

Statewide Quality Advisory Committee (SQAC) Meeting

Monday October 31, 2016

1:00pm – 2:15pm

MEETING MINUTES

Chair: Ray Campbell (CHIA)

Committee Attendees: Michael Sherman (Harvard Pilgrim Health Care), Katie Shea Barrett (Health Policy Commission), Jon Hurst (Retailers Association of MA), Carolyn Langer (MassHealth), Jim Feldman (Mass Medical Society), Rick Lopez (Atrius Health), Dana Gelb Safran (BCBSMA)

Committee Members Attending by Phone: Roberta Herman (Group Insurance Commission), Dianne Anderson (Lawrence General Hospital)

Other Attendees: Cristi Carman (Center for Health Information and Analysis), Vivian Haime (Health Policy Commission)

1. Chair Ray Campbell opened the meeting.
2. Chair Campbell introduced himself and Roberta Herman and acknowledged that Amy Whitcomb Slemmer had recently ended her tenure at Health Care For All.
3. Chair Campbell asked for a motion to approve the minutes from the April 11, 2016 meeting. Minutes were unanimously approved.
4. Katie Shea Barrett and Vivian Haime (HPC) presented on the topic of quality measurement alignment in Massachusetts.
 - a. Katie Shea Barrett described the need for alignment of quality measurement and noted that although there are many uses for quality data, the HPC is focusing on facilitating alignment of measures used for Alternative Payment Models (APMs) as a starting point in addressing this issue.
 - b. Katie Shea Barrett highlighted that in the case for advancing a coordinated quality strategy, she particularly wanted to note that “Providers do not receive a unified message on quality measurement from state agencies, diluting each agency’s impact and increasing administrative burden” as a key priority. She noted input from payers and providers about the reporting burden on physicians and the need to simplify reporting.

- c. Vivian Haime noted that there has been minimal improvement in quality measurement alignment among the agencies, health plans and programs surveyed between 2013 and 2016. She highlighted that there are a wide variety of independent approaches and measures being utilized, and they typically vary by payer-to-provider contracts.
 - d. Katie Shea Barrett noted that Medicare, Medicaid, and commercial payers serve very different populations, and these differences are an important part of the alignment conversation.
 - e. Vivian Haime highlighted the provider burden of measures requiring manual chart-abstraction, and the necessity for practices to establish independent internal infrastructures in order to meet reporting requirements in the absence of a unified system for quality data collection and reporting. She noted that there is growing interest in more outcome measures, but also hesitancy because they are so much more burdensome to collect and report.
 - f. Vivian Haime noted differences in benchmarking approaches: some payers reward improvement and others reward absolute performance; some treat all measures equally and others weight performance on some measures more than others. She said these differences, as well as varying reporting mechanisms across measures and payers, further complicate quality data reporting.
 - g. Vivian Haime shared that the HPC looked at states that have centralized, streamlined approaches to quality data collection, naming Maryland, Michigan, and Washington as examples. She said these states may give Massachusetts useful ideas for administrative simplification.
 - i. Katie Shea Barrett added that the HPC hopes to reach out to states who have figured out how to centrally collect data and share it back with payers and providers to learn more.
 - h. Katie Shea Barrett noted that one of the limitations of HEDIS data that providers have brought up is a lag between changes in clinical guidelines and updates to measure specs that limits the usefulness of the data.
5. Carolyn Langer (MassHealth) asked if the decision in the Supreme Court case, *Gobeille v. Liberty Mutual Insurance Co.* has had/will have an impact on quality reporting.
- a. Ray Campbell responded that the impact of the decision depends on what a researcher is trying to do with the data, so just how limiting the decision will make APCD data is hard to specify. He is hopeful that the data will be filled in by federal sources in the coming years, and cited an initiative among state agencies

across the country, including CHIA, for the US Department of Labor to collect APCD claims.

6. Dana Gelb Safran (Blue Cross Blue Shield of Massachusetts) noted that the discussion of measure alignment involves three components: data availability, data use to create quality measures, and using quality measures to create provider incentives and rewards. She expressed concern about conflating these issues while acknowledging that they are interrelated.
 - a. Dana Safran also noted that incentives from payer to provider contracts almost never overlap with clinician incentives on the front lines, and expressed doubt that these models will be able to align, so she encouraged working to answer the question, “How can Massachusetts become a leader in capturing clinical data for quality measurement?”
 - i. Katie Shea Barrett asked whether it would help if larger provider groups agreed to pass on the incentives in their contracts down to the front lines. Dana Safran responded that this would be inappropriate at times, and cited total cost of care as an example where it would not work. She said that for smaller providers, sufficient sample sizes to measure performance towards incentive targets would be a problem at the individual clinician level.
 - b. Dana Safran commented on the need to use core measure sets while still emphasizing the importance of innovation, to encourage payers and providers to create better outcome measures and explore new incentives and models for clinicians. She said this work should not be limited by core measures, targets, and benchmarks that we are not sure are best, in order to achieve alignment.
 - c. Dana Safran noted additional reporting burden of state versus national requirements, and suggested considering alignment across initiatives as well.
 - d. Michael Sherman said that in innovative APMs, discussions about which quality measures to use are generally done in negotiation between payers and providers and are highly individualized to these contracts.
 - i. Richard Lopez said that the incentives from these contracts are then translated differently by each organization to get to the front lines. He said that Atrius has achieved alignment in measures with all payers except Blue Cross Blue Shield of Massachusetts, which has simplified the process of translating incentives down to the front lines. He said that alignment even between government programs would be a step in the right direction.

1. Carolyn Langer said that MassHealth heard similar input from many stakeholders when determining its ACO measure slate. She said that measures were being selected that were not only of interest to the MassHealth population, but that might also be readily translated to populations covered by other payers.
 - e. Katie Shea Barrett said that CMS has asked Massachusetts to attempt alignment, and indicated their willingness to use measures on which the state has aligned.
 - f. James Feldman said that the statutory requirements of the SQMS, defining specific measures for the set to be used in provider tiering, can be limiting in identifying new and innovative measures. He also noted that only some measures have been found to actually improve care. He cited the catheter-associated UTI measure that he believes has changed care practices for the better, but said that other measures may not actually change care.
 - g. Richard Lopez suggested that the state consider taking a lead in developing patient-reported outcomes measures, since individual payers are currently bearing the responsibility and expense for doing this work.
 - h. Katie Shea Barrett acknowledged the need for innovation, and said that the innovation could be coordinated to focus on certain areas, rather than each payer addressing fundamentally different areas at the same time.
 - i. Dana Safran said that there are not many outcome measures to draw from at the moment, and said process measures were by nature not helpful in creating a parsimonious core measures set because they are so specific. She said that in order to create a smaller set, outcomes measures would need to be central, but providers may not like some of these measures, such as the number of pre-diabetic patients that convert to diabetic.
7. Cristi Carman reviewed the staff's recommended updates to the SQMS, including formalizing the use of the HEDIS Specifications for Physicians in the set, rather than the HEDIS specifications for Health Plans. She also discussed routine updates to the mandated HEDIS and CMS sets. Committee members did not disagree with these changes.
 - a. Dana Safran suggested the SQAC consider adding hospital outpatient measures, and named three specifically: OP-3b (Median time to transfer to another facility for acute coronary intervention), OP-4 (Aspirin at arrival), and OP-5 (Median time to ECG). She said hospital outpatient measures are a gap in the SQMS, and that BCBSMA was using these measures in their contracts.

- b. Carolyn Langer asked for input on the use of depression remission measures. Dana Safran said that implementing these measures is difficult because the science of how the potential for change is affected by the baseline is new. She said that they may not be ready for use in incentive programs yet because of this challenge, but encouraged proliferation of outcomes measures including these in order to improve the science.
- 8. Chair Campbell asked for a vote to approve the 2016 SQAC Report. The report was unanimously approved.
- 9. The meeting adjourned at 2:15 p.m.