AMP Measure Set & Public Comment Summary

Background

The AMP public comment period gives stakeholders the opportunity to comment on any proposed updates to the AMP programs. The public comment period began when the draft version of the MY 2019 and MY 2020 AMP Measure Sets and MY 2019 AMP Program Manual were released on September 1 and continued through September 30.

AMP staff released a Call for Public Comment document and invited stakeholders to comment on any program policy updates, changes to the measure set, or changes to measure specifications. IHA staff reviewed comments and drafted responses. These responses were reviewed with the AMP Committees in the fall and were posted on the IHA website alongside the final MY 2019 AMP Program Manual released December 1, 2019.

The 2019 AMP Public Comment period highlighted changes to the following areas:

- **Measurement Year 2019**
  Changes to processes and guidelines for collecting results, testing measures, and specification updates to align with measure stewards; results will be collected and reported during calendar year 2020.

- **Measurement Year 2020**
  Changes to the set of measures recommended for program use in MY 2020; results will be collected and reported during calendar year 2021.

The report containing all comments received, as well as IHA's response, are below in Attachment A. Additionally, the 2019 Call for Public Comment document is included as Attachment B for further detail and reference.

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
Performance Measurement Collaborative Program Updates					
Program Timelines Updates for Measurement Year 2019 and Beyond	1	PO - Physician Organization	Support		Thank you for your support.
	2	Plan	Support		Thank you for your support.
Aligning Total Cost of Care Measurement Across the AMP Programs	3	Plan	Support		Thank you for your support.
	4	Plan	Support	Positive that IHA has incorporated TCOC using the HealthPartners metric (MN makes public).	Thank you for your support.
	5	Health Systems	Support with modifications	Regarding Total Cost of Care measurement for the ACO population: Page 255 of the 2019 AMP Program manual, in the continuous enrollment logic section IHA states: "For Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care, include members with at least 9 months of enrollment in the health plan and the PO during the measurement period. For Commercial ACO, include members with at least 9 months of enrollment in the health plan and at least 1 attributed month to a PO during the measurement period." We do not support including ACO members in a PO's TCOC measurement who were only attributed to the PO for 1 month. We strongly feel that the same continuous enrollment logic that applies for the HMO population should apply for the ACO population as well, meaning that ACO members should need to be attributed to a PO for at least 9 months to be included in the ACO TCOC measurement. We participate in many ACO contracts with various payors, all of whom apply a continuous enrollment logic prior to calculating final cost and quality performance at the end of each year. However, all of them use a 6-9 month minimum continuous enrollment threshold for members to be included in year-end performance measurement, none of them use a 1 month minimum attribution threshold. The main focuses of ACO arrangements are to provide members with high quality health care, improve outcomes, and reduce the provision of low value services, thus, reducing unnecessary spending. There is an understanding that all of these goals take time to achieve, which is why continuous enrollment logic is applied before payor's evaluate a POs performance in an ACO arrangement. A PO has virtually no control over the quality outcomes or TCOC of a patient who was only attributed to them for 1 month. For these reasons, we recommend using a 9 month minimum continuous enrollment logic for the ACO TCOC measurement, instead of a 1 month minimum.	Thank you for your comment. For AMP Commercial ACO and Medi-Cal Managed Care the continuous enrollment criteria for the measures generated by Onpoint Health Data was adjusted - specifically, members had to meet the full continuous enrollment with the health plan, but the continuous enrollment with the physician organization was relaxed. This adaptation was intended to ensure sufficient sample sizes across the measures, given the higher churn rates of patients and limited aggregation in these populations. IHA will be working with the Technical Measurement Committee to bring the continuous enrollment criteria across all AMP programs into closer alignment for MY 2019.

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Evolving Medi-Cal Managed Care Measurement	6	Plan		Neutral on the current decision process; We are not currently providing Medi-Cal Information for use by IHA.	Thank you for your comment.
Advancing Encounter Data Measure Development	7	Plan	Support with modifications	The overview document refers to Appendix A so we are answering this for the two metrics in that categoryEncounter Format:We are an integrated healthcare system that currently supports a modified data extract to On Point for AMP and ATLAS reporting. Due to the nature of our file structures and internal claims generation, we do not provide all off the indicators for measurement. This may cause incomplete outcomes for the metric For example, we do not currently support in claims extracts: - Procedure Modifiers - Revenue Codes - Provider indicators are provided currently at the medical group level, not the provider level Encounter TimelinessDue to our integrated system...the concept of a "paid date" is different for our claims. The time between incurred or data of service and the date of payment are the only two concepts within our claim files. Data of submission is not a concept with in our internal work flows as it would be considered in other systems. We are not sure how this measure will be reflective in our system.	Thank you for your comment. IHA will work with the AMP Committees and Onpoint to continue refining the specifications for the measure before they are included in the final MY 2019 AMP Manual. The measure testing process, which includes review by participants and committee, will identify any data comparability issues across health plan submissions and IHA will work to resolve any identified issues.
Advancing Patient Reported Outcomes Measurement for Depression	8	Plan	Support	It doesn't appear like there are a lot of new metrics (for MY 2020), but we support expansion of behavioral health metrics (depression screening, monitoring, remission).	Thank you for your support. IHA staff aim to minimize annual changes to the measure set whenever possible to ensure continuity in measures used for accountability and include new measures that provide new, useful, and clinically relevant information to AMP participants.

	9	Plan	Support with Modifications	We are currently not engaged or involved in providing metrics for the ACO categories, but we are supportive of the use and development of metrics in this area. The application of this metric with in our organization needs to be evaluated and reviewed for appropriateness and use. We would like to understand more about its detailed use in the AMP and ATLAS metrics set as IHA moves to test this in the MY 2020	Thank you for your comment and support. The Technical Measurement Committee understands that the systematic collection of patient reported outcomes measures for depression poses clinical, operational and legal challenges and, with that in mind, has recommended an extended development and testing cycle for these measures. The collection of non-claims based measures like PROMs is a priority because it enables measurement of high prevalence, high morbidity measures like depression that aren't feasible with claims data. The prioritization of these measures also signals that successful measurement may require purchasers and health plans to focus initial investments to ACOs for reporting these measures (e.g. "pay for reporting"). All AMP measures include a multi-year testing process before being incorporated for program use. At a minimum this process includes: public review and comment on specifications, committee review and validation of testing results, and participant access to testing results. PROMs testing will also include the development and validation of a supplemental data collection system. Testing these measures can also be an opportunity for both IHA and NCQA to learn from the AMP participating POs and health to better implement standardized data collection and reporting of this measure. The testing of these measures is contingent on the ability to develop and scale a new supplemental data collection approach that would enable POs to submit member level data, including depression screening information, using a standard file layout to IHA's data partners, who will then generate the measure results. The Technical Measurement Committee has recommended that initially physician organizations should receive credit simply for submitting the data for PROMs measurement ("pay for reporting"). The Technical Measurement Committee recommends proceeding with testing the three identified depression PROMs in AMP Commercial ACO in MY 2020, which is contingent on successful development of a data collection approach for supplemental data.

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Element Name	#	Org Type	Support Type	Comment	Response
Advancing Patient Reported Outcomes Measurement for Depression	10	PO - Physician Organization	Do not support	We encourage alignment with HEDIS, but only after HEDIS has finished testing measures. HEDIS has a rigorous development process that aims to ensure measures are relevant, scientifically sound and feasible for implementation. Since Depression Remission at Six Months is a non-HEDIS measure, and therefore not in alignment with HEDIS, we are not in support of this measure. DSF and DMS are both HEDIS testing measures, specifically Electronic Clinical Data System (ECDS) measures, and we believe it is premature for IHA to begin testing these given their current limitations acknowledged by NCQA at this stage in their development. NCQA's expert panels have recommended, that NCQA continue collecting behavioral health measures (including DSF and DMS) but not publicly reporting the rates until the reported data show strong validity and reliability for these measures. Thus, we believe the DSF and DMS measures are not yet ready for testing with IHA. We also caution against inclusion of any ECDS measures in the AMP program until NCQA has been able to ensure reporting by all health plans. ECDS is still a new reporting process that has not yet been fully refined and streamlined. Last year, NCQA had a stop-work order released on 11/28/18 for ECDS measures, including DSF and DMS, after October updates were released. New updates were not released until 12/12/18 (ECDS Technical Update memo 12-12-18). Then another memo was released 1/30/19 with further updates due to inconsistencies among the difference versions of the spec (regular tech spec vs 'human readable' spec vs 'machine readable' spec). This led to the oversight where plans were directed to count certain immunizations after the measurement period with an undefined end date in order to align with the flawed machine-readable spec (ECDS Update memo 1-30-19). Given the misalignment of the specs being recognized so late in the reporting cycle last year, we believe ECDS measures are not ready to be expanded beyond NCQA's own internal testing. NCQA understands that ECDS measures present so many challenges for health plans that NCQA is planning several activities in the next year to try to provide more support for implementation, including the Digital Measurement Community, soliciting further input from plans, and planned pilots with states and health systems. We believe IHA should wait to allow NCQA to refine its current ECDS reporting processes and to see whether NCQA efforts are successful before requiring reporting to IHA that might be both flawed and problematic.	SEE RESPONSE TO COMMENT #9 Additionally, your comments were reviewed by NCQA who provided the following response to some of the specific concerns raised around the HEDIS ECDS measures: *"While the ECDS depression measures are still voluntarily reported for HEDIS and not yet recommended for public reporting, we encourage the use of these measures to both advance the measurement of this important clinical area and to provide learnings from implementation in settings outside of HEDIS. We also encourage measure users to join the new NCQA Digital Measurement Community (https://www.ncqa.org/hedis/the-future-of-hedis/the-digital-measurement-community/), launching in 2020, to share their experiences in using digital and ECDS measures and learn from others' experiences. Regarding the ECDS specification issues experienced for HEDIS 2019, we have implemented several process improvements to avoid the re-release of measures. For example, for HEDIS 2020 there is now only one 'human readable/tech spec' version of the specification."*

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Element Name	#	Org Type	Support Type	Comment	Response
MY 2019 Measure Specification Updates					
Statin Measures (SPD, SPC)	11	MCO - Managed Care Organization	Support with modifications	Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year are exclusions but allergies are not? From a clinical workflow standpoint many providers put myalgia as a Statin allergy because it is then available for all to see in the EMR vs. dropping a code in an encounter for it. Secondly, why are allergic responses to statins not an exclusion? Third, why are patients who are on a PCSK9 inhibitor not excluded or included on the med list as an alternative to statins for those with intolerance?	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following response: *"1) The only exclusions for the SPC and SPD measures are members who meet the criteria under Step 2 of the event/diagnosis. These exclusions include pregnancy, IVF, cirrhosis; please refer to the MY2019 manual for a full list. 2) Statin allergy was previously reviewed by NCQA's measurement team and panels and it was determined there were no codes specific enough to determine allergic reaction was due to statin use. The measure does include exclusions for muscle pain and disease which are proxies for statin intolerance. HEDIS 2020 specifications (AMP MY 2019) have already been finalized; however, NCQA will take allergy exclusions into consideration for future revisions to the measure. 3) The Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Therapy for Patients With Diabetes (SPD) measures were approved in May of 2015 for inclusion in HEDIS 2016. These drugs were not available when the measures were specified. However, these medications were recently reviewed by our clinical team and it was determined the PCSK9 medications are used "in addition to a statin"; so it wasn't necessary to include them in the measure. We will continue to monitor the use of this drug class and any changes in guidelines. Any changes would be considered by clinical panels during the measures next re-evaluation cycle. HEDIS measures are typically re-evaluated every three years or when clinical guidelines change significantly; measure specifications, codes and medication lists are revisited for minor updates with each annual HEDIS publication. As a reminder, NCQA holds a public comment period each March and the public is welcome to comment on HEDIS measures at that time."*

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Element Name	#	Org Type	Support Type	Comment	Response
Statin Measures (SPD, SPC, SUPD, PDC- Statin)	12	Medical Group	Support with modifications	Applies to all statin measures , patients that are on a PCSK-9 should not be bound to these metrics (because they normally wouldn't be prescribed both a statin & a PCSK-9). PCSK med prescription should make patients excluded from these measures. Thank you.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the appropriate measures stewards (NCQA/PQA) who provided the following responses: *"These drugs were not available when the measures were specified. However, these medications were recently reviewed by our clinical team and it was determined the PCSK9 medications are used "in addition to a statin"; so it wasn't necessary to include them in the measure. We will continue to monitor the use of this drug class and any changes in guidelines. Any changes would be considered by clinical panels during the measures next re-evaluation cycle."*
Statin Use in Persons with Diabetes (SUPD)	13	MCO - Managed Care Organization	Support with modifications	For other statin measure sets these are exclusions: Pregnancy, IVF, Rx for clomiphene, Cirrhosis and Myalgia, myositis, myopathy or rhabdomyolysis - are they also applicable to SUPD? (age range starts at 40 which is still a pregnancy potential). Why are PCSK9 inhibitors an exclusion or included on med list?	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (PQA) who provided the following responses: *"1) The other exclusions that are used in other statin measures (e.g., IVF, etc.) are being considered during PQA's Measure Update Panel, but are not currently exclusions. If the exclusions are approved, the measure specifications will be updated accordingly. 2) Documentation that a patient is taking PCSK9 inhibitors is not a valid exclusion for this measure. PQA has taken this under consideration, any changes will be adopted during the next measure update."*
Statin Therapy for Patients With Diabetes (SPD)	14	MCO - Managed Care Organization	Do not support	The SPD measure includes the advanced illness/frailty exclusion, but the SUPD measure does not. These measures are meant to look at the same population, members with diabetes, so their exclusions should align. We understand that the measure stewards are different, but IHA should consider developing its own measures based on PQA and HEDIS recommendations in order to live up to the "Align" component of the rebranding of VBP4P.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by PQA who provided the following response: *"PQA will take these exclusions into consideration with our Measure Update Panel in the future. Thank you for the feedback."*

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Element Name	#	Org Type	Support Type	Comment	Response
Proportion of Days Covered by Medications (PDC)	15	MCO - Managed Care Organization	Support with modifications	Given that the Pharmacy Quality Alliance NDC list is released twice a year, are both versions used toward measure compliance? It appears that the MY2018 Value Set Directory only contains one version of the list, but it would be helpful if both lists were used in order to capture new NDC codes that are released between versions.	Thank you for your comment. The AMP Value Set Directory released on September 1 contains all current codes as provided by PQA as of July 31, 2019.
Diabetes Care (CDC)—Eye Exam	16	MCO - Managed Care Organization	Support with modifications	Code Z13.5 is often used by eye care professionals to indicate a diabetic retinal screening but it is not in the Diabetic Retinal Screening Value Set.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: "*Encounter codes (ICD-10 Z codes) are not included because these codes indicate a screening that was planned. Encounter codes do not indicate the procedure was actually performed. If a procedure is performed, NCQA would expect to see a procedure code in the claims data (the expected procedure codes are included in the value sets). ICD-10-CM Official Guidelines for Coding and Reporting state: 'Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe the procedure performed.'*"
	17	MCO - Managed Care Organization	Support with modifications	Given that the American Medical Association is adding or revising codes for diabetic retinopathy screening (2022F, 2023F, 2024F), will these codes be added to the 2019 AMP value set? Also, can you please clarify why CPT 99202 is not included in the value set for this measure?	Thank you for your comment. The new and revised codes (2022F, 2023F and 2024F) were released by the American Medical Association for implementation on October 1, 2019. These updates will be included in the final MY 2019 AMP Program Manual released December 1. The code 99202 is included in the Outpatient Value Set for the CDC measure.
Diabetes Care (CDC)—HbA1c Control <8%	18	MCO - Managed Care Organization	Support with modifications	Given that the American Medical Association is deleting CPTII code 3045F and adding 2 new CPTII codes to indicate HbA1c control (3051F and 3052F), will those be added to the 2019 AMP value set?	Thank you for your comment. The deleted and added codes were released by the American Medical Association for implementation on October 1, 2019. These updates will be reflected in the final MY 2019 AMP Program Manual released December 1.

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Element Name	#	Org Type	Support Type	Comment	Response
Controlling High Blood Pressure (CBP)	19	Medical Group	Support with modifications	CBP should be modified to exclude diabetic patients from the measure, as they were in CBPH, so that the same patient population is not being measured for the same thing in two different measures. Or retire the CDC- blood pressure measure.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: *"The intent of the CBP measure is different from the CDC measure. In the CBP measure, the provider who is managing the member's hypertension is accountable for bringing the hypertension under control later in the year. The CDC measure is focused on management of hypertension in all patients with diabetes. The Technical Measurement Committee noted that there is overlap in denominators, however, the committee reinforced the value in separately evaluating hypertension management for patients with hypertension and diabetes since it is a particularly important clinical priority for IHA stakeholders.IHA will maintain the CBP and the CDC-blood pressure indicator, as specified by the measure steward, in the MY 2019 measure set."*
	20	PO - Physician Organization	Support with modifications	Currently, in the CBP measure, there is not a way to capture blood pressures done at nurse visits without billing the patient. Nurses are an integral part of the care team and can measure blood pressures, provide education, and gather information for the physician to review in between physician visits. However, when patients are charged for these nurse visits, it creates a barrier to accessing care. It would be helpful if there was an encounter code in the VSD for this measure such as 99199, or other code, which would allow blood pressure to be captured during an office visit encounter where the patient is not charged. Thank you.	Thank you for your comment. BP readings taken during a nurse or medical assistant visit meet numerator criteria provided that the BP is eligible; there is no provider type requirement and an actual visit is not required when assessing medical record data. Ineligible BPs are those that are taken during an acute inpatient stay or an ED visit, BPs reported by or taken by the member and BPs taken on the same day as a diagnostic test or diagnostic/therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test (with the exception of fasting blood tests). During Technical Measurement Committee discussions, it was noted that when nurses or medical assistants try to capture BP administratively using the CBP Value Set Directory codes, this documentation may result in a copay depending on the member's insurance coverage. While BP readings documented in the patient's medical record can continue to be used as supplemental data for AMP reporting, IHA and NCQA are aware that supplemental data poses additional reporting burden for POs. NCQA will bring this feedback to their coding panel to evaluate whether the 99199 code or other code not linked to a patient copay, can support administrative documentation of this measure by non-clinician team members. Since the MY 2019 Value Set Directory for HEDIS is already final, this will be considered for MY 2020.

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Element Name	#	Org Type	Support Type	Comment	Response
Controlling High Blood Pressure (CBP)	21	PO - Physician Organization	Support with modifications	Please remove the requirement that BP be measured at a billable visit. Patients are much more likely to f/u for a BP check if they can see an LVN and not have to pay a copay.	*SEE RESPONSE FROM COMMENT #20*
Cervical Cancer Overscreening (CCO)	22	PO - Physician Organization	Do not support	Non-HEDIS measure. We strongly support alignment with HEDIS, which decreases the burden associated with multiple reporting programs.	Thank you for your comment. While it is AMP program policy to align with regional and national performance measurement efforts whenever possible, the Technical Measurement Committee may identify a compelling clinical reason or need not to align. While the HEDIS Cervical Cancer Screening is currently measured, cervical cancer screening can be overutilized resulting in unnecessary additional procedures for women and increased costs. CCO assesses whether POs are overscreening for cervical cancer. According to MY 2018 AMP Commercial HMO benchmarks, approximately 1 in 5 women are still be overscreened for cervical cancer. The Technical Measurement Committee did discuss that there may be valid clinical reasons for "overscreening" patients and plan to re-evaluate both the Cervical Cancer Screening and Overscreening measures to make sure that these measures are the best reflection of appropriate care guidelines. Additionally, POs who self report AMP measure results may choose not to report on measures that pose undue burden. **Decision: IHA will maintain the CCO measure in the AMP measure set for MY 2019.**
	23	Plan	Support with modifications	We recognize the purpose of this metric. Our organizational direction has been to use evidence-based medicine to provide the right care at the right time. This metric assumes that certain types of care may be due to purposeful over-screening for Cervical Cancer, when there could be legitimate care reasons for additional screening. We believe the CCS metric is a better method to measure the appropriateness of this care. Historically, we have preferred metrics that have been approved and accredited by organizations like NCQA.	*SEE RESPONSE TO COMMENT #22* **Decision: IHA will maintain the CCO measure in the AMP measure set for MY 2019.**

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Element Name	#	Org Type	Support Type	Comment	Response
Cervical Cancer Screening (CCS)	24	POA - Physician Organization Association	Support with modifications	Hello, We would like you to consider adding transgender as an exclusion to the Cervical Cancer Screening (CCS) measure. Thank you.	Thank you for your comment. If it is documented in the medical record that the member was assigned male at birth (e.g., transgender male to female), then this is evidence that the member does not have a cervix and the member meets optional exclusion criteria and may be removed from the measure. If a member meets any of the required exclusions (e.g. hysterectomy) for the measure, the member is excluded regardless of biological sex. In addition, medical record documentation of cervical agenesis or clinical synonyms (e.g., evidence a patient was born without a cervix) may also be used to exclude these members. Please note that if the organization is unable to find the appropriate documentation, these members should remain in the measure.
Cervical Cancer Screening (CCS)	25	MCO - Managed Care Organization	Support with modifications	We would like to see any deletions from measures from one year to another have a strikethrough rather than simply being deleted. This would help us to identify the changes year over year without needing to have both the 2018 and 2019 manuals open. Doing so means it takes us much longer to review the manual and submit comments/measure questions.	Thank you for your comment. The AMP measure sets indicate which measures have been added and retired using color coding and strikethrough formatting. In addition, the summary of changes (Appendix 1 of the AMP Program Manual) identifies substantial measure specification changes from the prior measurement year, Measure specification changes are also summarized at the top of each measure specification, with changes noted in red/strikethrough formatting. Changes not highlighted are minor language edits made for clarity.
	26	Plan	Support		Thank you for your support.
	27	PO - Physician Organization	Support		Thank you for your support.
Colorectal Cancer Screening (COL)	28	Medical Group	Support with modifications	Patients during the MY in active chemo/radiation therapy should be excluded from the COL measure due to their increased risk of bleeding, making it not safe for them to undergo colonoscopies, etc. thank you.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: "*Members undergoing chemo or radiation therapy are currently not excluded from this measure. NCQA will take this exclusion into consideration. The AMP program will align specifications based on any future revisions to the HEDIS measure.*"

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Element Name	#	Org Type	Support Type	Comment	Response
Childhood Immunization Status (CIS) Childhood Immunization Status (CIS)	29	Physician	Support with modifications	As a pediatrician, I strongly urge the childhood immunization measure to allow a little more flexibility with regard to the amount of doses. Sometimes kids find themselves off schedule or delayed, and this decreases the amount of doses they receive. This is the case, especially with Hib and pneumococcal vaccines. They can be counted as fully vaccinated and up to date per the CDC/ACIP/pediatrician, but we end up not meeting the measure. These situations are not common, but they do affect our numerators. I would greatly support having a little more flexibility in this matter since these kids are up to date but not being counted as such in the measure.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: "*The HEDIS CIS measure is intended to assess whether children are immunized based on evidence-based guidelines from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). The measure does not give credit for children who are immunized on the "catch-up" schedule as catch up schedules are for patients who missed the initial timing for immunizations and are specific to smaller populations. NCQA has no current plans to change this practice for immunization specifications and/or reporting.*"
	30	MCO - Managed Care Organization	Support with modifications	Although we support measurement of childhood immunization rates, the influenza immunizations are difficult to capture because parents often opt not to have their child receive this vaccine, or have it administered outside the provider office. Similarly, many patients are not able to receive the vaccine during office visits due to illness. As a result, the influenza component of this all-or-nothing combination measure artificially lowers the physician organization's immunization compliance rate. We propose converting back to the Combination 3 measure that excludes influenza. Or, adding an exception for patients who are unable to receive the vaccine due to illness.	Thank you for your comment. The Technical Measurement Committee recommended the transition to Combo10 and continues to support the use of Combination 10 because it reflects practice guidelines and aligns with HEDIS health plan accreditation standards. Your comments were reviewed by NCQA who provided the following responses: The Childhood Immunization Status (CIS) measure is based on the Advisory Council on Immunization Practices (ACIP) routine vaccination schedule for children, which recommends an annual influenza vaccine for children age 6 months and older. Additionally, the immunization measures allow vaccines to be identified using administrative claims data, as well as supplemental data such as immunization registries that can capture vaccines given outside of the provider's office. As a reminder, the AMP program does not allow patient refusal to count as exceptions. Guidelines are intended to apply for the majority of patients, but are not intended to replace either clinical judgment or patient choice. As such, the AMP programs understand that no guideline is expected to be followed 100% of the time. This measure represents the best thinking in regards to measuring performance of evidence-based care. **Decision: IHA will continue to collect CIS Combination 10 in MY 2019.**

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Immunization for Adolescents (IMA)	31	MCO - Managed Care Organization	Support with modifications	With the change in the HPV immunization dosing recommendations to reflect that a 2-dose schedule is recommended for people who get the first dose before their 15th birthday, many families choose to defer the vaccine until closer to 15 years of age. Given the current recommendations, could the measure age be revisited to accommodate up to age 15 years?	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: *"The Immunizations for Adolescents (IMA) measure is based on the Advisory Council on Immunization Practices (ACIP) routine vaccination schedule which recommends routine HPV vaccination at age 11 or 12 years; vaccination can be given starting at age 9 years. Better immunogenicity is achieved when the vaccine series is completed earlier. ACIP does not have a 'cutoff' date of age 15. The IMA measure is specific to the 9 -13 age group; therefore, vaccines given after age 13 do not count towards the measure. NCQA monitors the ACIP immunization schedules annually for changes; if changes are made that impact the measures they are reviewed by the appropriate staff and panels to determine if a change to the measure is warranted. Regional and clinic based guidelines are not used in the development of this national measure and thus the CDC ACIP guidelines are used for this and NCQAs other immunization measures."*
Asthma Medication Ratio (AMR)	32	PO - Physician Organization	support with modifications	Too many patients are captured in this measure. The move toward automatic enrollment of patients into auto-renewal programs at the pharmacy causes a lot of problems.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: *"This has been noted and will be taken into consideration for future revisions to the measure specification."*
	33	MCO - Managed Care Organization	Support with modifications	We would like to recommend that exercise induced bronchospasm be excluded from the measure eligibility criteria.	Thank you for your comment. It is an AMP program policy to align with measure steward's specifications whenever possible to align with regional and national performance measurement and benchmarking efforts. IHA encourages participants to provide input on measure specifications during public comment periods hosted by the measure steward. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: "*Your recommendation has been noted by the appropriate staff and panels for future revisions to the measure."*

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
Asthma Medication Ratio (AMR)	34	Medical Group	Support with modifications	Why has Dupixent not been added to the controller list? Thank you.	Thank you for your comment. Your comments were reviewed by the measure steward (NCQA) who provided the following responses: *"Dupilumab (Dupixent) is a Interleukin-4 receptor alpha antagonist. This drug class is currently not included in our asthma controller medication list; therefore, this medication is not currently eligible for use in reporting. However, we will have this drug class and medication reviewed by the appropriate staff and panels for its appropriateness or inclusion in future releases of HEDIS measure."*
Appropriate Testing for Pharyngitis (CWP)	35	Medical Group	Do not support	Hello, States in the measure update section of the spec that added the Medicare product line. But does not reflect this in the product lines section or on the MY 2019 or MY 2020 measure sets.	Thank you for your comment. This update was added in error and we will remove all references in the final MY 2019 AMP manual. The CWP measure is not specified for AMP Medicare Advantage reporting.
	36	PO - Physician Organization	Support		Thank you for your support.
	37	Plan	Support		Thank you for your support.
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)	38	Medical Group	Do not support	States in the measure update section of the spec that added to Medicare product line. But does not reflect this on the MY 2019 or MY 2020 measure sets	Thank you for your comment. This update was added in error and we will remove all references in the final MY 2019 AMP manual. The AAB measure is not specified for AMP Medicare Advantage reporting.
	39	PO - Physician Organization	Support		Thank you for your support.
	40	Plan	Support		Thank you for your support.
Osteoporosis Management in Women Who Had a Fracture (OMW)	41	PO - Physician Organization	Support		Thank you for your support.
	42	Plan	Support		Thank you for your support.
Prenatal and Postpartum Care (PPC)	43	PO - Physician Organization	Support		Thank you for your support.
	44	Plan	Support		Thank you for your support.
Use of Opioids at High Dosage (HDO)	45	PO - Physician Organization	Support		Thank you for your support.

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
Use of Opioids at High Dosage (HDO)	46	Plan	Support with modifications	We provide the information to NCQA for assessment of this metric on an annual basis. We would like to be part of a conversation where this metric has become stable in the market. We would prefer to use metrics in a public setting like AMP when the metric has had a stable/consistent specification and application over a set period.	Thank you for your comment. Every year, the Technical Measurement Committee reviews a summary of AMP measures where a trending break has been identified by IHA and NCQA staff to ensure measures have enough stability for use in incentive, public reporting, and award methodologies where applicable. As a reminder, the HDO measure is **not** used for any of these in the AMP programs; it is informational as the opioid epidemic continues to be an important clinical priority.
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	47	MCO - Managed Care Organization	Do not support	Although we support appropriate clinical care for patients with rheumatoid arthritis, we find that the measure performance percentage is rarely a reflection of appropriate clinical care. Rather, patients are often mis-diagnosed with rheumatoid arthritis, or the provider has a valid reason for not prescribing a DMARD (e.g., patient tried and failed with intolerance), or there is difficulty collecting data on filled DMARD prescriptions. These issues are further augmented by the small denominator for the measure, which makes the rate very sensitive to change. We propose that this measure be retired in favor of other measures that will have a greater impact on clinical care.	Thank you for your comment. The HEDIS ART measure was reviewed by NCQA's performance measurement team and performance rates in HEDIS were determined to be nearly topped out. This measure was retired from the Commercial and Medicaid product lines for HEDIS 2020 (AMP MY 2019); however, to remain in alignment with CMS, who plans to retire this measure for the CMS 2023 Star Ratings program (AMP MY 2021). **Decision: ART will continue to be reported in AMP Medicare Advantage until MY 2021**.
MY 2019 Measure Retirements					
Ambulatory Care: Emergency Department (AMB) - (HMO, ACO)	48	PO - Physician Organization	Support		Thank you for your support.
	49	Plan	Support		Thank you for your support.
Inpatient Utilization: General Hospital/Acute Care (IPU) - (HMO)	50	PO - Physician Organization	Support		Thank you for your support.
	51	Plan	Support		Thank you for your support.
Generic Prescribing Rate (Therapeutic Classes) - (HMO, MC)	52	PO - Physician Organization	Support		Thank you for your support.
	53	Plan	Support		Thank you for your support.

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
MY 2019 Testing Measures					
Encounter Format (HMO, ACO, MA, MC)	54	Plan		Encounter Format: We are an integrated healthcare system that currently supports a modified data extract to OnPoint for AMP and ATLAS reporting. Due to the nature of our file structures and internal claims generation, we do not provide all off the indicators for measurement. This may cause incomplete outcomes for the metric For example, we do not currently support in claims extracts: - Procedure Modifiers - Revenue Codes - Provider indicators are provided currently at the medical group level, not the provider level	Thank you for your comment. IHA will work with the AMP Committees and Onpoint to continue refining the specifications for the measure before they are included in the final MY 2019 AMP Program Manual.
Encounter Timeliness (HMO, ACO, MA, MC)	55	Plan		Due to our integrated system...the concept of a "paid date" is different for our claims. The time between incurred or data of service and the date of payment are the only two concepts within our claim files. Data of submission is not a concept with in our internal work flows as it would be considered in other systems. We are not sure how this measure will be reflective in our system"	Thank you for your comment. IHA will work with the AMP Committees and Onpoint to continue refining the specifications for the measure before they are included in the final MY 2019 AMP Program Manual.
Hospital Average Length of Stay- (HMO, ACO, MC)	56	Plan	Support with modifications	We support this metric in principle. We are open to the testing of this metric with the chance to review and influence the methodology as needed to create a stable metric	Thank you for your comment. The specifications that will be used to test this measure will be made available before December 1 of this year. Testing results for this measure will be brought to the AMP Committees for review when the results are available next year.
Prenatal and Postpartum Care (PPC) - (MC)	57	Plan		Neutral on the current decision process; We are not currently providing Medi-Cal Information for use by IHA	Thank you for your comment.
Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life (W34) - (MC)	58	Plan		Neutral on the current decision process; We are not currently providing Medi-Cal Information for use by IHA	Thank you for your comment.

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
MY 2020 Testing Measures					
Depression Patient Reported Outcome Measures: • Screening for Clinical Depression & Follow-Up Plan (DSF) • Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS) • Depression Remission at Six months	59-61	MCO - Managed Care Organization	Do not support	Although we support depression screening and treatment for adults and adolescents, this measure will be difficult to execute for independent practice associations (IPA). First, although many providers conduct depression screening in the office, organizations without an integrated/single EHR system will not have visibility into the results and would not be able to collect and report the information in an automated fashion. Furthermore, if an IPA chooses to conduct depression screenings in-house, this could cause duplication and/or confusion for patients who prefer to communicate directly with their provider, or, who have already undergone screening with their provider.	*SEE RESPONSE TO COMMENT #9* **Decision: IHA will proceed with testing the three identified depression PROMs in AMP Commercial ACO for MY 2020.**
	62-64	Plan	Support with modifications	We are currently not engaged or involved in providing metrics for the ACO categories, but we are supportive the use and development of metrics in this area. The application of this metric with in our organization needs to be evaluated and reviewed for appropriateness and use. We would like to understand more about its detailed use in the AMP and ATLAS metrics set as IHA moves to test this in the MY 2020	*SEE RESPONSE TO COMMENT #9* **Decision: IHA will proceed with testing the three identified depression PROMs in AMP Commercial ACO for MY 2020.**
MY 2020 Measure Retirements					
Adult BMI Assessment (ABA) - (MA)	65	PO - Physician Organization	Support		Thank you for your support.
	66	Plan	Support		Thank you for your support.
All Other Comments					
ACO Plan Reporting	67	Medical Group	Support	Is UHC definitely participating in the ACO reporting this year?	Thank you for your question. All health plans will be confirming their intent to participate in the AMP programs for MY 2019 in the coming months. Currently, the following plans have indicated their intent to participate in AMP Commercial ACO: Aetna, Anthem, Blue Shield of California, Health Net, Oscar Health Plan and UnitedHealthcare.

ATTACHMENT A: 2019 AMP PUBLIC COMMENT RESPONSES

Element Name	#	Org Type	Support Type	Comment	Response
PQA Measure Reporting	68	Medical Group	Support with modifications	OnPoint is running the HDO, COB, and SUPD measures. Why are they running these PQA measures but not the PDC measures? Or why is OnPoint running any of them at all? We would like to see consistency among Onpoint's running of pharmacy measures.	Thank you for your comment. Onpoint is running the SUPD and the two opioid measures, HDO and COB, from health plan claims data only per a Technical Measurement Committee recommendation intended to alleviate plan and PO reporting burden associated with programming pharmacy measures. In contrast, the PDC measures have been reported by health plans and POs as part of the traditional audited clinical submission to TransUnion since MY 2012. IHA is working with Onpoint and NCQA to evaluate the feasibility of transitioning the results generation for **all** pharmacy based measures to Onpoint and removing them from the audited clinical submission to TransUnion. The Technical Measurement Committee will assess this approach in 2020.
Measurement - General	69	Plan		Consistent with last year, we would like us to use many of IHA measures in our quality scorecard for CA deals and will need to change out one on diabetes from last year (remove the HbA1c testing if we want to align with the 2020 IHA ACO metrics) Once we obtain the full list of true HEDIS metrics we can compare and see where IHA lands.	Thank you for your comment. The AMP Committees and IHA are supportive of efforts to promote further alignment of individual health plan accountability sets and the AMP measure set.
Measurement - General	70	Plan		IHA covers a broader array than our internal metrics for our ACOs. In CA, we could assign staff member to help us map out a process for doing that in the future. We would like to quickly incorporate controlling high blood pressure, provider communication, and statin use.	Thank you for your comment. The AMP Committees and IHA are supportive of efforts to promote further alignment of individual health plan accountability sets and the AMP measure set.
Measurement - General	71	Plan		We would like to see an expansion into specialty metrics. Would like to understand how (if) IHA has given thought to use of many MIPS metrics that specialists are reporting. In Medicare FFS, approx 95% of practitioners are still on the MIPS side, not AAPM. [PLAN] is doing an analysis of what quality improvement and metrics IHA is focusing on, so that we can find ways to align, benefit our aco partners. Functional status reporting by orthopedists is a particular area of interest.	Thank you for your comment. The AMP measure set is revised annually based on stakeholder input from the annual public comment period and through discussion with the AMP committees. IHA would be interested in speaking with your plan to determine priority areas for specialty care measurement.

ATTACHMENT B: 2019 AMP CALL FOR PUBLIC COMMENT

To: Integrated Healthcare Association (IHA) Stakeholders

From: Lindsay Erickson, Director, Program Operations, IHA

Subject: Measurement Years 2019 & 2020 Proposed Changes to the AMP Programs and Measure Sets

2019 IHA Public Comment Period
September 1 – September 30, 2019

IHA staff invite public comment on the following:

1. **General Feedback on IHA Performance Measurement Collaborative Updates**
   IHA staff welcome general comments on programmatic changes including updates to the program timelines and measurement priorities, including Total Cost of Care alignment across all AMP programs, expansion of encounter data measures, development of depression care patient reported outcomes measures, and testing of Department of Health Care Services' accountability measures for Medi-Cal.
2. **Measurement Year 2019 (MY 2019) Measure Set Changes**
   Measures approved for AMP program use for MY 2019 were finalized on December 1, 2018. Proposed changes to the MY 2019 measure set reflect the addition of proposed testing for MY 2019 and any measure retirements or specification updates prompted by measure steward changes to national standards. Given the recent additions of the Medi-Cal Managed Care and Commercial ACO programs, avoiding changes to IHA's measurement is a top priority. However, the IHA Committees identified several priority testing measures for Commercial ACO and Medi-Cal Managed Care to align with participant priorities.
3. **Measurement Year 2020 (MY 2020) Measure Set Changes**
   The changes outlined reflect the measures that are proposed for program use for MY 2020; results will reflect the care provided to members in calendar year 2020 and be collected and reported during calendar year 2021.

Comments are due by 5 p.m. PDT on Monday, September 30, 2019 to the Public Comment website at the following link: https://my.ncqa.org/.

Public Comment Login Instructions:

Access the Public Comment System

Existing NCQA Users: The public comment system is integrated with NCQA's my.ncqa.org. If you have access to the NCQA Policy/Program Clarification Support (PCS) system or other NCQA products and services, you can use the same credentials to login and submit your comments.

*Note: Use the **Forgot Password** button if you are unsure of your password. By using this feature you are changing your password for any NCQA system to which you have access.*

New NCQA Users: If you do not have access to my.ncqa.org click the **Create an Account** button and complete the entire form. Please retain the password for your records.

Submit a Comment

Step 1 Go to the Public Comment page using the following link: https://my.ncqa.org/

Step 2 Complete the **Register** section.

Step 3 Log in and click **My Services**.

- To submit a comment, click **Public Comments** in the drop down**.**
- Click **Add Comment.**
- For *Product,* click **2019 IHA Public Comment** in the drop-down box.
- For *Topic,* select the appropriate category for your question.
- For *Element,* scroll down and click the appropriate measure for your question.
- For *Support Type,* scroll down and click the appropriate support type.
- For *Comments*, enter a comment.
- Type your question (2,500 characters or less).

Step 4 Click **Submit Your Comment**.

Step 5 If you are submitting more than one comment, click **Close** and repeat the process. All of your submitted comments will be displayed on the **Public Comments** page where you have the option of exporting.

Introduction

To complement the expansion of IHA's performance measurement work, the Align. Measure. Perform. (AMP) programs (formerly our suite of physician organization level performance measurement programs) and the California Regional Health Care Cost & Quality Atlas (Atlas), are now collectively known as the Performance Measurement Collaborative. The Performance Measurement Collaborative highlights our deep expertise and commitment to health care that promotes quality improvement, accountability, and affordability.

The Performance Measurement Collaborative was created to collectively establish standardized healthcare performance measures, data collection and aggregation, and reporting processes that could transform how providers, payers, and purchasers deliver, evaluate, and pay for care. The Performance Measurement Collaborative is governed by a multi-stakeholder committee structure, which enables IHA to rigorously generate objective and valid insights to increase accountability, enable performance improvement, and align payment incentives to drive toward high-quality, patient-centered, affordable care. IHA hosts an annual Public Comment period every year to allow IHA stakeholders to provide feedback on the program and on the measure set.

All comments received during the Public Comment period will be reviewed by the IHA Technical Measurement Committee or Technical Payment Committee, and responses, including applicable changes, will be approved by the IHA Governance Committee before being incorporated where appropriate.

General IHA Performance Measurement Collaborative Updates

1. Updates on Program Timelines for Measurement Year 2019 and Beyond

Based on HEDIS©'s efforts to accelerate the finalization of specifications and IHA efforts to improve the predictability of the AMP deliverable timeline, there are several anticipated changes for MY 2019 and MY 2020. The proposed timelines reflect the transition to an earlier finalization of the AMP Program Manual and an updated reporting time for the Onpoint-generated results. A detailed timeline can be found on pages 7-10 of the draft MY 2019 AMP Program Manual.

Earlier this summer, NCQA announced an updated release schedule for HEDIS Volume 2, which will impact future release dates of the AMP Program Manual and Public Comment period. To take full advantage of these updates, IHA anticipates the following timelines for the AMP Program Manual and Public Comment releases.

September 2020	Draft AMP Program Manuals for MY 2020 and MY 2021 released at the same time, and annual Public Comment opens for both MY 2020 and MY 2021.	
December 2020	Final MY 2020 AMP Program Manual released.	
June 2021	Final MY 2021 AMP Program Manual released.	*Six months earlier than previous December releases*
October 2021	Draft MY 2022 AMP Program Manual released and annual Public Comment opens.	*Eleven months earlier & prior to measurement year start*
June 2022	Final MY 2022 AMP Program Manual will be released.	*Six months earlier than previous December releases*

2. Aligning Total Cost of Care Measurement Across the AMP Programs

Measuring total cost of care is critical for addressing affordability and improving the value of care delivered by provider organizations (POs) in California. Total cost of care has also been a key differentiator for IHA's value-based performance measurement efforts. Standard measure specifications for total cost of care, using the NQF-endorsed *Total Cost of Care (TCOC)* measure from HealthPartners, were adopted for use in AMP Commercial HMO, Commercial ACO and Medi-Cal Managed Care in MY 2017. The IHA Governance Committee recommended adding *TCOC* to the AMP Medicare Advantage program. Expedited testing maximizes the use of existing data collected for the Medicare Advantage population, emphasizes the importance of total cost of care measurement across all payers and aligns collection of *TCOC* across all AMP programs. *TCOC* is generated by IHA's data partner and requires no additional reporting from health plans or provider organizations. *TCOC* testing results for AMP Medicare Advantage were distributed to participants for review with the preliminary results release on August 26. Testing results will **not** be publicly reported or used in the generation of star ratings or recognition awards at this time. Measure specifications for *TCOC* can be found in the draft MY 2019 Manual.

3. Evolving Medi-Cal Managed Care Measurement

With nearly 11 million Medi-Cal enrollees receiving care through managed care plans and increasing overlap in provider networks serving commercial and Medi-Cal members, aligned and comparative performance measurement is critical. MY 2017 marked the first year for AMP Medi-Cal Managed Care with one health plan reporting results for over 40 POs and Federally Qualified Health Centers. The AMP Medi-Cal Managed Care program features a common measure set that spans clinical quality, patient experience, utilization and total cost of care. Recognizing the unique measurement needs of Medi-Cal providers and patients, alignment with the Department of Health Care Services (DHCS) Managed Care Accountability Set, which holds managed care plans accountable to a minimum performance level (MPL) on 17 measures, is a priority identified by stakeholders. The AMP Medi-Cal Managed Care measure set currently includes 65% of the MPL measures. To support increased alignment with the MPL measures on the Managed Care Accountability Set, the Technical Measurement Committee recommends testing *Prenatal and Postpartum Care (PPC)* and *Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life (W34)* in MY 2019.

4. Advancing Encounter Data Measure Development

Complete and accurate claims and encounter data plays a critical role in accurate risk adjustment and data completeness. IHA currently collects and reports a standard measure of encounter rates per member per year, including granularity reflecting professional and facility encounters (*Encounter Rate by Service Type - ENRST*). Expanded use of risk-adjustment in performance measurement, health plan reconciliation payments, and State Medi-Cal priorities have driven stakeholder and participant interest in expanding IHA's encounter data measurement to support holistic measurement of encounter data quality. This measurement is intended to help guide organizations' understanding of encounter data quality, identify opportunities for improvement, and support meaningful financial incentives for better data quality. As an initial step in this direction, the IHA committees have identified encounter data timeliness and format as appropriate areas for measure development and testing in MY 2019. Descriptions of the two areas of proposed encounter measures are included in **Appendix A of this document**.

5. Advancing Patient Reported Outcomes Measurement for Depression

Major depressive disorder affects millions of Americans, resulting in significant disability and loss of productivity. Yet, depression is often underdiagnosed and undertreated. Access to behavioral health services is a top-ranked health concern for Californians. In response to purchaser priorities, IHA, the Pacific Business Group on Health, and the California Quality Collaborative co-hosted a multi-stakeholder workgroup to further a collective approach for depression measurement and care redesign. Based on the workgroup's feedback and the AMP Commercial ACO priorities around patient reported outcomes measures (PROMs), the Technical Measurement Committee recommended developing a supplemental data collection system that would support testing of a suite of three depression PROMs measures. The system would enable POs to submit member level data, including depression screening information, using a standard file layout to IHA's data partners, who will then generate the measure results. The measure set recommendations target the testing of these measures in the AMP Commercial ACO program for MY 2020. Recognizing the financial investment in clinical workflows and data infrastructure required by POs to enable routine collection and submission of depression data, the Technical Measurement Committee noted that successful measurement may require purchasers and health plans to focus initial investments to ACOs for reporting these measures (e.g. "pay for reporting"). These recommendations are contingent on the ability to develop and scale the new supplemental data collection approach that IHA is working to pilot. Descriptions for the three depression PROMs measures are included below.

Measurement Year 2019 (MY 2019) Measure Set Changes

The IHA Committees recognize AMP program participant desire to focus on improvement and data collection for existing AMP measures and have made it a priority to maintain stability in the AMP measure sets as much as possible, including minimizing the number of testing measures. To this end, testing of the *Prenatal Immunization Status*—previously slated for MY 2019—has been deferred. The MY 2019 Measure Sets for Commercial HMO, Commercial ACO, Medicare Advantage and Medi-Cal Managed Care are available here. Other changes to the MY 2019 measure sets are summarized below, including the measure name, the AMP program(s) for which the measure is recommended, a brief description and rationale for inclusion.

1. Measure Retirements

A. ***Ambulatory Care: Emergency Department (AMB) - Commercial HMO, Commercial ACO***
NCQA retired *AMB* for the commercial and Medicare product lines for HEDIS 2020, supporting the transition to the available risk-adjusted emergency department utilization measure, *Emergency Department Utilization (EDU)*. *EDU* was adopted for use in the AMP program in MY 2017. In accordance with HEDIS guidelines, *AMB* will be retired for the commercial product lines. Since *EDU* is not specified for the Medicaid product line, *AMB* will be maintained for AMP Medi-Cal Managed Care.

B. ***Inpatient Utilization-General Hospital/Acute Care (IPU) - Commercial HMO, Commercial ACO***
NCQA retired *IPU* for the commercial and Medicare product lines for HEDIS 2020, supporting the transition to the standard risk-adjusted measure for hospital use, *Acute Hospital Utilization (AHU)*. *AHU* was adopted for use in the AMP program in MY 2017. Since *AHU* is not specified for the Medicaid product line, *IPU* will be maintained for AMP Medi-Cal Managed Care.

C. ***Generic Prescribing Rate (Therapeutic Classes) - Commercial HMO, Medi-Cal Managed Care***
All therapeutic classes of the *Generic Prescribing Rate (GRX)* measure, with the exception of diabetes medications, have "topped out" (defined as any measure whose rate of performance exceeds 90% at the 25th percentile) indicating high performance across the measured population. As such, the IHA Committees recommend retirement of all *GRX* therapeutic classes. IHA will continue to measure and report the *Overall Generic Prescribing Rate*.

2. Testing Measures

Testing measures allow IHA to incorporate relevant new measures to AMP measure sets while ensuring the measure can be reliably collected and produces useful information to AMP program participants. Measures recommended for testing are summarized below, including the measure name, the AMP program(s) for which the measure is recommended for testing, a brief description and rationale for inclusion.

A. Encounter Format - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care
This measure will assess whether key encounter data elements meet expectations on use of standard codes, consistency, and completeness. Correct coding and formatting of the content included in an encounter submission affects both its acceptance by a health plan and its usability for a variety of purposes – everything from care gap reporting and performance measurement to risk adjustment and rate setting. Specifications for this measure can be found in **Appendix A of this document**.

B. Encounter Timeliness - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care
This measurement area assesses the elapsed time in days between the date a patient receives care (i.e., Date of Service (DOS)) and the date when encounter is accepted by the health plan (i.e., Submission Date). The number of calendar days between those dates is the "lagtime." Shortening the lagtime between the DOS and Submission Date ensures that the information provided on the encounter is available for health plan quality improvement initiatives, performance measurement reporting, and risk-score calculations. Specifications for this measure can be found in **Appendix A of this document**.

C. Hospital Average Length of Stay - Commercial HMO, Commercial ACO, Medi-Cal Managed Care
This measure calculates a risk-adjusted inpatient average length of stay (ALOS) for medical and surgical admissions. The collection and reporting of a risk-adjusted ALOS measure emerged as a priority to support IHA's value-based incentive design: the measure is intended to complement the transition to *Acute Hospital Utilization*, which focuses only on discharges and does not reflect the effective management of hospital stays. Additionally, this measure has been identified as a priority by health plans for AMP Commercial ACO measurement. Towards these ends, the Technical Measurement Committee has recommended the addition of risk-adjusted *ALOS* in MY 2019. Draft specifications for this measure can be found in **Appendix B of this document**.

D. Prenatal and Postpartum Care (PPC) - Medi-Cal Managed Care
This measure assesses the timeliness of prenatal and postpartum care. This measure was approved for testing in the AMP Medi-Cal Managed Care program because of its importance to the Medi-Cal population. Adoption of this measure also supports alignment with the Department of Health Care

Services Managed Care Accountability Set which all Medi-Cal Managed Care plans in California are held accountable to performance standards. Refer to the draft MY 2019 Manual for measure specifications.

E. Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life (W34) - Medi-Cal Managed Care

This measure assesses children 3-6 years of age who received one or more well child visits with a primary care practitioner during the measurement year. This measure was approved for testing in the AMP Medi-Cal Managed Care program due to its importance to the Medi-Cal population. Adoption of this measure also supports alignment with the Department of Health Care Services Managed Care Accountability Set, which all Medi-Cal Managed Care plans in California are held accountable to performance standards. Refer to the draft MY 2019 Manual for measure specifications.

3. Measure Specification Updates

A. *Align with Measure Steward Specifications Updates - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care*

Alignment with measure steward specifications is a key strategic priority for IHA's performance measurement programs. IHA intends to align with all measure steward specification updates to ensure measure alignment and reduce reporting burden for participating POs and health plans. A summary of changes is listed at the beginning of each measure specification, and a complete Summary of Changes can be found in Appendix 1 of the draft MY 2019 Manual. Measures with notable steward specification updates include:

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)*
- *Appropriate Testing for Pharyngitis (CWP)*
- *Cervical Cancer Screening (CCS)*
- *Cervical Cancer Overscreening (CCO)*
- *Osteoporosis Management in Women Who Had a Fracture (OMW)*
- *Prenatal and Postpartum Care (PPC)*
- *Use of Opioids at High Dosage (HDO)*

Measurement Year 2020 (MY 2020) Measure Set Changes

The draft MY 2020 AMP Measure Set is available online for review and comment here. Proposed changes to the MY 2020 measure sets are summarized below, including the measure name, the AMP program(s) for which the measure is recommended, a brief description and rationale for inclusion.

1. Measure Retirements

A. *Adult BMI Assessment (ABA) - Medicare Advantage*

Retirement of this measure in MY 2020 will align with CMS's retirement of this measure in CMS Stars. This measure has high performance (above 90%) and low variation (standard deviation is less than 11% based on MY 2018 benchmarks).

2. Testing Measures

A. *Test the Depression Patient Reported Outcomes Measures (PROMs) suite - Commercial ACO*

The Technical Measurement Committee has recommended that the following three depression focused PROMs measures be tested for AMP Commercial ACO in MY 2020:

1) ***Depression Screening and Follow-Up for Adolescents and Adults (DSF).***
This NCQA measure is adapted from CMS (NQF# 0418) and assesses the percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, received follow-up care within 30 days. Current U.S. Preventive Services Task Force guidelines recommend that all adolescents and adults, including pregnant and postpartum women, be screened for depression at least once a year. Note that this measure is currently used in programs such as CMS's Child and Adult Medicaid Core Set and the California Department of Health Care Services Managed Care Accountability Set. This measure is also part of the new HEDIS Electronic Clinical Data Systems (ECDS) reporting system which leverages electronic health record data in addition to claims and case management data. Specifications for this measure can be found in **Appendix C of this document**.

2) ***Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS).***
This NCQA measure is adapted from Minnesota Community Measurement (NQF # 0712) and assesses the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. While the *Depression Screening and Follow-Up* measure allows the use of multiple validated depression screening tools, the PHQ-9 is the most commonly used tool in primary care to diagnose and monitor depression and all NQF-endorsed remission measures use the PHQ-9 result as the marker for remission. This measure signals the need to monitor patients diagnosed with depression after the initial screening over time. This measure is also a HEDIS ECDS measure. Specifications for this measure can be found in **Appendix C of this document.**

3) ***Depression Remission at Six Months.***
This NQF-endorsed measure (NQF #0711) is stewarded by Minnesota Community Measurement and assesses adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months, defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. Monitoring depression severity and ensuring patients are treated to target is crucial for improving the well-being of patients diagnosed with depression or dysthymia. Specifications for this measure can be found in Minnesota Community Measurement's 2019 Depression Care Direct Data Submission Guide.