STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
August 30, 2017

Meeting Location: Webinar

Members Present: Stacy Beck; Elizabeth Courtney; Mehul Dalal; Amy Gagliardi; Daniela Giordano; Karin Haberlin; Arlene Murphy; Leigh Anne Neal; Steve Wolfson; Janette Yetter; Robert Zavoski

Members Absent: Rohit Bhalla; Amy Chepaitis; Mark DeFrancesco; Tiffany Donelson; Steve Frayne; Kathy Lavorgna; Steve Levine; Robert Nardino; Jaquel Patterson; Tiffany Pierce; Andrew Selinger; Thomas Woodruff

Other Participants: Robert Aseltine; Sarah Auer; Andrea Barbo; Susannah Bernheim; SB Chatterjee; Faina Dookh; Karen Dorsey; Liz George; Jackie Grady; JoAnn Ettienne-Modeste; Ifeoma Nwankwo; Mark Schaefer; Victoria Veltri

Call to Order
The webinar was called to order at 12:00 p.m. Mehul Dalal chaired the webinar. Members introduced themselves.

Public Comment
There was no public comment.

CT Disparities Presentation
Ms. Dookh, of the CT State Innovational Model Program Management Office (SIM PMO), introduced the purpose of the meeting as introducing the Quality Council to the Health Equity Project. The work aligns with the Quality Council's recommendation to use health equity measures in the core quality measure set. The SIM has been working with the CT Health Foundation which awarded a grant to the Yale Center for Outcomes Research and Evaluation (CORE) for this project. Today the CORE team is seeking the Quality Council's feedback on which measures should be prioritized to develop a methodology for quantifying disparities in care. Ms. Dookh explained that the end goal of the project is to incorporate health equity quality measures into incentive programs, like the CT value-based payment scorecards, to drive improvement. The work so far on this project has involved the CT Department of Health and Human Services (DSS), the SIM PMO, CORE and the Community Health Network of Connecticut (CHNCT).

Dr. Bernheim, of CORE, introduced the CORE team and reiterated that the purpose of the meeting is to provide the Quality Council with an update on the project and to receive their input on selecting from currently used quality measures to adapt for measuring racial and ethnicity disparities in CT. Dr. Bernheim explained the timeline of the project and that the CORE team has been working with CHN and DSS to identify the data needed to do an initial assessment of the measures and to propose a methodology for quantifying disparities. While waiting for data, CORE has started the first steps of measure selection and will finalize measure selection after looking at the CT Medicaid data. Dr.

Bernheim noted that although PCMH+ is included in the slide deck, it is too early to determine whether the measures will go incorporated into any specific program.

Dr. Bernheim also spoke about the key challenges of the project, which include the fact that 2015 Medicaid race and ethnicity data that will be used initial analyses for this project are not reliable at this time, due a process in which any race or ethnicity that was not recorded was defaulted to Caucasian. There is a new protocol implemented in 2016 that records non-responses as missing values rather than a default race so the accuracy of the race and ethnicity data will improve overtime. Dr. Bernheim noted that there are always issues of missing values when collecting race and ethnicity data, especially when it's not a required field. CORE recommends that the methodology be re-tested with updated data. Dr. Bernheim explained that the CORE team has a plan to assess the quality of the data when it is received and emphasized the value of starting work with the 2015 Medicaid data. The team may still be able to confirm which measures have the largest disparities among Medicaid patients in this data and propose a preliminary methodology. Dr. Bernheim explained that perfect data is not required for developing a measure, as long as it scientifically valid and the medical community confirms its validity.

Dr. Bernheim then highlighted the second key challenge. In any work in which there is subdivision of a provider's population, it is important to consider how patients are divided among providers and whether there will be adequate sample sizes for measurement. There may be some providers where disparities cannot be adequately assessed.

In response, Dr. Wolfson emphasized the necessity of getting the data to a good enough state and recommended following a timeline to accomplish this. Ms. Murphy agreed with Dr. Wolfson that it is important to think about the progress that needs to be made in terms of race and ethnicity data. Ms. Murphy noted that further progress will be made but it's important to start where possible.

Dr. Schaefer, of the SIM, suggested leaving time at the end of the call to discuss other work being done at the SIM and with the Quality Council related to the work that CORE is doing. This decision was agreed upon.

Dr. Bernheim explained that not every measure is ideal for measuring disparities and that when choosing measures, CORE is taking into account whether there is evidence of disparity, clinical considerations, Quality Council input, and measure methodology considerations. The hope is that the work done on this project can be used more broadly, beyond Medicaid, in the future. Dr. Bernheim explained that for our initial work, the CORE team prioritized among the measures currently in use in the PCMH+ program for which CHN could provide data for this project. Prioritization was based on the results of a literature review of national studies and input from clinicians.

Dr. Bernheim outlined how the CORE team first classified the measures into four groups based on the results of the literature. The four measures with the most evidence of a racial or ethnic disparity in the literature were two Comprehensive Diabetes Care measure, Eye Exam and Hemoglobin A1C Testing, HPV Vaccine for Female Adolescents, and Medication Management for People with Asthma. There was less evidence, but some indication of racial or ethnic disparities for six measures: Breast Cancer Screening. Cervical Cancer Screening, Medical Attention for Nephropathy. Follow-Up Care for Children Prescribed ADHD Medication, Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life, and Prenatal and Postpartum Care. Measures for which there was evidence of racial or ethnic minority groups having better rates than the white majority group and measures for which there

was no evidence of disparities were both de-prioritized for the purposes of selecting a limited initial set of measures for this project. Dr. Bernheim noted that this may still be important to look into in the future.

Ms. Dookh underscored that the Quality Council met with a Health Equity Design group with the data they have about the core set to determine priority measures. One of those measures that was deemed high priority was Medication Management for People with Asthma. Many of the others were not in the PCMH+ measure set and therefore aren't included in CORE's priority list. Dr. Dalal mentioned that the Hemoglobin A1c measure was listed as a priority measure by the Health Equity Design group as well and that the A1C testing measure is standing in for that measure in the current measure set.

Dr. Bernheim asked the Quality Council's feedback on the nine measures the CORE team has chosen preliminarily and whether any of the measures should be added or excluded from this list. Ms. Murphy asked why the readmission measure was not on the list and Dr. Bernheim explained that the team decided to first focus on process measures as opposed to outcomes measures because of the structure of the outcomes measures and the complexity of risk adjustment. Producing measure results stratified by different patient groups is more feasible in a process measure. Dr. Bernheim offered to share how the CORE team looking at disparities in outcome measures as part of the Medicare component of CORE's work at a later date. Dr. Dalal commented that he didn't see colorectal cancer screening on the list. Dr. Bernheim and Ms. Dookh confirmed that it was not on the currently list of PCMH+ measures because it requires electronic health record data. Dr. Bernheim confirmed that the team will look at data for every measure data is provided for but the primary focus will be on the prioritized measures.

Dr. Bernheim outlined the methodology development steps and explained that the data is likely to systematically underrepresent minority groups as opposed to over represent. The CORE team anticipates proposing a metric that will examine within provider disparity and the rates of a given measure for the minority subgroups compared to the white group of patients. Dr. Bernheim added that the team will need to finalize how granular the team can get in terms of patient groups as the literature indicates that measures display differently across various minority groups. An alternative approach is to compare the performance among providers for the subgroup of beneficiaries with worse rates. Dr. Bernheim noted that the team will consider this approach as well. She also acknowledged that measures that assess improvement in disparities rather than just the degree of disparity is a later piece of work in this project.

Dr. Wolfson enquired about collecting data on whether some services may produce larger disparities depending on substantial changes to the Affordable Care Act that may make some services more expensive and potentially less accessible. Dr. Schaefer highlighted that this is important for high commercial populations but it is highly unlikely that there will be high cost sharing on Medicaid in CT in the future. But if that happened, there is no question that it would affect access. Dr. Zavoski stated that federal rules prevent the implementation of cost-sharing in Medicaid. It becomes a tax on providers as opposed to members, though many members don't understand that it's not imposable on them and therefore don't seek care. Dr. Wolfson also said that it would be useful to know the process for race/ethnicity data and timeline to getting to good data quality.

Ms. Murphy asked for an update on the project during Quality Council meetings in the future as she believes it would be helpful for the Council to see its progression. Dr. Bernheim confirmed that the team will provide regular updates to the Quality Council via Ms. Dookh.

Next Steps and Adjournment

Dr. Schaefer provided updates for future Quality Council work. Meetings are going to resume in the fall. The Council wants to reevaluate the core measures to make sure that endorsement stands and the measures are up to date. Additionally, the Council is considering substance abuse and long acting contraception measures. The Quality Council is hoping to more formally develop the reporting set in January. They are also going to start Scorecard work (extended grant through end of January). This work will begin in September.

The meeting was adjourned at 1:00 p.m.