EOHHS Total Cost of Care Guidance - CHC ACO's Feedback 8/25/2017

Addendum: Quality Framework and Methodology

Draft for distribution, July 28, 2017

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value based model is critical to ensuring that quality is maintained and/or improved while increasing cost efficiencies. As such, the payment model must be designed to both recognize and reward historically high quality Accountable Entities while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds.

As a starting point, the Year 1 (July 2018 – July 2019) guidance described below is intended to provide an interim structure that permits baseline measurement and assessment, while allowing for future refinements that continuously "raise the bar" toward critical improvements in quality and outcomes.

B. Medicaid Accountable Common Measure Slate

EOHHS requires the use of the measures included in the attached Medicaid Accountable Entity Common Measure Slate. In addition to the 10 required core measures, each MCO and AE must also include up to an additional two measures as follows:

- One (optional) measure: must be identified by MCO and AE from the SIM menu measure set, and/or Medicaid Child and/or Adult Core Set,
- One ~~(~~mandatory~~)~~ measure not included in the SIM suite of ~~:~~ measures: must be a self-assessment/rating of health status (e.g. IHI). This measure is to be defined and submitted to EOHHS for approval. ~~–~~Suggest this be moved to the grid with the 10 SIM Core requirements as it is mandatory.
- ~~o~~ Upcoming measure: EOHHS may define an additional member retention measure (for the entire ACO not at the agency/aco provider level) for piloting in Year 1, and full implementation beginning in Year 2.~~-~~

Please see the Medicaid Accountable Entity Common Measure Slate (attached). This Common Measure Slate has been developed with the following considerations:

- Alignment with the RI State Innovation Model (SIM) core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful reward
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner

C. Shared Savings Opportunity

Medicaid Accountable Entities are eligible to share in earned savings based on a quality multiplier to be determined as follows.

- The Accountable Entity must meet the established total cost of care threshold as determined using the EHHOS approved total cost of care methodology to be eligible for shared savings.
- The quality and patient engagement measures included as part of the ~~minimum~~ required set of Medicaid Accountable Entity Common Measure Slate (including up to 2 additional menu measures) will be used to determine a quality score for each Accountable Entity.
- If desired, the AEs will be allowed to generate clinical data-based measures for their entire Medicaid AE population, rather than be required to do so for each MCO~~.~~
- The quality score will be used as a multiplier to determine the % of shared savings the AE is eligible to receive.
- The first performance year will be used to establish a ~~baseline~~ (please see comment directly below this paragraph) threshold of performance, the multiplier will be determined allowing 50% based on the ACO's ability to ~~of which will be~~ report on a measure ~~ing~~ and 50% based on measure performance.

  Comment- It is not clear that year 1 is used to establish a baseline when year 1 has performance targets included. If this is to be determining a baseline, please explain at a high level how that will impact year 2. Or perhaps consider not making this performance based in year 1.

D. Quality Score Determination

Part 1: Relative Weight of Individual Measures

The Quality Score is to be developed based on assigning a weight to each individual measure. For each measure included in the Measure Slate, the AE will receive two scores:

- a "Measure - Score" according to the criteria specific below in part 2.
- A Reporting score: a pass/fail score (either 100% or 0%), based on timely submission of required data in accordance with agreed upon formats. There will be no partial credit for reporting.

The Measure Specific Quality Score must value the Measure Score and the Reporting Score each at fifty percent. The overall Quality Score must be a sum of the Measure Weights times the Measure Specific Quality Score for each measure.

Example:

List of Measures	Tiered Measure-Score *(50/85/100%). Value= 50%*	Reporting Score. *Value = 50%*	Measure specific Quality Score	Sample Weight*	Overall Quality Score
Measure 1	50%	100%	75%	20%	15.0%
Measure 2	85%	100%	93%	20%	18.5%
Measure 3	0%	0%	0%	20%	0.0%
Measure 4	100%	100%	100%	30%	30.0%
Measure 5	0%	100%	50%	10%	5.0%
Overall Quality Score					**69%**

*To be determined in the contract between the MCO and the AE, with the exception of the SDOH measure (#10) which must have a measure weight of at minimum 10%.

Column Definitions:

- Tiered Measure Score – based on measure specific performance tiers found in the grid in part 2 of this section
- Reporting Score – if the AE can report on the measure to the MCO, the AE receives 100% of the 50% allocated for he given measure
- Measure specific Quality Score – sum the total of the measure for performance and for reporting ability.
- Sample weight – negotiated between AE and MCO
- Overall Quality Score – Measured specific multiplied by the Sample weight

Part 2) Measure Specific Performance

Measure specific performance is intended to both reward historically high-quality providers and create opportunities for low performers to benefit from improvement.

For each measure included in the Measure Slate, AE baseline performance shall be established relative to the MCO Medicaid average (please see comment directly below this paragraph), and the AE shall be assigned to a Performance Tier. AEs in each performance tier will either receive a "pass" or "fail" on each measure based on the criteria listed below. AEs who receive a passing score shall earn a corresponding Tiered Measure Score, depending on the Performance Tier. The criteria for the AE to "pass" on a measure differs according to the AE's measure specific Performance Tier, as shown below.

It should be considered that RI typically scores very high in the national ratings. There is a possibility that this can cause a deficit for an AE even when they score better than the national a, but not bettee than the MCO.

Example of a Tier 1 Issue – In the diagram below the AE score is more than 5% less than the MCO but it performed better than the US National 75th percentile. In that case, the MCO would only reap a 50% Tiered Measure Score. In subsequent years, the AE could continue to be above the US National 75th percentile and receive no Tiered measure score.

US National 75th percentile	**MCO 50th percentile**	**AE score**
70%	77%	71%

We recommend that the framework allow for acknowledging the ACO efforts when it is below the MCO average but above the US National Average.

Measure Specific Performance Tiers

Performance Tier	Tiered Measure Score *(Passing Score)*	AE Performance relative to MCO Performance on Measure	Criteria for AE to receive Passing score on Measure
Tier 1 – Low	50%	AE score is **more than 5 percentage points less** than the MCO Medicaid members average baseline (please see comment # 3 directly below this grid) score *(i.e. MCO score on a measure is 60%, AE score on measure is less than 55%)*	~~**Statistically Significant Improvement***~~ AE must show ~~statistically significant~~(please see comment # 1 directly below this grid) improvement (please see comment #2 directly below this grid) using a one-year lookback in Year 2, a two-year lookback in Year 3, and a three-year lookback thereafter
Tier 2 – Medium	85%	AE score is **within 5 percentage points** in either direction of the MCO Medicaid members average baseline score *(i.e. MCO score on a measure is 60%, AE score is between 55% and 65%)*	**Maintain or Improve Quality** AE must either maintain or improve quality level using a one-year lookback in Year 2, a two-year lookback in Year 3, and a three-year lookback thereafter
Tier 3 – High	100% 115%	AE score is 0 through ~~more than~~ **5 percentage points above** the MCO Medicaid members average baseline score. If the AE score is over 5% of the MCO Medicaid members score than the tiered measure score is 115%. *(i.e. MCO score on a measure is 60%, AE score is over 65%)*	**Remain at least 5% above MCO Level** AE can maintain, improve or decline no less than 5% above the MCO quality level using a one-year lookback in Year 2, a two-year lookback in Year 3, and a three-year lookback thereafter. If MCO score is 95% the AE must maintain or improve.

- ~~Statistical significance is defined as a P value ≤ .05~~

Comments on the grid:

1) We believe this (statistical significance)will become extremely burdensome for the MCO's to administer and will increase the demand on ACO providers to comply with chart reviews. As you can see in our comments, 5 of the proposed measures are hybrids that the MCO can only determine by chart reviews. Determining the "p" value makes this more complex and we contend will dramatically increase the workload associated with those chart reviews. We do not believe this will provide enough value to make it worth the effort. Perhaps simply make it a required decimal value such as o.1 improvement.

2) This is a bit unclear(showing improvement). Please clarify, if an AE does not make improvements over the previous year, does the tiered Measure Score automatically become a zero? If so please specify that in the document, perhaps add a row to the table diagram. If that is the case we recommend that the AE get credit whether it maintains or improves, not just improves. The importance related to quality for an ACO

is assuring we maintain our quality while decreasing the cost of their care(as noted in our overall comment at the end of this document).

3) We contend that the comparison data must be population based. To compare the Medicaid AE against the entire MCO population could cause a disparity that is not intended by the Medicaid ACO efforts. The disparity in results can happen for many reasons, transient population, sicker patients that seek care more often than commercial members, etc.…

Example: Measure 1. Breast Cancer Screening, MCO score = 55%

AEs	Year 1 Score	Performance Tier	Year 2 Score	Result	Tiered Measure Score
AE 1	39%	1 – Low	39%	Fail	0%
AE 2	30%	1 – Low	35%	Pass	50%
AE 3	50%	2 - Med	48%	Fail	0%
AE 4	50%	2 – Med	50%	Pass	85%
AE 5	75%	3 - High	70%	Pass	100%

Proposed Medicaid Accountable Entity Common Measure Slate - Use the Measure Steward column to obtain technical specifications for creation of the targets.

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Description	Age Cohort
1. Breast Cancer Screening		HEDIS®	Preventive Care	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer at any authorized Breast Cancer screening provider.	Adults
2. Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	0024	HEDIS®	Preventive Care	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/Gyn and who had evidence of the following during the measurement year: BMI percentile, Counseling for Physical Activity and Nutrition.	Pediatric
3. Developmental Screening in the 1st Three Years of Life	1448	OHSU	Preventive Care	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are	Pediatric

				screened by 12 months of age, by 24 months of age and by 36 months of age	
4. Adult BMI Assessment	N/A	HEDIS®	Preventive Care	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	Adult
5. ~~6.~~Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI	Preventive Care	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Adult
~~6~~7.Comp. Diabetes Care: HbA1c Control (<8.0%)	0575	HEDIS®	Chronic Illness	The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control <8.0%.	Adult
~~7~~8.Controlling High Blood Pressure	0018	HEDIS®	Chronic Illness	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • 18-59 years of age-BP was <140/90 mmHg • 60-85 years of age-w/ a dx of diabetes whose BP was <150/90 mmHg • 60-85 years of age-w/ a dx of diabetes who BP was ~~<~~>150/90 mmHg	Adult
8.Follow-up after Hospitalization for Mental Illness (7 Days from receipt of notification)	0576	HEDIS®	Behavioral Health	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner~~.~~(BH Clinician, PCNS, CHT, Social worker).	Adult and Pediatric

				Issues: • MCO's must send AE's data on these admissions in a comprehensive and timely fashion. This is not the case currently for BH related admissions, nor are they all reflected in the RIQI Care Management Dashboard • We do understand why 7 days has been chosen as a target for follow up related to a BH admissions (faster return to the hospital), however there is difficulty for CHC and CMHCs to know when a pt is admitted/discharged for BH reasons. If the MCO's cannot get d/c notifications to us in a timely fashion than we recommend changing the 7 days to 14, 21 or 30 days for year 1 from the date of notification – NOT DISCHARGE. HEDIS 2017 requires a 30-day reporting and a 7 day reporting number. Until systematic issues with this can be eased the 7 day requirement is too stringent. • What is the current rate of this? • We believe this measure can best be reported by the MCO's. If the ACO is unable to house all payer claims than it will not have comprehensive view of MH visits. • NexGen clients will have a difficult time to implement any reporting on this. The reason for the follow up is currently housed in a free form text field and unreportable. Significant changes woud have to be made	

				to accommodate this. Some of the providers may need the vendor to make those changes.	
9.Screening for Clinical Depression & Follow-up Plan	0418	CMS	Behavioral Health	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Adult and Pediatric
10. Social Determinants of Health (SDOH) Screen	N/A	N/A	Social Determinant	% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*	Adult and Pediatric

Section 5.2.2 of the AE Certification Standards requires that each AE
"*Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for any -Attributed New Members being seen by an ACO provider in that contract year .based on a defined protocol…. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:*

- *Housing stabilization and support services;*
- *Housing search and placement;*
- *Food security;*
- *Support for Attributed Members who have experience of violence.*
- *Utility assistance;*
- *Physical activity and nutrition;…"*

Issues with the above measures:

- *We understand that items # 3,4,5,9 and 10 are not reportable by the MCO's and would have to be self-reported by the AE. The way that is done currently is by a chart review performed by the MCO's. This could allow for a vast variance in the comparison between the MCO Medicaid average and the AE score.*
- *The AE and the MCO currently have the ability to perform a collaborative HEDIS review to ensure that the chart reviews are comprehensive (i.e. include results from all sources of data available to us; not all results can be found in the ACO providers emrs). This collaborative HEDIS review must remain in this process. This review must occur at least 3 months prior to the close of the fiscal year/contract year so that additional results could be included. We recommend adding this to the framework and methodology.*
- Typically, the MCO average is completed based on HEDIS reporting. HEDIS reporting is currently executed against a calendar year. If the same HEDIS processing timeline remains than how will we apply this on a fiscal year that encompasses two calendar years, i.e. 7/18 through 6/19?
- It is necessary for the AE to know at the end of the first quarter each year what their target is so that it can prepare accordingly.

Optional Menu Metrics

Select no more than 1 measure from the SIM Menu Measure Set and/or the Medicaid Child and/or Adult Core Quality Measure Set.


2017-child-core-set (1).pdf


2017-adult-core-set .pdf


Crosswalk of RI Aligned Measure Se

Overall comment: It appears that the MCO's plan is to include Quality Improvements through the ACO contract and not within their individual provider contracts. As the ACO objective is to ensure quality does not suffer as a result of shared savings initiatives, we contend that Quality Assurance, not quality improvement is the appropriate component of our ACO contracts to be coupled with shared savings. We recommend any reference to Quality Improvement in ACO documentation be changed to Quality Assurance. We completely understand the goal of the MCO's to include quality improvement work , however we believe this should be a separate incentive and decoupled from the shared savings.