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Proposed 2018 QIP Measures
Invitation for Provider Comment

Partnership HealthPlan of California is pleased to propose the measurement set for the 2018 Quality Improvement Program (QIP) and invite your comment. The measures were developed in collaboration with PHC's QIP Advisory Group, which is comprised of medical and administrative leadership across all fourteen participating counties. Your involvement is very important to the success of the program, and we hope to hear your comments on the merits of the measures.

Please carefully review this document, which includes the following:

1) An overview of the guiding principles of the QIP (p.2);
2) A summary of proposed measures (p.3-5);
3) Definitions of new measures and rationale for proposed changes to the measurement set (p.6-11).

Comments on any of the measures, as well as its relative weight, are welcome. Note that measure thresholds are not part of this provider comment.

Please email your feedback no later than February 10, 2017 to QIP@partnershiphp.org. You can note comments in the space provided, next to each proposed measure in section III, on p.6 – p.11. You can also provide additional comments or questions on the last page.

Your comments will be shared with the QIP Technical Workgroup to consider prior to finalizing recommendations for the 2018 measurement set. Final recommendations for measures will be presented to the PHC Physician Advisory Committee (PAC) for review and approval by the end of March.

This material is to be shared during an interactive webinar on January 30th. Information for that opportunity is found below. Thank you for your participation in the QIP!

Date: Monday, January 30th
Time: 12:00-1:009m
Registration Link:
https://attendee.gotowebinar.com/register/256111818869563139

I. Guiding Principles of the Quality Improvement Program

1. Pay for exceptional performance and improvement
2. Sizeable incentives
3. Distribute 100% of Fixed Pool Per Member Per Month Funds
4. Actionable measures
5. Feasible data collection
6. Collaboration with providers
7. Simplicity in the number of measures
8. Comprehensive measurement set
9. Align measures that are meaningful
10. Stable measures

II. Summary of Proposed Measures

(A) Fixed Pool Per Member Per Month (PMPM) Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

2016-2017 Measures	2018 Recommendations
Clinical Domain	
Family Medicine: 1. Monitoring Patients on Persistent Medications 2. Well Child Visits (3-6 years) 3. Childhood Immunization (DTaP) 4. Controlling High Blood Pressure 5. Cervical Cancer Screening 6. Colorectal Cancer Screening 7. Diabetes Management: HbA1C Good Control 8. Diabetes Management: Retinal Eye Exams 9. Diabetes Management: Nephropathy	**Family Medicine:** 1. Monitoring Patients on Persistent Medications 2. Well Child Visits (3-6 years) 3. Controlling High Blood Pressure 4. Cervical Cancer Screening 5. Colorectal Cancer Screening 6. Diabetes Management: HbA1C Good Control 7. Diabetes Management: Retinal Eye Exams 8. Breast Cancer Screenings 9. Childhood Immunization Combo-3 10. Immunizations for Adolescents
Internal Medicine: 1. Monitoring Patients on Persistent Medications 2. Controlling High Blood Pressure 3. Cervical Cancer Screening 4. Colorectal Cancer Screening 5. Diabetes Management: HbA1C Good Control 6. Diabetes Management: Retinal Eye Exams 7. Diabetes Management: Nephropathy	**Internal Medicine:** 1. Monitoring Patients on Persistent Medications 2. Controlling High Blood Pressure 3. Cervical Cancer Screening 4. Colorectal Cancer Screening 5. Diabetes Management: HbA1C Good Control 6. Diabetes Management: Retinal Eye Exams 7. Diabetes Management: Nephropathy 8. Breast Cancer Screening
Pediatric Medicine: 1. Nutritional Counseling 2. Physical Activity Counseling 3. Well Child Visits (3-6 years) 4. Childhood Immunization (DTaP) 5. Childhood Immunization (MMR) 6. Adolescent Immunization 7. Asthma Care	**Pediatric Medicine:** 1. Nutritional Counseling 2. Physical Activity Counseling 3. Well Child Visits (3-6 years) 4. Adolescent Immunizations 5. Childhood Immunization Combo-3 6. Asthma Medication Ratio

Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Admissions/1000* 2. Readmission Rate* 3. Pharmacy Utilization 4. Opioid Safety * Available back-up measure: Follow-up Post Discharge	**Family Medicine & Internal Medicine:** 1. Admissions/1000* 2. Readmission Rate* * Available back-up measure: Follow-up Post Discharge
Pediatric Medicine: 1. Pharmacy Utilization	**Pediatric Medicine:** No measures in this domain
Access and Operations	
All Practice Types: 1. Avoidable ED Visits 2. Practice 'open' to PHC members 3. PCP Office Visits	**All Practice Types:** 1. Practice 'open' to PHC members 2. PCP Office Visits
Patient Experience	
All Sites: 1. CAHPS for sites that meet member volume criteria, or Survey/Training Option for other sites	**All Sites:** 1. CAHPS for sites that meet member volume criteria, or Survey/Training Option for other sites

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites: 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led Self-Management Support Groups 5. Utilization of CAIR 6. Buprenorphine Qualified Providers 7. SBIRT Screenings 8. Health Information Exchange	**All Sites:** 1. Advance Care Planning Attestations 2. Extended Office Hours 3. Peer-led Self-Management Support Groups 4. SBIRT Screenings 5. Health Information Exchange 6. Suboxone Inductions 7. Initial Health Assessment 8. Timely Data Submission via eReports 9. Social Determinants of Health Screenings 10. Fluoride Varnish Application

(C) Paying for Improvement

There is no change from last year to the methodology for earning points. Sites will earn points for meeting absolute performance thresholds and relative improvement thresholds. For Clinical Domain measures that have baseline data (i.e. all existing and unchanged measures), providers can receive up to the full allotment of points for relative improvement using the following calculation:

$$\frac{(2018\ Performance) - (2017\ Performance)}{100 - (2017 Performance)}$$

III. Descriptions of Potential Measures and Measure Changes for Measurement Year 2018

A. Potential Additions as New Measures – Fixed Pool

Breast Cancer Screening (family and internal medicine)

Percentage of women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years

Rationale:

Added to HEDIS 2017 External Accountability Set (EAS). PHC will start reporting on this measure in 2017 to figure a baseline rate, and beginning 2018 our performance will be held to the minimum performance level (MPL). This will be an administrative measure.

Childhood Immunization Combo-3

The percentage of children age who have had all required doses of the below seven immunizations by their second birthday: DTaP, IPV, MMR, HiB, HepB, VZV, PCV

Rationale:

The goal of this measure is to increase the focus on pediatric immunizations and to increase the distribution of pediatric measures within the Family Medicine set. This is already an existing HEDIS measure.

B. Potential Additions as New Measures – Unit of Service

Fluoride Varnish Application

Sites will be reimbursed based on the number of Fluoride Varnish Application claims for PHC members ages 5 and below.

Rationale:

Tooth decay is one of the most prominent chronic diseases in children. Fluoride is covered as a medical benefit, but there is still a lot of room for improvement, evident in the low number of claims billed (only two during CY2016).

Proposal:

Primary care provider sites will receive $50 per fluoride varnish application. PHC will extract this data 3 months after the end of the reporting year (March 30, 2019) by identifying claims for CPT code 99188 submitted through the claims department. Claims submitted in excess of three applications per individual within a year time frame will be excluded. There will be a maximum of 100 applications (any combination of patients) per measurement year per site.

Suboxone Induction

As a replacement to the Buprenorphine Qualified Providers Measure, providers will receive incentive payment for successful transfer of adult (18+) patients diagnosed with Opioid addiction to Suboxone Therapy.

Rationale:

Buprenorphine is an opioid medication used to treat opioid addiction by preventing symptoms of withdrawal, and can be prescribed in the privacy of a physician's office. Any physician with a special "X" number issued by the DEA can prescribe Buprenorphine. "X" licensure is an involved process: doctors must take an 8-hour class on addiction treatment, or already possess such credentials, to apply for the special DEA number. Because Buprenorphine is an attractive treatment option for patients addicted to opioids, and because the process of obtaining an X license is already incentivized in the QIP program as a UOS measure, we are proposing the addition of a UOS measure to encourage use of our providers' X licenses.

Proposal:

Primary Care Provider sites will receive $100 per successful transfer to treatment on Suboxone therapy, as indicated by an Induction Attestation, subject to audit by PHC. This measure is only valid for first-time inductions. The following components must be included in each attestation in order to receive incentive payment:

1) Patient Name, DOB, CIN
2) Clinician's name and organization
3) Date of Induction
4) Attestation that this is a new induction
5) Attestation that the member was given a prescription, or the induction in-person

Initial Health Assessment

Reward provider sites for seeing newly enrolled members within 120 days of plan enrollment.

Rationale:

The California Department of Health Services requires that all members should visit their PCPs to conduct an initial health assessment (IHA) within 120 days of enrollment with PHC. The goal of this measure is to strengthen the rate PHC reports to DHCS concerning IHAs. Despite efforts such as sending PCPs address labels for newly assigned members, our IHA rate is low. Members may not establish care in a timely manner as a result. This may also subject us to corrective action plans.

Proposal:

Providers would be awarded $100 for each processed IHA claim.

Timely Data Submission via eReports
Reward providers for entering the majority of their relevant data records before the end of the measurement year.

Rationale:
As a result of the application of continuous enrollment to the denominators of clinical measures, some sites do not submit data to us until the end of the measurement year. Our hope would be to minimize the "data rush" at the end of the year and make the data already available in January much more meaningful, with the goal of strengthening the supplemental data set available to the HEDIS team for its sampling.

Proposal:
This measure would calculate the number of records entered into eReports across all applicable clinical measures. Based on the rate of uploads in previous years, the target for this measure would be 70%.

The incentive amount for this measure would be based on member volume as seen below.

	Total Members	**Incentive Amount**
Small	1-350	$3000
Medium	351-1,300	$4000
Large	1,301 or greater	$5000

Calculation:
# of all uploads by December 1st/# of all uploads by end of measurement year

Social Determinants of Health Screening
Reward provider sites for screening patients for social determinants of health, using the PRAPARE (or equivalent) social determinants of health screening tool.

Rationale:
Social Determinants of Health are defined by the World Health Organization as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. Currently, the understanding of health and wellbeing has shifted from being a result of access to a high quality healthcare system to the knowledge that external factors in a person's living and/or working environment dictate a large portion of their health status. Evidence has shown that only 10-11% of a person's health status is able to be impacted by medical care. Screening for Social Determinants of Health will allow health centers to understand which social determinants of health are impacting their patients and use that information to improve patient and population health.

Proposal:
Primary Care Provider sites will receive payment based on screening volume as seen below.

	Total Members Screened	Incentive Amount
Small	10-19	$1000
Medium	20-99	$2000
Large	100 or greater	$3000

Final submission criteria are still to be determined. Potential criteria include submission of one attestation form per screening to the QIP OR submission of an EHR generated report containing patient identification numbers for the PHC members screened. Primary Care Provider sites interested in participating in this measure should select a PHC-authorized screening tool OR send a separate tool meeting PHC's minimum screening criteria for review and approval at the beginning of the QIP measurement year.

C. Potentially Remove from Current Measurement Set

Opioid Safety (family and internal medicine)
Percentage of unique members on chronic pain medications who have had a U-Tox Screen during the measurement year.

Rationale:
PHC has several external programs focusing on opioid safety and minimizing opioid usage. Programs such as Managing Pain Safely has significantly reduced the number of new opioid prescriptions for our members. This measure on the other hand relies on providers continuing to prescribe in order for a denominator to be calculated.

Pharmacy Utilization (all practice types)
Percentage of generic prescription fills compared to total fills (generic + brand) for prescriptions written by professional staff assigned to the primary care site for the site's assigned members only.

Rationale:
PHC has seen dramatic improvement in the network's use of generic prescriptions. There is little room for continued improvement. With the new additional clinical measures being proposed, there is less need for focus on this measure.

Avoidable ED Visits (all practice types)
The average rate of assigned members' ER visits per member per year considered avoidable based on diagnostic code.

Rationale:
This measure is hard to achieve or influence for most providers, as many factors for ED use extend outside of the provider's control. The Extended Office Hours measure is more likely to affect change and will still be available.

PCMH Certification (Unit of Service - all practice types)
One-time payment for achieving Level 1 ($2,000), Level 2 ($3,000), or Level 3 ($3,500) recognition from NCQA, or equivalent from AAAHC or JCAHO.

Rationale:
As a one-time measure, we believe the practices that are likely to participate in this measure likely already have.

CAIR Utilization (Unit of Service - all practice types)
Sites will be reimbursed by meeting the specified threshold for utilizing the California Immunization Registry (CAIR).

Rationale:
Other clinical measures are focusing on key immunizations more directly.

Buprenorphine Qualified Providers (Unit of Service - all practice types)
Reimbursement for newly trained and certified Buprenorphine providers.

Rationale:
The suboxone induction measure incentivizes qualified providers to actually transfer opioid-addicted patients to alternative therapies while reducing the number of opioids prescribed to members.

D. Potential Updates for Existing Measures

Lowering the threshold for Colorectal Cancer Screening (family and internal medicine)
The percentage of members 51–75 years of age as of June 30, 2017 who had appropriate screening for colorectal cancer.

Rationale:
The QIP measure in 2015-16 uses the 50th percentile of NCQA Medicare performance for full points which is 67.5% (no Medicaid threshold exists for this measure). Data for the 15-16 QIP year shows Adult and Family Medicine sites that reported had an average rate of 28.2%. We have received concerns from sites on whether the Medicare targets are realistic.

Proposal:
Use the 75th and 90th percentile performance based on 2016-2017 QIP data for reporting sites. For reference, 2015-16 performance is as follows:
75th percentile: 39.1%
90th percentile: 50.75%

Replace Medication Management for Asthma with Asthma Medication Ratio (pediatric medicine)
Percentage of members 5-85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Rationale:
The AMR measure has been added to the EAS for HEDIS 2017. This administrative measure would replace the current Medication Management for Asthma measure, which measures the proportion of days covered by asthma control medications, for the QIP. In addition, we have heard from some providers that the current measure is not helpful for improving outcomes.

Immunization for Adolescents (pediatric medicine)
Percentage of adolescents 13 years of age who had Tdap, meningococcal, *and two doses of the human papillomavirus (HPV) vaccine* by their 13th birthday.

Rationale:
The HPV vaccine has been added to the IMA measure and the EAS for HEDIS 2017. The measure will require complete dosages of two vaccines by both male and female members' 13th birthday. This is a hybrid measure that will report as one rate.

IV. Additional Comments/Questions