Quality Council

Care Coordination Measure Design Group

October 15, 2015

Meeting Agenda

Item	Allotted Time
Call To Order	
Base rate review	
Feedback from health plans re: DM and asthma admission measures/discussion	

Special Meeting of the Care Coordination Measures Design Group

Condition specific measures for Diabetes & Asthma

Recap of follow-up from previous meetings

9/16 meeting:

- 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.

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.

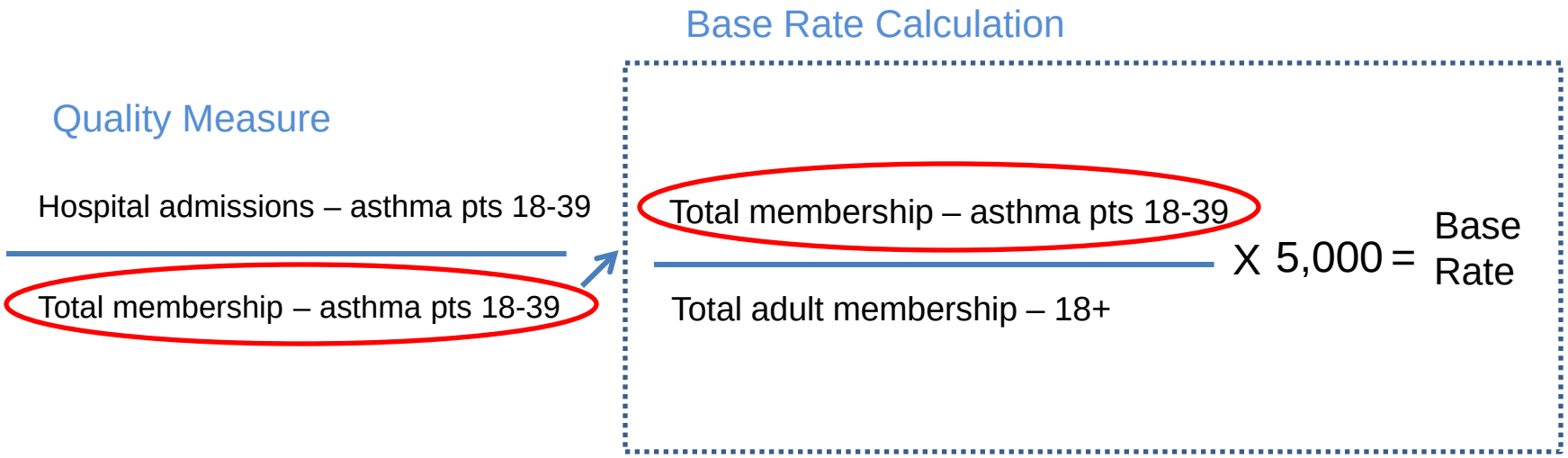
Base Rate Considerations – A brief review

- 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

Issue Brief Re: Care Coordination Measures - Options

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

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