

## Statewide Quality Advisory Committee (SQAC) Meeting

Monday April 11, 2016

3:00pm – 4:15pm

MEETING MINUTES

**Chair:** Áron Boros (CHIA)

**Committee Attendees:** Michael Sherman (Harvard Pilgrim Health Care), Katie Shea Barrett (Health Policy Commission), Jon Hurst (Retailers Association of MA), Carolyn Langer (MassHealth), Wei Ying (BCBSMA), Ray Campbell (Group Insurance Commission)

**Committee Members Attending by Phone:** Jim Feldman (Mass Medical Society), Rick Lopez (Atrius Health), Dianne Anderson (Lawrence General Hospital)

**Other Attendees:** Beth Waldman and Deepti Kanneganti (Bailit Health Purchasing, LLC.)

1. Chair Áron Boros opened the meeting.
2. Chair Boros introduced new committee members, including Carolyn Langer and Ray Campbell, and individuals sitting in for committee members, including Alyssa Vangeli (Health Care For All) and Wei Ying (BCBSMA).
3. Chair Boros asked for a motion to approve the minutes from the September 21, 2015 and October 19, 2015 meetings. Minutes were unanimously approved.
4. Chair Boros reviewed the final report on the SQAC's 2015 quality priority setting process. He noted that this was a highly interactive engagement process. He also noted that measures to evaluate ACOs and coordination on measures across plans and programs are important topics nationally and locally.
5. Aparna Higgins (AHIP) presented on the Core Quality Measures Collaborative. Dr. Michael Sherman and Wei Ying also participated in the Collaborative.
  - a. Aparna Higgins described the need for having core quality measures. She noted that health plan measures in private and public programs varied considerably, even when measuring the same condition. She commented on the challenges that physicians face because of this. As a result, the Collaborative focused on “measures that matter” to consumers, purchasers, and providers.
  - b. Aparna Higgins highlighted the three aims of the Core Measure Collaborative and noted Patrick Conway's simultaneous goal of streamlining reporting for federal programs. The Collaborative's process began with CMS and payers and was

refined as more stakeholders (e.g., provider organizations, consumers, and employers) were engaged.

- c. Aparna Higgins noted that the Collaborative utilized guiding principles to focus their work: that measure sets be aligned, measures be endorsed, sets had a comprehensive view of quality, and that measures be manageable in number, outcome-oriented, and consider patient experience and costs.
- d. Aparna Higgins shared that the Collaborative selected areas on which to focus knowing that there was room for quality improvement and enough variation amongst practices that needed to be addressed. The Collaborative formed workgroups for each area of focus, created a draft core set over the course of 18 months (based on measures in use by plans and CMS, endorsed by NQF, etc.), and then reviewed measures with the full Collaborative for additional vetting and to come to a consensus.
- e. Aparna Higgins noted that the core set of measures were announced on February 16, 2016 and anticipated that measures would be modified over time. She also noted that the measures were likely to be phased in over time depending on contracts between plans and providers and the availability of clinical data for select measures.
- f. Michael Sherman highlighted four takeaways from the Collaborative:
  - i. Providers were integrated with the workgroups, effectively “endorsing” measures by provider organizations. He noted how this makes it hard for providers to argue that the measure sets are not fair.
  - ii. Alignment with multiple stakeholders, especially CMS, is notable.
  - iii. Additive specialty measure sets replace broad measure sets and do not conflict with other measures.
  - iv. Measures will be implemented in a multi-year process and should be leveraged as a first choice.
- g. Chair Boros asked about implementation details, specifying the denominator statement and patient attribution to plans.
  - i. Aparna Higgins noted that plans are looking to implement the measures into their contracts as they come up for renewal and can be modified. She noted the potential difficulties around infrastructure and the ability to collect data (e.g., registry-based data). She also noted that the goal of the

Collaborative was not to stifle innovation and that testing of new measures (e.g., patient-reported outcomes) will still be allowed.

- ii. Aparna Higgins noted that implementation details were identified during the process. She shared that the Collaborative highlighted these details as other areas that needed to be addressed because they were outside the scope of what the Collaborative was trying to do.
- h. Katie Shea Barrett asked about CMS' timeline for implementation.
  - i. Aparna Higgins suggested asking Kate Goodrich at CMS for more details and noted the need for public comment.
  - i. Wei Ying noted that there was much overlap with measures that were already implemented and those in the Collaborative's measure sets, making them "applicable and doable." She noted that there are some measures that are clinical and outcome driven, but are already encountering issues (e.g., do not have data available at this time, have topped out, and have small denominators). She noted that BCBSMA view the measure set as a tool, but not as a requirement.
    - i. Chair Boros asked about the maintenance of the measure set.
      - 1. Michael Sherman noted that it was a large effort to put together the measure set and that health plans know that this is a continuous process. He added that the timeline for review is unclear.
      - 2. Aparna Higgins agreed and noted that individuals are currently asking about next steps. She shared that there will be a process going forward to update the measure set. She also noted that there were many discussions about data availability, but the Collaborative felt that the measures were too important to exclude and that data pieces could be accrued over time.
- 6. Katie Shea Barrett presented on Performance Metrics for the ACO Certification Program.
  - a. Katie Shea Barrett noted that the Health Policy Commission (HPC) wants to "piggyback" on national alignment efforts to create alignment when measuring quality and certifying ACOs/PCMHs. She noted that it can be difficult to align measures when CMS and MassHealth may be requiring different measures. She also noted CMS and CMMI's interested in alignment.
  - b. Katie Shea Barrett noted that the goals of the ACO Certification Program were to create a roadmap for what ACOs are and its structure components, balance standards with room for innovation, establish a common framework to collect

data, and to align closely with payers. She shared that MassHealth is going to require certification for ACOs through the HPC.

- c. Katie Shea Barrett noted that the ACO Certification Program will build baseline knowledge and that certification is required every two years by statute.
- d. Katie Shea Barrett shared that there are three types of measures including certification standards, performance on quality measures, and performance on medical expenses.
  - i. Ray Campbell asked if standards are binary and if there were consequences for not meeting a measure.
    - 1. Katie Shea Barrett said that the program is voluntary, so there are no consequences other than not being certified. She shared that the measures are binary.
- e. Katie Shea Barrett shared that the proposed design is a minimum set of criteria. She noted that the number of measures was reduced after speaking with providers. She also noted that there will be some assessment of the program in year 1.
  - i. Dianne Anderson noted that many were awaiting the next set of details from Medicaid as part of ACO reform and asked if these details would be applied in the ACO Certification Program.
    - 1. Katie Shea Barrett noted that the ACO Certification Program will be a gate for those participating in MassHealth payment reform.
    - 2. Carolyn Langer added that MassHealth will have additional contractual requirements.
  - ii. Carolyn Langer asked about HPC's views on EHR and inter-operability across the continuum.
    - 1. Katie Shea Barrett shared that she expected assessment-based criteria in the next phase and noted that very few ACOs would meet inter-operability today if there was strict criteria.
- f. Katie Shea Barrett shared MassHealth's draft quality measures.
  - i. Carolyn Langer noted that the measures were revised, but 90% were concordant with the list in Katie's presentation. Differences were mainly a result of adding LTSS and BH measures to MassHealth's draft list.

- ii. Katie Shea Barrett noted the overlap between the Core Measure Set and MassHealth's measures. She also noted that BCBSMA has a complimentary set of hospital measures for ACOs.
- g. Katie Shea Barrett shared the HPC-proposed Measure Set, for discussion only, and noted implementation will likely occur in 2018. She noted that HPC began with CMS' primary care set, but highlighted the need for additional hospital and pediatric measures.
  - i. Wei Ying noted that the ADHD measure for children listed in the presentation as used by BCBSMA is used by them, but it is not a HEDIS measure. She also noted that the measure was only used for children because of a small denominator issue. She also shared that BCBSMA does not have an immunization measure.
  - ii. Katie Shea Barrett asked if MassHealth has thought about pediatric measures.
    - 1. Carolyn Langer noted that the small denominator issue has come up with the LTSS population, but not for pediatric populations.
- h. Katie Shea Barrett asked for reactions to the HPC-proposed Measure Set.
  - i. Ray Campbell asked about the sensitivity around the state collecting clinical information.
    - 1. Chair Boros noted that CHIA has respect for the privacy and security of data. He shared that the state does collect clinically-relevant data today via hospital discharges. He noted that CHIA's principal is to collect data as part of a multi-agency coordinated effort with appropriate stakeholder engagement.
  - ii. Michael Sherman noted that Harvard Pilgrim Health Care does not focus as much on pediatric measures.
  - iii. Carolyn Langer applauded HPC's emphasis on pediatric measures because they are important but not necessarily the drivers of high-cost utilization. She shared that they were important measures at MassHealth.
  - iv. Chair Boros noted that if BCBSMA is having small denominator issues with pediatric measures, that MassHealth would likely have issues as well. He also noted the potential for CHIA to help look at pediatrics as a whole.
  - v. Michael Sherman noted that the AHIP-led effort was focused on plans and providers, not on implementation and regulation within states.

1. Katie Shea Barrett noted the use of a hospital case mix as a solution to small sample sizes for hospital measures. She asked if this would also be applicable for ambulatory measures.
    - a. Michael Sherman noted the significant value of common measures and shared that there is less credibility when health plans give different scores to different providers.
    - b. Wei Ying noted that the hospital side is different because having CMS as the constant driver allows for use of all payer data. She noted that this would be difficult on the ambulatory side.
  - vi. Wei Ying noted that asthma is addressed within MassHealth's measures and that BCBSMA is also looking at adopting this measure.
  - vii. Chair Boros asked if CMS has embraced the CMS-AHIP measure set for their programs.
    1. Michael Sherman shared that CMS helped to create the measure set, but did not specify an implementation plan.
    2. Katie Shea Barrett noted that CMS and CMMI were looking at regulations as part of the MACRA discussion. She noted that there would be 10% at risk for providers that are not participating in alternative payment models.
  - viii. Carolyn Langer asked why the low back pain measure was selected over other utilization members. She noted the MassHealth believed this measure was too narrow.
    1. Michael Sherman noted that it was hard to create the distinction between "bad" and worthwhile measures.
    2. Wei Ying shared that BCBSMA sees large variation in this measure and believes that there is some inappropriate use there.
  - i. Katie Shea Barrett noted that having data to evaluate ACOs will be a long process, beginning with a patient experience survey procurement in 2016 and survey fielding in 2017, followed by an aligned measure set for recertification in 2018.
7. Chair Áron Boros closed the meeting and noted that the SQAC's next meeting will be June 20, 2016.