Statewide Quality Advisory Committee (SQAC) Meeting

Monday, April 14, 2014

11:30am - 1:30pm

MEETING MINUTES

Location:
Center for Health Information and Analysis (CHIA)
2 Boylston Street, 5th Floor
Boston, MA 02116

Chair: Áron Boros (CHIA)

Committee Attendees: Dianne Anderson, James Feldman, Jon Hurst, Iyah Romm (non-voting), Amy Whitcomb Slemmer, Madeleine Biondolillo (non-voting), Dolores Mitchell, Michael Sherman

Committee Members Participating by Phone: Dana Safran

Committee Members Not Present: Ann Lawthers, Richard Lopez, Kim Haddad (non-voting)

Other Attendees: Marit Boiler (HPC), Kristina Philipson (CHIA)

1. Chair Boros opened the meeting and Committee members introduced themselves. Chair Boros reviewed the agenda, and said that the purpose of the meeting was to discuss the use of standard quality measure set (SQMS) measures by health plans for provider tiering. He said that the Division of Insurance (DOI) asked for CHIA's recommendations on the use of the SQMS for tiering, and that CHIA would like the SQAC's input on its recommendations.
2. Chair Boros introduced Marit Boiler from the Health Policy Commission (HPC) to provide an update on the agency's Patient-centered Medical Home (PCMH) certification plans.
3. Marit Boiler said that the public comment period regarding PCMH certification ended on April 4, 2014. She said that the HPC received and is incorporating feedback from many providers, payers, and other stakeholders.
    a. There are 3 tiers of certification, stratified by the level of patient-centeredness. The HPC presented the certification level definitions during the recent public comment period.
    b. In May there is a planned public comment period to address the proposed process and tools by which HPC will measure and validate that an organization has met the certification criteria. She said that the current validation tool requires practices to choose measures for one chronic condition focus area and one preventive care focus area, as well as behavioral health and patient experience measures.
    c. Practices would report on approximately 10 measures and, to the extent possible, those measures would align with the validation tool and certification criteria.
    d. Dolores Mitchell suggested that if practices can choose specific measures, they may select measures that they specialize in or know they can pass, and ignore weak areas.

She also asked how this proposed process aligned with the existing NCQA accreditation process. Dianne Anderson also asked for clarification on this point.

i. Marit Boiler responded that the HPC's validation process is meant to complement the practice's performance on the selected measures. She clarified that the HPC aimed to align its program with existing accreditation processes, and to give more practices an opportunity to become certified and make progress toward NCQA accreditation.

e. Michael Sherman said that Harvard Pilgrim has encouraged practices to become medical homes and supported NCQA accreditation to ensure that practices are, in fact, doing things differently. He said he has heard the suggestion to give more credit for the progress practices have made toward becoming a PCMH.

f. Michael Sherman added that he supported the focus on behavioral health, but suggested the HPC using baseline measures for certain areas where a practice's improvement is expected, rather than allowing practices to choose areas where they are already strong.

g. Amy Whitcomb Slemmer said that the certification process presents an opportunity to help patients and consumers learn where they can receive the most patient-centered care. She added that the HPC has an opportunity to reward with PCMH certification the practices that have truly transformed the way they deliver care.

i. Marit Boiler responded that HPC's goal is to make the certification process and criteria transparent, including to patients.

4. Chair Boros turned the conversation to provider tiering. He reminded the Committee that Chapter 288 of the Acts of 2010 required that merged market carriers offer a selective plan, and that carriers tier based on cost, using CHIA's Total Medical Expenses, and based on quality, using the SQMS. He said the law does not specify how the SQMS is to be used for tiering and that the DOI has asked CHIA for guidance as it considers its regulation related to these products.

a. Chair Boros said that CHIA gathered input from providers and health plans on tiering and the SQMS. He said that health plans are currently using the SQMS for tiering and consider the set appropriate for that purpose. He added that the timing of the final SQMS recommendation was a very important consideration for health plans.

b. Chair Boros referred to the straw model advice to DOI (handout) and asked if it is appropriate to tier providers based on quality measures drawn exclusively from the SQMS. He said that the consensus among health plans was that the SQMS is appropriate for this purpose.

i. Dolores Mitchell said that she does not agree with this consensus; plans should not be limited to SQMS measures and that the GIC uses additional measures that are not included in the SQMS. Some of these are specialist measures, but others are for PCPs. She also asked how CHIA plans to address tiering based on cost and quality, while only discussing quality.

1. Chair Boros responded that the core question for the Committee's discussion at this meeting was quality and whether SQMS measures are an appropriate basis for quality-related tiering decisions.

ii. Dolores Mitchell said that there are gaps in the set, notably mental health, pediatric mental health, and end of life measures. She said that some well-established measures are not included in the SQMS, but also that well-established measures are not available in some areas.
iii. Amy Whitcomb Slemmer said that using the SQMS as the basis for tiering would increase transparency of tiering in Massachusetts. She said that she would support the use of the SQMS to tier specialists eventually as well.
iv. Michael Sherman said that the SQMS is a good set, but it needs to be refined in order to capture value.
v. Dana Safran said that, with regards to the question of whether measures outside the SQMS should be permitted for tiering, the core idea behind the SQMS was to standardize tiering practices. She noted that even with a standard set, providers could be in different tiers for different payers because payers choose different targets for each measure, patient outcomes within each payer vary, and costs between payers vary. She said that she would recommend allowing payers to choose measures beyond the SQMS, but proposed that those measures be required to be nominated to the SQAC and evaluated to ensure they adhere to the same principles (e.g. validity and reliability) as other measures considered for the SQMS.
vi. James Feldman said that the SQMS was appropriate for tiering at the present time. He said that he understood why providers accept the use of the SQMS for tiering, because the measures in the set come from established organizations and have been carefully evaluated and. He said additional measures for tiering should be considered and agreed with Dana Safran that they should go through the same vetting process as other measures considered for the SQMS.
vii. Dianne Anderson said that the SQMS is adequate but not complete. She said the SQAC's role and responsibility is to provide oversight of the measures in the set and to refine the set.
viii. Jon Hurst said that, among small businesses, limited networks have gained some traction because those plans are affordable. He noted, however, that more timely quality information is needed. He said that these limited and tiered networks are driving innovation and competition, and that health insurers should have more tools in their toolbox, or more measures to choose from, to continue to drive competition.
ix. Amy Whitcomb Slemmer said there is a risk that patients experience tiering as a cost-shift, which may enhance disparities between patients who can pay more and those who cannot. She said transparency about how providers are tiered is important because limited and tiered plans can reduce peoples' choices.
    1. Michael Sherman agreed there is a need for transparency. He said that product design is intended to drive patients toward the high-value providers.

2. Dolores Mitchell expressed a concern about regulating tiering methodologies before the state of the art of quality measurement is ready to support tiering. She said that the GIC changes its measures on a yearly basis to improve its methodology. She cited outcome measures as an area in which quality measures are still in development.

x. Jon Hurst said it was important to remember why the SQAC exists: there were double-digit premium increases, small businesses were impacted, and there was demand for more competition in the marketplace. He said that providers in Massachusetts generally provide high quality care, and that the cost problems outweigh the quality problems.

xi. Iyah Romm said that the language of the law states that tiering should be based in part on the SQMS, so the challenge for the Committee is to ensure that the SQMS is a dynamic tool that can be used for this purpose.

xii. Chair Boros summarized the Committee's discussion.

1. He said that there is a sense among Committee members that the SQAC's purpose is to promote standardization and that the legislation reinforces this mission.
2. He said that the Committee emphasized the need for competition and innovation in product design, but also that the SQMS should be modified over time in order to be a meaningful tool.
3. He summarized that the Committee proposes that measures outside the SQMS could potentially be used for tiering but that those measures should adhere to SQAC principles.
4. He noted that the GIC and commercial payers have operational timelines that the measure review process should account for.

c. Chair Boros asked the Committee whether DOI regulations should distinguish between measures to be used for hospital tiering and measures to be used for primary care provider tiering. He said the consensus from stakeholders was that the measures clearly apply to certain provider types.

i. Dolores Mitchell asked Chair Boros if he was referring to individual physicians or physician groups.

1. Chair Boros said that, to date, discussions have referred to physician groups.

ii. Dianne Anderson stated that defining physician groups is also a challenge; this term could refer to a single practice or a group of physicians joined in an independent practice association.

1. Chair Boros proposed that CHIA's distinguish instead between hospital measures and physician measures, and that plans can determine how to apply the measures to physicians. The Committee agreed.

d. Chair Boros said that the SQMS does not currently identify measures that are appropriate for specialists. He said his recommendation was that DOI not regulate specialist tiering at this time.

i. Madeliene Biondolillo said that DOI should work toward this in the future.
ii. Iyah Romm said that some specialties may have more robust measures than others and that the SQAC could pursue those specialties.
    1. Chair Boros said the SQAC staff could consider this as they continue to explore specialist measures.

e. Chair Boros asked whether the DOI should define methodological requirements for the use of quality measures in tiering. He said that CHIA's straw model recommendation is to allow payers to determine the methodology, such as sample size, the number of measures to use, performance thresholds, weighting of measures, and the use of composites.
    i. The Committee agreed with the straw model.
    ii. Iyah Romm said that the SQAC could likely agree on some methodological criteria, such as measures where compliance is high and variability low. He said that tiering based on quality when quality does not vary is effectively tiering based on cost alone.
        1. Dolores Mitchell said that while many organizations retire high compliance measures, this could cause important information to not be available to patients. She cited "never events" as an example of this.
        2. James Feldman said some retired measures could continue to be collected but they could be categorized separately in the SQMS or weighted differently by plans.
        3. Dana Safran said that removing high compliance measures could mean performance erodes because monitoring has stopped. She said that tiering should take many performance measures into account, and if performance on some measures is very high, patients still receive good information. She added that if performance is universally high but price varies between providers, tiering might drive consumers to change providers.
    iii. Dolores Mitchell asked whether the DOI regulation would apply only to fully-insured products. She said that because three-quarters of the market is self-insured, the DOI regulation would only impact a minority of the market.
        1. Dana Safran disagreed; she said that while the regulation may only apply to insured products, developing and maintaining tiered products is complex so a payer is not likely to develop one approach for fully-insured products and another for self-insured products.
    iv. Amy Whitcomb Slemmer said that the DOI should set the standard for the way the SQMS are used.

f. Chair Boros asked whether the DOI should require minimum sample sizes for a measure to be used, when one is recommended by the measure steward.
    i. Dolores Mitchell said that for a small, regional HMO, achieving a minimum sample size might be a challenge unless a larger plan provides this data.

g. A member of the public from the Massachusetts Coalition of Nurse Practitioners asked whether the measures apply only to physicians or if there are measures that can apply to nurse practitioners and physician assistants. She said that plans have not been using quality measures for nurse practitioners.
    i. Chair Boros said CHIA could explore and consider this further.
h. Chair Boros asked whether CHIA should publish standard measure specifications for SQMS measures. SQAC members said yes.
i. Chair Boros said that CHIA will in the future publish all-payer performance results for certain measures based on APCD data. He asked whether DOI should require that plans use CHIA's all-payer performance results, or whether plans should be allowed to calculate performance using other data sources.
    i. Dana Safran said that plans should be able to use their own data if they have adequate sample size.
    ii. Amy Whitcomb Slemmer said that plans should use standard, CHIA-published results. She said transparency is a concern when plans use internal data. She asked why internal calculations would differ from the all-payer calculation.
        1. Dana Safran said that using internal data is a truer reflection of the patient's experience with the plan. She said that all-payer data is better if there are small sample sizes, but internal calculations are a more accurate proxy for the individual patient or member's experience.
        2. Iyah Romm said that if there is significant variation between the all-payer finding and a plan's internal findings, the SQAC should be made aware.

5. Chair Boros asked for a motion to approve the minutes from the February 10, 2014 meeting.
    a. The Committee approved the February 10 meeting minutes unanimously.
6. Kristina Philipson discussed CHIA's review of a set of pediatric behavioral health measures. She said that CHIA collaborated with the Child Health Quality Coalition (CHQC) to learn more about the 2014 Core Pediatric Set for Medicaid and CHIP and the Pediatric Clinical Quality Measure Set.
    a. The CHQC's advised that the primary gaps in pediatric quality measurement are in outcomes and care coordination.
    b. She said that CHQC suggested several principles for considering pediatric quality measurement: explore measures in domains of care (e.g. screening, medication use and management, and post-hospitalization follow-up); consider the whole child rather than limiting measures to specific provider types; be sensitive to provider burden by ensuring that measures are not duplicative; leverage the data available in the APCD.
    c. Kristina Philipson said that AHRQ has proposed for HEDIS five new measures related to antipsychotic drug use among the pediatric population. NCQA has held a public comment period; if measures are approved for HEDIS, they will automatically become part of the SQMS as required by law.
    d. Kristina Philipson asked whether SQAC staff should proceed with a review of measures for the geriatric population or consider something other than population analyses of the

SQMS. The Committee said that SQAC staff should proceed with the review of geriatric measures.

7. The meeting was adjourned at 1:00 PM.

Meeting Materials:

- Meeting agenda
- Presentation
- CHIA Straw Model Advice to DOI
- Pediatric behavioral health measures in the SQMS
- Committee meeting minutes from February 10, 2014

Next Meeting:

Monday, June 16
3:00-5:00 p.m.
2 Boylston Street, 5th Floor
Boston, MA 02116