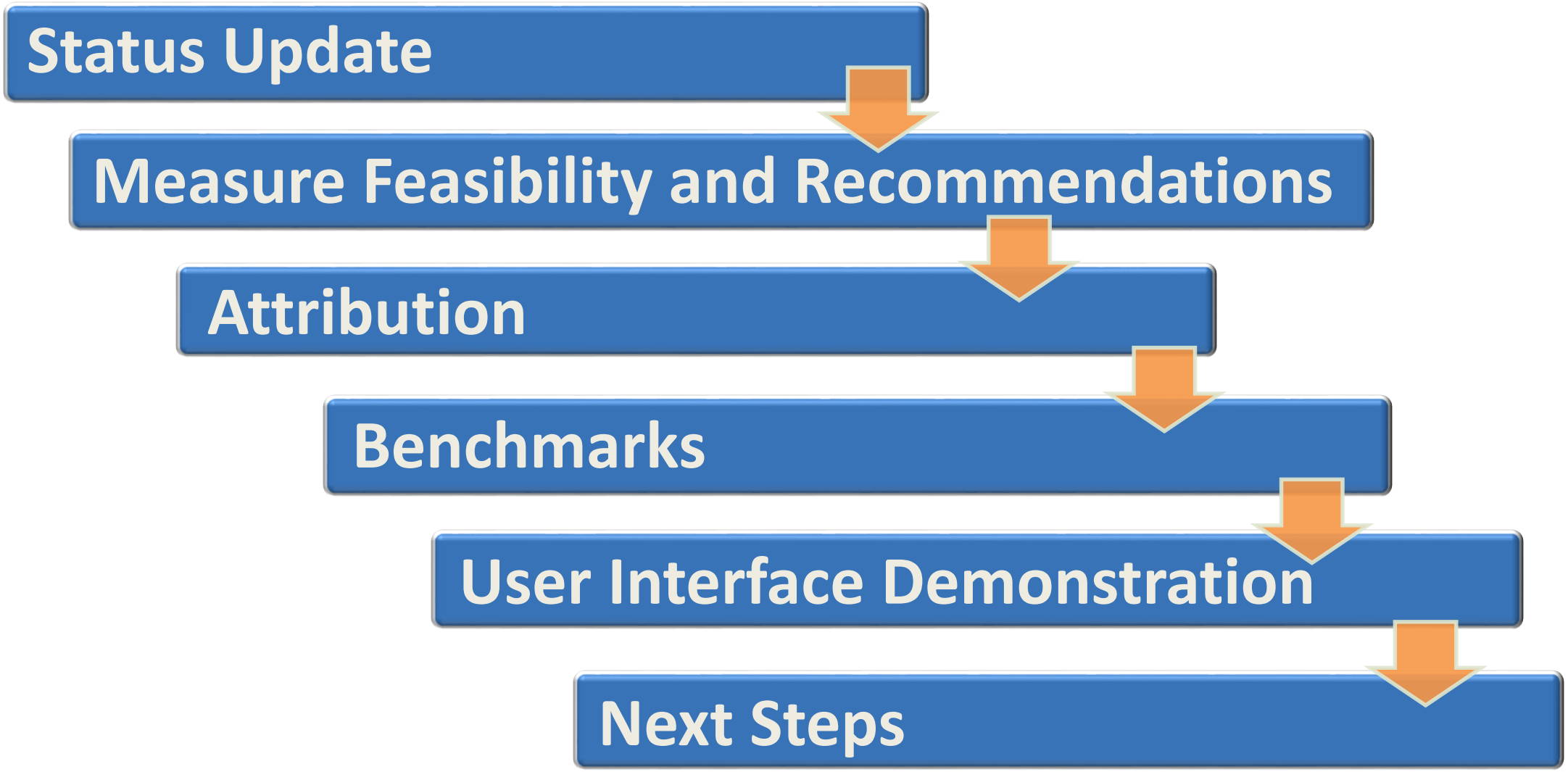
Quality Council

March 14, 2018

Public Scorecard Update

Agenda: Online Healthcare Scorecard



Status Update

Decision Points: Timing of Pending Decisions

- Measure feasibility
- Attribution
- Benchmarks
- Web presentation

} March Meeting

- Scoring/Rating
- Risk Adjustment

} Discussion after receipt of data

- Finalize scorecard

} Final pre-publication presentation- June

Decision Points: Timing of Pending Decisions

- Measure feasibility
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March Meeting

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~~Discussion after receipt of data~~
April/May Meeting

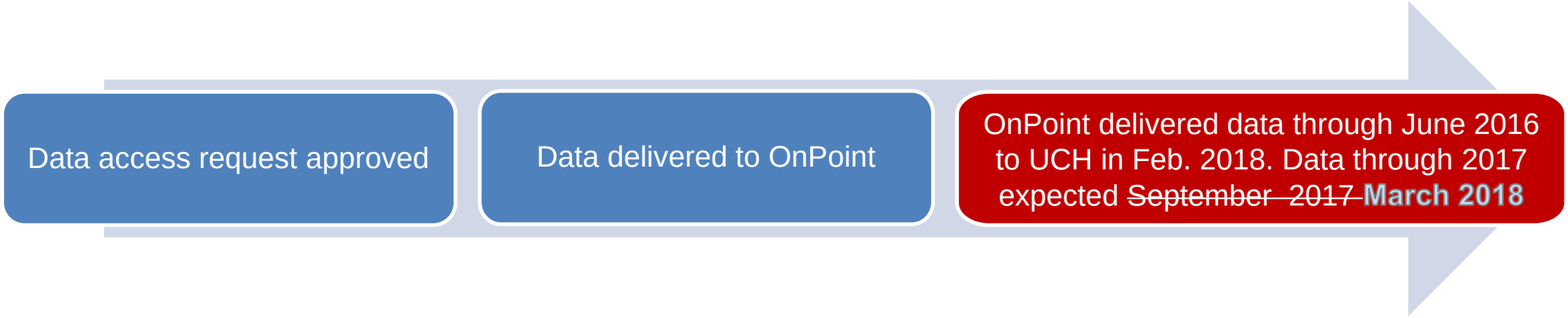
- Finalize scorecard

Final pre-publication presentation - June

Data Status Update: Claims Data

- Medicare data

- Non-Medicare APCD data from commercial claims



- Medicaid data – Data release decision pending

Measure Feasibility and Recommendations

Measure Feasibility (1 of 5)

- February discussion of measure issues and possible solutions:

1. Measures with anchor dates:

   ☑ Use age documented in eligibility file

2. Measures requiring age in months:

   ☑ Obtain separate APCD data extracts containing only eligible individuals (APCD has agreed to provide these)

3. Measures with EMR components:

   ☑ Present only the claims component

Measure Feasibility (2 of 5)

4. Measures with EMR requirements for operationalization (i.e. laboratory results, clinical notes):

Recommendation: Omit the EMR information when calculating the measure.

- More information requested: How do payers implement these measures?
  - Payer feedback indicates that payers receive additional data from providers and CPT-2 codes to address these measures

Measure Feasibility (3 of 5)

5. Measures with unavailable value sets (contains requirement to identify patients who have “prolonged use of corticosteroids” but does not define “prolonged use”)

Recommendation: Quality Council decides to utilize 12, 24 or 52 weeks to define “prolonged use”

- More information requested: How do payers implement these measures?
  - Payers provided feedback
    - One uses 90 days on the lower back pain diagnosis or in the 365 days prior to the diagnosis
    - The other considers 2-4 months as prolonged use

Measure Feasibility (4 of 5)

- Immunizations for Adolescents (Tdap, TD and meningococcal)
  - Numerator requires immunization by 13th birthday but APCD cannot provide full time period
    - ➢Can examine vaccine history from age 11 to 13 years
  - Cannot meet exclusion of previous anaphylactic reaction to vaccine or vaccine components (available in EMR only)
  - Value set for Td is not provided

Measure Feasibility (5 of 5)

- Contraceptive Care- Access to LARC
  - Cannot meet exclusion of live birth in past 2 months
    - ➢Can exclude all women with deliveries in past 2 months
  - Value set for “infecund for non-contraceptive reasons” is not provided
  - Value set of long acting reversible contraception is not provided
    - ➢Can use HCPCS codes from US Department of Social Services:

HCPCS Code	Contraceptive Name
J7297	Levonorgestrel iu 52mg 3 yr
J7298	Levonorgestrel iu 52mg 5 yr
J7300	Intraut copper contraceptive
J7301	Levonorgestrel iu 13.5 mg
J7307	Etonogestrel implant system

Attribution

Attribution (1 of 9)

- What is attribution?
  - Assigning a provider who will be held accountable for a member based on an analysis of the member's claims data. The attributed provider is deemed to be responsible for the patient's quality of care and cost.

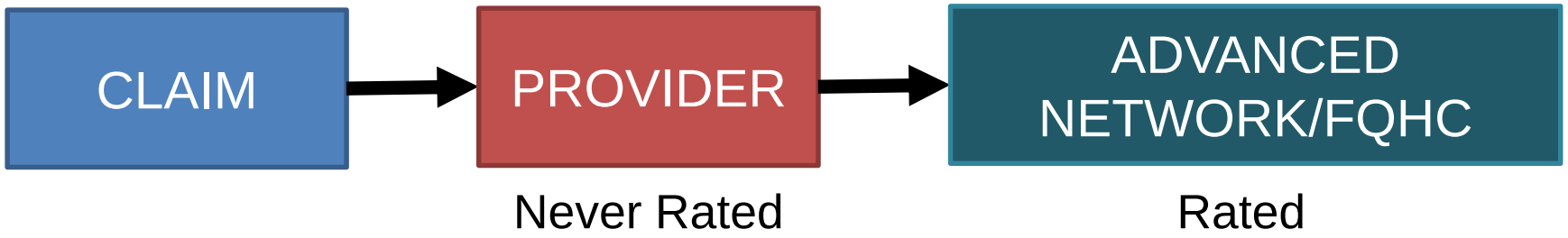
- Why is attribution important for Value-based Payment (VBP) contracts?
  - Attribution determines which patients are assigned to what (groups of) providers, thereby determining the analysis of the outcomes, total costs of care, potential shared savings per VBP arrangement per provider combination.

- In this case attribution is being used for quality ratings only and not for provider payment

Sources:
1. Pantely SE. Whose patient is it? Patient attribution in ACOs. Milliman Healthcare Reform Briefing Paper. 2011 Jan.
2. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_patient_attribution.pdf

Attribution (2 of 9)

- Recommend methodology based on 3M/Treo
- Adapted methodology
  - Part one: Attribute patients to eligible providers based on preponderance of Evaluation & Management (E&M) visits in a set time period
  - Part two: Link providers to ANs/FQHCs using billing NPI or site of care



Attribution (3 of 9)

- Decision Points:
  - **Decision point 1***:* Should OB/GYNs, Nurse Practitioners and/or Physician Assistants be included as PCPs?

Quality Council Decision:

- PCPs include NPs and PAs but not OB/GYNs
- Attribute to OB/GYNs in absence of a PCP relationship and before other specialists

Attribution (4 of 9)

Quality Council questions:

- *Are NPs and PAs listed as rendering providers?*

  Medicaid: NPs and PAs are listed as rendering providers (not as billing providers)

  Commercial Payers: Payer feedback indicated that they do not attribute to PAs but that they can be billed as servicing providers in claims

- *Does Medicaid consider OB/GYNs to be PCPs for attribution?*

  Medicaid does not recognize OB/GYNs as PCPs (follows NCQA)

Attribution (5 of 9)

- **Decision Point 2:** If no Evaluation & Management (E&M) services are found with a PCP in the given time period, should attribution be made to a specialist? If so, which specialties are eligible?

  Quality Council Decision: Specialist attribution should be made

  Quality Council Questions:

  - *Should physiatrist and/or developmental pediatrics be eligible for attribution*

    Physiatrists are on the Medicare SSP specialist list

    Developmental pediatricians are not listed

Attribution (6 of 9)

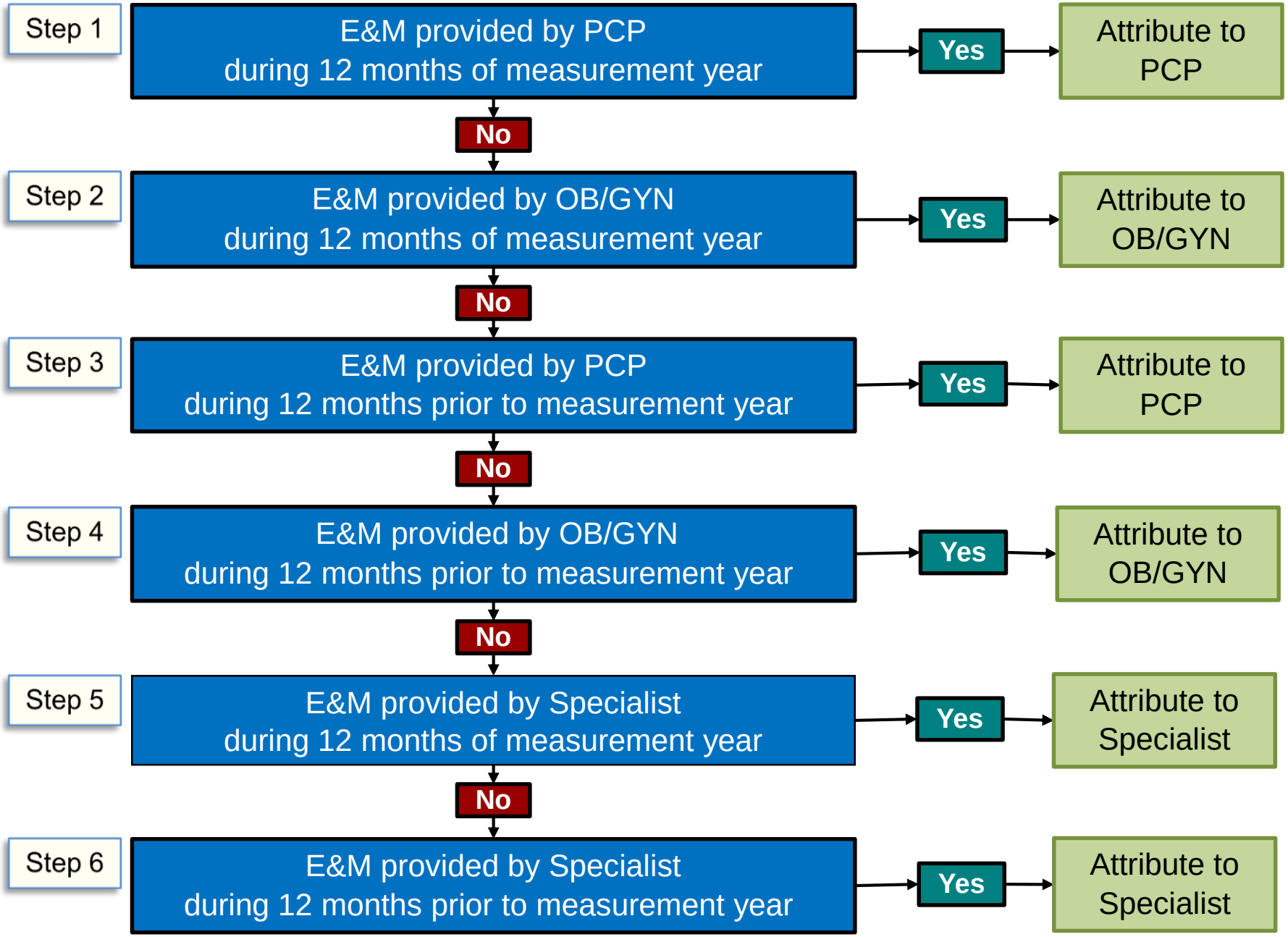
Specialties Eligible for Specialist Attribution	
Addiction medicine	Neurology
Cardiology	Neuropsychiatry
Endocrinology	Osteopathic manipulative medicine
Geriatric psychiatry	Palliative/hospice
Hematology	Physician medicine and rehabilitation/physiatrist
Hematology/oncology	Preventative medicine
Medical oncology	Psychiatry
Multispecialty clinic or group practice	Pulmonary disease
Nephrology	Sports medicine

Attribution (7 of 9)

- **Decision Point 3:** Define the time period for eligible services and the order of preference for specialist attribution:

  Quality Council Decision: Look back an additional 12 months for PCP attribution before moving to OB/GYN and then specialist attribution.

Patient Attribution Flow Chart



Attribution (9 of 9)

- Implications, possibility of adverse selection, and anticipation of future issues?

User Interface Demonstration

User Interface

- UConn Health is requesting a sub-group to make decisions about presentation

- Will hold 3-4 WebEx style meetings with 2-4 decisions for each
- Meetings to begin in early April and will be held weekly or every other week

  - Decision points will be emailed out in advance for members to review
  - During the meeting the options will be displayed
  - The group will discuss and decide

- Decisions will be presented to the full Council once the subgroup has concluded work

Next steps

Next Steps

- Receive Medicare data
- Continue work on commercial/Medicare claims from APCD
- Finalize plan for scoring, benchmarks, risk adjustment
- Continue User Interface development
  - Convene subgroup on presentation