:00PM to 4:30PM**