

**Quality Alliance Steering Committee
Measure Implementation Strategy Work Group Meeting**

**Monday, November 9, 2009
1:00 PM – 2:00 PM EST**

**Call-In Number: 888-870-8270
Pass Code: 202 797 6068**

Agenda

Time	Agenda Item	Presenter
1:00-1:05	Welcome and Introductions	Paul Tang / Lew Sandy
1:05-1:20	Update on AHIPF Data Aggregation Effort <i>Objective:</i> For discussion and input <ul style="list-style-type: none">• <i>Tab 1:</i> Progress on Project Implementation	Carmella Bocchino/ Aparna Higgins
1:20-1:35	Review of “Blueprint for Registries” Policy Brief Outline <i>Objective:</i> For discussion and input <ul style="list-style-type: none">• <i>Tab 2:</i> Registries Policy Brief Outline	Mark Legnini
1:35-1:55	Update on Indirect Estimation Pilot in MA <i>Objective:</i> For discussion and input <ul style="list-style-type: none">• <i>Tab 3:</i> Indirect Estimation Pilot Update	Kalahn Taylor-Clark
1:55-2:00	Wrap up	Paul Tang / Lew Sandy



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A Nationally-Consistent Data Aggregation Methodology

November 2009

Supported By:

Robert Wood Johnson Foundation
Engelberg Center for Health Care Reform at the Brookings Institution
America's Health Insurance Plans Foundation



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Project Update

- ▶ Pilot Site Implementation
- ▶ Signed agreements with four plans (Aetna, Cigna, Humana, and United) and are under implementation (data preparation and processing) with each of these plans in Florida and Colorado
- ▶ Ongoing discussions with two Blues plans in Florida and Colorado, about their participation which will depend on availability of plan resources to submit data to the AHIPF hub within a timeframe consistent with the overall project timeline
- ▶ Ongoing discussions with Colorado Medicaid ,Florida Medicaid, and CMSas both programs have expressed interest in possibly participating in the project
- ▶ Expect data submissions from plans to AHIPF Hub November/December 2009

Project Update

- ▶ Pilot Site Implementation
- ▶ Health Plans are iterating input data extracts based on data quality feedback received from processing their data through the data validation utility software tool
- ▶ Data quality issues that have been identified and are being resolved include:
 - Completeness of provider data
 - Availability of mental health claims data
 - Availability of pharmacy data
 - Consistency of data between medical files and provider files
- ▶ Received AHIPF Measurement Utility (AHIPF MU) software tool and testing execution on AHIPF servers prior to releasing tool to health plans
 - AHIPF MU calculates the measures, performs the attribution, and creates the output files that will be sent from each health plan to the AHIPF Hub

Validation of Performance Measure Results

- ▶ Objective: Ensure valid and reliable performance measure results from the project
- ▶ The scope of the validation effort primarily involves developing and executing a methodology that ensures:
 - Components of the technical solution accurately implement and function according to the project methodology
 - Project input and output data have been validated
- ▶ Main components of the Solution that require validation:
 - Plan Solution
 - AHIPF Hub solution
- ▶ Approach to validation performance measure results
 - Validation by Plan staff, AHIPF staff, and Ingenix
 - Independent validation by NCQA
 - AHIPF used a competitive bid process to select vendor for validation efforts
 - NCQA was awarded the contract to validate the performance measure results

Validation of Performance Measure Results

- ▶ NCQA's validation of AHIPF hub Solution includes the following areas:
 - Confirmation of data submission by plans.
 - Provider crosswalk and specialty assignment.
 - Aggregation of data across plans.
 - Aggregation of data with CMS
 - Calculation of benchmarks and assignment of peer groups including use of confidence intervals for measurement.
 - Use of adequate sample size for measure reporting
 - Display of provider performance measure results

- ▶ NCQA is developing the analysis plan for the validation of the AHIPF MU and the AHIPF Hub solution and will be presenting the details of the analysis plan on November 11th during the in-person Data Oversight Workgroup meeting

- ▶ NCQA has submitted the first test deck for validating the AHIPF MU to AHIPF

Project Update

- ▶ Update on outreach activities in Florida and Colorado:
- ▶ Met with Florida Medical Association (FMA) and Health Plan Regional Medical Directors in September to discuss our project and identify other organizations for additional outreach
 - Agency of Health Care Administration in Florida
 - Additional Outreach to FMA
 - FAFP
 - Florida Chapter of ACP
- ▶ Met with Director of Health, Center for Health Information and Policy Analysis , Agency of Health Care Administration in Florida
- ▶ Added Dr. Dave Downs from Colorado (former President of Colorado Medical Society, Representative to Colorado's Center for Improving Value in Health Care) to the Data Oversight Workgroup and working on adding physician from Florida to Workgroup
- ▶ Ongoing discussions with RWJF on physician outreach in Florida and Colorado

Project Update

- ▶ Ongoing discussions with CMS on:
- ▶ Matching providers between commercial and Medicare data
- ▶ Sent the specifications for the provider crosswalk that we are using for our project to CMS to help enable matching of providers between commercial data and Medicare data and improving the validity of aggregating GEM and commercial data
- ▶ Scheduling a call with CMS to also discuss collaborating on Medicaid data from the federal perspective, given interest from state Medicaid agencies in Florida and Colorado

“Blueprint for Registries” Policy Brief: Outline

- **Overview:**
 - Registries have a potentially significant but currently limited role in providing clinical data for performance measurement
 - Significant short-comings: silo-ed nature of registries, etc.
 - Must change/adapt to be useful and sustainable in the future

- **Purpose & Design of Existing Registries:**

- **Current Functions**

- **Challenges and Limitations of Registries for Quality and Cost Measurement**
 - Common, core datasets and definitions are lacking; multi-stakeholder consortiums have been initiated to address this (NC²D)
 - Lack of uniformity in patient identity management
 - No national identifier
 - Lack of interoperability with EHRs
 - “Meaningful use” discussions are an opportunity
 - Lack of standard sampling, auditing and risk adjustment methodologies
 - Lack of standard linkage methods
 - Highly variable provider participation
 - Use of registries for public reporting will discourage voluntary participation
 - Registry participation linked to economic importance/mandates
 - E.g. linking participation to licensure, reimbursement, etc.
 - Registries which solely focus on quality improvement (QI) or research have less participation
 - Need to identify and support initiatives that link participation to economic incentives
 - Lack of confidence in the sustainability of registries
 - Varied business models; often rely on payer fees for constructing provider bonus programs from registry data

- **HIPAA Implications: Effects of HIPAA and the Privacy Rule on Registries, Research & Data Linkage**
 - Opposing concerns of assessing quality and protecting privacy
 - HIPAA and the Privacy Rule dictate how covered entities and business associates may use and disclose protected health information (PHI)
 - Privacy Rule specifically allows a covered entity to use and disclose PHI for QI and quality measurement (QM) activities.
 - Issues arise with the use of PHI by covered entities for a purpose not stated in the Privacy Rule (e.g. research)
 - There is ambiguity/confusion regarding the distinction between research and quality improvement purposes and implications for how it is interrupted

- Various Approaches to how registries can use or disclose PHI
 - While there is not a broad consensus, there is a general sense that linking data from health plans and registries is permissible as the goal is generally more QI/QM related.
 - Considering the varying interpretations of whether linking claims and registry data is permissible, it would be beneficial for HHS to provide guidance on the subject and further define what will qualify as “quality improvement activities.”
- **Empty Measure Set: Few Endorsed Quality/Cost Measures That Require Linked Administrative and Clinical Data**
 - Advantages of Developing Measures Using Linked Clinical and Administrative Data
 - A hybrid database drawing on the strengths of claims & registry data would enable the development of measures that:
 - Improve Precision
 - More clinically-sophisticated, comprehensive and longitudinal dataset
 - Facilitate Quality Improvement Efforts
 - Dataset more actionable by physicians for QI
 - Support Patient-Centric Care
 - Spur the development of utilization and resource use measures.
 - Challenging to make a case for hybrid measures since hybrid databases don’t currently exist.
- **Collecting Race & Ethnicity (R/E) Data**
 - R/E disparities well documented
 - National Health Disparities Report
 - Race and/or ethnicity data elements in registries but not claims
 - Data and Equity: Strategies for Improvement
 - Registries as a clinically rich data source across geographically diverse service/provider settings
 - Integrating indirectly estimated and directly collected R/E data to assess equity at population level
 - Utilizing R/E data to improve equitable access to cardiac care
- **Migration of Registries From Specialty Societies to Large Provider Organization EHRs**
 - Are registries evolving in provider organizations to avoid the shortcomings of current, specialty-based registry programs?
 - Clinical registries have been adopted by physician groups, integrated delivery systems (IDS) and HIEs

- Payers use registries to generate provider performance reports
- **Data Integration: Current Methods vs. Future Data Models**
 - Currently, in order to link registry data with claims, need to periodically merge large databases to create an even larger hybrid database – expensive, time-consuming and can be done only periodically.
 - In the future, under a distributed data model, PHI and other data will remain behind payer, registry firewalls. A transactional data reporting system will mean that, at the point of care, administrative and clinical data elements will be concurrently transmitted, in various combinations, to payers, registries and other authorized repositories so that all data elements (clinical and administrative) necessary to construct quality measures will be reported directly from the point of care. This will obviate the need for periodic data linkage.
- **Conclusion**
 - HVHC Activities as a short-term, immediate solution
 - Long-term solution will evolve from development of EHRs, etc.



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MIS Workgroup Update
**Health Plan Indirect Estimation Pilot in
Massachusetts**

November 9, 2009

**The Brookings Institution:
Racial/Ethnic Health Care Equity Initiative**

The RAND Corporation

Overview of Pilot

- 3 health plans:
 - BC/BS
 - Tufts
 - Harvard Pilgrim
- Software training (August 2009)
- Target completion date: October 1, 2009
- Deliverable: White Paper (December 2009)

Goals for Indirect Estimation (IE) Pilot

Goal 1: Feasibility of running software in-house

- Encourages distributed data model
- Allows plans to use own data immediately

Goal 2: Feasibility of combining direct/indirect data

- Identifies necessary IT modifications for combining data

Goal 3: Feasibility of using IE as a “quality check” for directly acquired data

- IE can facilitate a trumping logic for determining best data from multiple sources

Strategies for Broad Dissemination

- Make software “user-friendly”:
 - Automated web-based system – however, program should run on plans’ system
- Develop a collaborative, which would allow multiple plans that serve one area to combine data
- Field additions: No major change to the extract
 - Same estimation program
 - Add 6 probability fields at end of submission file
- Submission flexibility – how do plans feed estimates into their extract?
 - Run in-house and include in extract sent to state, or
 - Run data through automated system and send directly to the State

Overarching Questions for MIS Workgroup

- At what level should we consider strategies for dissemination/advancement of estimation activities (health plans specifically, (regional) collaboratives, states, CMS/feds.)?
- In what form should we share results of pilots with broader QASC community?
How should results be framed?