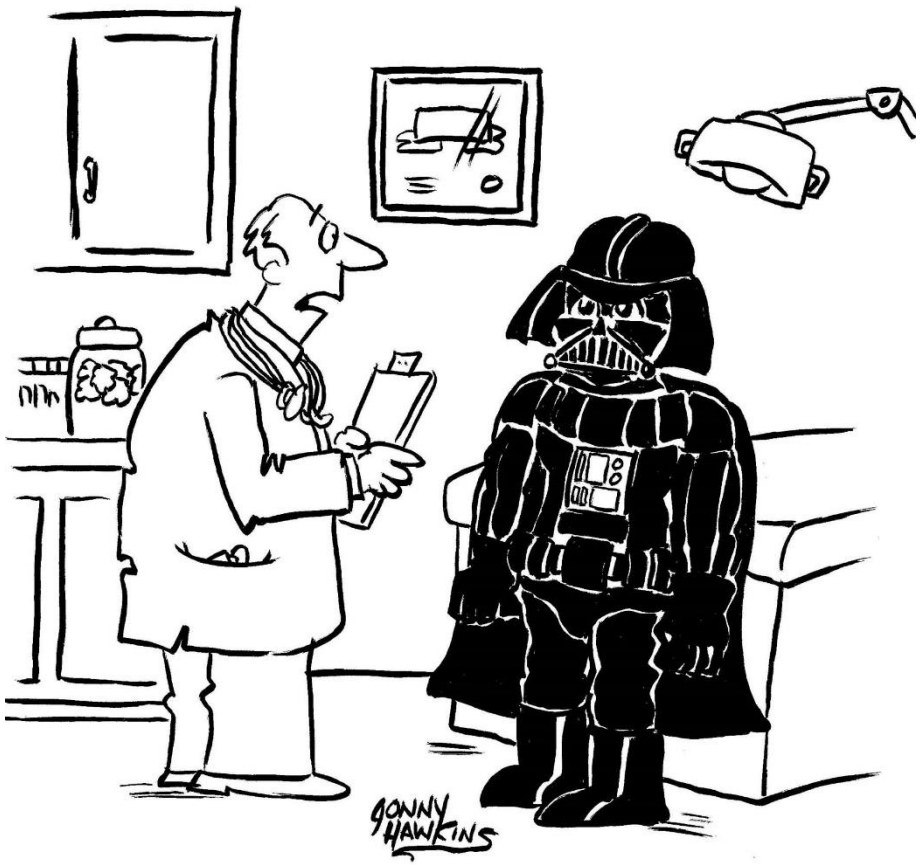
OHS CONNECTICUT Office of Health Strategy

SIM Quality Council

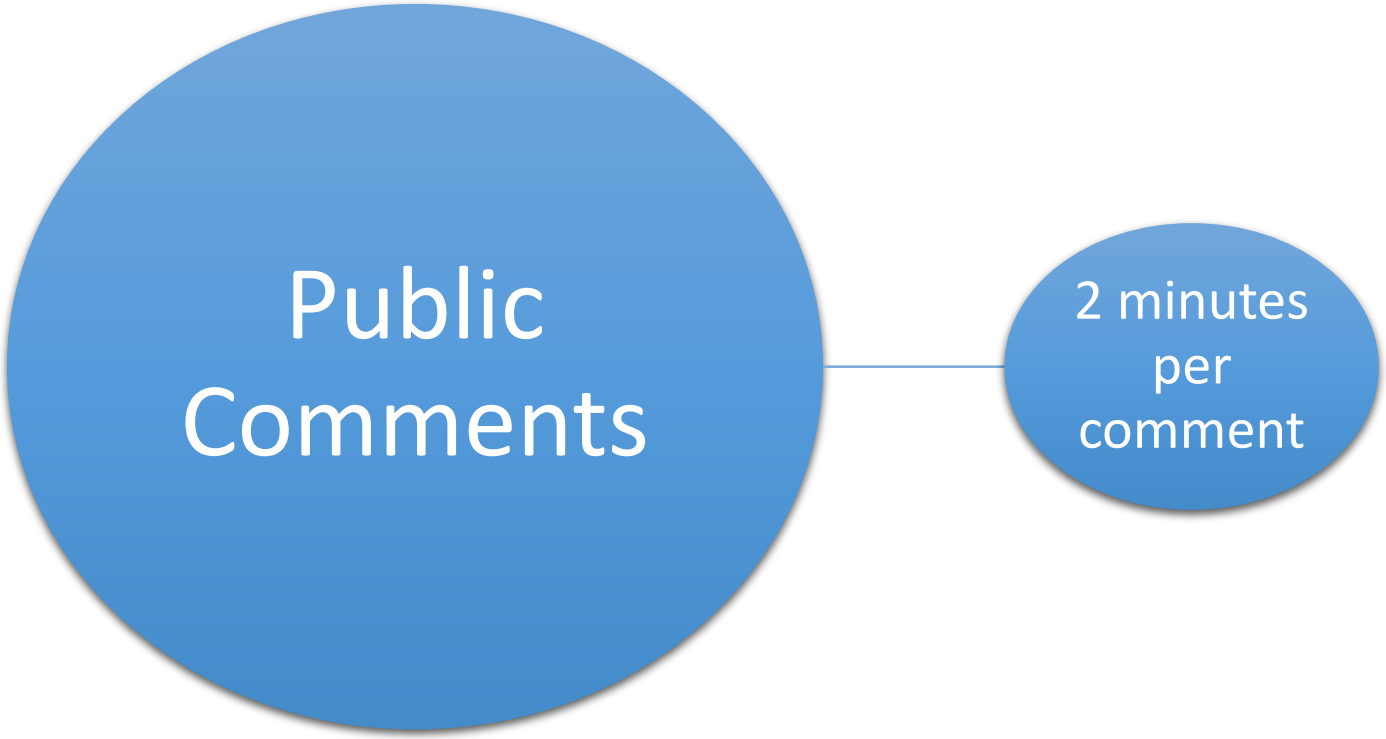
April 11, 2018



**“I’m worried about your breathing.
How much exercise are you getting?”**

Meeting Agenda

Item	Allotted Time
Introductions/Call to Order	5 min
Public Comment	5 min
Approval of Minutes	5 min
Purpose of Today's Meeting	5 min
Recap of 3/14/18 Meeting	5 min
Health Equity Measure Project	40 min
Public Scorecard Update	60 min
Next steps and Adjournment	5 min


Public Comments
2 minutes per comment

Approval of the Minutes

Purpose of Today's Meeting

Recap from 3/14/18 Meeting

Recap and Follow Up from 3/14/18 Meeting

- **Quality Measure Alignment:**
  - Reviewed the progress made towards our All Payer Quality Measure Alignment goal of 75%. We are currently at 60% with 4 payers reporting for 2017.
- **Public Scorecard:**
  - Addressed issues of Measure Feasibility and Attribution
  - Established a workgroup to review the user interface

Health Equity Measure Project

Meeting Agenda

Item	Allotted Time
1. Introductions/Public Comment	5 min
2. Purpose of the Meeting	5 min
3. Background on Health Equity Measures Project	5 min
4. Measure Development Status	10 min
5. Quality Council Discussion	10 min
6. Next Steps	5 min

Purpose of the meeting

- To provide a brief update on the Health Equity Measures Project
- To describe our process of selecting the most appropriate methodology for a disparity measure
- To solicit feedback from the Quality Council about final measure selection and methodologic decisions

Measurement and Transparency Drive Improvement

Measurement and Transparency Drive Improvement

- The Quality Council recommended the use of health equity quality measures as part of their core quality measure set recommendation.
- No quality measure scorecard or incentive models incorporate improving health disparities as a potential performance target.
- The Quality Council recommendation around health equity quality measures could not be implemented because no methodology existed.
- Connecticut State Innovation Model (SIM) Program Management Office (PMO) enlisted the Yale Center for Outcomes Research and Evaluation (CORE), with the help of a Connecticut Health Foundation grant, to progress this effort.

We are working to ensure health equity is incorporated into healthcare value based payment model incentive systems

Health Equity Quality Measures Project

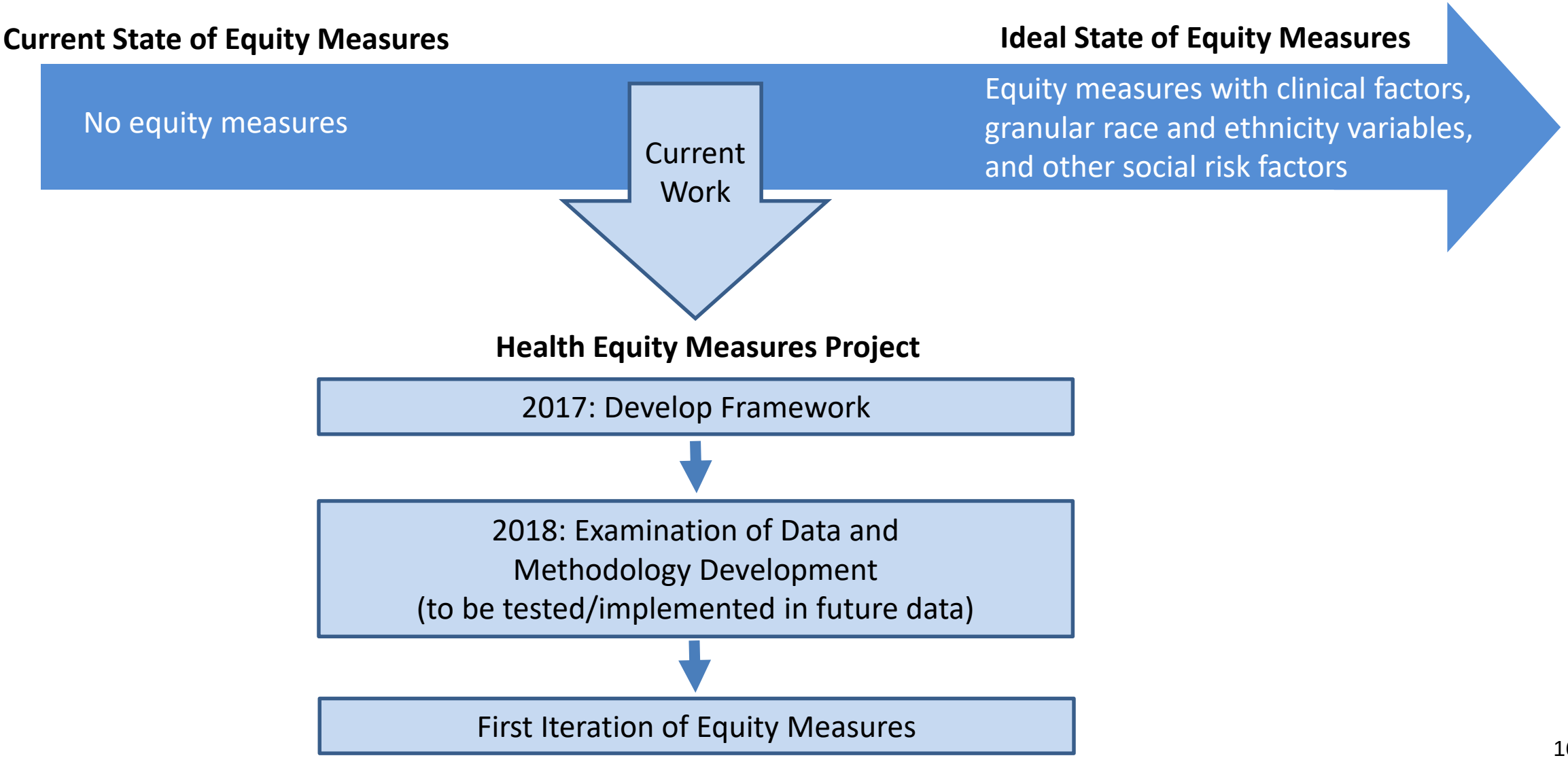
- Connecticut State Innovation Model (SIM) Program Management Office (PMO)
- Yale Center for Outcomes Research and Evaluation (CORE)
- Department of Social Services, Medicaid (DSS)
- SIM Quality Council

Goal: Use data to propose a disparity measure methodology that can be incorporated into alternative payment models, in order to promote racial and ethnic health equity in healthcare delivery and outcomes

Project Background and Aims

- There are persistent disparities in health outcomes and quality of care.
- There are few quality measurement initiatives to directly illuminate disparities in healthcare and incentivize improvement in equity.
- Project Aims:
  - Select first set of measures for assessing disparities
  - Develop a methodology for measure calculation
  - Consider how a measure of disparities could be incorporated into programs to assess and reward providers' efforts to reduce these disparities
- The initial methodology will focus on disparities among patients based on race and/or ethnicity, and may look at other indicators (for example, zip code).

Project Background and Aims



Quality Council Input

Today's Presentation:

- Preliminary evaluation of the data
- Evaluating criteria for measure selection
- Developing equity measure methodology

Questions for the Quality Council:

- Do you have any additional considerations to add to our criteria for measure selection?
- Do you have recommendations for thresholds in selecting measures?
- Do you have suggestions for alternate ways of grouping or reporting race and ethnicity categories?

Current Work

1. **Preliminary evaluation of the data***
    - Reviewing the number of measures, patients, and provider groups included in the data
    - Checking face validity of the race and ethnicity data to determine if suitable for preliminary measure development
2. **Evaluating criteria for measure selection**
    - For each measure:
        - Understanding constraints based on sample size by racial and ethnic categories and provider group
        - Reviewing the existence and significance of current disparities in measure rates for CT Medicaid patients
3. **Developing equity measure methodology**

**2015 Connecticut Medicaid data from CT DSS, with known race and ethnicity variable validity issues (see slide 12)*

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Preliminary Evaluation of the Data

Measure development dataset

- 2015 Connecticut Medicaid data from CT DSS
- Patient-level claims for 30 measures currently used in the Person-Centered Medical Home Plus (PCMH+) program*
  - Patient-level variables included: birth date, gender, race, ethnicity, primary care provider, zip code
  - For each measure, the data included: patients in the numerator and denominator of the measure, the provider group (Tax Identification Number [TIN]) for each patient

Known issues with race and ethnicity data

- Reliability of Medicaid race and ethnicity data was affected in the process of implementing the integrated eligibility process with Access Health.
- Depending on the degree of the problem, true disparities in outcomes may exist, but may not be captured in equity measurement in the current data. Because a default of white was used when race or ethnicity were not provided, the data is potentially biased toward seeing no disparity.

**Five measures were not included because analyses are still in progress: Emergency Department Visits, Postpartum Care, Prenatal Care, Follow-Up Within 7 Days of an Inpatient Discharge, Readmissions Within 30 Days*

Evaluation of the Data - Race and Ethnicity Variable Validity

Question

- To understand face validity of race and ethnicity variables in our data, we compared the distribution of the race and ethnicity variables in data we received to the distribution for Medicaid patients in Connecticut.
  - *Future equity measurement work will include additional race and ethnicities in more granular categories and examining additional social risk factors.*

Methods

- We grouped the racial and ethnic categories into White, Black, Hispanic and Other to be consistent with other reported rates and with hopes of having a sufficient number of patients in each category for measurement.
  - *We excluded patients with unknown race, zip code, or provider group.*
- We looked at the proportion of patients for each race and ethnicity variable in the denominator for each measure.
- We compared measure populations to data in the 2013 Medicaid Statistical Information System (MSIS) Data, reported by the Kaiser Family Foundation.

Evaluation of the Data - Race and Ethnicity Variable Validity

Results

- The race and ethnicity variables in our data appear to be broadly comparable to those in the CT Medicaid population overall.

Example measures (2015 CT Medicaid measure development data)

Annual Fluoride Treatments *(smallest proportion white patients)*				**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis** *(largest proportion white patients)*			
White	Black	Hispanic	Other	White	Black	Hispanic	Other
40%	16%	38%	6%	64%	13%	19%	4%

CT Medicaid Overall (Source: Kaiser Family Foundation)

Medicaid Statistical Information System (MSIS) Data, 2013				**Census Bureau's Current Population Survey**, 2015			
White	Black	Hispanic	Other	White	Black	Hispanic	Other
49%	20%	29%	3%	48%	12%	37%	N/A

Conclusions

- Because of the nature of the systematic error in data collection, there may be some non-white beneficiaries categorized as White in the dataset. However, there are sufficient numbers of Black and Hispanic patients to draw some initial conclusions about measure selection and methodology.
- For some low-volume measures there may be some benefit to re-examination in the future if correct categorization of beneficiaries substantially increases the sample size.
- We recommend re-testing the final methodology with updated CT Medicaid data in the future.

Results for all 2015 Medicaid measure development data are presented in the Appendix, p.4

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3. **Developing equity measure methodology**

Evaluating Criteria for Measure Selection

Criteria for measure selection:

- **Adequate Volume**
  - Are there provider groups with adequate volume of patients in each racial and ethnic category to detect a difference in measure performance between groups?
- **Provider-Level Disparity**

  Among provider groups with adequate volume:
  - Is there evidence of a disparity in measure results for some provider groups?
    - Evidence of lower quality care for minority patients among provider groups
    - Variation in the disparity across provider groups
    - Substantial or statistically significant disparity
- **Impactability**
  - Can the measure results/disparities be meaningfully and feasibly changed by provider groups?
    - 18 measures under consideration for this work were selected by both DSS for the PCMH+ Program and by the Quality Council for the Core and Reporting Sets.

Crosswalk of PCMH+ and Quality Council measures presented in the Appendix, p.2

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Crosswalk of PCMH+ and Quality Council measures presented in the Appendix, p.2

Evaluating Criteria for Measure Selection - Volume

Question

- Are there a sufficient number of provider groups with adequate patient volume in each racial and ethnic category?

Methods

- We determined the number of provider groups with at least 20 patients in each race and ethnicity category for each measure.
  - We set the requirement at 20 patients because it is enough patients to have a reliable estimate while being few enough patients that small provider groups can be included.

Evaluating Criteria for Measure Selection - Volume

Results Summary

- Comparing the results for **White and Black** patients:
  - 2 measures had 0 provider groups meeting the volume requirement (at least 20 White and 20 Black patients)
  - 5 measures had less than 20 provider groups meeting the volume requirement
  - **18 measures** had **more than 20 provider groups** meeting the volume requirement

- Comparing the results for **White and Hispanic** patients:
  - 1 measure had 0 provider groups meeting the volume requirement (at least 20 White and 20 Hispanic patients)
  - 6 measures had less than 20 provider groups meeting the volume requirement
  - **18 measures** had **more than 20 provider groups** meeting the volume requirement

Detailed results for all measures are presented in the Appendix

Evaluating Criteria for Measure Selection

Criteria for measure selection:

- **Adequate Volume**
  - Are there provider groups with adequate volume of patients in each racial and ethnic category to detect a difference in measure performance between groups?
- **Provider-Level Disparity**

  Among provider groups with adequate volume:
  - Is there evidence of a disparity in measure results for some provider groups?
    - Evidence of lower quality care for minority patients among provider groups
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Crosswalk of PCMH+ and Quality Council measures presented in the Appendix, p.2

Evaluating Criteria for Measure Selection - Disparities

Questions

- Is there variation in the measure results among different racial and ethnic categories within provider groups?

Methods

- We examined the results for each measure for each provider group, looking for variation in results for White patients compared to those for Black and Hispanic patients.
- Graphically, we included the measure results, volume of each provider group, and the proportion of Black or Hispanic patients.
- We also examined the statistical significance of the difference in measure results for White patients compared to Black or Hispanic patients.

Detailed results for all measures are presented in the Appendix

Evaluating Criteria for Measure Selection - Disparities

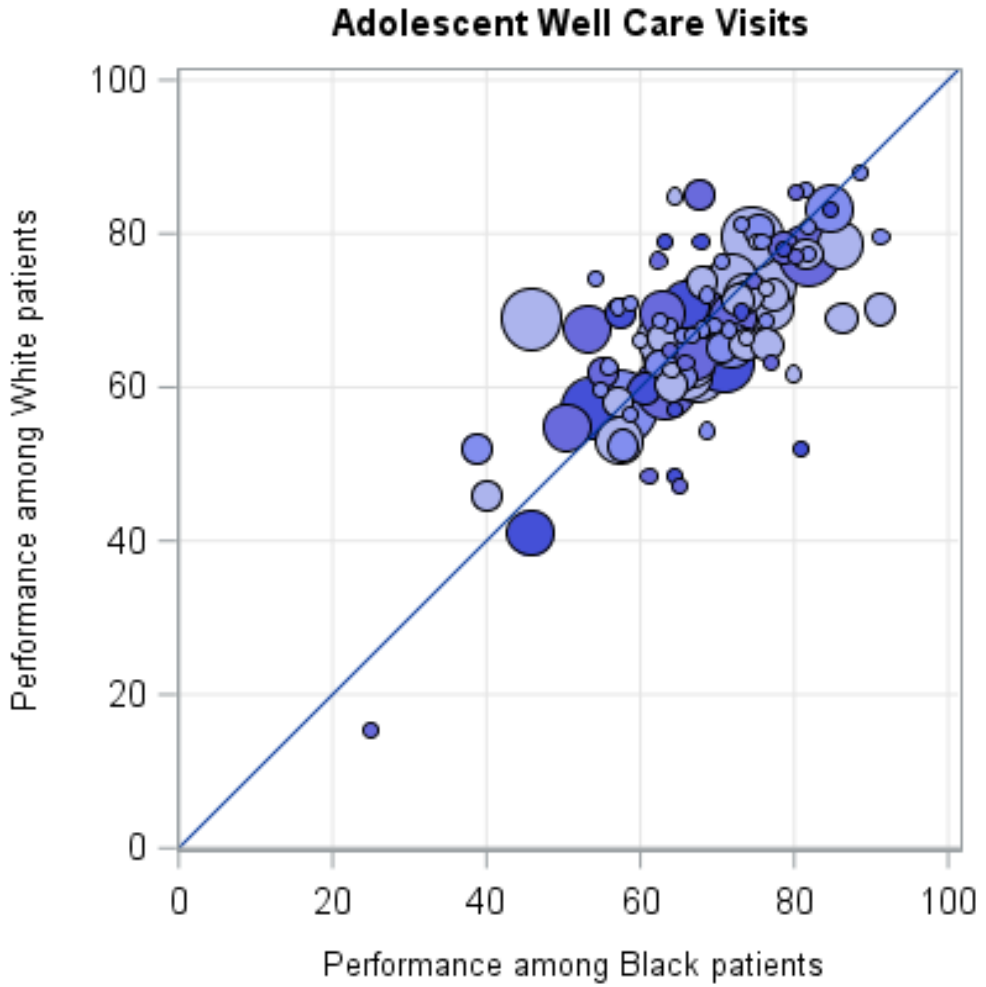
Results (example measure) - Adolescent Well-Care Visits: White-Black Disparity

Distribution of provider groups (105 total provider groups)	Disparity in Measure Results (% for White patients – % for Black patients)
Maximum	23.0
95th Percentile	14.4
90th Percentile	12.2
Upper Quartile (75th Percentile)	4.3
Median (50th Percentile)	-1.4
Lower Quartile (25th Percentile)	-4.8
10th Percentile	-10.9
5th Percentile	-15.9
Minimum	-29.0

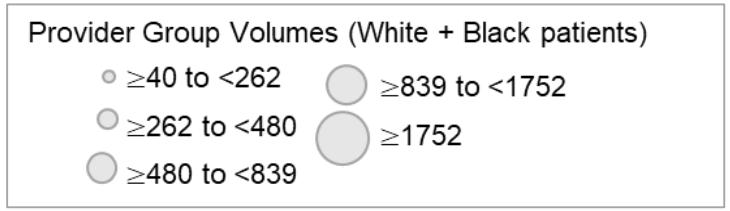
Detailed results for all measures are presented in the Appendix

Evaluating Criteria for Measure Selection - Disparities

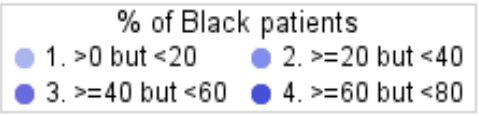
Results (example measure) - Adolescent Well-Care Visits



- Provider groups [bubbles] above the line have measure results that are better for White patients than for Black patients.
- Larger bubbles indicate more total patients at that provider group.



- The darker blue the bubble, the greater the proportion of Black patients in the measure for that provider.

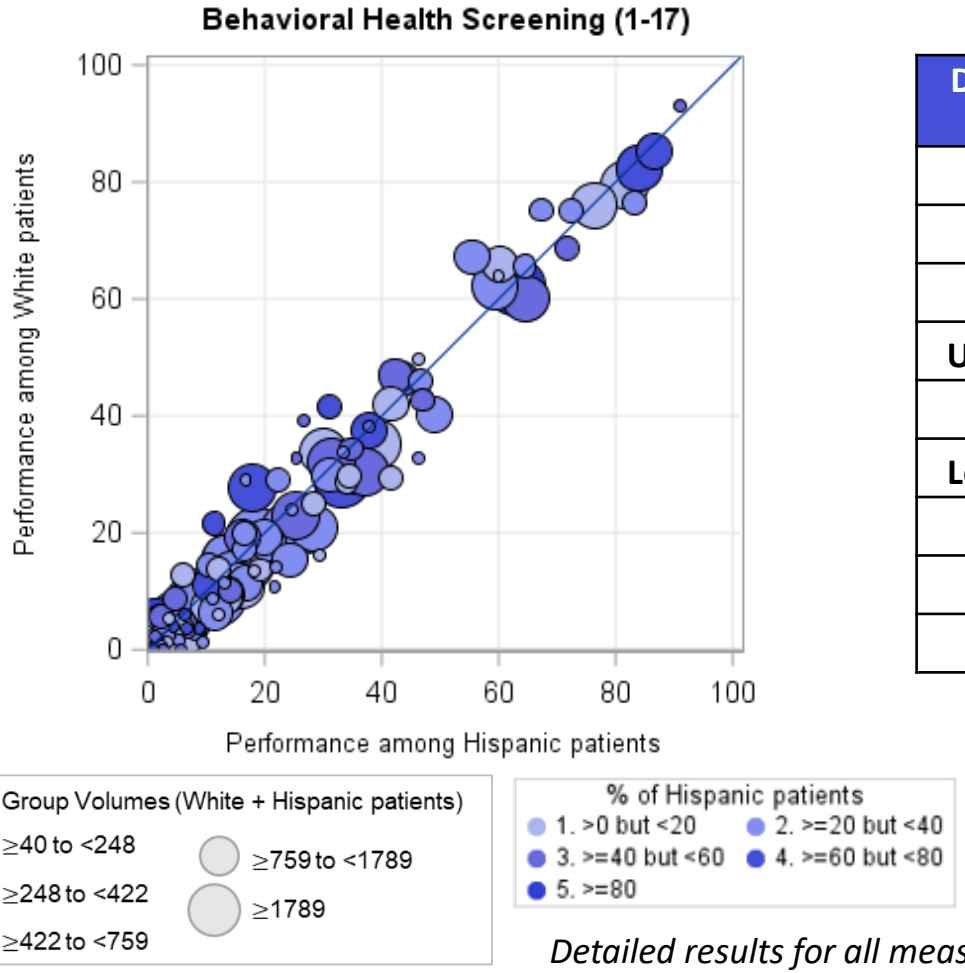


Detailed results for all measures are presented in the Appendix

Evaluating Criteria for Measure Selection - Disparities

Results (example measure) - Behavioral Health Screening (Ages 1-17)

- Provider groups [bubbles] above the line have measure results that are better for White patients than for Hispanic patients.
- Larger bubbles indicate more total patients at that provider group.
- The darker blue the bubble, the greater the proportion of Hispanic patients in the measure for that provider.



Distribution of provider groups (168 total provider groups)	Disparity in Measure Results (% for White patients – % for Hispanic patients)
Maximum	12.5
95th Percentile	6.9
90th Percentile	3.4
Upper Quartile (75th Percentile)	0.8
Median (50th Percentile)	-0.5
Lower Quartile (25th Percentile)	-2.8
10th Percentile	-5.2
5th Percentile	-7.5
Minimum	-13.3

Detailed results for all measures are presented in the Appendix

Evaluating Criteria for Measure Selection - Disparities

Results Summary

- Many measures show variation among provider groups in extent of disparity for both comparison of White and Black patients or comparison of White and Hispanic patients.
  - This is true despite a data error that we suspect leads to underestimate of disparities.
- In some cases the difference show higher rates for patients of minority race or ethnicity.
- Despite substantial absolute gap in rates, few providers are statistically significant outliers.

Detailed results for all measures are presented in the Appendix

Quality Council Input

Do you have any specific considerations to add to our criteria for measure selection?

Criteria for measure selection:

- **Adequate Volume**
  - Are there provider groups with adequate volume of patients in each racial and ethnic category to detect a difference in measure performance between groups?
- **Provider-Level Disparity**

  Among provider groups with adequate volume:
  - Is there evidence of a disparity in measure results for some provider groups?
    - Evidence of lower quality care for minority patients among provider groups
    - Variation in the disparity across provider groups
    - Substantial or statistically significant disparity
- **Impactability**
  - Can the measure results/disparities be meaningfully and feasibly changed by provider groups?

Crosswalk of PCMH+ and Quality Council measures presented in the Appendix, p.2

Quality Council Input

Do you have recommendations for thresholds in selecting measures?

Based on:

- Number of provider groups meeting volume requirement
- Size of disparity
- Overall measure results variation

Do you have suggestions for alternate ways of grouping or reporting race and ethnicity categories?

- Currently: White, Black, Hispanic, and Other based on sample size considerations
- Alternatives: Black vs. all others, Hispanic vs. all others

Next Steps

Current Work

1. **Preliminary evaluation of the data**
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2. **Evaluating criteria for measure selection**
    - For each measure:
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        - Reviewing the existence and significance of current disparities in measure rates for CT Medicaid patients
3. **Developing equity measure methodology**

Developing an Equity Measure Methodology

- Examine within provider disparity:
  - Relative or absolute difference in rates for each provider.
  - Finalize patient racial/ethnic categories for measurement.
  - Determine threshold or significance for reporting results.

- Alternative: Report provider's performance on the measure for minority populations compared to other providers' or benchmark performance.

- Later iterations of methodology could evaluate providers' improvement, looking at disparities regionally, at levels other than the provider group, and using different race and ethnicity categories and other social risk factors.

Public Scorecard

Agenda: Online Healthcare Scorecard

- Status Update
- Measure Feasibility and Recommendations
- Attribution
- FQHC Rating
- Benchmarks
- Next Steps

Status Update

Status Update

- Continued development of user interface
- Continued work with APCD commercial claims data
  - Coding of some measures is complete
  - Specifications for additional data sets submitted to APCD
  - Communication about data questions with APCD
  - Medicare data from APCD expected soon

Measure Feasibility and Recommendations

Measure Feasibility (1 of 2)

- Measure: Use of imaging studies for low back pain
  - Prolonged use of corticosteroids found as 90 consecutive days of corticosteroid treatment any time during the 12 months prior to and including the episode start date

Measure Feasibility (2 of 2)

- Contraceptive Care- Access to LARC
  - Amy Gagliardi and Dr. DeFrancesco have provided LARC that confirms those presented in March

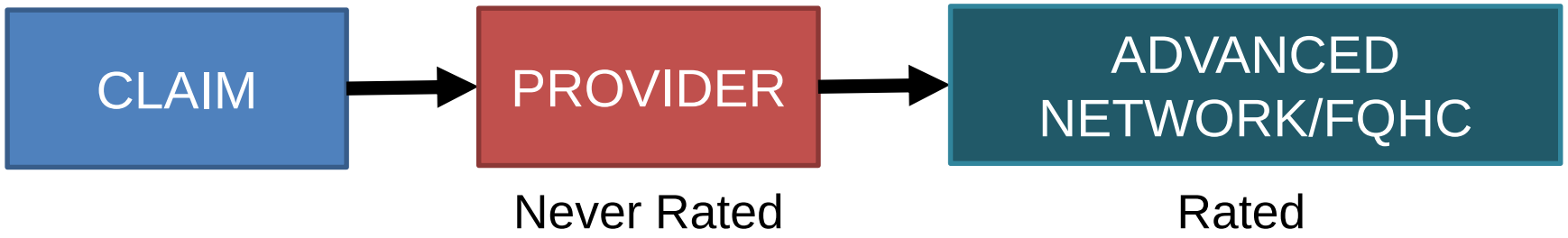
HCPCS Code	Contraceptive Name
J7297	Levonorgestrel iu 52mg 3 yr
J7298	Levonorgestrel iu 52mg 5 yr
J7300	Intraut copper contraceptive
J7301	Levonorgestrel iu 13.5 mg
J7307	Etonogestrel implant system

Attribution

Attribution (1 of 4)

- Reminder: Attribution is being used to produce quality ratings only and not for provider payment

- 3M/Treo Adapted methodology
  - Part one: Attribute patients to eligible providers based on preponderance of Evaluation & Management (E&M) visits in a set time period
  - Part two: Link providers to ANs/FQHCs using billing NPI or site of care



Attribution (2 of 4)

- Part one: link patient to provider- already addressed
- Open Issues:
  - Attribution to developmental pediatricians: Dr. Lisa Honigfeld confirmed that developmental pediatricians would not typically provide primary care so will not be considered for attribution
  - Dr. Selinger indicated that he finds PAs and NPs as rendering providers with most but not all payers. UConn Health will include NPs and PAs as PCPs if data allows.

Attribution (3 of 4)

- Part two: Link provider to AN/FQHC
  - All patients attributed to a provider for the rated entity will be included in the sample, not just those being seen under a SSP
    - Billing NPIs will be used to link FQHCs and ANs
    - UConn Health has identified billing NPIs for each of the FQHCs and ANs
    - List will be finalized by each rated entity

Attribution (4 of 4)

- Open Issues remain: AN changes during or after the measurement year
  - ANs that no longer exist as distinct entities
    - St Francis and St. Mary's now in Trinity
  - ANs that have changed composition
    - St. Vincent's transferred one facility to SW Community Health Center (approved 11/27/17)

FQHC Rating

FQHC Rating (1 of 4)

- It is likely that commercial sample size is insufficient to support commercial ratings for FQHCs

- FQHC Population by Insurance type (2016)* indicates:
  - Less than 5-21% of FQHC patients have commercial insurance
  - 5-11% of FQHC patients have Medicare

*https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2016&state=CT#glist and https://bphc.hrsa.gov/uds/lookalikes.aspx?year=2016&state=CT#glist

FQHC Rating (2 of 4)

FQHC	Total # of Patients	Uninsured	Medicaid/ CHIP	Medicare	Commercial/Other Third Party
Charter Oak Health Center, Inc.	18,122	21%	61%	7%	11%
Community Health & Wellness Cntr Greater Torrington	6,817	18%	60%	9%	13%
Community Health Center, Inc.	89,278	14%	68%	7%	12%
Community Health Services, Inc.	17,829	17%	65%	7%	11%
Connecticut Institute For Communities, Inc.	13,364	20%	52%	10%	18%
Cornell Scott Hill Health Corporation	34,563	10%	68%	9%	14%
Fair Haven Community Health Clinic, Inc.	17,251	24%	55%	7%	14%
Family Centers, Inc.	341	35%	55%	5%	5%
First Choice Health Centers, Inc.	20,755	13%	65%	6%	16%
Generations Family Health Center, Inc.	22,129	10%	58%	11%	21%
Intercommunity, Inc.	3,295	8%	69%	10%	13%
Norwalk Community Health Center, Inc.	13,655	31%	52%	6%	11%
Optimus Health Care, Inc.	49,521	22%	57%	7%	14%
Southwest Community Health Center	22,432	22%	61%	8%	10%
Staywell Health Care, Inc.	24,331	14%	73%	6%	7%
United Community and Family Services, Inc.	18,197	7%	64%	8%	21%
Wheeler Clinic, Inc.	4,597	10%	63%	6%	21%

FQHC Rating (3 of 4)

- Measure sample size will be lower (age and condition inclusion criteria)
- Reported rates by FQHC are:
  - Children 3-42%
  - Asthma 3-11%
  - Hypertension 7-23%
- UConn Health will investigate numbers in the APCD data as data analysis continues
- Most likely FQHCs will be rated only after Medicaid data is available

Benchmarks

Benchmarks (1 of 2)

- Levels against which performance of rated entities will be compared
  - Comparative benchmarking is most common and available for CT scorecard
  - Will be utilized in scoring
- Comparative group options

1. **National:**
   - Two sources exist (NCQA and Medicaid Core Set)
     - neither provides benchmarks for all measures
   - Separate benchmarks exist for Medicare, Medicaid, commercial PPO, and commercial HMO
     - No combined commercial benchmark
     - no separate benchmarks for FQHCs versus ANs.
   - Used by many other states, facilitates comparison
2. **State:**
   - Would need to calculate
   - Provides more control over comparison groups (insurance and/or entity type)
3. **Rated Entities:**
   - Similar to above but more sensitive to high and low performers

Benchmarks (3 of 3)

Proposal

- Benchmarks for scoring – presented on default view
  - State comparison level by payer type

- Benchmarks for additional comparisons – presented on advanced view
  - National and rated entity level

Quality Council Feedback?

Next steps

Next Steps

- Continue measure construction
- Begin engagement with rated entities
- Continue user interface development
  - Work with presentation subgroup
- Present on scoring and risk adjustment in May