
DELAWARE HEALTH CARE DELIVERY AND COST ADVISORY GROUP



QUALITY BENCHMARK SUBCOMMITTEE

APRIL 2, 2018

AGENDA

Topic	Time
1. Welcome and Introductions (Secretary Walker)	9:00 am – 9:10 am
2. Charge of the Subcommittee (Michael Bailit)	9:10 am – 9:25 am
3. Criteria for Benchmark Measure Selection (Michael Bailit)	9:25 am – 9:55 am
4. Candidate Quality Measure Consideration (Michael Bailit)	9:55 am – 10:25 am
5. Assessment of Candidate Measures Against Criteria (Michael Bailit)	10:25 am – 10:55 am
6. Break	10:55 am – 11:05 am
7. Methodology for Defining Benchmarks (Michael Bailit)	11:05 am – 11:40 am
8. Public Comment (Interested Parties)	11:40 am – 11:55 am
9. Wrap-up and Next Steps (Secretary Walker)	11:55 am – 12:00 pm



QUALITY BENCHMARK SUBCOMMITTEE CHARGE

BACKGROUND

- Governor Carney's Executive Order #19 established an Advisory Group that will provide feedback to the Secretary of the Department of Health and Social Services (DHSS) on:
 - Quality metrics across the health delivery system that will be used to create quality benchmarks for 2019.
- The Executive Order also calls for additional work related to a health care spending benchmark and reporting on variation in health care delivery and costs.
- The purpose of this subcommittee is to dig deeper into the methodological issues of the quality benchmarks and to provide feedback to the Advisory Group as it continues to work through its charge from the Governor.

WHAT WAS THE RATIONALE FOR GOVERNOR CARNEY'S EXECUTIVE ORDER?

- “Enhanced transparency and shared accountability for spending and quality targets can be used to accelerate changes in our health care delivery system, creating benefits for employers, state government, and health care consumers; and
- The establishment, monitoring, and implementation of annual health care cost and quality targets are an appropriate means to monitor and establish accountability for the goal of improved health care quality that bends the health care cost growth curve...”
 - excerpt from Governor Carney's Executive Order #19

SO WHAT ARE THESE “BENCHMARKS” EXACTLY?

- The Executive Order describes the intended benchmarks as “annual health care cost and quality targets”.
- Therefore, the benchmarks envisioned by Governor Carney should be understood as objectives for desired health care system performance.
- During the March 22 Advisory Group meeting a member asked whether measures of population health status (e.g., BMI) were candidates for the quality benchmarks.
 - The wording of the Executive Order suggests that measures of population health status should only be considered to the extent that they are viewed by the Advisory Group as indicators of health care system performance.

BACKGROUND

- By agreeing to participate on this subcommittee to the Advisory Group, you are committing to participate in a thoughtful and respectful process to consider the Advisory Group's charge and make recommendations to the Advisory Group.
- We will not discuss the merits of the charge, but only how we can best respond to it.
- The Advisory Group, and therefore this subcommittee, is advisory only. Because both bodies are advisory, there is no requirement that there be full consensus across all members on future recommendations.

QUALITY BENCHMARK SUBCOMMITTEE: CHARGE (1 OF 2)

- I. Provide input to the Advisory Group regarding the creation of quality benchmarks that will:
 - Target improvement for no fewer than two and no more than five health care quality improvement priorities for Delaware;
 - Utilize measures from recognized measure developers such as the National Committee for Quality Assurance (NCQA), or that have been endorsed by the National Quality Forum (NQF).
 - Make use of currently available data sources;
 - Be set at the state level, and, as practicable, at the market (commercial, Medicare, Medicaid), insurer, and health system/provider levels.

QUALITY BENCHMARK SUBCOMMITTEE: CHARGE (2 OF 2)

2. Provide input to the Advisory Group regarding the creation of a quality benchmarks that will:
 - Inform benchmark selection by consideration of publicly available benchmark data for the selected measures from the National Committee for Quality Assurance, the Centers for Medicare and Medicaid Services or comparable national bodies;
 - Be established for use for the first time in Calendar Year 2019, and then annually thereafter; and
 - Be used in comparative analysis to actual performance following the end of the Calendar Year 2019 and annually thereafter.

QUALITY BENCHMARK SUBCOMMITTEE: PROCESS

- We are currently scheduled to meet once; additional meetings may be scheduled in May or June depending upon how the Advisory Group's work progresses.
- This subcommittee's feedback will be reported to the Advisory Group on April 16.
- A separate health care spending benchmark subcommittee will meet this afternoon to address the methodology for that benchmark and will follow a similar process to this subcommittee.



TOPIC I: CRITERIA FOR BENCHMARK MEASURE SELECTION

CRITERIA FOR SELECTING BENCHMARK MEASURES

- Before we can discuss measures and methods for establishing benchmarks, we need to discuss criteria to be employed when identifying candidate measures. Please see the worksheet from Buying Value (www.buyingvalue.org) that contains the following criteria examples:
 1. NQF Measure Endorsement Criteria
 2. Measure Application Partnership
 3. CMS/AHIP Core Quality Measures Collaborative Measure Selection Principles
 4. National Academy of Medicine — Vital Signs: Core Metrics for Health and Health Care Progress — Criteria for Core Measure Development
 5. Maine Medicaid Measure Selection Criteria
 6. Oregon Medicaid Metrics & Scoring Committee Criteria for Selecting Incentive Measures

CRITERIA FOR SELECTING BENCHMARK MEASURES

- There are potentially two different types of measure selection criteria:
 1. Criteria that are applied to individual measures
 2. Criteria that are applied to the measure set as a whole
- Do you believe the Advisory Group should consider both types of criteria?
- Which criteria do you suggest the Advisory Committee adopt, and why?

CRITERIA FOR SELECTING BENCHMARK MEASURES

- The Executive Order asks the Advisory Group to consider not less than two and no more than five quality benchmarks.
 - Before we begin to consider candidate measures, have you any thoughts regarding a preferred number of quality benchmarks for 2019?



TOPIC 2: CANDIDATE QUALITY MEASURE CONSIDERATION

CANDIDATE QUALITY MEASURE CONSIDERATION

- DHSS staff suggest that the Advisory Group work from the Common Scorecard measure set when identifying the 2-5 measures that could be used to define the quality benchmarks:
 - The Common Scorecard consists of 26 quality measures that will be reported by the State in 2018 using data from health plans.
 - Data will be reported publicly by the HCC, with analytic support from the DHIN.
 - Most of the measures come from the NCQA HEDIS data set. The remainder were derived from other sources (e.g., Pharmacy Quality Alliance) or homegrown.

CANDIDATE QUALITY MEASURE CONSIDERATION

- Why select from the Common Scorecard measures?
 - One State Innovation Model (SIM) objective is to align payer performance measure use. It has been reported that currently most insurer contractual performance measures with providers are found in the Common Scorecard.
- Must the Advisory Group limit its consideration of quality measures for benchmark use to those found in the Common Scorecard?
 - No.

CANDIDATE QUALITY MEASURE CONSIDERATION

- Let's take a look at the Common Scorecard measures. To help inform your work, we have included some basic descriptive information about each measure (see handout).
- We have collected measures from some other pertinent measure sets to look at the extent to which the Common Scorecard measures are aligned with those measure sets. Those sets are:
 - Highmark
 - Medicaid Managed Care Organization contracts
 - Medicare ACO (MSSP and Next Generation ACO)
 - We also have outstanding requests for measures from:
 - Aetna
 - AmeriHealth Caritas
 - State employee health plan TPA contracts
 - UnitedHealthcare

CANDIDATE QUALITY MEASURE CONSIDERATION

- One additional resource to support your consideration of the measures is an analysis of the opportunities for performance improvement that exist for each of the Common Scorecard measures (see handout).
 - This analysis was performed for those Common Scorecard measures for which comparable CY16 national data are available.
 - Separate analyses were performed for commercial and Medicaid populations.
 - **Commercial:** Aetna and Highmark weighted average
 - **Medicaid:** Highmark and UnitedHealthcare weighted average
 - The handout uses color coding to identify where Delaware has the largest and smallest opportunities for improvement compared to national best practice.

CANDIDATE QUALITY MEASURE CONSIDERATION

- Remember that the Executive Order indicates that the Governor anticipates that the quality benchmarks will be established annually. This means that:
 - Quality measures used for benchmarks may be retained for multiple years.
 - Quality measures used for benchmarks may be added and/or dropped annually.
 - The benchmark values may change over time, e.g., “raising the bar”.



TOPIC 3: ASSESSMENT OF CANDIDATE MEASURES AGAINST CRITERIA

ASSESSMENT OF CANDIDATE MEASURES AGAINST CRITERIA

- To ensure that the candidate measures comport with our selection criteria, please consider the measure selection criteria discussed earlier in the meeting.
- As a check, following today's meeting we will formally score the measures that you suggest for Advisory Group benchmark consideration against your suggested selection criteria to confirm that they align well.



TOPIC 4: METHODOLOGY FOR DEFINING BENCHMARKS

METHODOLOGY FOR DEFINING BENCHMARKS

- Now that we have identified a set of measures that could be considered for the quality benchmarks, we need to discuss how to set the benchmarks.
- There is no standard methodology for doing so.
- However, many states, health plans and provider organizations choose to set their performance goals relative to best practice, either as:
 - Achievement of best practice-level performance, or
 - “Substantive” or statistically meaningful improvement towards best practice-level performance.

METHODOLOGY FOR DEFINING BENCHMARKS

- How do you suggest Delaware go about setting quality benchmarks for Calendar Year 2019?
- Should the method be the same for all measures, or is there reason for it to vary across the measures?



PUBLIC COMMENT



WRAP-UP AND NEXT STEPS