



COLORADO

Department of Health Care
Policy & Financing

MINUTES OF THE MEETING OF THE HEALTH IMPACT ON LIVES: HEALTH IMPROVEMENT SUBCOMMITTEE

225 East 16th Avenue 1st Floor Conference Room

April 22, 2015

Call to Order

David Keller called the meeting to order.

Roll Call

A. Members Present

Keller, David; Mortenson, Katie; Bodart, Brooke; Kennedy, Russ; Miller, Erin; Wheeler, Justin; Nate, Jenny; Bontrager, Jeff; Koltonski, Christian; Solomon, Sula; Hejny, Marilyn; Montrose, Gary; DeShay, Rachel

B. Members on the Phone

Bartilotta, Kathy; Lessley, Todd; Vivian, Kelley; Hudson, Jackie; Reeder, Lesley; O'Brien, George; Jaime, Meadow; Leonard, Joanna;

General Announcements

Date and location of the next Health Improvement meeting: The next meeting is scheduled to be held Wednesday May 27, 2015 beginning at 3:00 p.m. at 303 East 17th Avenue, Denver, CO 80203, Conference Room 7B

Approval of Minutes

A motion was made to approve the minutes from March 25, 2015. Motion was seconded and the minutes were approved.

Discussion

A. PIAC Meeting Report-out

David Keller shared that our subcommittee's charter (Health Impact on Lives: Health Improvement Subcommittee) was the first to be approved by PIAC. Erin Miller stated that a solicitation for the Colorado Opportunity Project will be released in the near future. She also shared that the bi-laws have been updated and that it has been decided that each subcommittee must meet at least 8 times a year. Todd Lessley reminded everyone to look at their schedules, as the subcommittee needs to figure out which months in the summer we will not meet.



B. Pre Colorado Health Institute (CHI) CAHPS Discussion- Russ Kennedy
Russ began his presentation by talking about Consumer Assessment of Healthcare Providers and Systems (CAHPS) that the Department will soon be wrapping up. Two years ago, funding was made available to run the CAHPS survey by RCCO. Each RCCO had a sample size of 1350, with an oversampling of 500 surveys.

The one in the field is running both adults and children CAHPS as well as NCQA measures per RCCO. The results should be released late August or early September. Due to limited funding, moving forward the Department will alternate administering the CAHPS and analysis between children and adults.

David shared some work that occurred in Massachusetts with Managed Care Organizations (MCOs) for Medicare and Medicaid. PCMH; initiatives are used as outcome means; CSI is used as evaluation measure. Practices pull lists of clients and then randomly choose. There is interest in looking at the data at a provider level.

C. CHI Analysis Presentation- Jeff Bontrager

Jeff began by giving a brief overview of the approach Colorado Health Institute (CHI) is the culmination of a lot of hard work. He pointed out that there was input from both the Department and the RCCOs, and are interested in reaching out to others in the future.

His presentation had three takeaways: 1) the results were similar or slightly lower in the ACC population compared to the Fee for Service population. At the RCCO level, the data is case mix adjusted, and no statistically significant differences existed between RCCOs; 2) The data that is being shared shows the national NCQA data and does represent the Medicaid population; 3) A hybrid approach is used for the survey—some information comes from the Health Plan CAHPS (others were not relevant) and some from the Primary Care Medical Home (PCMH) CAHPS, including medical management and care coordination.

There was then a discussion about the case mix adjustments. HSAG has some select measures to be comparable with age, health status, and education level. This tries to adjust for differences. Erin asked if this was all self-reporting and Jeff verified that this was in fact the case. He pointed out that he got a lot of questions about the population over 65. The thought was that FFS data would reflect unique qualities of the population, so they factored out the 65+ from FFS. This population is being looked at so trends can be shown.

Pack 1:

Question: On a scale of 0-10, with 10 being the most positive, what number would you use to rate all of your healthcare in the last 6 months?



Findings: A difference that was statistically significant existed between FFS Medicaid and ACC Medicaid, but not between the RCCOS

Discussion: Susan brought up that part of the difference is a perception; Russ pointed out passive enrollment and transition phases may also be factors. David said this also suggests that there would be differences because of geography. Jeff said Susan's point brings up the fact that the question of where the client received care was not asked, so there is no way to pinpoint where the care was actually occurring.

Justin questioned if it would be possible to ask clients if they know what RCCO they are in. He asked if there has been any analysis of the new understanding of what the network of care is. Jeff responded that clients who receive a letter may or may not be attributed and few actually were able to name their RCCO correctly. Russ takes the opportunity to point out that the survey that is in the field is only of those who are attributed.

Gary added that the fact that all of the findings seem to suggest that the differences are unremarkable. He is interested in parsing out more details. He asks for clarification of what is meant by "risk adjusted." After a brief explanation from Jeff, Gary states that maybe the risk adjustment is causing the weakness of being able to see what differences to exist. He talked about the philosophy of supply and demand and the need to get at differences in socioeconomic status. He suggested that barriers are pushed in the future.

Jeff states that socioeconomic status may be factoring in level of education but income is not one. David stated that the patient's experience "is what it is." He gives the example of a patient that has given up hope versus a patient that is activated will respond very differently to the survey. Gary pointed out that those with disabilities tend to rate their experience with recent health care higher/more positively, despite all of the barriers that still exist. This may be simply because they do not want to complain and are vulnerable.

Russ points out that efforts exist to keep people's answers anonymous to avoid that possibility. Jeff adds that other issues such as cost and the Internal Review Board, and brings the discussion back to pointing out that CAHPS is simply **one** strategy, not **the** strategy, and while accessibility does bare a conversation, this would best be discussed at a later date.

Pack 2:

Question: On a scale of 1 to 10 with 10 being the best, what is the rating of your personal doctor? (Only those who indicated they had one were asked this question)



Findings: Those in the 65 or older population were more likely to say that they were satisfied. Not only did they rate this higher than other populations, but also rated it higher than their overall care.

Discussion: Erin stated that putting a face to a name is difficult because the interest is in parsing out how those who like personal doctor rated their overall care. David shares that he likes it more when CAHPS try to measure the services and not about if they like certain people. Jeff reminded people that they can take a look at the raw data online and that “subsets” of questions could also be found there. For example, one question is, “How often do you have to wait more than 15 minutes at your doctor’s office?”

Todd asked about the population that was surveyed versus the current enrollment in the ACC: Are there factors that are different, that may act as bias? Susan talked about how when the ACC was started in the spring of 2011, the Department started enrolling focus communities—60,000-80,000 people. At the time the Department was not enrolling based on risk type, but rather those that wanted to be early adopters. Initially, a great proportion of adults were being enrolled. This is due to the need to show savings or be budget neutral, and as children are generally more inexpensive, it would appear that money was being lost, so that could be a bias. Jeff added that those adults mostly represented parents but as of June 2012, Adults without Dependent Children (AWDC) began enrolling.

Erin asked if anything was being done to make the data more similar in the 65+ population that has been separated. Jeff responded that the data was not adjusted. Gary asked if the subcommittee are going to be able to differentiate between the Medicaid Medicare Population (MMP), as there is a national effort on behalf of the Center for Medicare and Medicaid Systems (CMS). Russ points out that the MMP data is tricky because some of the reporting could be mistakenly reporting on Medicare services rendered and not Medicaid. He then stated that there are other health related self-reporting questions that might be able to get at a client’s acuity and/or if they have a disability.

David questioned if the response rates were different between the years and Russ indicated that this was not the case, but the sample size as indeed larger. Russ continues that the survey may be useful as a tool, and most effective in driving change around access, but we need to make the clients aware. David shared that in Rhode Island they used the tool at the practice level and were able to link the data back to the patient, which allowed for quality improvement and a marker of patient experience. Jeff points out that it would also be wise to draw on experience that is happening within our state—like Denver Health. Justin adds that CCHN administer the CAHPS as well and are interested in



casting the net wider to get better results. IPA sample thousands of clients so this may be doable.

Pack 3:

Question: On a scale of 0-10, with 10 being the best, Coordination of care

Findings: No statistically significant difference in ACC versus FFS

Discussion: *put on parking lot list*

Pack 4:

Question: On a scale of 0-10, with 10 being the most positive, what is the overall rating of your health care?

Findings: The average score was 7.5 and FFS scored an 8.0.

Discussion: This score was cross tabulated with care coordination. The takeaway is that for those with care coordination, the ratings were higher. This underscores the importance of care coordination. Justin points out that it would be interesting to look at the data on a practice level versus the RCCO level. Russ shares that they have yet to look at the data by RCCO.

Pack 5: *put on parking lot list*

Francesca asked if there was a difference between substance abuse and behavioral health. She shared that she doesn't like the term, but is a "dual" eligible. She said she also doesn't like that FFS Medicaid is being used for substance abuse. She goes on to share her knowledge of a law in 1995 that substance abusers would lose their benefits if their primary diagnosis was substance abuse. She continued that she believes that Medicaid is paying for clients who have DUIs, which takes away from those who need behavioral health services. Susan tells Francesca that there would be follow-up with the Department staffer that manages the Substance Use Disorder benefit in hopes of addressing her concerns.

Jeff posed the questions, how might CAHPS be used and what is the best comparison group? Erin noted that it will be interesting to see this year's data to see if the same trends exist. Russ added that this is the tool we have; it shouldn't be the only tool. He states that Oregon is currently using CAHPS data in an incentive program. Gary stated in defense of the RCCOs that questions would be asked about selection bias, which could lead to an issue with intent to treat. Jenny shares that while she was with CIVHC for five years, they did a great deal of analysis on CAHPS and there is no real good way to simplify the data. Concern that combining surveys might affect the responses. Brooke closes the meeting by telling everyone to take time to think about all that was discussed today.



Wrap-up

Decisions: Charter was approved.

Action Items: N/A

Next Meeting Topic(s): Colorado Opportunity Project presentation and discussion

Adjourn

The meeting was adjourned at 4:25 pm.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Rachel DeShay at 303-866-5313 or rachel.deshay@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

