OHS Quality Council Meeting

October 1, 2020

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

- Welcome and Introductions - 5 minutes
- Public Comment - 10 minutes
- Approval of July 22, 2020 Meeting Minutes - 5 minutes
- Quality Scorecard Discussion - 30 minutes
- Draft Charter and Draft Bylaws - 20 minutes
- Cost Growth Benchmark Technical Team Report - 10 minutes
- Next steps - 10 minutes
- Adjourn - 1 minute

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Quality Council members

Elizabeth Courtney, Consumer Representative

Nikolas Karloutsos, Consumer Representative

Alan Coker, Consumer Representative

Marlene St. Juste, Consumer Representative

Andrew Selinger, Quinnipiac

Steve Wolfson, Cardiology Associates of New Haven, PC

Joe Quaranta, Community Medical Group

Mark DeFranceso, Westwood Women's Health

Amy Gagliardi, Community Health Center of Connecticut, Inc.

Robert Nardino, American College of Physicians, CT Chapter

NettieRose Cooley / Stephanie DeAbreu, United Healthcare

Laura Quigley, ConnectiCare

Michael Jefferson, Anthem

Christine Tibbits / Carolyn Trantalis, Cigna

Syed Hussain, Trinity Health New England

Steven Choi, Yale New Haven Health

Rohit Bhalla, Stamford Health

Paul Kidwell, Connecticut Hospital Association

Tiffany Donelson, Connecticut Health Foundation

Lisa Freeman, Connecticut Center for Patient Safety

Sandra Czunas, Office of the State Comptroller

Kate McEvoy, Department of Social Services

Orlando Velazco, Department of Public Health

Karin Haberlin, Department of Mental Health and Addiction Services

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Public Comment

Approval of July 22, 2020 Meeting Minutes

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Quality Scorecard Discussion
Rob Aseltine

Agenda: Online Healthcare Scorecard

- Status Update
- Medicare Measures: LARC
- Medicare Attribution Decision Point
- Next Steps

Status Update

Status Update (1 of 2)

- First set of Medicare measures are published (2016)
  - Breast cancer screening
  - Cervical cancer screening
  - Follow-up after hospitalization 7 and 30 days
- Second set of Medicare measures (2016, 2017) in final validation.
  - After validation, blinded results will be shared with the Quality council
  - Entities get two week review of their results prior to publication

Status Update (2 of 2)

- Next scorecard iterations - one year each of:
  - Commercial (2018)
  - Medicare (year TBD by data)
  - Medicaid (year TBD by data)
- Will require new data extract and updated provider lists

Medicare Measures: LARC

Medicare Measures: LARC (1 of 2)

- Contraceptive Care – Access to LARC:
  - Percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (Steward: HHS Department of Population Affairs)
- Issues with this measure have arisen:
  - Requires complete data on pregnancies that end during the measurement year (live birth, still birth, miscarriage, abortion).
    - Identifying abortion requires state Medicaid data for duals

Medicare Measures: LARC (2 of 2)

- Steward does not recommended use for healthcare quality measurement in a way that might encourage abuse (rates of 1-2% considered adequate).
  - Current CT Medicare rate is around 60% (validation not complete)

✓ Decision point: retain or drop measure for Medicare scorecard?

- UConn Health team recommends dropping the measure for Medicare

✓ Discussion and Quality Council recommendation?

Medicare Attribution: Decision Point

Medicare Attribution Decision Point (1 of 6)

- Current attribution method includes Medicare beneficiaries with Medicare claims
- This method incudes most beneficiaries but excludes:
  - Beneficiaries who did have any healthcare claims
    - These members are unattributed so have no impact on entity scores
  - Beneficiaries who only had commercial claims
    - These members will be attributed (to an Advanced Network, FQHC or
      “other healthcare provider”) and may impact entity scores

Medicare Attribution Decision Point (2 of 6)

- Alternative method uses all beneficiaries in the eligibility file, whether not they had any Medicare claims

✓ Decision Point: On future iterations should Medicare beneficiaries who have only commercial claims be included in the Medicare scorecard?

➢ Impact: Individuals using only commercial insurance, but who are covered by Medicare, will be “counted” (or not) in entity’s score for Medicare patients?

Medicare Attribution Decision Point (3 of 6)

- Medicare attribution has been run both ways for 2017 to examine impact on attribution results
  - On Providers: Using all eligible beneficiaries adds 22 providers with attributed patients to rated entities to the original total of 2,793

Medicare Attribution Decision Point (4 of 6)

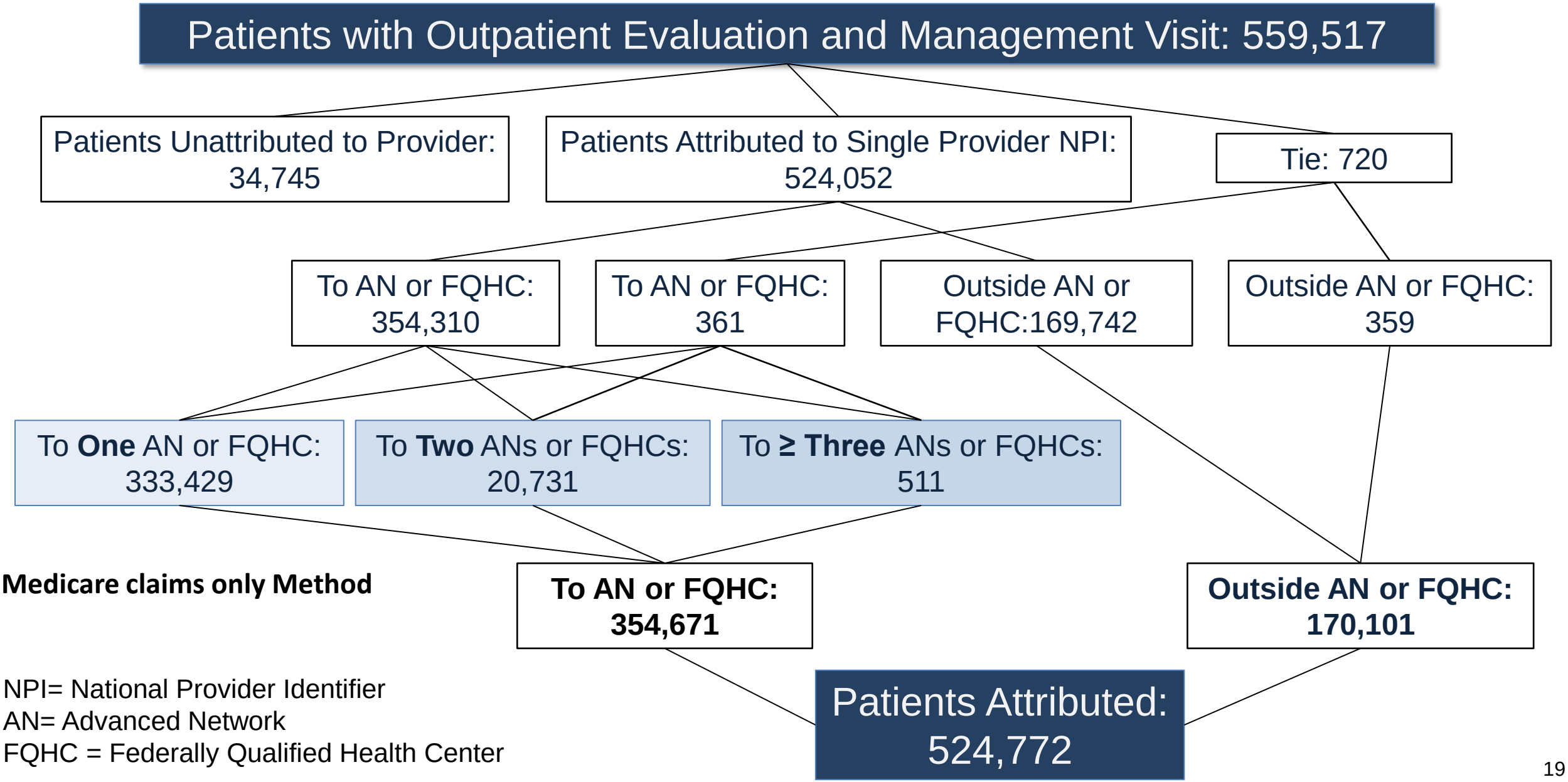
- On patients:

Patient Attribution	Using Medicare Claims only	Using all beneficiaries Medicare eligibility file	Additional individuals on scorecard
Attributed - to rated entity	354,671	367,823	13,152*
Attributed - to other providers	170,101	175,974	5,873*
Unattributed	34,745	36,040	1,295
Total	**559,517**	**579,837**	**20,320**

*Individuals with only commercial claims

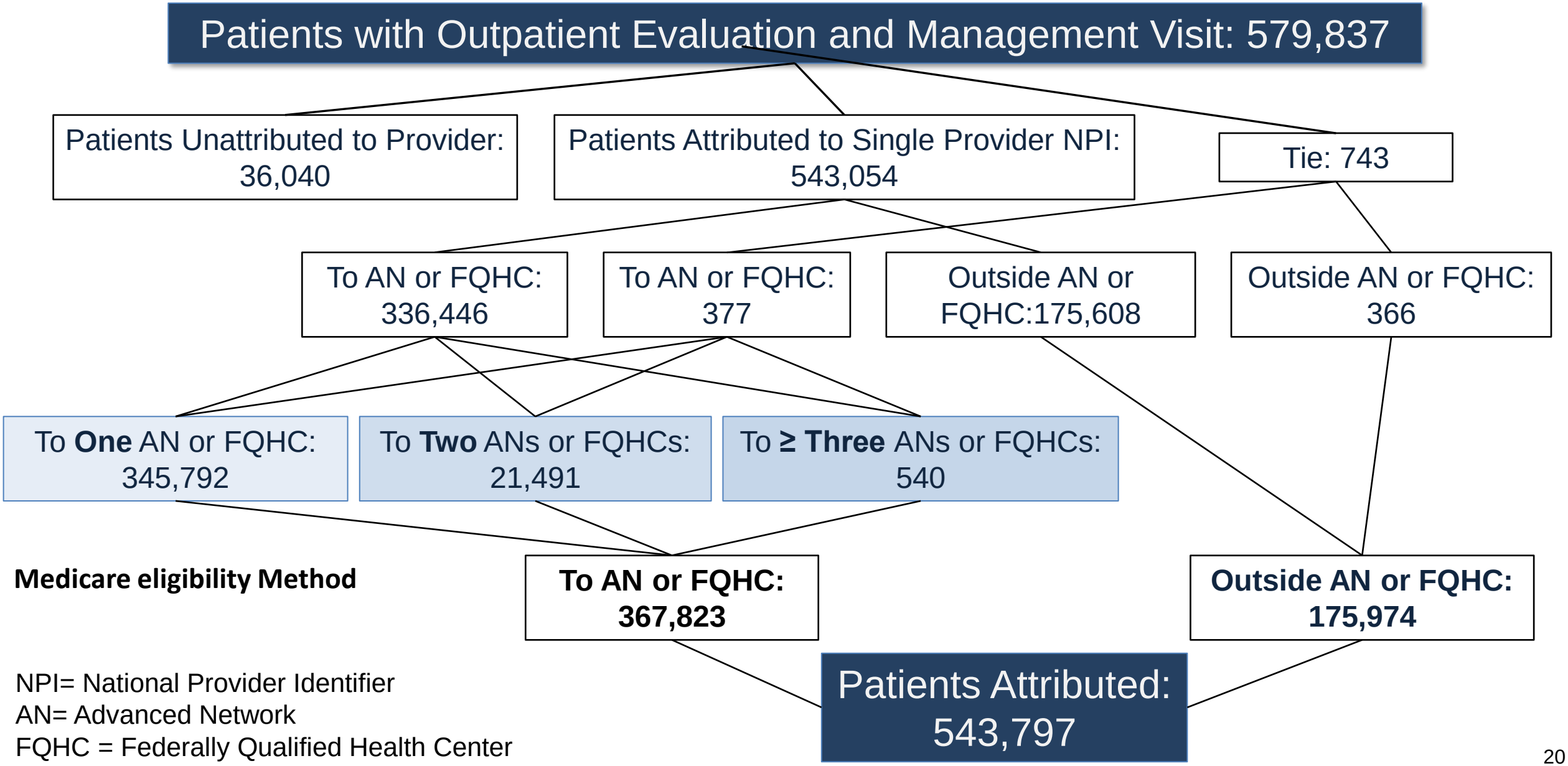
**Individuals with no claims or ineligible (non- E&M) commercial claims

Medicare Attribution Decision Point (5 of 6)



NPI= National Provider Identifier
AN= Advanced Network
FQHC = Federally Qualified Health Center

Medicare Attribution Decision Point (6 of 6)



NPI= National Provider Identifier
AN= Advanced Network
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Medicare Attribution

- ✓ Discussion and Quality Council recommendation?

Next Steps

Next Steps

- Entity engagement followed by publication of second set of Medicare results
- Update provider lists for 2018 and 2019
- Receive new data extract with updated data

Draft Charter

Objectives of Quality Council

The Quality Council will work to meet the following objectives: Development of

- Annual quality benchmarks effective CY22, and analysis of the impact of cost growth benchmarks and primary care targets on quality and equity and vice versa.
- A core measurement set for use in the assessment of primary care, specialty, and hospital provider performance.
- A common provider scorecard format for use by payers and providers.

Achieving the Objectives

A. Convene monthly meetings between October and June

B. Assist OHS, in the development of quality benchmarks across all public and private payers beginning in calendar year 2022

C. Reassess the core clinical quality measurement set to identify gaps, to incorporate new national measures as they become available, and to keep pace with changes in technology and clinical practice

D. Ensure the development of clinical quality measures and quality benchmarks that can be stratified by race and ethnicity and advise OHS of capabilities or supports needed to ensure such measures and benchmarks are developed and implemented

Achieving the Objectives

E. Identify unintended consequences of the quality benchmarks and relay potential solutions to unintended consequences to OHS

F. Identify existing health inequities that could be exacerbated by the quality benchmarks and relay potential solutions to OHS

G. Identify and formulate a plan for engaging key stakeholder groups to provide input to various aspects of the Council's work

H. Convene ad hoc design teams to resolve technical issues that arise in its work.

Draft Bylaws

Cost Growth Benchmark Technical Team Report

Next Steps

Adjourn