Commonwealth of Massachusetts

Executive Office of Health and Human Services

EOHHS QUALITY MEASURE ALIGNMENT TASKFORCE

May 18, 2021

Agenda

1. **Welcome**
2. **Follow-up items from April**
   a. Social risk factor screening measures
   b. Substance Use Treatment in Primary Care
3. **Continuation of Annual Review**
   a. Consider new HEDIS and CMS measures
   b. Consider proposed HEDIS changes
   c. Consider care coordination measures
   d. Consider fluoride varnish measures
4. **Recommendations from the Health Equity Work Group**
5. **Revisit Recommended Changes to the Aligned Measure Set**
6. **Next steps**

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Social Risk Factor Screening Measures

- During the April meeting, the Taskforce discussed social risk factor screening measures used in Massachusetts, North Carolina, and Rhode Island.
- The Taskforce expressed interest in re-visiting the social risk factor screening measures in order to:
  - gauge if there should be a social risk factor screening measure included in the Aligned Measure Set for 2022 or for a future year, and, if so,
  - select the social risk factor measure that should be included, and specifically, decide whether to add the MassHealth measure to the Menu Set.
- Details regarding the social risk factor screening measures are included on the next slide.

Social Risk Factor Measures

- **Does the Taskforce wish to further consider any of these measures for inclusion?**

Measure	Domains Screened	Description
Health-Related Social Needs Screening - MA	Core: Food, Housing, Transportation, Utility Supplemental: Employment, training, or education; Experience of Violence; Social Supports	ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
Screening for Social Determinants of Health - NC	Food Insecurity, Housing Instability, Transportation, Interpersonal Violence	All managed care enrollees for whom the Prepaid Health Plan completed a social determinants of health screening within 90 days of enrollment.
Social Determinants of Health Screening - RI	Food Insecurity, Housing Insecurity, Transportation, Interpersonal Violence, Utility Assistance	Individuals attributed to the primary care clinician who were screened for social determinants of health once per measurement year and for whom results are in the primary care clinician's EHR.

Substance Use Assessment in Primary Care

- At the April meeting, the Taskforce reviewed the Substance Use Workgroup's recommendations on **SUD Assessment in Primary Care**
  - The Work Group supported incentivizing routine screening of substance use as starting place for measurement and liked that this is an administrative measure.
  - This measure will help to encourage universal screening and increased coding. If clinicians are not routinely coding for the measure, the measure may need a ramp-up period prior to use in the Aligned Measure Set.
  - The Work Group supported utilizing a multi-year strategy that would first implement a screening-only measure, which would be replaced with a screening and follow-up measure for alcohol and other drugs, and would include adolescents.

Substance Use Measures Glide Path

2022

- **Substance Use Assessment in Primacy Care** becomes an on-deck measure.
- **IET** remains in the Menu Set

2023

- **Substance Use Assessment in Primacy Care** becomes a Core Set reporting-only measure.
- **IET** remains in the Menu Set.

2024

- **Substance Use Assessment in Primacy Care** becomes a Core Set pay-for-reporting measure.
- **IET** drops from the Menu Set if NCQA has not yet demonstrated validity.

2025

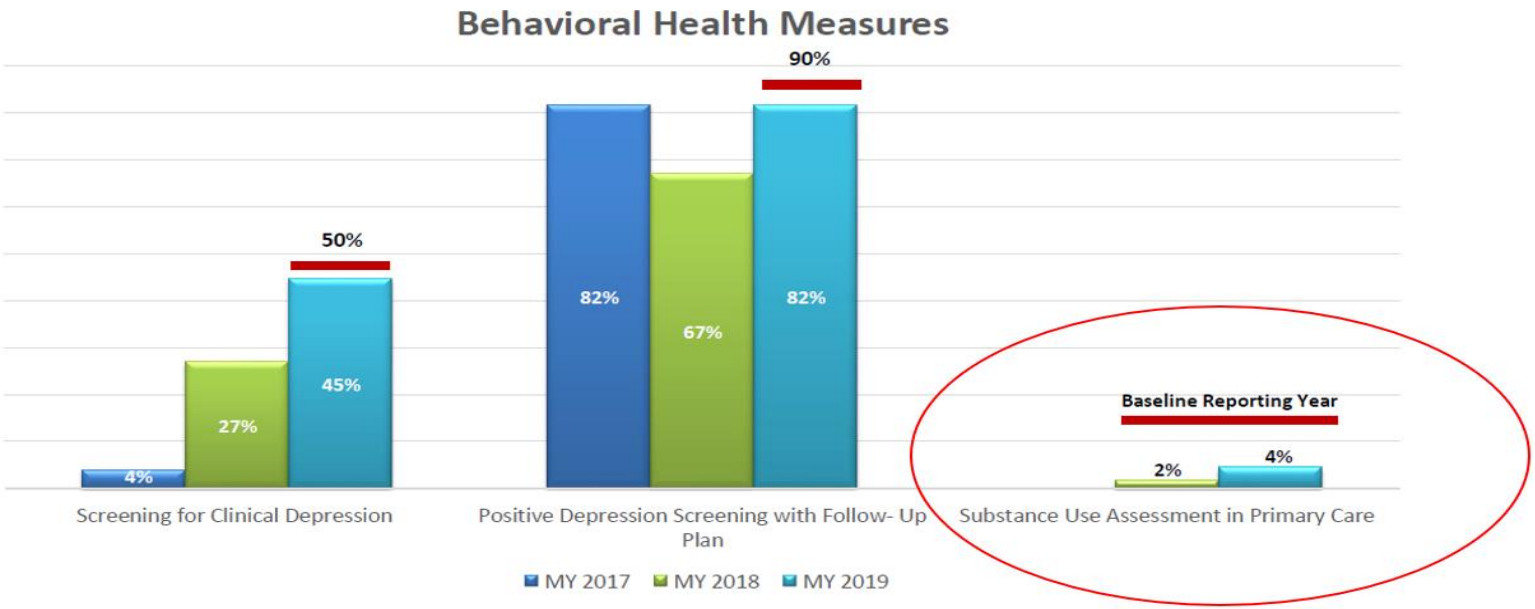
- A future measure that incorporates **follow-up** and **adults and adolescents** is introduced as an on deck or Menu Measure.

Substance Use Assessment in Primary Care

- The Taskforce asked if there were data from IEHP, the measure steward, regarding performance on the measure.

2019 Final Performance

IEHP Inland Empire Health Plan



New information as of 5/18: 2020 performance (the first year of PFP) was 10%.

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Annual Review Process

Step	Timing
1. **Background** • Measure selection criteria • State priorities	November
2. **Review of the existing measure set** • Opportunities to promote health equity • Specification changes • Use in contracts (through review of the Quality Catalogue) • Recent performance	January - March
3. **Consideration of new measures** • Revisit Prenatal and Postpartum Care: Postpartum Care and discuss Effective Contraceptive Use • Revisit 2020 Developmental Measures • New to HEDIS, the Medicaid Core Set, and MIPS • Others as recommended by the Taskforce • Substance use disorder measures scan	November, March – April
4. **Revisit tentatively proposed changes, consider removal of measures, and finalize the Aligned Measure Set for 2022**	May

Continuation of Annual Review

- Today we will consider four remaining topics as part of the Annual Review:
  a. Consider new HEDIS and CMS measures
  b. Consider proposed HEDIS changes
  c. Consider care coordination measures
  d. Consider fluoride varnish measures

HEDIS 2019/2020 Measures of Interest to the Taskforce

- **During the December 9, 2019 Taskforce meeting,** members expressed interest in the following new 2019 and 2020 HEDIS measures once benchmark data became available.
  - Benchmark data are still not available for these measures; some data may become available as updated Quality Compass data are released during the summer and fall.
- **Does the Taskforce recommend revisiting these measures for inclusion during the next Annual Review process?**

Measure	LOB	Data Source	Description
Adult Immunization Status	Comm., Medicaid, Medicare	ECDS	The percentage of adults 19 years and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, Tdap, herpes zoster and pneumococcal.
Post-partum Depression Screening and Follow-up	Comm., Medicaid	ECDS	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

Proposed HEDIS 2022 New Measures

- **In its public comment request, NCQA shared proposed new measures for HEDIS 2022.**
  - We excluded Advance Care Planning and Prescribing of Benzodiazepines in Older Adults as they are only for the Medicare product line.
- **Does the Taskforce recommend adding the measure below to the Aligned Measure Set once finalized by NCQA, and then again once performance data are available?**

Measure	LOB	Data Source	Description
Antibiotic Utilization for Acute Respiratory Conditions	Comm, Medicare, Medicaid	Admin	The percentage of episodes for members 3 months of age and older with a diagnosis of an acute respiratory condition that resulted in an antibiotic dispensing event.

New 2021 CMS Core Set Measures

- The following measure was added to the 2021 Medicaid Child Core Set.
  - We excluded Low-Risk Cesarean Delivery, as it is a hospital measure.
- **Does the Taskforce recommend adding either of the measure below to the Aligned Measure Set?**

Measure	Steward	Description
Sealant Receipt on Permanent 1st Molars	American Dental Association /Dental Quality Alliance	Percentage of children who have ever received sealants on permanent first molar teeth by their 10th birthdate. *Replaced Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk, which is being retired by the steward.*

Proposed HEDIS Changes

- Taskforce staff have reviewed NCQA's public comment request for HEDIS measurement year 2022.
- In addition to the proposal on stratification by race and ethnicity for select HEDIS measures and new measures (discussed during the March meeting), we also want to share with you measures within the Aligned Measure Set with a proposed change.
  - We excluded measures without a substantive change.
- One factor we've included for your consideration is ECDS reporting. Before looking at individual measures with changes, we will review highlights from NCQA's proposed ECDS reporting roadmap.
- **As we review these proposed changes, please consider whether any of these proposed changes would influence your recommendation on retention and placement of the given measure within the Aligned Measure Set for 2022.**

ECDS Roadmap

- ECDS is a HEDIS reporting standard introduced in 2015 that encourages the use and sharing of electronic clinical data across health care systems.
- NCQA introduced a variety of measures for ECDS reporting over the last five years, including new measures addressing behavioral health and immunizations.
- For Measurement Year (MY) 2019, NCQA allowed voluntary ECDS reporting alongside traditional reporting for three existing HEDIS measures (two of which are Menu Set measures):
  - Breast Cancer Screening (BCS)
  - Follow-Up Care for Children Prescribed ADHD Medication (ADD)
  - Colorectal Cancer Screening (COL)
- **NCQA has proposed a timeline to remove the Administrative reporting method for BCS and ADD for MY 2023 and for the Hybrid method in COL for MY 2024.**

ECDS Roadmap

- NCQA has also proposed expanding voluntary ECDS reporting.
  - For MY 2022:
    - Childhood Immunization Status (CIS)
    - Immunizations for Adolescents (IMA)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
  - For MY 2023:
    - Cervical Cancer Screening (CCS)

Impact of Proposed Changes on the MA Aligned Measure Set - Core Measures

Core Set	R/E Stratification	Transition to ECDS	Spec. Change
Controlling High Blood Pressure	MY 2022		

Impact of Proposed Changes on the MA Aligned Measure Set - Menu Measures

Menu Set	R/E Stratification	Transition to ECDS	Spec. Change
Breast Cancer Screening		MY 2022 –ECDS Optional MY 2023 – ECDS Only	
Cervical Cancer Screening		MY 2023 – ECDS Optional	
Childhood Immunization Status (Combo 10)		MY 2022 – ECDS Optional	For MY 2022, proposal for previous optional exclusions for contraindications to vaccinations for CIS and IMA to be respecified as required exclusions or included in the numerator to better align with their clinical intent.
Colorectal Cancer Screening		MY 2022 – ECDS Optional MY 2023 – ECDS Only	
Comp. Diabetes Care: Eye Exam	MY 2022		Non-substantive

Impact of Proposed Changes on the MA Aligned Measure Set - Menu Measures

Menu Set	R/E Stratification	Transition to ECDS	Spec. Change
Immunizations for Adolescents (Combo 2)		MY 2022 – ECDS Optional	
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			Changes discussed during the April 2021 Taskforce meeting.
Metabolic Monitoring for Children and Adolescents on Antipsychotics		MY 2022 – ECDS Optional	
Use of Imaging Studies for Low Back Pain			• Expanding the upper age limit from 50 to 74 years of age • Applying four additional guidelines-based clinical exclusions • Applying existing cross-cutting exclusions for members with advanced illness/frailty and in palliative care.

Impact of Proposed Changes on the MA Aligned Measure Set - Monitoring Measures

Monitoring Set	R/E Stratification	Transition to ECDS	Spec. Change
Comprehensive Diabetes Care: Hemoglobin A1c Testing			Retired for MY 2022
Prenatal & Postpartum Care: Timeliness of Prenatal Care	MY 2022		
Prenatal and Postpartum Care: Postpartum Care	MY 2022		
Well-Child Visits in the First 30 Months of Life	MY 2022		

Care Coordination Measures

- **During the September 9, 2020 Taskforce meeting**, Taskforce members agreed with Clara Filice's recommendation to add care coordination as a developmental priority given MassHealth's interest in the topic.
  - Clara Filice asked that the Taskforce consider the inclusion of care coordination measures during the 2020-21 annual review.
- Taskforce staff conducted an environmental scan of care coordination measures for the Taskforce to consider.
- We did so using the following sources:
  - National Quality Forum environmental scan of measures and measure concepts related to care coordination
  - Agency for Healthcare Research and Quality Care Coordination Measures Atlas
  - Centers for Medicare & Medicaid Services' Merit-Based Incentive Payment System 2020 measures list

Care Coordination Measures: Background Information

- Historical context: The Taskforce first considered the topic of care coordination measures on 2-27-18.
  - At that time, Rich explained that *care coordination* is the set of activities that go with co-creating and implementing a care plan with a patient, family, and caregiver. *Care integration* is related to the experience of an outcome (e.g., communication with care team, access to appointments, linkage to the community).
  - Rich described two complementary surveys for consideration.
    - **Patient Perceptions of Integrated Care (**PPIC): For adult patients. Focuses on a primary care provider as the entity that anchors care, even for individuals with complex care needs.
    - **Pediatric Integrated Care Survey (**PICS): For pediatric patients. Allows a patient, family, or caregiver to evaluate the entirety of a care team, and not only a primary care provider.

Care Coordination Measures: Background Information

- Three other surveys - Care Coordination Quality Measure for Primary Care (CCQM-PC), Client Perception of Coordination Questionnaire (CPCQ) and Family Experiences with Coordination of Care (FECC) – were briefly discussed but not endorsed.
- Barbra advocated for including one or more surveys to test in addition to CG-CAHPS. She said care coordination was partially addressed within CAHPS, but integration was not. Others agreed.
- The Taskforce endorsed the following as a developmental measure:
  - A version of CG-CAHPS that supplements, modifies, or substitutes questions, potentially including questions from the following surveys:
    i. Patient Perceptions of Integrated Care (PPIC) survey
    ii. Pediatric Integrated Care Survey (PICS)
- No subsequent work was ever performed to develop and test this developmental measure.

Care Coordination Domains

COORDINATION ACTIVITIES

- Establish accountability or negotiate responsibility
- Facilitate transitions
- Assess needs and goals
- Create a proactive plan of care
- Monitor, follow-up and respond to change
- Support self-management goals
- Link to community resources
- Align resources with patient and population needs

BROAD APPROACHES

- Teamwork focused on coordination
- Health care home
- Care management
- Medication management
- Health IT-enabled coordination

PATIENT/FAMILY PERSPECTIVE

- Patient report of satisfaction with coordination of care
- Family report of confusion or hassle
- Patient report of unnecessary care

HEALTH CARE PROFESSIONAL(S) PERSPECTIVE

- Nurses reports of confusion or hassle
- Physician survey of effectiveness of medication management process at averting drug interaction complications

SYSTEM REPRESENTATIVE(S) PERSPECTIVE

- Quality of care measured through analysis of medical chart data, HER or administrative data
- Health care utilization by a group of patients
- Costs

Source: AHRQ, "Care Coordination Measures Atlas," AHRQ Publication No. 11-0023-EF, December 2010.

Overview of Findings

- **Overall, researchers and measurement experts note significant gaps due to the complexity of the construct itself, and the difficulty in collecting data on care coordination activities.**
- Literature on care coordination measures emphasize the importance of considering three perspectives on care coordination:
  - patient/family
  - health care providers
  - health care system
- Most measures assess performance on care coordination from only one of the three perspectives.
- Some condition-specific measures that are based on administrative data could be considered as care coordination measures.
- The *vast majority* of measures that specifically look at care coordination are *survey-based*.

Criteria for Identifying Candidate Measures

Taskforce staff outlined the following criteria for identifying candidate measures:

- Developed and validated (i.e., "ready for prime time") based on generally accepted criteria
- Minimizes member and plan/ACO data collection burden
- Because the request came from MassHealth, addresses member scenarios prevalent in the MassHealth population, including:
  - Mental health and substance use disorder
  - Multiple chronic conditions
  - Children with medical complexity
  - Social complexity alone or in combination with above conditions

Measures That Meet Criteria

Based on the identified criteria, we found the following candidate measures for consideration:

1. Closing the referral loop
2. Care coordination questions in the MHQP version of the CAHPS Clinician & Group Survey (CG-CAHPS)
   - Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test
   - Provider was informed and up-to-date about care the patient received from other specialists.

- These candidate measures do *not* provide a comprehensive assessment of care coordination. Rather, they focus on one element.

Potential Measures That Meet Criteria

Measure Name | Steward	Description	Previous Discussion
Closing the Referral Loop: Receipt of Specialist Report | CMS	The percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Not previously discussed.
MHQP version of the CAHPS Clinician & Group Surveys (CG-CAHPS) | AHRQ	The MHQP version of CG-CAHPS includes two questions that could be used to measure care coordination: • In the last 12 months, how often did your provider seem informed and up-to-date about the care you got from specialists? • In the last 12 months, when your provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you these results?	Not previously discussed.

Measures That Did Not Meet Criteria But May Merit Consideration

Other measures of care coordination that could be considered if the criteria were broadened include:

- Client Perception of Coordination Questionnaire
- Care Coordination Quality Measure for Primary Care
- Family Experiences with Coordination of Care

Candidate Measures Utilizing Survey Data

Measure Name | Steward	Description	Previous Discussion
Client Perception of Coordination Questionnaire | AHRQ	31-item questionnaire to measure patient-centered care and care coordination in health care delivery from a consumer perspective. Addresses identification of need, access to care, patient participation, patient-provider communication, and global assessments of care.	Previously presented, but not discussed.
Care Coordination Quality Measures for Primary Care | AHRQ	Survey of adult patients' experiences with care coordination in primary care settings.	Previously discussed; determined by Taskforce to be too long.

Candidate Measures Utilizing Survey Data

Measure Name | Steward	Description	Previous Discussion
Family Experiences with Coordination of Care Measure Set | Center of Excellence on Qualify of Care Measures for Children with Complex Needs	Survey developed to gather information needed to score 20 separate and independent quality measures that assess the qualify of care coordination services received by children with medical complexity.	Not previously discussed.

Fluoride Varnish

- Fluoride Varnish is currently categorized as a Developmental measure. In February 2020, Taskforce members expressed support for the measure due to:
  - recommendations from the American Academy of Pediatrics;
  - the opportunity to promote prevention and address the high prevalence of dental caries in the state;
  - the service is often reimbursed by insurers, and
  - the measure is actionable for medical groups and health systems.
- The Fluoride Varnish measure was developed by the Rhode Island Department of Health. The Taskforce recommended piloting the measure with interested pediatric practices and payers before adoption in the Aligned Measure Set.
- MassHealth recently request a fresh review of fluoride varnish measures by the Taskforce.

Fluoride Varnish

- **Does the Taskforce wish to further consider any of these measures for inclusion in the Aligned Measure Set?**

Measure	Steward	Description	Data Source	Notes
Fluoride Varnish	Rhode Island Department of Health	The percentage of children who received a fluoride varnish application in primary care in the 12 months preceding their first, second, or third birthday.	Claims	Focuses on very young children.
Topical Fluoride Varnish	Dental Quality Alliance (adapted by Oregon Health Authority)	Percentage of children aged 1–21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least two topical fluoride applications as dental OR oral health services within the reporting year.	Claims	Includes a broader age group, specific to the population of children with elevated risk (identified by CDT code) of dental carries, and requires two treatments.

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Health Equity Work Group Recommendations

- During the March 23rd Taskforce meeting, a subgroup of Taskforce members agreed to meet to further specify the following Taskforce recommendations:
  1. a new measure of ACO RELD data completeness
  2. ACO reporting of stratified measures
  3. partnering with a national organization(s) on research into methods for assessing accuracy of patient-level race and ethnicity data

- The Work Group met on April 5th and April 29th to develop a recommendation for the Taskforce, as described on the next slides. Participating members included:
  - Lisa Ahlgren, Rich Antonelli, Kim Ariyabuddhiphongs, Clara Filice, Mark Friedberg, Vivian Haime, and Barbra Rabson

Health Equity Work Group Recommendations

1. Address **RELD data collection and RELD disparity measurement** through the creation and administration of two surveys – one for payers and one for providers.

   - These surveys are designed to enhance the Taskforce's understanding of RELD data collection and disparity measurement.
   - Survey content has been informed by a November 2020 MassHealth survey sent to contracted MCOs, ACO and Community Partners.
   - The draft survey was distributed with the meeting materials. Please provide feedback on the survey to risaacson@bailit-health.com by May 26th.

Health Equity Work Group Recommendations

2. Create a new Menu Measure focused on **race, ethnicity, and language stratification** of three core measures and one pediatric measure.

- The three core measures are HbA1c Poor Control, Controlling High Blood Pressure, Screening for Clinical Depression and Follow-up Plan.
- Rich Antonelli and Allison LaRussa of Children's have recommended as a pediatric measure Well Child Visits in the First 30 Months of Life.
- Collectively, this measure (of measures) would be implemented on a "for reporting" basis in the 2022 Aligned Measure Set.
- Component measures would be stratified by race, ethnicity and language. Performance would not be stratified by disability status because the methods used collect and report on disability status are too heterogenous and are of questionable validity.

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Revisit Refined List of New Measures for Inclusion

- The following slides will display the tentative measure set changes based on the annual review process to date.
- As you review the list, please consider if you are comfortable finalizing the currently constructed measure set for 2022. In so doing, please think about:
  - the measure selection criteria we have adopted
  - the distribution of measures across care domains and demographic groups
- Please consider the size of the Menu Set in your review. Increasing the size of the Menu Set may detract from our goal of alignment.

Core Measures (4) – Tentative for 2022

1. Controlling High Blood Pressure
2. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
3. CG-CAHPS (MHQP version)
4. Screening for Clinical Depression and Follow-Up Plan

Menu Measures (20) – Tentative for 2022

1. Asthma Medication Ratio
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Childhood Immunization Status (Combo 10)
5. Chlamydia Screening - Ages 16-24
6. Colorectal Cancer Screening
7. Comprehensive Diabetes Care (CDC): Eye Exam
8. Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
9. Continuity of Pharmacotherapy for Opioid Use Disorder
10. Follow-up After Emergency Department Visit for Mental Health (7-Day)
11. Follow-Up After Hospitalization for Mental Illness (30-Day)
12. Follow-Up After Hospitalization for Mental Illness (7-Day)
13. Immunizations for Adolescents (Combo 2)
14. Influenza Immunization
15. Informed, Patient-Centered Hip and Knee Replacement
16. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
17. Metabolic Monitoring for Children and Adolescents on Antipsychotics
18. Prenatal and Postpartum Care: Postpartum Care
19. Shared Decision-Making Process
20. Use of Imaging Studies for Low Back Pain

Monitoring Measures (5) – Tentative for 2022

1. Child and Adolescent Well-Care Visits
2. Comprehensive Diabetes Care: Hemoglobin A1c Testing
3. Incidence of Episiotomy
4. Prenatal & Postpartum Care - Timeliness of Prenatal Care
5. Well-Child Visits in the First 30 Months of Life

On Deck and Developmental Measures – Tentative for 2022

On Deck Measure: [placeholder]

Developmental Measures:

1. Kindergarten readiness
2. Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia
3. Developmental Screening in the First Three Years of Life

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Next Steps

- The annual review process is complete – congratulations and thank you!
- The next Taskforce meeting is scheduled for **June 21st from 2:00 – 4:00 pm.**