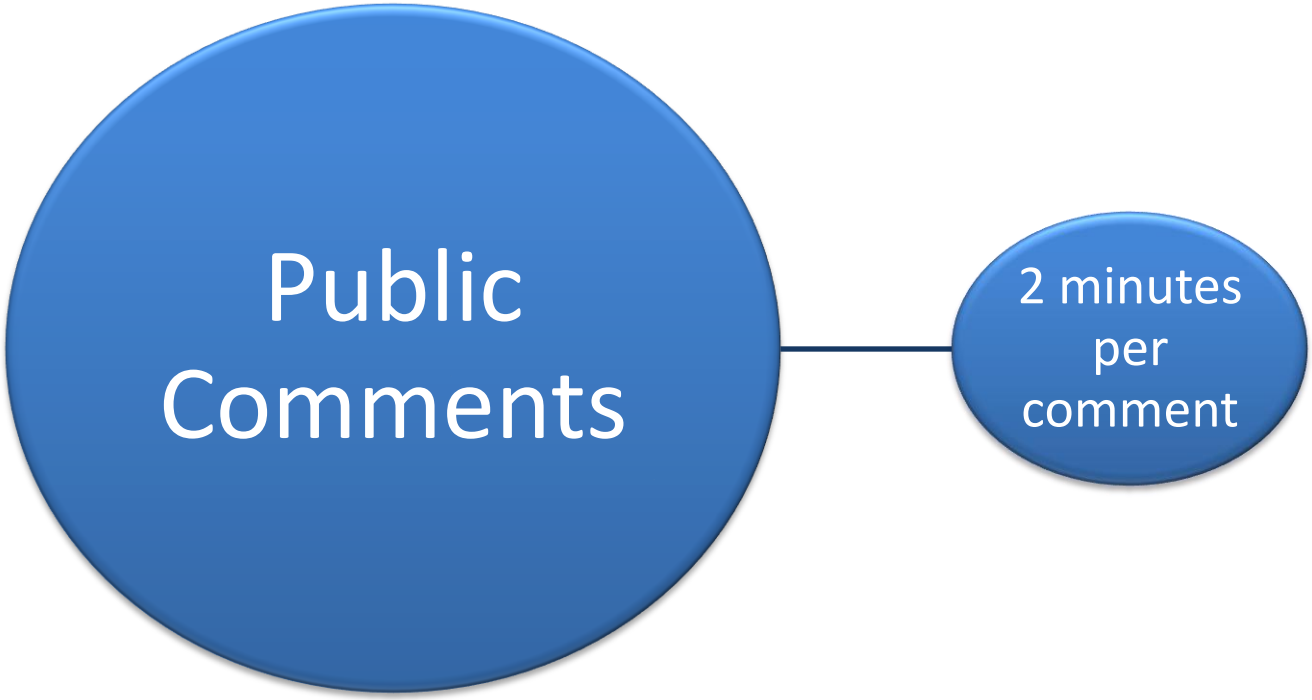
Quality Council

September 30, 2015

Meeting Agenda

Item	Allotted Time
Welcome and public comment	10 min
Minutes	5 min
Recap	5 min
Level 3 culling	35 min
Size of Quality Measure Set	35 min
Quality Measure Alignment Plan: Health Plan Interviews	10 min
Meeting schedule/ Next Steps	
Special Meeting: Care Coordination Design Group Diabetes & Asthma Admission Rate Measure Follow-up	30 min


Public Comments
2 minutes per comment

Recap

Current Provisional Measure Set – For Payment

Consumer Experience

	PCMH- CAHPS consumer experience survey	1768

Care Coordination/Patient Safety

1	Plan all-cause readmission	1768
2	All cause unplanned admissions for patients with diabetes	
3	Asthma in younger adults admission rate	0283
4	Annual percentage of asthma patients (2-20) with 1 or more asthma related ED visits	
5	Asthma admission rate (child)	0728
6	ED Usage per 1000	
7	Documentation of current medications in medical record	0419
8	Annual monitoring for persistent medications (roll-up)	2371
9	Adult major depressive disorder (MDD): coordination of care of patients with specific co-morbid conditions	

Red denotes measures that will be further discussed today

Current Provisional Measure Set – For Payment

Prevention Measures

10	Breast cancer screening	2372
11	Cervical cancer screening	0032
12	Chlamydia screening in women	0033
13	Colorectal cancer screening	0034
14	Adolescent female immunizations HPV	1959
15	Weight assmnt & counseling nutrition and physical activity for children/ adls	0024
16	Preventative care and screening: BMI screening and follow up	0421
17	Developmental screening in the first three years of life	1448
18	Well-child visits in the first 15 months of life	1392
19	Well-child visits in the third, fourth, fifth and sixth years of life	1516
20	Adolescent well-care visits	
21	Tobacco use screening and cessation intervention	0028
22	Prenatal Care & Postpartum care	1517
23	Frequency of Ongoing Prenatal Care (FPC)	1391

Current Provisional Measure Set – For Payment

Prevention Measures (continued)

24	Oral health: Primary Caries Prevention	~~1419~~
25	Screening for clinical depression and follow-up plan	0418
26	Oral Evaluation, Dental Services (Medicaid only)	2517
27	Behavioral health screening (pediatric, Medicaid only, custom measure)	

Current Provisional Measure Set – For Payment

Acute & Chronic Care Measures

28	Medication management for people with asthma	1799
29	Asthma Medication Ratio	1800
30	*DM: Hemoglobin A1c Poor Control (>9%)*	0059
31	DM: HbA1c Screening (interim measure pending NQF 0059)	0057
32	*DM: Diabetes eye exam*	0055
33	*DM: Diabetes foot exam*	0056
34	DM: Diabetes: medical attention for nephropathy	0062
35	*HTN: Controlling high blood pressure*	0018
36	Use of imaging studies for low back pain	0052
37	Avoidance of antibiotic treatment in adults with acute bronchitis	0058
38	Appr. treatment for children with upper respiratory infection	0069
39	Cardiac stress img: Preoperative eval in low risk surgery patients	0670
40	Cardiac stress img: Testing in asymptomatic low risk patients	0672

Current Provisional Measure Set – For Payment

Behavioral Health Measures

41	Follow-up care for children prescribed ADHD medication	0108
42	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)	
43	Depression Remission at 12 Twelve Months	0710
44	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365
45	Unhealthy Alcohol Use – Screening	

Obstetrics Measures

46	Elective Delivery	0469

Current total approximately 51 measures, assuming 5 care experience domains

Current Provisional Measure Set – For Reporting

Reporting Measures

1	Anti-Depressant Medication Management	0105
2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
3	Follow up after hospitalization for mental illness, 7 & 30 days	
4	30 day readmission (MMDLN)	
5	ED Use (observed to expected) – New NCQA	
6	% PCPs that meet Meaningful Use	

Recap of follow-up from previous meetings

9/2 meeting: Dr. Woodruff offered to provide data re: cardiac stress measures

9/16 meeting:

- Quality Council reviewed draft HIT Council Charter and suggested the attached edits. Edits were shared with the HIT Council chairs this evening.
- Discussed Issue Brief on Care Coordination Measures. Council recommended Option 1 (two condition specific), recognizing objections from the health plans that even these high prevalence conditions may have base rates too low for use with many ACOs. Council recommended that all participating health plans undertake an analysis of these measures in order to determine how many of their ACO type contracts would have base rates insufficient to support these measures.

Recap of follow-up from previous meetings

- **9/16 meeting** (continued)
- Council further recommended Option 4 which would establish a design group to further explore the following options:
  - steward a risk-standardized Preventable Hospital Admissions (NCQA) composite for commercial and Medicaid populations. This option would require approximately one year for measure development, and then time for payers to program and run. Target date for implementation as payment measure would likely be no earlier than 2018.
  - steward a risk-standardized composite of the MSSP condition specific measures,
  - test implementation of selected condition specific measures with the APCD,
  - test implementation of selected condition specific measures using edge-server technology.

Recap of follow-up from previous meetings

- **9/16 meeting** (continued)
- Council did not recommend Option 2 (all condition specific). Health plans felt the additional measures would be base rate insufficient in nearly all contracts. The Council did not recommend Option 3 (composite) for a variety of reasons. Among the concerns, the absence of risk standardization could lead to unfair comparisons, and possibly an incentive to patient select. The Council did not recommend Option 5. This option appears to allow for too much variation, even over the short term, which is contrary to the primary aim of this Council

Level 3 culling

Current Provisional Measure Set – For Payment

Acute & Chronic Care Measures

Medication management for people with asthma	1799
Asthma Medication Ratio	1800
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DM: HbA1c Screening (interim measure until NQF 0059 is stood up)	0057
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Cardiac Stress Imaging Measures

Follow-up from 9/2/15

	Waste Categories	Total Services Measured	Percentage of all Services	Services Measured per 1000		(Likely & Wasteful Combined) Services	Wasteful Services per 1000	Total Wasteful & Likely Wasteful Dollars
	Totals:	***393,944***	***74%***	***1864.5***		***58,320***	***276.1***	***22,985,710***
	Diagnostic Testing							
	Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	46,039	9%	217.9		5,287	72.4	12,765,474
	Screening Tests							
	Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms	347,905	65%	1646.6		3,033	203.7	10,220,236

Current Provisional Measure Set – For Payment

Care Coordination/Patient Safety	
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Emergency Department Use - asthma

Domain: care coordination/patient safety		NQF	Steward	Source
	Annual % of asthma patients (ages 2-20) with one or more asthma-related emergency department visits	~~1381~~	Alabama	Claims

- Comment on asthma ED measure:
  - Asthma ED possible strong indicator of effective asthma management; however, NQF endorsement removed and AL will no longer steward
  - NCQA measure is risk standardized, age stratified, results in observed to expected ratio; can do all ages or limit to pediatric; use of this measure for scorecard and payment appears to be without precedent.

Recommendation: Eliminate ED Use- asthma due to NQF endorsement and steward elimination. Rely instead on ED/1000 and stand up new NCQA measures for reporting.

Current Provisional Measure Set – For Payment

Behavioral Health Measures

Follow-up care for children prescribed ADHD medication	0108
Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)	
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Unhealthy Alcohol Use – Screening	

Obstetrics Measures

Elective Delivery	0469

Current Provisional Measure Set – For Payment

Behavioral Health Measures

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Obstetrics Measures

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Size of Quality Measure Set

Size of Quality Measure Set – Other States

Delaware

- Standard measure set for payers to adopt in DE value-based payment arrangements
- **19 measures**

Oregon

- CCO (Medicaid ACO) measure set
- **15 measures (and 2 CAHPS measures)**

Vermont

- Standard measure set for commercial and Medicaid payers
- **11 measures (8** claims based; **2 measures** clinical-data based; **1 measures** Medicaid only)
- 21 reporting measures (3 claims-based; 1 commercial only, 7 clinical-data based, 10 CAHPS measures)

Size of Quality Measure Set – Other States & CT

New Jersey Medicaid

- NJ Medicaid ACO program
- **21 measures (7 of which are CAHPS)**
- 37 "voluntary measures" (must choose a total of 6 from select domains)

CT Medicaid

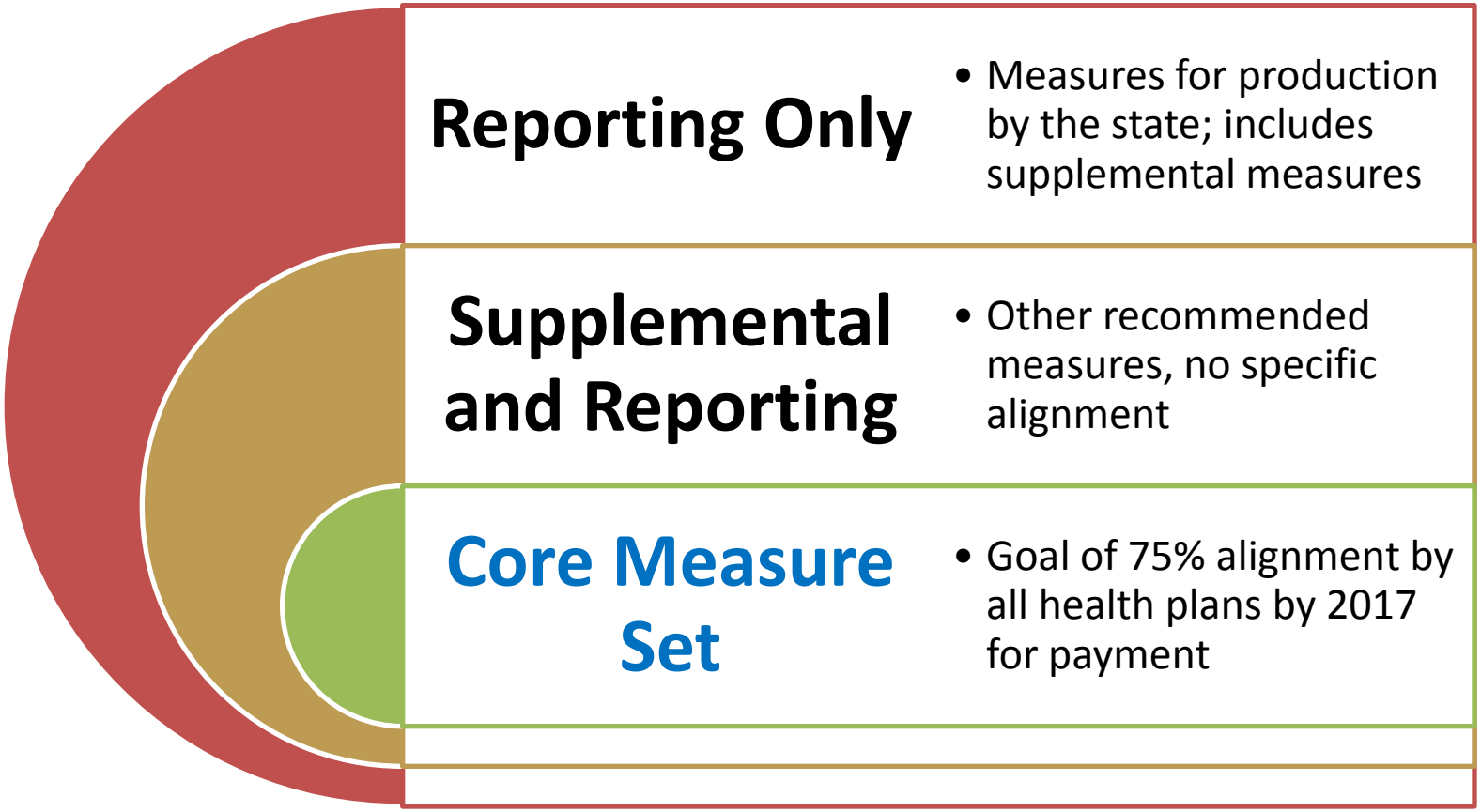
- Medicaid Quality Improvement & Shared Savings Program (MQISSP)
- **8 measures** for payment (provisional)
- 16 measures for reporting (provisional)
- 4 "challenge measures" (provisional)

CT Health Plans

- Health Plans: **10-27 measures**
- Based on report of 3 health plans

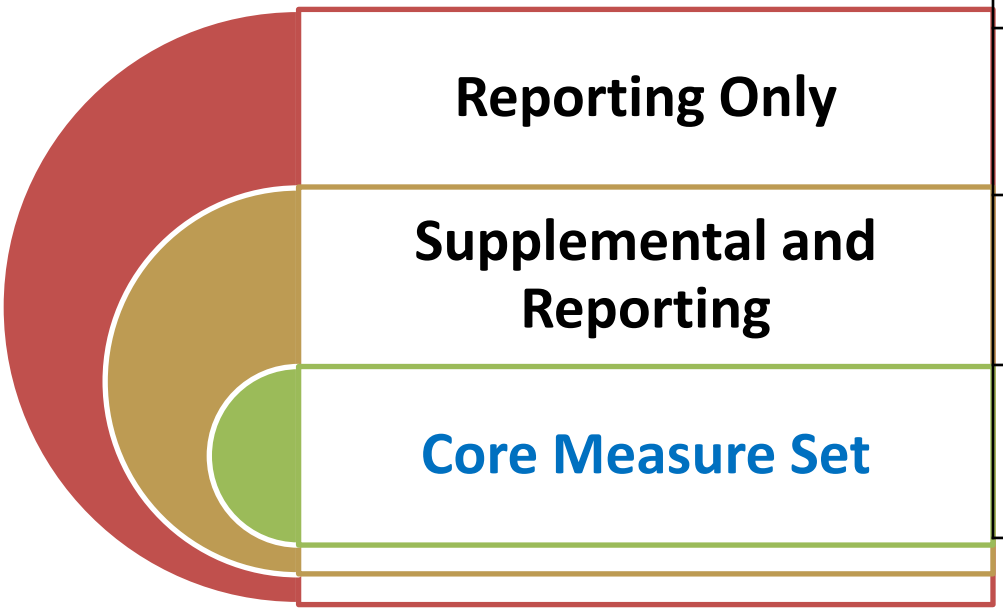
Size of Quality Measure Set

- **Question:** How many measures should be in the "core set" of measures?
- **Core Measure Set =** Those measures that we would prioritize for alignment in 2017



Size of Quality Measure Set

- **Sample Options**



	Option 1	Option 2	Option 3	Other
Reporting Only	6	6	6	6
Supplemental and Reporting	26	20	11	?
Core Measure Set	20	26	35	?

Note: Counts do not include 4-7 care experience measures

Quality Measure Alignment Plan: Health Plan Interviews

Health Plan Interview Update

Purpose of interviews:

- Gauge support for quality measure alignment
- Processes and requirements to program, produce, and report on SIM measures;
- Contracting and negotiation processes including the lead time required to write measures into existing and new contracts; and
- Gauge support for the production of a state-wide quality scorecard using provider performance data

Based on our discussions with the health plans and other constituents participating with the SIM Quality Council, we will propose **a multi-payer alignment process** for the quality measure set.

Number of interviews completed: 2 out of 5

Health Plan Interview Update

Key themes:

- Health plans are negotiating contracts now for 2 or 3 year terms;
- Level of commitment varies;
- Too late to add measures for 2016;
- Multi-payer measures alignment offers the opportunity for some plans to introduce more measures if all payers are requesting the same measures

Health Plan Interview Update

Key themes:

- For multi-year contracts, would be helpful to signal how many measures they intend to add, and potentially which measures, beginning in 2017;
- Request that QC identify set of core measures that are highly recommended (HR) or “Core”, even if not final;
- Some currently use small number of EHR measures by means of provider chart abstraction and data submission or by means of lab data

Next Steps

Proposed Next Steps

- Complete health plan interviews by 10/14/15
- Conduct ranking survey for claims and EHR measures to identify those with the highest recommendation
- Propose grouping:
  - Core, Supplemental, Reporting
- Release draft report 10/16/15
- QC Meeting 10/21 – review draft report, proposed groupings, and plan for alignment

Proposed Next Steps

- QC Meeting 10/28 or 11/4 to resolve outstanding issues and finalize report
- Release report to HISC, 11/5
- Presentation to HISC, 11/12
- Release for public comment, 11/17
- Close public comment, 12/15
- January 2016, final recommendations to HISC

Quality Council Calendar: September - October 2015

Monday	Tuesday	Wednesday	Thursday	Friday
28	29	30 **Quality Council Meeting**	1	2
5	6	7	8	9
12	13 **Health Plan Interviews Complete**	14	15	16 **Release draft Quality Council Report**
19	20	21 **Quality Council Meeting: *Review draft report***	22	23
26	27	28 **Quality Council Meeting (or Nov. 4)**	29	30

Quality Council Calendar: November 2015

Monday	Tuesday	Wednesday	Thursday	Friday
2	3	4 **Quality Council Meeting (or Oct. 28)**	5 **Release Report to Steering Committee**	6
9	10	11	12 **Steering Committee: Present Report**	13
16	17 **Release Report for public comment (due 12/15)**	18	19	20
23	24	25	26	27
30				

Adjourn

Special Meeting of the Care Coordination Measures Design Group

Condition specific measures for Diabetes & Asthma

Base Rate Considerations – A brief review

- Earlier in the year, NCQA said they focus on base rates when they implement performance measures. Base rates are the # of cases or events in the numerator or denominator.

- If base rates are too low, changes in measured performance can be a result of chance, rather than real improvement.

- NCQA recommended that we focus on the denominator. They did not feel that the # of events in the numerator was an issue.

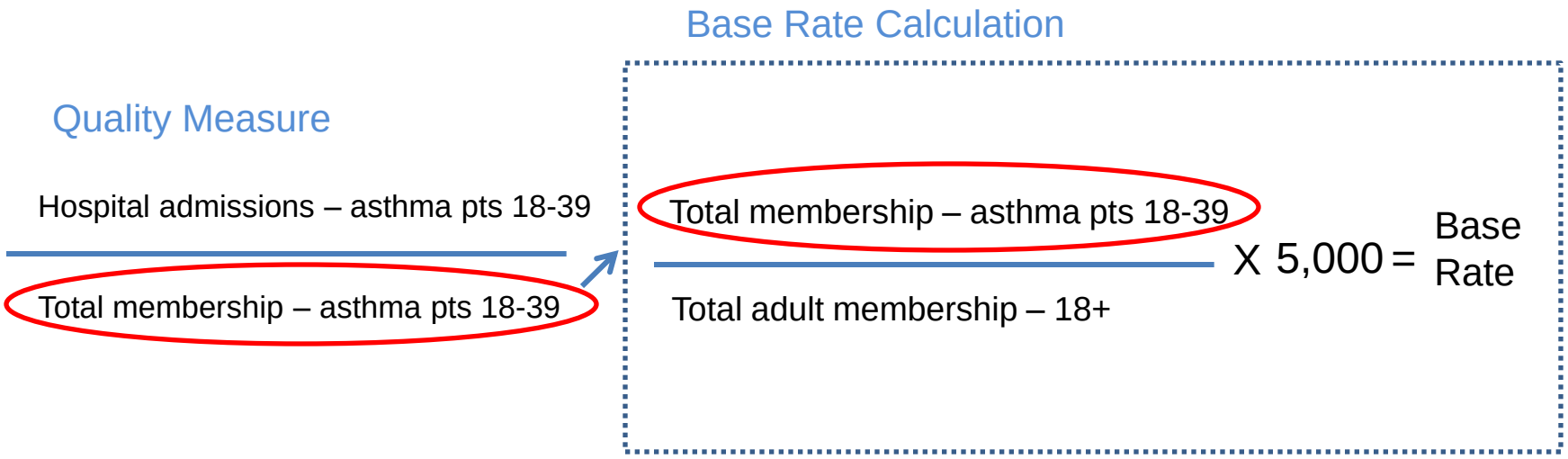
Base Rate Considerations – A brief review

- Accordingly, NCQA suggested a minimum standard of 150 in the denominator.

- This approach makes sense for NCQA because for most HEDIS measures, there is a value in the numerator. E.g., for DM, most patients have an Hba1c test so there are plenty of values in the numerator.

Sample Base Rate Calculation – Ambulatory Care Sensitive Condition

Hospital Admission Young Adults with Asthma



- Our rule of 150 is essentially the same as a population prevalence of 3%. If a condition is not present in 3% of the population, it is not likely to meet the test of 150 per 5,000.
- We assumed that a small ACO will have at least 5,000 attributed adult members.

Base Rate Considerations – New information

- Yale CORE's work on Medicare SSP measures has focused on hospital admission measures for CHF, DM, COPD, etc.
- Yale CORE is more focused on numerator sufficiency.
- If the denominator is 150, but the # of admissions in the numerator is 5 or 10, changes in measured performance may not reflect actual performance. So focusing on numerators makes sense for hospital admission measures.
- For some of our measures, e.g., RA, a focus on the denominator was entirely appropriate.
- For hospital admissions measures, we should have also considered numerator sufficiency.

Base Rate Considerations – New information

- We have also begun to receive feedback on our assumption that small ACOs have 5,000 attributed adults.*
- Health plans vary in terms of their minimum attributed population.
- It is not uncommon to have an attributed population of children and adults of 2,500.
- A measures that is base rate sufficient (150/5,000) based on our initial analysis is not base rate sufficient in a population of 2,500 children and adults.
- If the number of adults is only 1,750, the denominator might only have 53 patients in the denominator.

*One plan reported a “very large ACO” has about 6,000 adults

Recap of last meeting

Option 1

- Implement the hospital admission measures for DM and asthma (young adults) for which base rates are likely to be sufficient for all or nearly all ACOs.

Option 2

- Implement all of the condition specific hospital admission measures listed in Table 1. Suppress measures on a provider-by-provider basis when base rates are insufficient.

Option 3

- Implement the PQI Overall Composite, or adaptation thereof, at the payer's discretion. Reward improvement over baseline rather than against benchmark due to lack of risk standardization.

Option 4

- In combination with 1, 2 or 3 above, establish a design group to further explore the following options:
  - Steward a risk-standardized Preventable Hospital Admissions (NCQA) composite for commercial and Medicaid populations. This option would require approximately one year for measure development, and then time for payers to program and run. Target date for implementation as payment measure would likely be no earlier than 2018.
  - Steward a risk-standardized composite of the MSSP condition specific measures,
  - Test implementation of selected condition specific measures with the APCD,
  - Test implementation of selected condition specific measures using edge-server technology.

Option 5

- Acknowledging the formative status of hospital admission measurement in commercial and Medicaid populations, recommend that health plans implement at least one hospital admission measure, whether composite or condition specific, for pediatric and adult populations, while working with the SIM PMO and a design group of the Quality Council to explore the strategies outlined in Option 4.
- Methods c and d would be examined in conjunction with the HIT Council.

  - 1

Option 1

Option 1

- Implement the hospital admission measures for DM and asthma (young adults) for which base rates are likely to be sufficient for all or nearly all ACOs

PMO reached out to health plans to gather information as to the feasibility of implementing these measures

- **X plans have reported that these measures do not have sufficient base rates in their current ACO contracts to implement at this time**