

Commonwealth of Massachusetts

Executive Office of Health and
Human Services



EOHHS QUALITY MEASURE ALIGNMENT TASKFORCE

October 18, 2021



Agenda



- 1. Welcome and Introduction of New Members**
- 2. Acknowledgement of Members Leaving the Taskforce**
- 3. Brief Updates on Activity Since the June Taskforce Meeting**
 - a. Insurer Access to Immunization Data through DPH's MIIS**
 - b. Efforts to Increase Payer Adoption of the Aligned Measure Set**
 - c. Creation of the Health Equity Technical Advisory Group**
 - d. Identification of Electronic Clinical Data Collection Use Cases**
- 4. RELD Survey Findings**
- 5. Taskforce Goals for 2021-22**
- 6. Next Steps**



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Acknowledgement of members leaving the Taskforce



- The following members have discontinued their service on the Taskforce:
 - Jackie Spain, Health New England
 - Lisa Iezzoni, Health Policy Research Center at Mass General
 - Elisabeth Okrant, Massachusetts Behavioral Health Partnership
 - Joe Finn, Massachusetts Housing and Shelter Alliance
 - Ben Asfaw, South Shore Hospital
- We acknowledge their time on and service to the Taskforce, and thank them each for their substantive contributions to the improvement of quality measure alignment in Massachusetts.



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Activity since the June Taskforce meeting: *insurer access to the MIIS*



- In the course of conducting insurer interviews in the winter to understand barriers to measure set adoption, Taskforce staff learned of insurer interest in obtaining access to vaccination data in the Massachusetts Immunization Information System (MIIS).
 - Access would improve reporting on plan and ACO vaccination rates.
- Section 44 of the SFY 2022 budget legislation includes a provision that affords insurers access to the MIIS. DPH is charged with making access available.
- BCBSMA reported that it anticipated having access by the end of October.



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Activity since the June Taskforce meeting: *increasing measure set adoption*



- During the winter and spring the Taskforce reviewed data on adoption of the Aligned Measure Set.

Statewide (All-Payer)	BMC					
	MassHealth	HPHC	BCBSMA	HealthNet	THP	HNE
2019: 61%	2019: 100%	2019: 45%	2019: 47%	2019: 59%	2019: 61%	2019: 34%
2020: 70%	2020: 100%	2020: 53%	2020: 62%	2020: 57%	2020: 56%	2020: 42%
2021: 83%	2021: 100%	2021: 85%	2021: 81%	2021: 67%	2021: 60%	2021: 38%

- Taskforce staff met over the summer to identify actions that they could take to further improve fidelity to the Aligned Measure Set.
- The adopted actions are summarized on the following slide.



Activity since the June Taskforce meeting: *increasing measure set adoption*



1. Transparency

- CHIA will add information on insurer adherence to the Aligned Measure Set to its Tableau dashboard.
- HPC will add information on insurer adherence to the Aligned Measure Set to its Tableau dashboard.

2. State purchasing

- The GIC will consider addressing Aligned Measure Set adherence in its next procurement.
- MassHealth will ask Tufts for a commitment to supporting ACO attention to the Measure Set by using it in commercial contracting.

3. EOHHS targeted outreach

- On 9/30 Taskforce staff met with the MMS/MHA Taskforce on Physician Burnout. The members expressed appreciation for the Taskforce's work and expressed a willingness to expand alignment by the plans with current low fidelity – Anthem, Tufts/Point32Health, and UnitedHealthcare. They also expressed hope that plans will modify quality benchmarks due to the impact of COVID-19 and be sensitive to the impact of PA burden on practices and their workforce.



Activity since the June Taskforce meeting: *increasing measure set adoption*



3. EOHHS targeted outreach (cont'd)

- Following release of the 2021 Quality Catalogue survey results in January, EOHHS will directly communicate with the largest Massachusetts payers that are not highly adherent to the Aligned Measure Set (currently, Anthem, Point32Health and UnitedHealthcare) to request a commitment to alignment.



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Activity since the June Taskforce meeting: *Health Equity Technical Advisory Group*



- The Taskforce has spoken extensively about health equity over the past year. It added an equity-focused measure to the 2022 measure set and also made several other policy recommendations.
- As an important next step forward, EOHHS is creating a Health Equity Technical Advisory Group. Its charge will be to provide subject matter expertise and input on an aligned approach to:
 1. **standardize data collection** related to social risk factors including (but not limited to) race, ethnicity, language, disability (RELD), sexual orientation, and gender identity (SOGI), after consideration of existing approaches;
 2. promote and assure **completeness and integrity of RELD and SOGI data**;
 3. **measure and report on health and healthcare disparities**, both in the outpatient and acute inpatient settings;



Activity since the June Taskforce meeting: *Health Equity Technical Advisory Group*



- The Health Equity Technical Advisory Group's charge will be to provide subject matter expertise and input on an aligned approach to (continued):
 4. introduce **accountability for reducing disparities** in the outpatient and acute inpatient settings, including timing and technical design, and
 5. ensure providers serving vulnerable populations are **not unfairly disadvantaged** by the introduction and implementation of accountability for closing disparities.
- Deliverables may include recommendations on: RELD and SOGI data standards; how to improve data completeness and integrity; how to measure health disparities; how to introduce financial accountability for reducing inequities; how to mitigate unfair impact on providers serving disproportionately disadvantaged populations, and/or related recommendations.



Activity since the June Taskforce meeting: Health Equity Advisory Group



- The Health Equity Technical Advisory Group will be comprised of three sub-groups:

Group	Potential Membership	Notes
Data Standards Group	Experts in data science, health equity, implementation, and provider group EHR leads	This group will be procured, and may be comprised of the same members as the HE Accountability Group.
Health Equity Measurement Group	Experts in quality measures and methodologies	The Taskforce will serve as this group.
Health Equity Accountability Group	Experts in value-based purchasing, payment model reform, pay-for-equity programs, and health equity	This group will be procured, and may be comprised of the same members as the Data Standards Group.

CONFIDENTIAL WORKING DRAFT – POLICY IN DEVELOPMENT



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Activity since the June Taskforce meeting: *electronic clinical data collection use cases*



- The Taskforce's charter identifies "*explore options for systemized means for electronic measure reporting for use in value-based contracts*" as one of EOHHS' intended purposes for the Taskforce.
- The Taskforce received a presentation during its September 2019 meeting regarding efforts in other states to electronically gather clinical data from EHRs to support quality measurement and to serve other aims.
 - Taskforce members expressed interest, but also raised concerns and questions. They also asked for more detail on work in other states
 - Due to the arrival and impact of COVID-19, the work did not continue.
- During the summer Taskforce staff decided to revisit the potential use cases of developing infrastructure in Massachusetts for standard collection of electronic clinical data.



Activity since the June Taskforce meeting: *electronic clinical data collection use cases*



- Taskforce staff have done the following during August and September:
 - connected with EOHHS' lead for its Digital Health Taskforce, Kevin Mullen, to coordinate efforts;
 - spoken with Micky Tripathi, National Coordinator for Health IT and former CEO of the Mass. eHealth Collaborative)
 - convened a small group of insurer and provider representatives who work at the nexus of quality measurement and health IT to answer the question *how can Massachusetts accelerate electronic clinical data measurement?*
- These conversations yielded the following insights:
 - TBD



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RELD Payer and Provider Surveys: Background



- In April 2021, a subset of Taskforce members with expressed interest participated in a health equity discussion. The purpose of the meeting was to develop recommendations for how the Taskforce could further promote health equity.
- The Work Group recommended that the Taskforce survey insurers and ACOs to assess race, ethnicity, language, and disability (RELD) data collection practices.
- Taskforce staff developed the Payer and Provider RELD surveys, to which Taskforce members provided multiple rounds of feedback.
- The final RELD Payer and Provider Surveys were distributed to payers and provider organizations (POs) in July 2021.



RELD Payer and Provider Surveys: Background



- The surveys assessed the following:
 1. categorization systems used to capture RELD data;
 2. data collection methods and data sources used to determine a member's RELD;
 3. frequency with which RELD data are updated;
 4. percentage of membership/patient population with member/patient or family-reported RELD data, and the percentage of membership/patient population that declined to respond;
 5. methods to and frequency that RELD data are assessed, and
 6. methods to improve RELD data accuracy and/or completeness.

- Taskforce staff reviewed each Payer and Provider Survey submission and emailed respondents with questions, when necessary.



RELD Payer and Provider Surveys: Background



- Nine payers and 19 POs responded, as listed on the next slides. Their survey responses have been de-identified and are reported anonymously.
- Survey results may be used by the Taskforce to assess the current state of RELD data collection and disparities measurement, and to inform planning for future Aligned Measure Set design and equity advancement.
- The following slides present a summary of results from both surveys.
 - More detail is included in the attached presentations and Executive Summary.



RELD Payer and Provider Surveys: Background



Nine payers responded to the RELD Payer Survey:

1. AllWays Health Partners
2. Anthem
3. Blue Cross Blue Shield of Massachusetts
4. Boston Medical Center HealthNet Plan
5. Commonwealth Care Alliance
6. Fallon Community Health Plan
7. Harvard Pilgrim Health Care
8. Health New England
9. Tufts Health Plan

Four payers did not respond:

1. Aetna / CVS Health
2. Beacon Health Options
3. Cigna
4. UnitedHealthcare



RELD Payer and Provider Surveys: Background



21 respondents from 19 providers completed the RELD Provider Survey:

1. Atrius Health
2. Baycare Health Partners
3. Baystate Medical Center
4. Beth Israel Lahey Health
5. Boston Children's Health ACO
6. Boston Medical Center
7. Cambridge Health Alliance (3 responses)
8. Cape Cod Healthcare
9. Community Care Cooperative
10. Fairview Hospital
11. Heywood Hospital
12. Mass General Brigham
13. Merrimack Valley ACO
14. Quality Hebrew Seniorlife
15. Signature Healthcare Corporation
16. South Shore Health
17. Southcoast Health
18. Steward Health Care Network
19. Wellforce



RELD Payer and Provider Surveys: Background



Four providers did not respond:

1. Mount Auburn Cambridge Independent Practice Association
2. Reliant Medical Group
3. Trinity Health (Mercy Hospital)
4. UMass Memorial Health



RELD Payer and Provider Surveys: Findings



Overall Findings

- Almost all POs and payers report that they collect race, ethnicity, and language data. About half of POs and payers report that they collect disability data.

	Number of Payers Collecting a Variable (n=9)	Number of POs Collecting a Variable (n=21)
Race	9 (100%)	20 (95%)
Ethnicity	8 (89%)	18 (86%)
Language	9 (100%)	20 (95%)
Disability	5 (55%)	11 (52%)

- Payers generally use similar data collection methods, data sources, and update frequencies for race, ethnicity, and language data.



RELD Payer and Provider Surveys: Findings



Overall Findings (continued)

- On average, POs' race, ethnicity, language, and disability data are much more complete than payers' data. Payers' and POs' language data are the most complete.

	Payers' Member or Family-Reported Data	POs' Patient or Family-Reported Data
Race	34%	81%
Ethnicity	32%	79%
Language	54%	93%
Disability	30%	69%

- Payers and POs report that they regularly update the RELD data that they collect. Beyond regular updates, most payers and POs do not have a process for assessing the accuracy of their RELD data.



RELD Payer and Provider Surveys: Findings



Findings on Data Sources

- In general, payers use multiple data sources for RELD data.
- About half of POs report that they use patient-reported data as a single data source for race and ethnicity. Most POs use multiple data sources to determine language and disability.
- Use of multiple data sources raises a “source of truth” issue, and the logic rules to determine which data sources take precedence to determine “truth” likely vary between payers and POs.
- POs might have less of the "source of truth" issue than payers for race and ethnicity, as it is less common for them to use multiple data sources.



RELD Payer and Provider Surveys: Findings



Findings on Data Categorization Systems

- There is a need to consider how to reconcile differences in data categorization systems used across payers and providers.
 - Most *payers* use the Office of Management and Budget (OMB) standards for race and ethnicity. There is not one system that is used by most payers for language or disability.
 - Many *POs* use the Health and Human Services standards for RELD, and a few *POs* use the OMB standards for race and ethnicity.
 - This may be both a significant opportunity and challenge to promote standardization within language and disability data collection, and between payers and providers.



RELD Payer and Provider Surveys: Findings



Additional Findings on Language and Disability

- To determine language, many POs will use multiple data sources.
 - This creates the “source of truth” issue that payers experience.
 - Collecting language data through sources other than patient-report may not account for a patient’s preferred language.
- Payers, and to some extent, POs, do not have a patient-centered way of collecting or categorizing disability data.
 - Some payers and POs report that they use claims or diagnosis codes as their data categorization system.
 - Some payers and POs collect disability data through means other than member/patient self-report.
 - At two payers and two POs, members/patients cannot self-report their disability status.



RELD Payer and Provider Surveys: Implications for Action



- Based on these learnings, what are appropriate actions for:
 - the Taskforce and its newly formed Health Equity Technical Advisory Group?
 - insurers?
 - provider organizations?
 - anyone else?



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Discuss Taskforce goals for 2022



- The Taskforce has historically established goals (and associated measures) for each calendar year, although that practice, like many things, was thrown off by COVID-19. EOHHS proposes returning to that practice for 2022.
- For example, the 2019 goals were as follows:
 1. Track and advise EOHHS on improved adoption of the Aligned Measure Set.
 2. Review and maintain the Aligned Measure Set.
 3. Track or sponsor four prioritized developmental measures for testing and implementation.
 4. Advise EOHHS and related entities and promote means of electronic measure reporting.
- What should the Taskforce's goals be for 2022?



Discuss Taskforce goals for 2022



- During an internal Taskforce staff planning meeting on July 15th, members discussed the following topics:
 - Health Equity
 - Electronic Health Information (e.g., centralized clinical data collection, ADT notifications)
 - Promoting Adoption of the Aligned Measure Set
 - Transparency of ACO Performance
 - Developmental Measures
- What goals around these topics - and any others - should we consider for 2022?



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Next Steps



- The upcoming Taskforce meetings are:
 - Monday, November 15th from 1:00 pm – 3:00 pm
 - Monday, December 13th from 1:00 – 3:00 pm
 - Wednesday, January 26th from 9:00 – 11:00 am
 - Thursday, February 24th from 1:00 – 3:00 pm
- Please note: All meetings will be virtual until it is appropriate to meet in-person again.