Setting Performance and Improvement Targets for Incentive Measures

Oregon Metrics and Scoring Committee
Michael Bailit
October 10, 2012

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PURCHASING

Meeting Agenda Items #7-9

#7: Status Check on Distribution of Measures

#7: Selecting Improvement and Performance Targets

#8: Structural Elements of the Incentive Pool

#9: Wrap- Up

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Committee Charge per Waiver Terms

- "The Committee will:
  - review data and the relevant literature,
  - determine which measures will be included in the CCO incentive program,
  - establish the performance benchmarks and targets to be used in this incentive program,
  - endorse/develop specifications for each measure." (p61)

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Current Measures Set

1. CAHPs Composite (7Qs)
2. Rate of PCPCH enrollment
3. ED Utilization (HEDIS)
4. Initiation and Engagement of AOD
5. Follow-up after hospitalization for mental illness
6. Composite measure: mental health and physical health assessment for children in DHS custody
7. Screening for clinical depression and follow-up plan
8. Elective delivery before 39 weeks
8. Prenatal care
9. Developmental screening by 36 months (hybrid)
10. Colorectal Cancer Screening (hybrid)
11. Alcohol and Drug misuse, screening, brief intervention and referral for treatment (SBIRT)
12. Optimal Diabetes Care (D3)
13. Controlling Hypertension
14. Adolescent Well-Care Visit
15. EHR Composite measure (3Qs)

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Current CAHPS Composite

5 Questions from the CAHPs 4.0 H Adult Questionnaire:

1. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? (included in Exchange composite)
2. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? (not included in Exchange composite)
3. In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? (not included in Exchange composite)
4. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? (included in Exchange composite)
5. In the last 12 months, how often did your health plan's customer service give you the information or help you needed? (included in Exchange composite)

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Current CAHPS Composite

2 Questions from the CAHPs 4.0 H Child Questionnaire:

1. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental or behavioral problem? (not included in Exchange composite)
2. In the last six months how often was if easy to get this treatment or counseling for your child? (not included in Exchange composite)

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EHR Composite Measure

Composite of:

- Eligible Professional Meaningful Use Core Measure #2: Implement drug-drug and drug-allergy interaction checks (The EP has enabled this functionality for the entire EHR reporting period.)
- Eligible Professional Meaningful Use Core Measure #4: Generate and transmit permissible prescriptions electronically (eRx) (>40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.)
- Eligible Professional Meaningful Use Core Measure #5: Active Medication List: >80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data

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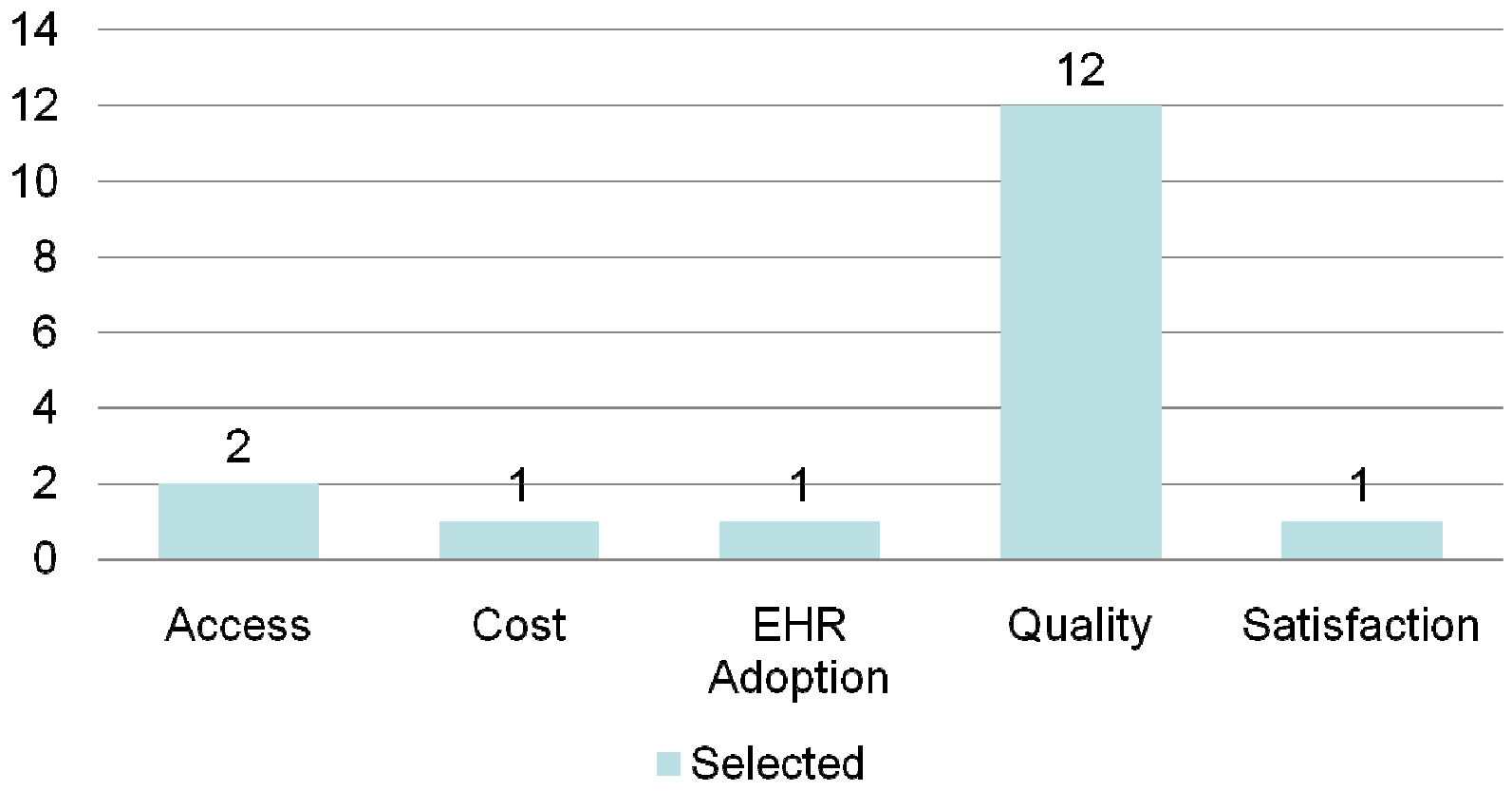
Number of Candidate Measures by Domain



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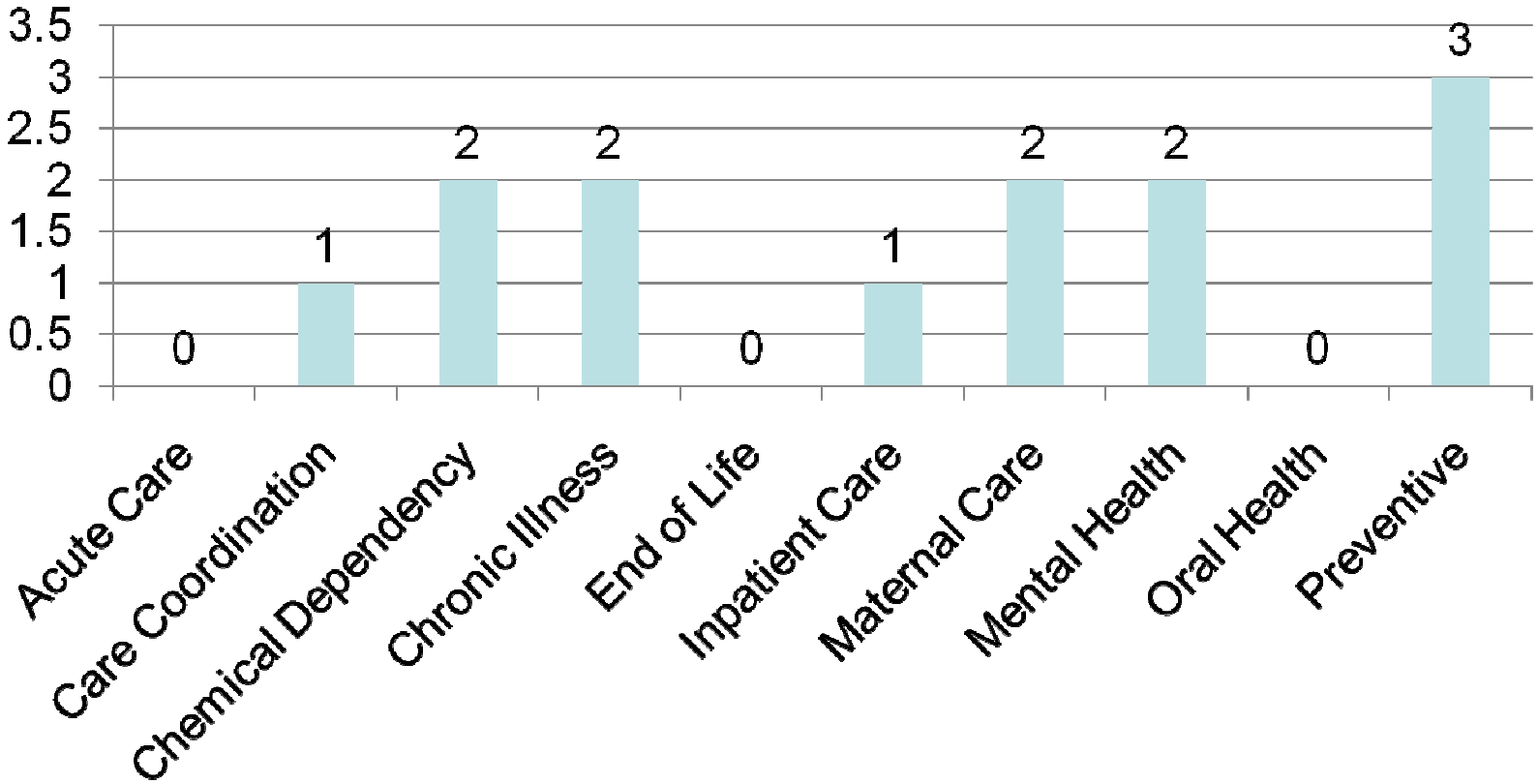
Number of Measures within Each Category in the Quality Domain



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Meeting Agenda Items #7

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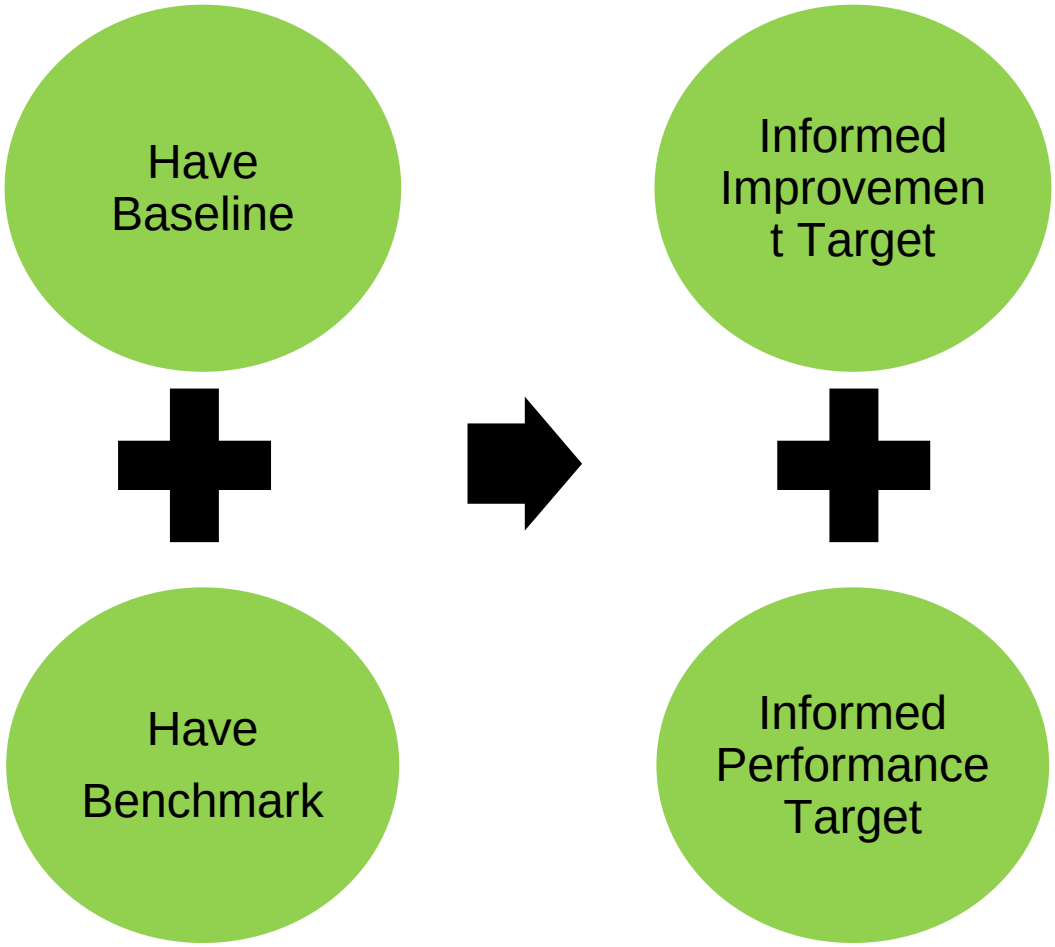
Data Supporting Target Selection



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Measures with Baseline and Benchmark Information

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
69a	Initiation of alcohol and other drug dependence treatment	28%	2011 Medicaid Total Population National: 90th: 60.72% 75th: 48.84% 50th: 40.81% 25th: 35.68%	Informed	Informed
69b	Engagement of alcohol and other drug dependence treatment	13%	2011 Medicaid Total Population National: 90th: 25.89% 75th: 20.52% 50th: 14.53% 25th: 5.72%	Informed	Informed

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Measures with Baseline and Benchmark Information (2)

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
250 a	Prenatal Care	30.4% (based on admin data)	2012 Medicaid Benchmarks/ Thresholds 90th: 92% 75th: 89% 50th: 84% 25th: 77%	Informed	Informed
	Ambulatory Care: ED utilization, Emergency Dept Visits/1000 (Total)	Feasible but not currently available	2011 Medicaid Benchmarks: 90th Percentile: 76.64 75th Percentile: 70.45 50th Percentile: 63.27 25th Percentile: 55.20	Informed	Informed

Measures with Baseline and Benchmark Information (3)

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
	Adolescent Well-care Visit	26.3% from the 2010 HEDIS trend report.	2011 Medicaid Benchmark data: 90th percentile: 64.1% 75th percentile 56.93% 50th percentile 46.23% 25th percentile 39.68%	Informed	Informed

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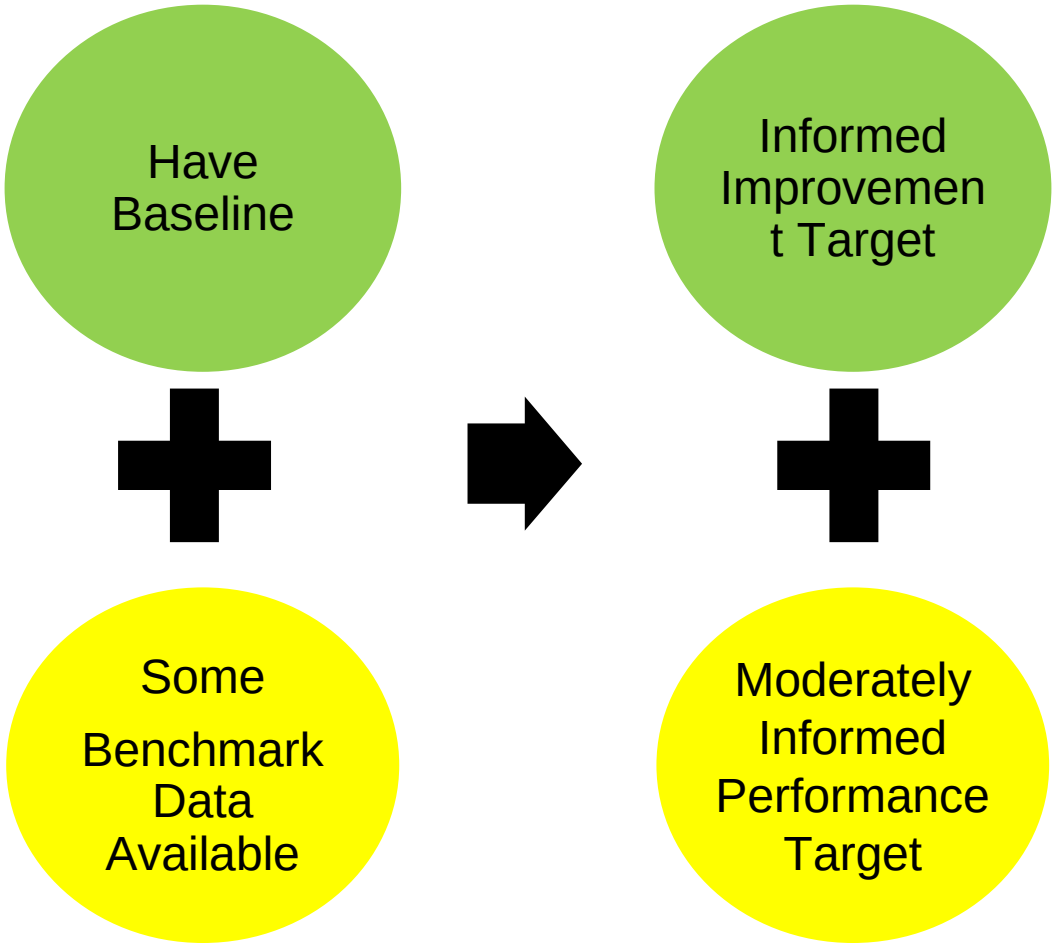
Data Supporting Target Selection



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Measures with Baseline/ Some Reference Information Available

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
42	Follow-up after hospitaliza-tion for mental illness	52%	2012 Medicaid Benchmarks/ Thresholds (for HEDIS measure w/out change in provider type): 90th: 68% 75th: 58% 50th: 45% 25th: 33%	Informed	Moderately informed

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Measures with Baseline/ Some Reference Information Available (2)

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
127	Elective delivery before 39 weeks	Feasible but not yet available	5% rate of elective early term delivery would be reasonable as a national quality benchmark. March of Dimes (OR) agrees this is a reasonable benchmark.[1]	Informed	Moderately Informed

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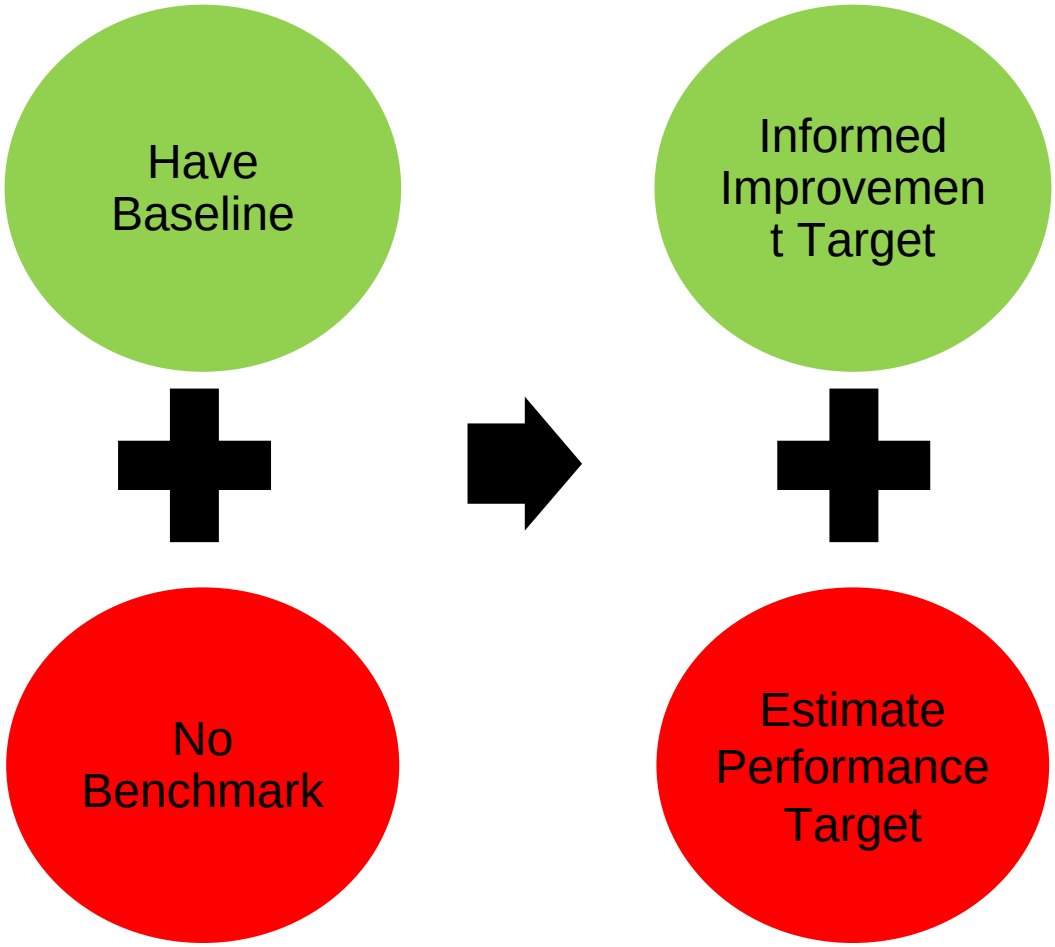
1: Clark SL, Frye DR, Meyers JA, et al. Reduction in elective delivery _39 weeks of gestation: comparative effectiveness of 3 approaches to change and the impact on neonatal intensive care admission and stillbirth. Am J Obstet Gynecol 2010;203 http://www.ncbi.nlm.nih.gov/pubmed/20619388

Data Supporting Target Selection



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Measures with Baseline/ No Benchmark

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
	Patient-Centered Primary Care Homes	Feasible but not yet available	No data available	Informed	Estimate
71a	Mental health assessment for children in DHS custody	58%	No data available	Informed	Estimate

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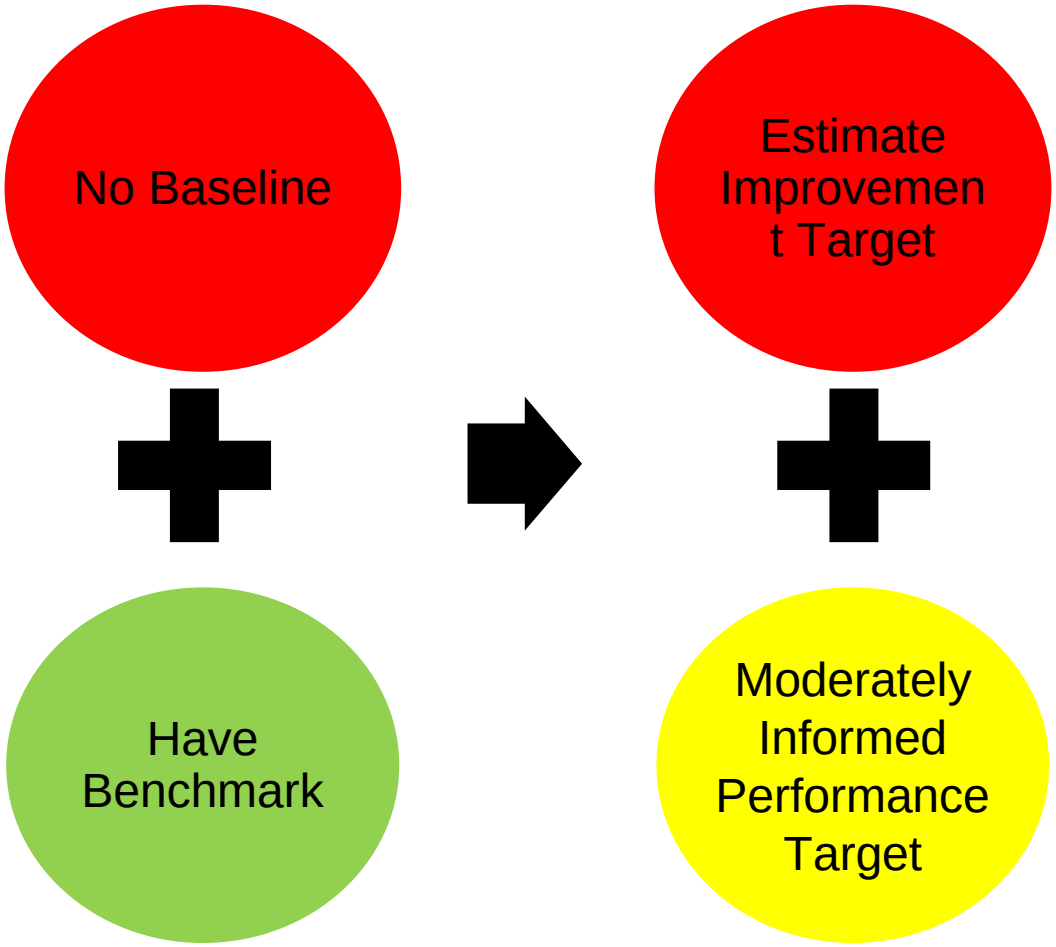
Data Supporting Target Selection



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Measures with Benchmark but No Baseline

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
72	Screening for clinical depression and follow up plan	No data available	CMS 2010 PQRI Experience report Average Performance Rate per Eligible Professional: 2008: 83.4% 2009: 67.2% 2010: 84.2% 2010: % of Eligible Professionals who had at least a 90% Performance Rate: 71.4% www.cms.gov/pqrs	Estimate	Moderately Informed

Measures with Benchmark but No Baseline (2)

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
55	Controlling High Blood Pressure	No data available	2012 Medicaid Benchmarks/ Thresholds: 90th: 66% 75th: 60% 50th: 56% 25th: 47%	Estimate	Moderately Informed

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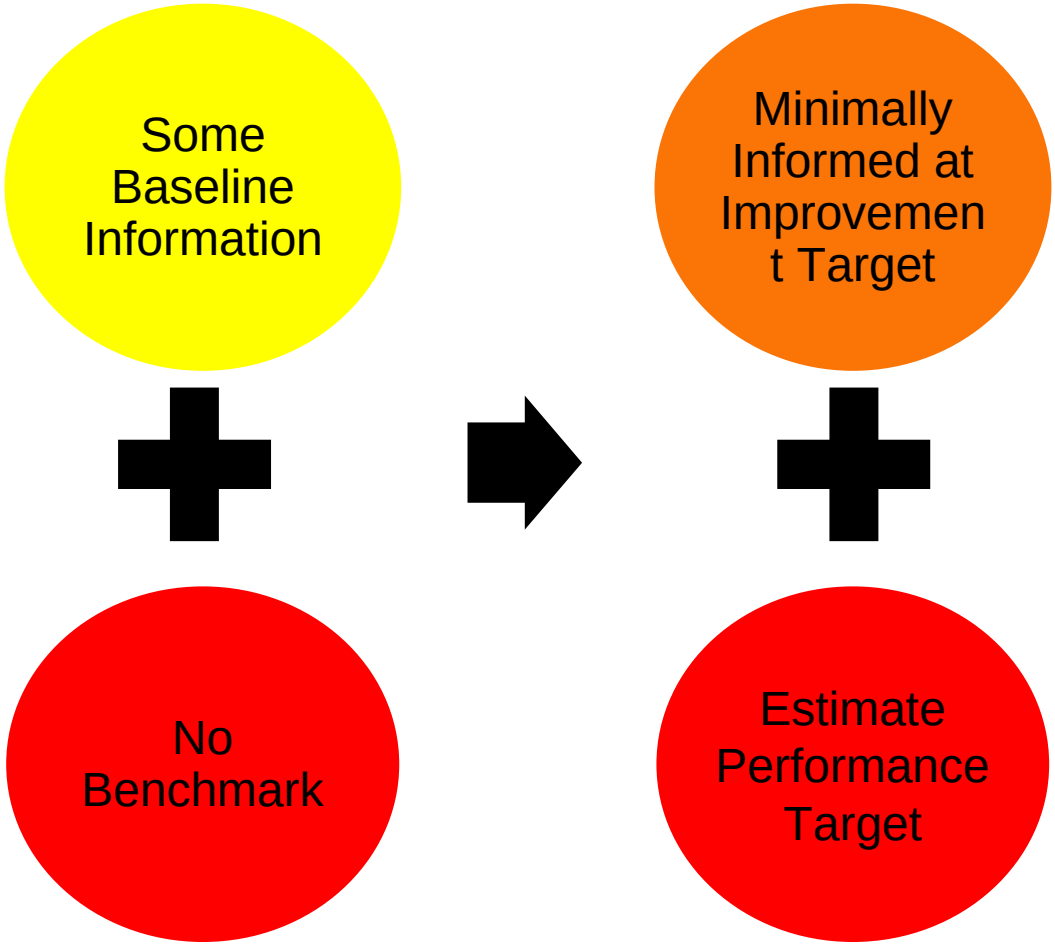
Data Supporting Target Selection



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Measures with Some Baseline Information Available/ No Benchmark

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
28	Substance abuse – SBIRT	Current data indicate a very low rate.	No data available	Minimally Informed	Estimate
76	Developmen -tal screening by 36 months	No data for hybrid approach. 14.6% using administrativ e data only	No data available	Minimally Informed	Estimate

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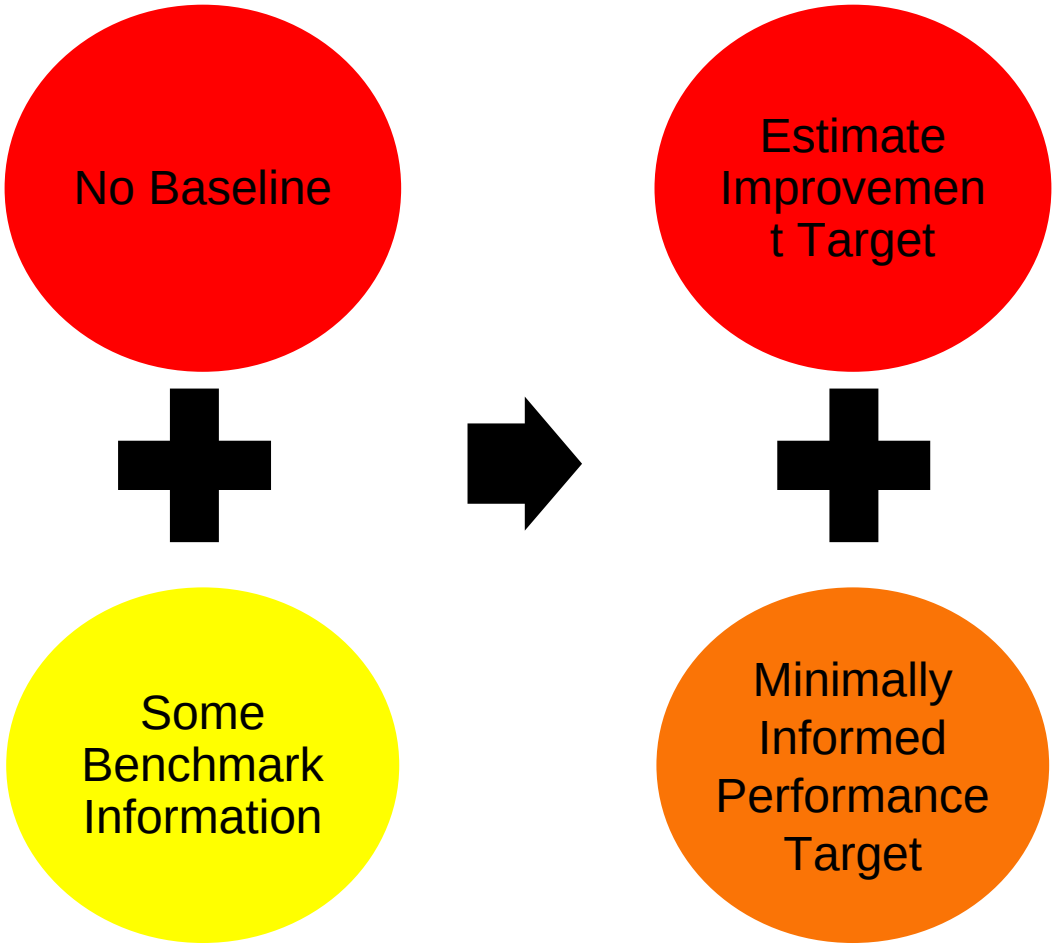
Target Options



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Measures with No Baseline/ Some Reference Information Available

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
	Optimal diabetes use (D3)	No data available	Diabetes Minnesota's statewide rate for the D5 (2010): 37% Minnesota's target for the D5: 41% (2012)	Estimate	Minimally Informed

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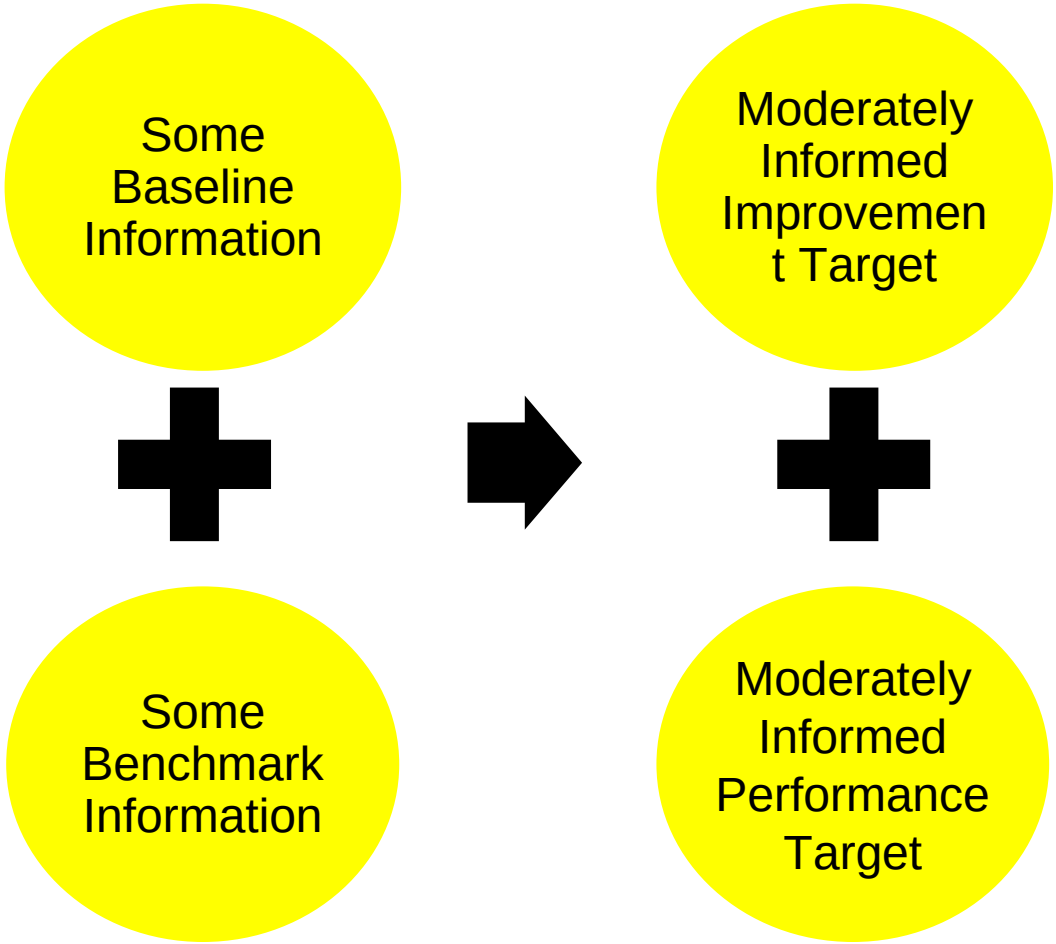
Data Supporting Target Selection



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Measures with Baseline/ Some Reference Information Available (2)

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
278	Colorectal Cancer Screening	No data available for hybrid specs (30.5% using admin data)	2012 Commercial Colorectal Screening: 90th: 71.67% 75th: 65.76% 50th: 58.39% 25th: 52.8%	Moderately informed	Moderately informed

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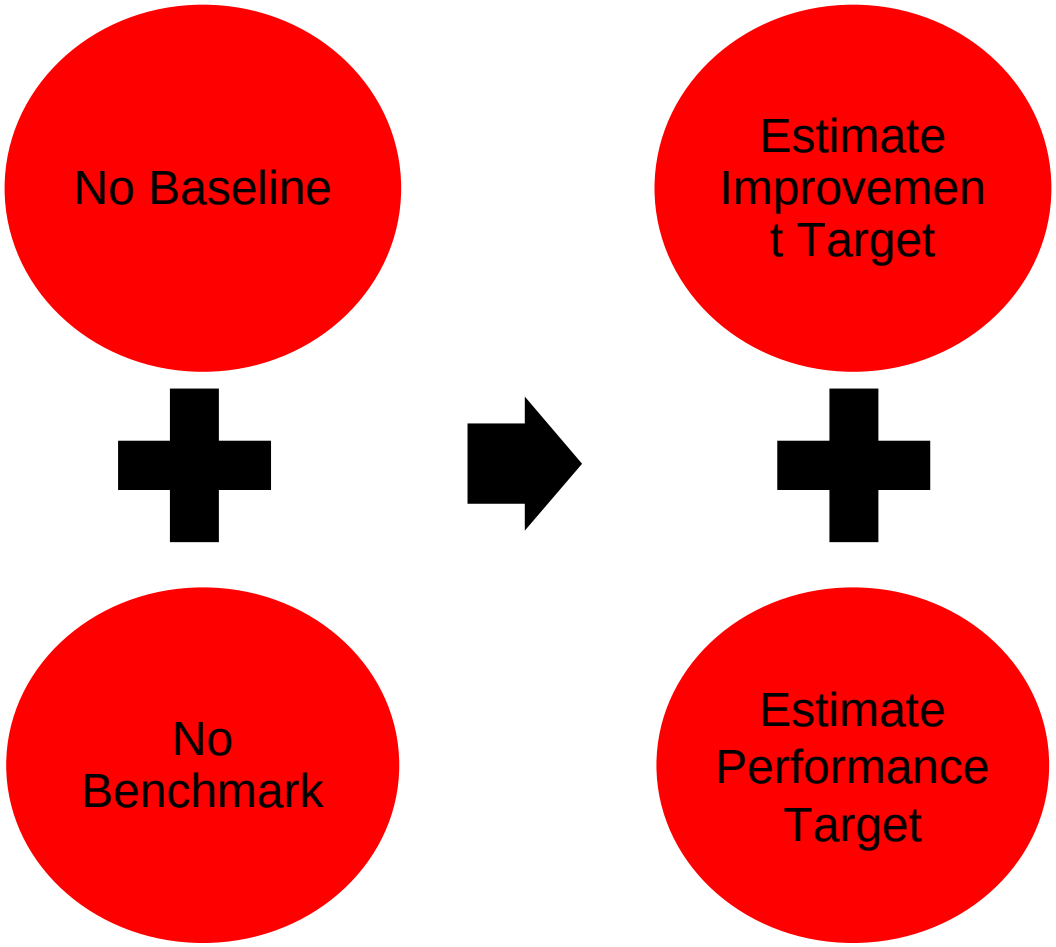
1: Clark SL, Frye DR, Meyers JA, et al. Reduction in elective delivery _39 weeks of gestation: comparative effectiveness of 3 approaches to change and the impact on neonatal intensive care admission and stillbirth. Am J Obstet Gynecol 2010;203 http://www.ncbi.nlm.nih.gov/pubmed/20619388

Data Supporting Target Selection



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Measures with No Baseline/ No Benchmark

#	Measure	Baseline	Benchmark	Imp. Target	Perf. Target
71b	Physical health assessment for children in DHS custody	No data available	No data available	Estimate	Estimate

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Structural Elements of the Incentive Pool

OHA is responsible for determining the structure of the incentive pool, but would appreciate comments from the Committee.

- Specifically, OHA is interested in getting comments on the following questions:
  - What should be the size of the incentive pool?
  - How should the incentive pool be divided among the CCOs?
  - How should the amount of incentive funds that are potentially available to the CCOs be determined?
  - What should be the timing of the distribution of funds?

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What should be the size of the incentive pool?

If OHA has a 4.4% increase in spending for Year 1 , what percentage of those dollars should go towards increasing the capitation rate and what percentage should be used to fund the incentive pool? A few sample options:

A. 2.0% to incentives and 2.4% to rate increase
B. 2.2% to incentives and 2.2% to rate increase
C. 2.5% to incentives and 1.9% to rate increase
D. 3.0% to incentives and 1.4% to rate increase

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How should the incentive pool be divided among the CCOs?

A. **All of the CCOs compete for the dollars across the entire incentive pool.**
   - The dollars are distributed to the CCOs on the basis of performance with the highest PMPM amounts going to the highest performers. Using this strategy, all of the incentive funds are distributed every year and there are no left over funds.

B. **Each CCO has a maximum amount of dollars from the incentive pool for which it is eligible in any particular year.**

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What happens to incentive funds not earned by CCOs?

If each CCO has a maximum amount of dollars from the incentive pool for which it is eligible in any particular year, then what happens to the Incentive pool funds that are not earned by CCOs?

A. They “revert back” to the state and are treated as savings to state taxpayers and CMS.
B. They are distributed to the highest performing CCOs as additional Quality Pool payments.
C. They are rolled over into the next year’s Quality Pool.

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How should the amount of funds that are available to the CCOs be determined?

- How should the amount of incentive funds that are potentially available to the CCOs be determined?
  A. The amount of potential funding should be determined based on the number of member months for the incentive period.
  B. The amount of potential funding should be determined based on the number of individuals enrolled for the entire incentive period.
  C. The amount of potential funding should be determined based on the amount of expenditures made by the CCO during the incentive period.

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What should be the timing of the distribution of funds?

What should be the timing of the distribution of funds?

A. The funds are distributed on an annual basis. The incentive period runs for one year; there is an additional six-month period to account for the lag in claims data, with the incentive payments being made shortly thereafter.

B. The funds are distributed on both an annual and quarterly basis, depending upon the measure. For both annual and quarterly performance assessments, there is an additional six-month period to account for the lag in claims data, with the incentive payments being made shortly thereafter.

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Wrap-Up

- Next Steps
- Next Meeting: Monday, October 22nd 1:00pm-4:00pm, Location TBD

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