Statewide Quality Advisory Committee (SQAC) Meeting

October 31, 2016

Agenda

- Welcome and Introductions 1:00 – 1:10
- Discuss Measure Alignment 1:10 – 1:40
- Review Final Report 1:40 – 2:10
- Wrap Up/Next Steps 2:10 – 3:00

MASSACHUSETTS
HEALTH POLICY COMMISSION

QUALITY MEASUREMENT LANDSCAPE IN THE COMMONWEALTH

Presentation at SQAC Meeting
10/31/2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Advancing quality within Massachusetts' healthcare system
- Current state of alignment in Massachusetts:
  - Quality measures
  - Benchmarking methods
  - Data reporting methods

The case for advancing a coordinated quality strategy

- Quality measurement is fragmented across public and private programs with few similar measures used to assess healthcare performance across all programs.
- Providers do not receive a unified message on quality measurement from state agencies, diluting each agency's impact and increasing administrative burden.
- Policymakers in the Commonwealth currently rely on a set of mostly process measures (through the Statewide Quality Measure Set) to assess the quality of non-hospital based healthcare in the Commonwealth.
- There is a growing interest in using outcome measures to more meaningfully evaluate quality. At present, outcome measures are burdensome to report for providers and payers alike in the absence of a centralized method for data collection and abstraction.
- More payers and health care organizations are entering into Alternative Payment Models (APMs), which tie financial rewards to performance on quality measures.
- The State as convener, monitor of system performance, and the largest payer and purchaser of healthcare services plays a unique role in leading efforts to develop a coordinated quality strategy in the Commonwealth.

Vision: A coordinated quality strategy that focuses the improvement of healthcare quality for all residents of the Commonwealth and reduces the administrative burden on provider and payer organizations.

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Providers and payers are calling for alignment of quality measures and data reporting

Providers and payers have consistently called for statewide alignment on quality measures to simplify reporting and to focus quality-improvement efforts.

PARTNERS HEALTHCARE

"[T]rying to focus on too many measures **dilutes the ability to focus on each measure**"

Atrius Health

"The lack of alignment means that…staff…must further **divide their attention** and…attempt to identify which measures and activities should be priorities… [t]his is particularly stressful for clinicians, contributing to **physician burnout** and the potential for…a **decline in the overall quality of care and time spent with patients**."

RELIANT MEDICAL GROUP

"[L]ack of alignment we believe only **adds to the cost** of providing high value care **without any clear clinical benefit.**"

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UnitedHealthcare

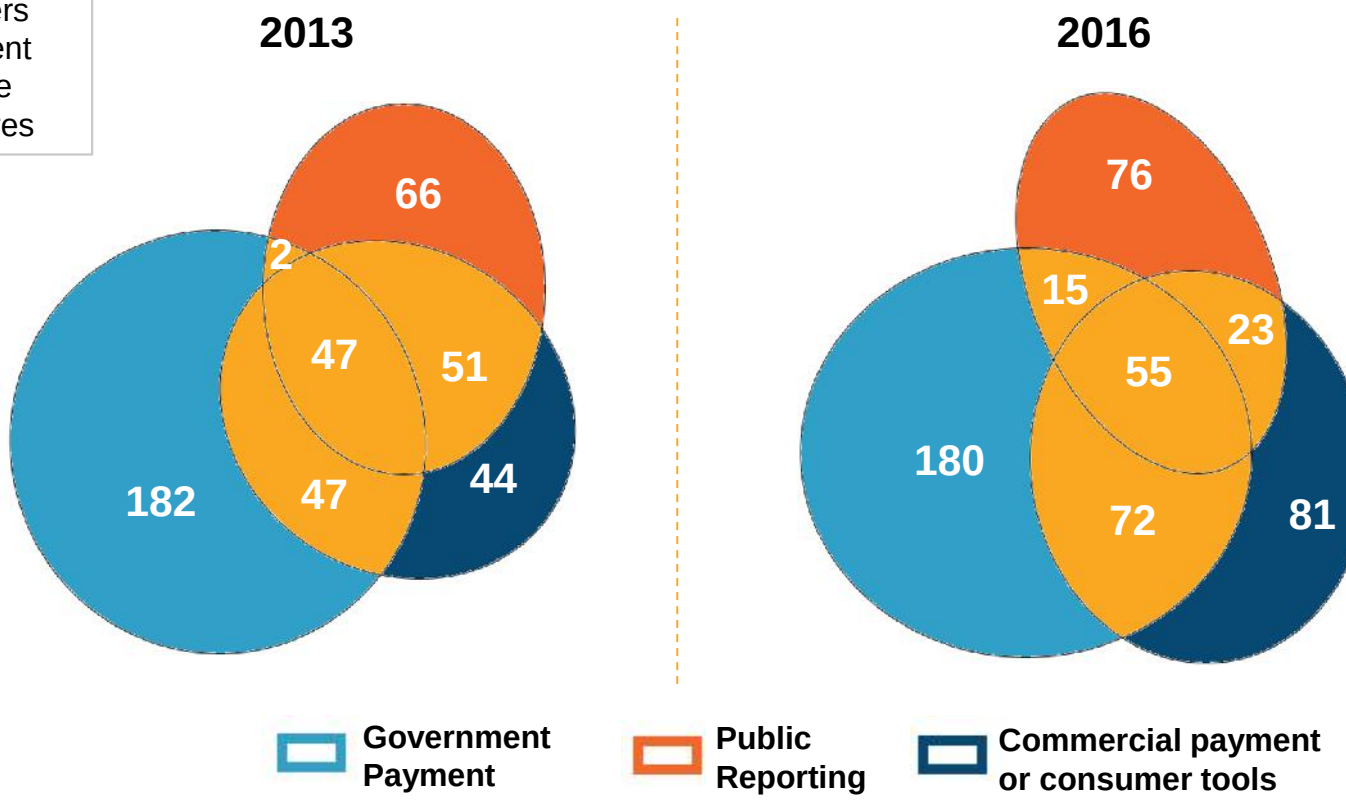
"Measures that require information, other than what can be gathered from a claim submission, can be **both time consuming and costly.** This is especially the case when measures require a chart audit, as it can be **a major inconvenience to the providers**."

CELTICARE Health Plan of Massachusetts

"[R]equirements are **currently being driven by multiple payers** in different ways and **without coordination**…There is a role for government to play in developing common standards to align APMs to **ease the burden on providers** and **increase the likelihood of success** in achieving improved cost and quality outcomes."

Currently quality measurement programs among Massachusetts plans and public reporting programs are not aligned

Numbers represent unique measures



- Over 500 quality measures are currently used in Massachusetts
- Few quality measures are collected by multiple programs
- Minimal improvements in quality measure alignment noted since 2013

Source: 2016 Massachusetts Quality Measure Catalog as developed and analyzed by Analysis (CHIA).

Quality measures are used to help guide payment in global budget alternative payment models (APMs)

Medicare ACO

- 32 core measures in Shared Savings, Pioneer and Next Gen ACO Programs
- % of shared savings based on performance on quality measures

MassHealth ACO

- 38 proposed measures
- % of shared savings will be based on performance on quality

BCBS

- Alternative Quality Contract
- 64 core measures (32 hospital/32 outpatient)
- % of shared savings awarded based on performance on quality

Tufts Health Plan

- Coordinated Care Model and Provider Engagement Model
- Uses 5 high-priority measures per provider contract on average

Harvard Pilgrim Health Care

- Quality Advance Contract; Rewards for Excellence
- Performance incentives for achieving quality metrics

Quality measure sets typically vary by payer-to-provider contract.

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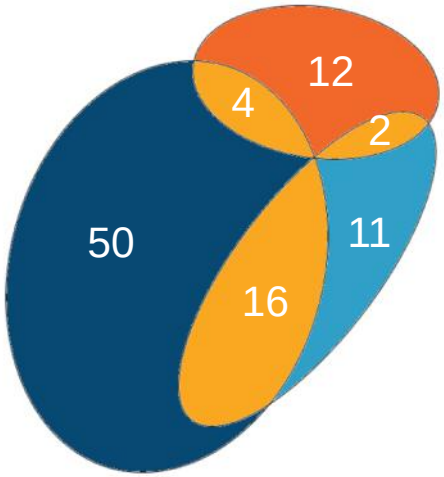
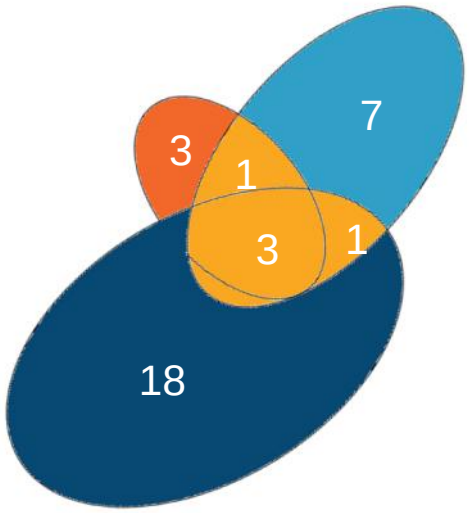
Specifically, there are many different quality measures in use by Massachusetts payers in APMs

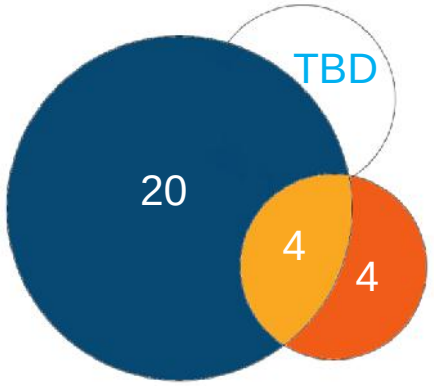
Process



Outcome



Patient Experience



Numbers represent unique measures

Any Commercial | Medicaid | Medicare

Note: Includes all Claims and Clinical Quality Measures (CQMs) currently in use by population-based payment models in Massachusetts as collected by CHIA as of February 2016. Excludes measures only used for reporting pediatric quality. Commercial represents: Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care.

Current state of outcome measurement in APMs in Massachusetts

Providers manually report 14 clinical outcome measures, which cannot be obtained from administrative data (e.g., claims, hospital discharge data)

Medicare ACO	
Medicaid ACO	
Blue Cross Blue Shield	
Harvard Pilgrim Health Care	
Tufts Health Plan	

2 measures are collected by every payer
3 measures are collected by ≥1 payer
All other measures collected by only 1 payer

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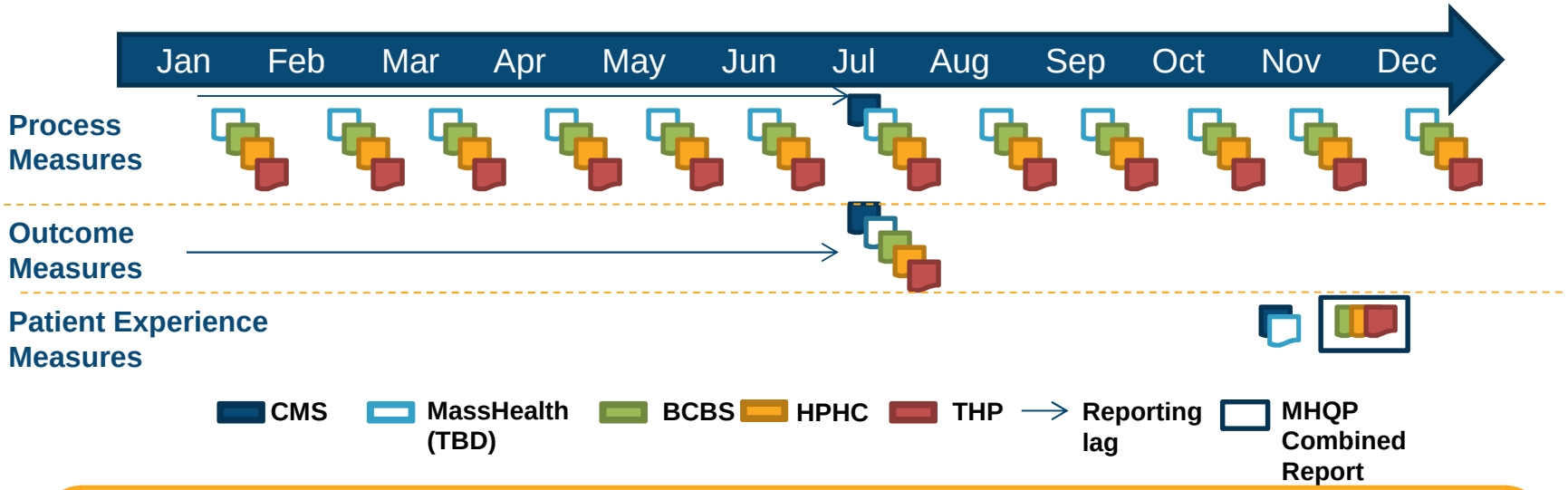
Providers in turn receive an array of reports from payers on their performance

- Provider organizations receive a number of reports from payers to inform them about their performance on contractual quality measures.
- These reports are not practical for quality improvement for providers as they are payer-specific and vary by time intervals (e.g., monthly or annual), measure sets, and measure specifications between contractual agreements.



In the absence of a unified report on quality measures, provider organizations must devote their resources to measure cost and quality in a way that is meaningful and actionable for quality improvement.

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Benchmarking approaches also vary among payers

Medicare ACO

- Rewards both improvement and absolute performance
- Based on Medicare FFS data
- 30th percentile represents the minimum attainment level and 90th percentile corresponds to the maximum attainment level

MassHealth ACO

- Will reward both improvement and absolute performance
- Pay for reporting for initial years to create benchmark; payment will be tied to performance on some of the quality measures starting in 2019

BCBS

- Use absolute rather than relative performance, with 5 possible levels of performance ("gates").
- The lowest level (Gate 1) is set at about the network median, and the highest level (Gate 5) is what evidence suggests could be achieved by an optimally performing physician group/hospital.
- Outcome measures are triple weighted in the aggregated quality score, on which the annual payment is based.

Tufts Health Plan

- Use a combination of benchmarks, including 90th percentile (national), THP average (peer comparison), and the provider organization's performance in that measure the previous year.
- Payment is based on meeting the benchmark for a certain percent of measures.

Harvard Pilgrim Health Care

- For process/outcome measures, use a national benchmark (eligible for payment at 75th percentile; full payment if >95th percentile)
- For patient experience measures, use HPHC percentile performance calculation (eligible to share in savings at 50th percentile; full payment if >75th percentile)

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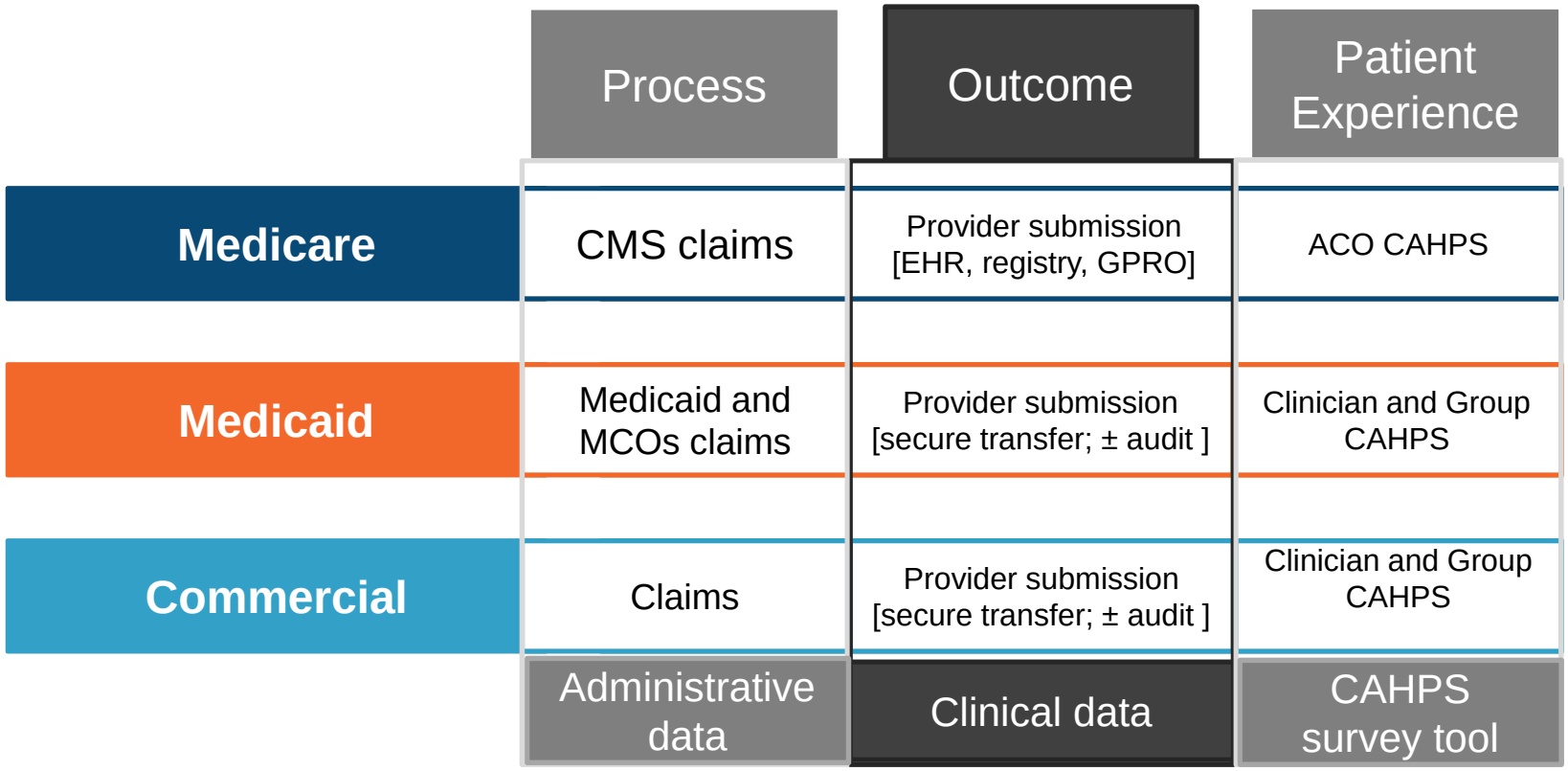
Current quality measure reporting mechanisms



There is an opportunity to achieve administrative simplification by centralizing provider reporting of clinical outcomes measures across payers in Massachusetts

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Current process by which providers submit clinical data to payers

- Payers collect outcomes data for two purposes and at two annual time points:
  - HEDIS reporting (~February/March)
  - Contractual settlement for risk-bearing providers (~June)
- At present, there is no easy way to collect outcomes data from provider organizations, so payers have developed various mechanisms which vary by:
  - **Patient population**: e.g., all of the patients attributed to the organization, a sample of patients attributed to the organization, a sample of patients that receive care at the organizations but for which the organization does not bear risk (for HEDIS only)
  - **Format:** e.g., web-based portal (i.e., GPRO), excel document, EMR feed
  - **Measure specifications:** e.g., time window, numerator/denominator.
  - **Frequency and timeline for reporting:** e.g., ongoing, quarterly, or annually.

Alignment: warranted and unwarranted differences

There are different reasons for why quality measure sets differ among health plans and programs:

Warranted Differences

- Differences in member population may require the use of certain measures to evaluate health services provided to particular demographic groups (e.g., age and life stage, case mix, low SES)
- More mature payer-provider partnerships may have capabilities to innovate and test new measures

Unwarranted Differences

- It is not always clear which measure is “the best”
- Plans may prefer to use certain measures over others
- Measures may use different inclusion and exclusion criteria
- Adjusting for differences in patient illness (risk-adjustment) may be different in different measures

Goal: To align quality measures as much as possible when appropriate

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Questions for the SQAC

- What are your initial reactions to the information presented?
- How best can the state facilitate quality measure alignment?

Review and Discuss

SQAC 2016 Final Report

Updates to 2017 SQMS

- Recommend formally referencing the HEDIS Physician Measurement set as the HEDIS sub-set of the SQMS
- This recommendation removes 11 measures from the SQMS as they are currently only in the HEDIS Health Plan set:
  1. Annual dental visit
  2. Aspirin use and discussion
  3. CAHPS health plan survey v3.0 children with chronic conditions supplement
  4. Counseling on physical activity in older adults
  5. Fall risk management
  6. Flu shots for adults ages 18-64
  7. Flu shots for adults ages 65 and older
  8. Medical assistance with smoking and tobacco use cessation
  9. Osteoporosis testing in older women
  10. Pneumococcal vaccination status for older adults
  11. Urinary incontinence management in older adults

Updates to 2017 SQMS

Changes to HEDIS set

- Added five new measures:
  1. Follow-up after emergency department visit for mental illness
  2. Follow-up after emergency department visit for alcohol or other drug dependence
  3. Depression remission or response for adolescents and adults
  4. Statin therapy for patients with cardiovascular conditions
  5. Statin therapy for patients with diabetes

- Removed two measures:
  1. Use of appropriate medications for people with asthma
  2. Human papillomavirus vaccine for female adolescents

Updates to 2017 SQMS

Changes to CMS process measures

- Eight measures retired
  1. Evaluation of Left Ventricle Systolic (LVS) function (HF-2)
  2. Surgery patients on beta-blocker therapy prior to arrival who received beta-blocker during the perioperative period (SCIP-Card-2)
  3. Prophylactic antibiotics discontinued within 24 hours after surgery end time (SCIP-Inf-3a)
  4. Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2)
  5. Cardiac surgery patients who controlled postoperative blood glucose (SCIP-Inf-4)
  6. Home management plan of care document given to patient/caregiver (CAC-3)
  7. Detailed discharge instructions (HF-1)
  8. Patients discharged on multiple antipsychotic medications (HBIPS-4)

Updates to 2017 SQMS

Changes to CMS process measures (continued)

- One measure added
  1. Patients discharged on multiple antipsychotic medications with appropriate justification (HBIPS-5)

For more information

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