Oregon Metrics and Scoring Committee

AGENDA

June 7, 2013
1:00 – 4:00 pm

Wilsonville Training Center
29353 SW Town Center Loop E
Wilsonville, OR 97070

Public Listen-Only Conference Line: Dial: 1-888-808-6929; participant code: 604851

#	Time	Item	Presenter	Action Item
1	1:00 – 1:15 pm	Welcome • Agenda review • April 5 minutes	Bob Dannenhoffer	X
2	1:15 – 2:30 pm	Review and adopt proposals from Technical Advisory Workgroup: • Colorectal cancer screening • Follow up after mental health hospitalization • SBIRT • Small denominators • Measurement period	Lori Coyner David Labby	X
3	2:30 – 3:15 pm	Review and adopt final measure specifications for: • Mental and physical health assessments for children in DHS custody • EHR adoption • Elective delivery • Depression screening • Clinical measures	Lori Coyner Michael Bailit	X
4	3:15 – 3:45 pm	Review and adopt final benchmarks for measures	Michael Bailit	X
5	3:45 – 4:00 pm	Public testimony	Bob Dannenhoffer	
		Adjourn	Bob Dannenhoffer	

Next Meeting:
August TBD

Agenda items:

- Alternate data submission for incentive measures
- Planning for 2014 reporting
- Measurement framework

Oregon Metrics and Scoring Committee
Minutes
April 5, 2013
1:00 p.m. – 4:00 p.m.
29353 SW Town Center Loop E
Wilsonville, OR 97070

Item
Welcome Committee members present: Gloria Coronado, Maggie Bennington-Davis, Robert Dannenhoffer, R.J. Gillespie, Phil Greenhill, Bob Joondeph, David Labby, Jeff Luck, Jeanine Rodriguez. Presenters: Michael Bailit, Kate Reinhalter-Bazinsky, Bailit Health Purchasing; Jim Winkle, John Muench, OHSU SBIRT Primary Care Residency Initiative; Michael Morris, OHA Addictions and Mental Health; Alissa Robbins, OHA Communications. OHA Staff: Tina Edlund, Chief of Policy; Lori Coyner, Director of Accountability and Quality; Jon Collins, Program Analysis and Evaluation Manager; Dana Peterson, Policy Analyst; Sarah Bartelmann, Project Manager; Ari Ettinger, Assistant to the Health Policy Board.
Consent Agenda
Technical Advisory Group Lori Coyner gave an overview of the technical advisory group (TAG), a new workgroup made up of CCO representatives that OHA is pulling together to address feedback received from CCOs about incentive measure specifications. The workgroup will address alternate data sources for incentive measures, the hypertension and diabetes control measures, coding for services and screening measures, and how to collectively build technological infrastructure for data collection and reporting. The Committee agreed they would like the TAG to pursue alternate data sources, to create a process to solicit alternate ideas from CCOs and community stakeholders, to solicit representation from behavioral health, and to bring back proposals to the Metrics & Scoring Committee. The presentation is available in the meeting materials online at: http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials130405.pdf
Baselines and Specifications Lori Coyner and Michael Bailit gave an overview of the feedback OHA has received from CCOs and community organizations on the 11 draft incentive measure specifications and baseline data that were released in March. They proposed strategies for how OHA will incorporate the feedback received for each measure for the Committee's discussion. A summary of the decisions for each measure is below:

DRAFT

- **Adolescent Well Care Visits**: The Committee agreed to use the national standardized specifications for this measure and will not ask the TAG to review alternate codes.
- **SBIRT:** OHA will revise the specifications to fix the denominator; The Committee agreed to exclude emergency department visits from the measures; The TAG will address coding issues.
- **Ambulatory Care:** The Committee agreed to use the national standardized specifications for this measure; OHA will explore options for reporting an expanded version of the measure separately that includes mental health services as "informational."
- **CAHPS**: No changes.
- **Colorectal Cancer Screening:** The Committee agreed to adopt a phased in approach for this measure using an absolute number of CRC screenings for adults from claims data in year one and moving to a hybrid approach using claims and additional data sources in year two. The Committee will set a revised benchmark/improvement target for year one based on historical data/trends. OHA will draft revised specifications and provide data at June meeting.
- **Developmental Screening:** The Committee agreed to only include validated screening tools for this measure; The TAG will address alternate data collection methodology. OHA will explore opportunities for improving shared tools/information systems that could support this measure.
- **Follow Up After Hospitalization for Mental Illness**: The Committee agreed on the importance of capturing the appropriate community mental health services and agreed on using an expanded measure as the incentive measure; The TAG will review additional codes for case management and wraparound services and will draft revised specifications; OHA will report the national standardized version of the measure as "information" in addition to the expanded measure.
- **Follow Up Care for Children Prescribed ADHD Medications:** The Committee agreed to use the national standardized specifications for this measure and to tie the incentive payment to the initiation rate only; OHA will report both the initiation and the continuation and maintenance rates for this measure.
- **PCPCH Enrollment:** No changes.
- **Timeliness of Prenatal Care**: TAG will review specifications and data sources for this measure and will bring a proposal back to the Metrics & Scoring Committee.

The Committee also discussed whether or not time/event dependent measures should only be measuring using data from the second half of 2013. The Committee will ask TAG to review this policy issue and bring back a proposal to the June meeting.

DRAFT

The presentation is available in the meeting materials online at:
http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials130405.pdf

Communications Plan

Alissa Robbins gave an overview of OHA's communication plan and available resources around these measures and OHA's new Health System Transformation quarterly progress report, which will present the metrics in a clear and accessible way.

The presentation is available in the meeting materials available online at:
http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials130405.pdf

USDOJ Measures Update

Mike Morris gave an overview of Oregon's agreement with USDOJ and the measures OHA is required to report to USDOJ:

- The USDOJ measures have some overlap with the CCO incentive measures (e.g., follow up after hospitalization), but the focus is on the narrow subset of people with severe and persistent mental illness (SPMI).
- The first report, containing approximately 110 data elements reported at the state level, was due April 1st and a copy will be provided to the Committee shortly.
- There will be ongoing discussion about the best ways to collect and report on these data, as well as an advisory group that will oversee changes to services based on these data.

Additional information about the USDOJ agreement and the list of measures are available online at:
http://www.justice.gov/usao/or/documents/20121109_civil_agreement.pdf

SBIRT Project Presentation

Jim Winkle and Dr. John Muench from the OHSU SBIRT Primary Care Residency Initiative presented on what SBIRT is, how it can fit within clinic workflows, and ways to measure it. The presentation is available online at: http://www.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials130405.pdf

The Committee then discussed options for revising the SBIRT incentive measure to look at the screening and the brief intervention separately, and what the appropriate benchmarks would be, based on alcohol and substance use in Oregon's adult population. The Committee agreed to have TAG address the coding options and come back to the Metrics & Scoring Committee with a proposal.

DRAFT

Oregon Metrics and Scoring Committee
Minutes
April 5, 2013
1:00 p.m. – 4:00 p.m.
29353 SW Town Center Loop E
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Public Testimony No public testimony was provided.
Adjourn

<u>Next Meeting:</u>

June 7, 2013
1:00 – 4:00 pm
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DRAFT

Technical Advisory Group (TAG) Recommendations

Metrics & Scoring Committee
June 7, 2013

Oregon Health Authority

TAG Overview

- OHA convened the group in April and May 2013 to address:
  - Specifications for incentive measures (especially clinical)
  - Small denominators and other methodology issues
- Consists of CCO representatives – quality improvement coordinators, data analysts, IT experts, Medical Directors.
- Made recommendations for Metrics & Scoring on:
  - Colorectal cancer screening
  - Follow up after hospitalization for mental illness
  - SBIRT
  - Small denominators
  - Measurement period

Oregon Health Authority

Colorectal Cancer Screening

Issue

- Need a developmental approach to capture services without the full 9 year look back period without hybrid data for the first measurement year.

Recommendation – Year 1

- Use administrative data (claims) only for an absolute count of screened adults occurring during a 12 month period (CY 2011 baseline). Report count as rate (e.g., per 1,000 adult member months, ages 51-75).

- The quality pool distribution for this measure will be based on a 3 percent increase in adults screened occurring within a 12 month period (CY 2013) as compared to baseline, similar to other improvement targets. There will not be a benchmark in year 1.

Oregon Health Authority

Colorectal Cancer Screening – Quality Pool

Recommendation – Year 2

- Year 2: Incorporate supplemental data from clinical records, registries, EHRs, etc and report the metric with supplemental data from medical records. TAG will continue to develop this approaches for the hybrid measure.

- No benchmark for year 1. Metrics and Scoring will establish a year 2 benchmark.

Oregon Health Authority

Follow Up after Hospitalization for Mental Illness

Issue

- CCOs recommended adding case management and wrap around service codes to the numerator.

Recommendation

- Include all recommended codes in the numerator.

Oregon Health Authority

SBIRT

Issue

- How to best measure SBIRT, what components of SBIRT should be tied to the incentive (e.g., initial screening, full screening, brief intervention).

Recommendation – Year 1

- Measure the full (secondary) screening, but also give credit for any brief interventions conducted and billed during the first year (due to the overlap in CPT codes).
- Measure will roll up CPT codes 99420, 99408 and 99409.
- Add Medicare codes G0396 andG0397 for cross-over claims.

Oregon Health Authority

SBIRT

Recommendation – Year 2

- Expand the measure to track (and potentially incentivize) brief intervention separately from screening.
- Identify ways to track initial (universal) screening.
- Identify ways to document CCO/clinic referral systems to ensure that members who need additional services are receiving them.

Oregon Health Authority

SBIRT

Recommendation – Benchmark

- Prevalence of risky, harmful or dependent drinking among patients attending primary care clinics: 22%
- Highest performing clinic in the OHSU SBIRT project screens members 60% of the time when indicated.
- **Benchmark: 60% of 22% = 13%**

Oregon Health Authority

Small Denominators

Issue

- For certain measures, several CCOs have small denominators (n<30). Rates will fluctuate with very small changes in the numerator and are therefore not stable.
- NCQA considers these denominators too small to report a valid rate.

Recommendation

- Omit measures with small denominators from each CCOs quality pool calculation.
- Modify the quality pool methodology, so CCOs are still eligible to earn the full amount of the quality pool: To qualify for 100% of the quality pool funds, CCOs will have to meet 75% of whatever their remaining total number of measures is after measures with small denominators have been dropped (e.g., 11 of 15 measures)

Oregon Health Authority

Measurement Period

Issue

- It was suggested through feedback from CCOs that the first measurement period be shortened from the full calendar year to July – December 2013 for measures that are time dependent (e.g., timeliness of prenatal care, elective delivery, etc).

Recommendation

- The measurement period should remain at 12 months (calendar year 2013).

→ The TAG requests that the Metrics & Scoring Committee consider revising the improvement targets for these measures to address the shorter period of time that CCOs will be working on these measures.

Oregon Health Authority

Incentive Measure Specifications

New Measure Specifications

- Mental and Physical Health Assessments for Children in DHS Custody
- Depression Screening
- EHR Adoption
- Elective Delivery
- Clinical measures (diabetes and hypertension)

Mental and Physical Health Assessments for Children in DHS Custody

Mental Health Assessment

Identified children/adolescents 4 – 17 years of age as of the first date of DHS custody, and remained in custody for at least 60 days. Custody date must be from January 1 through October 31 of the measurement year.

Physical Health Assessment

Identified children/adolescents 0 – 17 years of age as of the first date of DHS custody, and remained in custody for at least 60 days. Custody date must be from January 1 through October 31 of the measurement year.

Oregon Health Authority

Mental and Physical Health Assessments for Children in DHS Custody

Recommendations

- Combine mental and physical health assessments into one measure – children who have received both assessments in a timely fashion.
- Use 60 day time period for both.
- Benchmark remains at 90%.

Oregon Health Authority

Depression Screening

Denominator

- Members ages 18 and older with at least one outpatient office visit that would offer the opportunity for a depression screening and any needed follow up to occur.

Numerator

- Members in the denominator with a positive screening and documented follow up plan: G8431
- Members in the denominator with a negative screening: G8510

→ G codes are new. OHA is in the process of opening them, will be communicating and providing training on the new codes soon.

→ TAG will be working to develop non-claims based methods for CCOs to report depression screenings that occur in 2013.

Oregon Health Authority

EHR Adoption

This metric is calculated as the proportion of CCO providers that received EHR incentive payments under either the Medicaid or Medicare EHR Incentive Program for adoption or meaningful use of certified EHR technology, compared to an estimate of providers who could have received a payment (eligible providers).

- CCOs are reviewing 2011 baseline results.

Full methodology available online at:
http://www.oregon.gov/oha/CCOData/EHR%20Adoption.pdf

Oregon Health Authority

EHR Adoption

Benchmark

OHA proposes setting the benchmark at the federal assumed rates for non-hospital based EHR adoption and Meaningful Use by 2014: **49.2%**

Improvement Target

- Does the Metrics & Scoring Committee want to establish an improvement target?
- Minnesota Method with 3% floor?

Oregon Health Authority

Early Elective Delivery

OHA has calculated baseline (CY2011) results for deliveries that occurred between 37 and 39 weeks gestation using encounter (claims) data and vital statistics data (birth certificates). These rates were calculated using Joint Commission methods.

The results do not exclude deliveries with spontaneous rupture of membranes.

Hospitals in Oregon began to adopt “hard stop” policies in September 2011.

OHA proposes continuing to work with the Technical Advisory Group and the Perinatal Steering Committee to develop reporting criteria for 2013 CCO comparisons and further improve data sources.

Oregon Health Authority

Controlling Hypertension

The CCO must demonstrate to OHA that it:

(1) can report the percentage of patients 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement period, calendar year 2013.

(2) is taking steps towards electronic collection and reporting of this data.

The CCO can retrieve the information through any means that is most convenient; however the methodology will need to meet minimum specifications and the data dictionary to be defined with input from the Technical Advisory Group (TAG).

TAG will recommend sampling methodology for the first year and will recommend parameters for demonstrable steps for electronic data collection and reporting.

Oregon Health Authority

Diabetes: HbA1c Poor Control

The CCO must demonstrate to OHA that it:

(1) can report the percentage of patients 18 – 75 years of age with diabetes (type I or type II) who had an HbA1c test and the HbA1c test < 9.0 percent during the measurement period, calendar year 2013.

(2) is taking steps towards electronic collection and reporting of this data.

The CCO can retrieve the information through any means that is most convenient; however the methodology will need to meet minimum specifications and the data dictionary to be defined with input from the Technical Advisory Group (TAG).

TAG will recommend sampling methodology for the first year and will recommend parameters for demonstrable steps for electronic data collection and reporting.

Oregon Health Authority

Finalizing Benchmarks

Oregon Health Authority

Previously Determined Benchmarks - 1

Measure	Benchmark	Source
Ambulatory care: outpatient and emergency department utilization	ED Utilization: 44.4/1,000mm Outpatient Utilization: 439/1,000 mm	2011 National Medicaid 90th percentile Note: Only ED rate is used for determining incentive payment.
CAHPS – Access to Care	87%	2012 National Medicaid 75th percentile
CAHPS – Satisfaction with Care	84%	2012 National Medicaid 75th percentile
Controlling high blood pressure	60% - year 1 report only	2012 National Medicaid 75th percentile
Developmental screening in the first 36 months of life	50%	Metrics & Scoring Committee consensus

Oregon Health Authority

Previously Determined Benchmarks - 2

Measure	Benchmark	Source
Elective delivery	5% or below	Metrics & Scoring Committee consensus
Follow up after hospitalization for mental illness	68%	2012 National Medicaid 90th percentile
Follow up care for children prescribed ADHD medication	Initiation: 51% C&M: 63%	2012 National Medicaid 90th percentile Note: Only initiation rate used for incentive payment
Mental and physical health assessment within 60 days for children in DHS custody	90%	Metrics & Scoring Committee consensus
PCPCH Enrollment	100%	Metrics & Scoring Committee consensus Note: incentive payment is based on a sliding scale.

Health Authority

Proposed Benchmarks - 1

Measure	Proposed Benchmark	Source	Notes
Adolescent well care visits	53.2%	2012 National Medicaid 75th percentile (administrative data only)	Revised from 56.9%
Alcohol and drug misuse (SBIRT)	13%	TAG recommendation	
Colorectal cancer screening	n/a – improvement target only		Original benchmark: 61.3%, 2012 National Commercial data, with adjustment factor for Medicaid
Diabetes: HbA1c poor control	34% - year 1 report only	2012 National Medicaid 75th percentile	Parallel to hypertension benchmark

Oregon Health Authority

Proposed Benchmarks - 2

Measure	Proposed Benchmark	Source	Notes
EHR adoption	49.2%	Federal assumed rate for non-hospital EHR adoption for 2014	
Timeliness of prenatal care	69.4%	2012 National Medicaid 75th percentile (administrative data only, with adjustment factor)	Original benchmark: 89%, 2012 National Medicaid 75th percentile
Screening for clinical depression and follow up plan	n/a – improvement target only		

Oregon Health Authority

Colorectal Cancer Screening Recommendation

Based on discussion at the April 5th Metrics & Scoring Committee meeting and with the OHA Technical Advisory Workgroup (TAG), a developmental approach for the colorectal cancer screening measure is proposed.

This is a stop-gap solution to implement this measure for calendar year 2013, not the longer-term vision for this measure, which will incorporate a longer look back period. Additional development work is needed for subsequent measurement years.

Phased In

In year one, the colorectal cancer screening measure will only look at administrative data (claims) utilizing an absolute count of individuals who received screenings during a 12 month measurement period (CY 2013). OHA will report the absolute count as a rate (e.g., per 1,000 adult member months, ages 51-75) to account for changes in OHP population over time and across CCOs.

In year two, this measure will become hybrid – incorporating supplemental data from clinical records, registries, EHRs, etc. OHA will continue to work with the Technical Advisory Group and Metrics & Scoring Committee to develop an agreed-upon approach for the collection and/or submission of this supplemental data.

Quality Pool

In year one, the quality pool distribution for this measure will be based on a 3 percent increase from the baseline, similar to other improvement targets. The 3 percent increase will be measured by an absolute count of individuals who received screenings within a 12 month measurement period. OHA will report the absolute count as a rate (e.g., per 1,000 adult member months, ages 51-75) to account for changes in OHP population over time and across CCOs.

The Metrics & Scoring Committee will address quality pool distribution for this measure in year two.

Follow Up After Hospitalization for Mental Illness Recommendation

Based on CCO feedback received during the 30 day review period, the Oregon Technical Advisory Group (TAG) recommends that the following case management and wrap around service codes be added to the numerator for this measure:

- 2013 new therapy codes: 90791, 90792, 90832, 90834, and 90837.
- Psychotherapy add-on codes that would be used with E/M codes by a MD/NP in mental health (for DOS before 1.1.13): 90801, 90802, with psychotherapy codes 90804-90817
  (for DOS after 1.1.13): 90833, 90836, 90838.
- Mental health assessment by non-physician: H0031
- Case management services: T1016
- Outreach visit to help engage a youth in A&D treatment as recommended as a result of inpatient evaluation: H0006
- Community based wrap around services: H2021
- Family therapy without the child (day after discharge): 90846

Existing Numerator:
Discharges for members age 6 years of age and above who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharges. See details from HEDIS® 2012 Technical Specifications for Health Plans (Volume 2) below.

Existing Denominator:
Discharges for members age 6 years of age and above who were hospitalized for treatment of selected mental health disorders. See details from HEDIS® 2012 Technical Specifications for Health Plans (Volume 2) below.

➔ **NOTE:** Oregon does not limit this measure to mental health practitioners as outlined in HEDIS specifications below and is only looking at procedure codes used, regardless of the provider type.

Table 13.1. Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
295-299, 300.3, 300.4, 301, 308, 309, 311-314

Table 13.2 Codes to Identify Inpatient Services

MS-DRG
876, 880,887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Table 13.3 Codes to Identify Non Acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Table 13.4 Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT	POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner	
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	With: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	With: 52, 53
UB Revenue	
The organization does not need to determine practitioner type for follow up visits identified by the following UB revenue codes	
0513, 0900-0905, 0908, 0911-0917, 0919	
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table 13.1	
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983	

SBIRT Recommendation

Incentive Measure

The Oregon Technical Advisory Group (TAG) proposes tracking the full (secondary) screening for the first measurement year (CY 2013). Due to the overlap in CPT codes used for screening and brief intervention, the group agrees that CCOs should receive credit for any brief interventions also conducted and billed during the first year, but recommends rolling screening and brief intervention up together (CPT codes 99420, 99408 and 99409).

TAG also recommends including two Medicare "G" codes, for cross-over claims (G0396, G0397). Note these codes do not cover ancillary providers, including health educators, performing SBIRT under physician supervision. See specification details below.

TAG proposes expanding the measure for the second measurement year (CY 2014) to track (and potentially incentivize) brief intervention separately from screening.

TAG also proposes continuing to develop the SBIRT measure in subsequent years by identifying ways to track the initial (universal) screening, and potentially to also document CCO/clinic referral systems in a way that ensures that members who need additional services are receiving them.

Benchmark

TAG proposes a prevalence-based benchmark for the first measurement year (CY 2013). The benchmark will be structured around identifying what percentage of the adult members with unhealthy/risky alcohol and substance use are identified and receive screening.

A benchmark of 13% is proposed for this measure.

- Maxwell et al (1998) found the prevalence of risky, harmful, or dependent drinking to be 22% among patients attending primary care clinics. Therefore, a clinic with perfect performance and with an average percentage of patients with risky alcohol use would conduct a brief intervention on 22% of patients.
- The highest performing clinic implementing SBIRT into their workflow as part of the OHSU SBIRT project screens members 60% of the time when indicated.
- 60% of 22% = 13%

Note: the TAG would consider a slightly higher prevalence benchmark (~15% - based on adding substance abuse prevalence data into the mix, or based on prevalence of unhealthy/risky alcohol and substance abuse in the Medicaid population).

- NSDUH found the prevalence of substance use disorders for adults ages 18-64 on Medicaid to be 21.1%. OHA recommends setting the benchmark at 13%, knowing this may be an underestimate of alcohol and substance use seen in primary care.

TAG proposes shifting the benchmark in the second measurement year to incentivizing the brief intervention component of the SBIRT process.

Specifications

Numerator:
Unique counts of members age 18 years as of December 31 of the measurement year with one or more SBIRT screening services, defined by:

- Health Risk Assessment: 99420, with specific diagnosis codes for chemical dependency
- Alcohol and/or substance abuse structured screening and brief intervention services (15 – 30 minutes): 99408
- Alcohol and/or substance abuse structured screening and brief intervention services (greater than 30 minutes): 99409
- Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT, DAST) and brief intervention (15 – 30 minutes): G0397
- Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT, DAST) and brief intervention (greater than 30 minutes): G0397

Denominator:
Members age 18 years as of December 31 of the measurement year and having received an outpatient service as identified by the following CPT codes (based on the outpatient utilization component of the ambulatory care measure):

- Office or other outpatient visits: 99201-99205, 99211-99215, 99241-99245
- Home visits: 99341-99345, 99347-99350
- Preventive medicine: 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99408-99409.

Note that Emergency Department and mental health visits are currently excluded, as per previous Metrics & Scoring Committee discussion.

Note that there was a concern expressed at the TAG meeting that we are not excluding mental health providers from offering the screening/services in the case of co-location or integration of services.

Small Denominators Recommendation

For several of the CCO incentive measures, including Follow Up after Hospitalization for Mental Illness and Follow Up Care for Children Prescribed ADHD Medications, several CCOs have small denominators (n < 30). Rates based on small numbers may fluctuate dramatically from year to year, or differ considerably based on one or two members. NCQA considers these denominators too small to report a valid rate for these measures.

OHA will continue to provide CCOs with their rates for these measures, although the rates will be suppressed in public reporting, such as the Health System Transformation Quarterly Progress Report.

Based on discussion with the OHA Technical Advisory Group (TAG) and with the affected CCOs, and consultation with Michael Bailit, the recommendation is to omit measures with small denominators from each CCOs quality pool calculation.

- This would potentially affect 7 CCOs. If not including the Continuation & Maintenance Phase of the Follow Up Care for Children Prescribed ADHD Medications measure, this proposal would only affect 2 CCOs.

To ensure that these CCOs still have an opportunity to earn the full amount of the quality pool they are potentially eligible for, the following modifications to the quality pool methodology are proposed, based on the original tiered structure[1]:

- Instead of having to meet 12 of the 17 measures (75%) to qualify for 100% of the quality pool funds, CCOs would have to meet 75% of whatever their remaining total number of measures is after measures with small denominators have been dropped.
- For example, if a CCO has small denominators on two of the incentive measures, their total number of measures is now 15, and they must meet 11 of the 15 measures to qualify for 100% of the quality pool funds.
- Quality pool requirements related to the PCPCH formula and the EHR adoption measure remain unchanged, i.e., as per CMS requirements, a CCO must meet the EHR adoption measure to be eligible for 100% of their quality pool funds.

Note
The TAG expressed concern that this approach may take the easiest targets (i.e., the measures they may easily meet the benchmark or improvement target on) away from the affected plans, thus making it more difficult for them to earn their full quality pool distribution.

[1] Quality Pool Methodology available online at http://www.oregon.gov/oha/CCOData/Quality%20Pool%20Methodology.pdf (see page4-5 for the tiered structure)

Measurement Period Recommendation

OHA has received feedback from CCOs requesting that the first measurement period tied to incentive payments be modified from calendar year 2013 to measuring only the second half of 2013 (July – December) for those measures that are time dependent (e.g,. timeliness of prenatal care, elective delivery, etc). This would only apply for the first measurement year (2013).

The Technical Advisory Group (TAG) recommends that the measurement period should remain at 12 months (calendar year 2013) for all of these measures. The TAG noted some reservations about linking the quality pool payments to the original improvement targets, and requests that the Metrics & Scoring Committee consider revising the improvement targets for these measures to address the shorter period of time that CCOs will be working on these measures.

Pros	Cons
Using a shorter measurement period would not penalize CCOs for their performance on measures they cannot retrospectively work on after the specifications are finalized.	Moving from a 12 month to a 6 month measurement period would result in non-standardized measure specifications, moving further away from the national standards endorsed by the Metrics & Scoring Committee.
	Moving further away from national standards would mean that Oregon data for 2013 would no longer be comparable to national benchmarks. Benchmarks and improvement targets for these measures would need to be reset.
	Some CCOs will have very small denominators if only half a year of experience is included. Measurements with small denominators (<30) have large confidence intervals and need special consideration for incentive pool payments.

Oregon Health Authority
Statewide Revised Baseline Data 2011

The Oregon Health Authority (OHA) has produced state and coordinated care level (CCO) level baseline data for 14 of the 17 CCO Incentive Measures to date.

Specifications for all measures are posted online at:
http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

CCO Incentive Measures	Statewide Baseline (CY 2011)	Benchmark
Access to Care: Getting Care Quickly (CAHPS survey composites for adult and child)	83%	87% Average of the 2012 Medicaid 75th Percentile for adult and child rates.
Adolescent well-care visits (NCQA)	27.1%	53.2% 2011 National Medicaid 75th percentile, administrative data only.
Alcohol and drug misuse: screening, brief intervention and referral for treatment (SBIRT)	0.14%	13% Technical Advisory Group recommendation.
Ambulatory care: outpatient and emergency department utilization Note: Only ED utilization rate is used for determining incentive payment.	ED Utilization: 61.0/1,000mm Outpatient Utilization: 364.2/1,000mm	ED Utilization: 44.4/1,000mm Outpatient Utilization: 439/1,000mm 2011 National Medicaid 90th percentile
Colorectal cancer screening (HEDIS)	32.5%	Improvement target only.
Developmental screening in the first 36 months of life (NQF 1448)	20.9%	50.0% Determined by Metrics & Scoring Committee, based on results from 2007 National Survey of Children's Health.

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CCO Incentive Measures	Statewide Baseline (CY 2011)	Benchmark
Follow up after hospitalization for mental illness (NQF 0576)	57.6%	68.0% 2012 National Medicaid 90th percentile
Follow-up care for children prescribed ADHD medications (NQF 0108) Note: Only Initiation rate is used for determining incentive payment.	Initiation: 52.3% C&M: 61.0%	Initiation: 51.0% C&M: 63.0% National Medicaid 90th percentile
Mental and Physical Health Assessments within 60 days for Children in DHS Custody	Mental Health: 56.0% Physical Health: 67.1%	90% Determined by Metrics & Scoring Committee.
Patient-Centered Primary Care Home (PCPCH) Enrollment Calculated by: [(# of members in Tier 1)*1 + (# of members in Tier 2)*2 + (# of members in Tier 3)*3] / (The total number of members enrolled in the CCO*3)	51.7%	100% The percentage of dollars available to each CCO for this measure is based on a sliding scale, tied to the percentage of enrollees in PCPCHs, based on the measure formula.
Prenatal and postpartum care: timeliness of prenatal care (NQF 1517)	65.3%	69.4% 2012 National Medicaid 75th percentile, administrative data only
Satisfaction with Care: Health Plan Information and Customer Service (CAHPS survey composites for adult and child)	78%	84% Average of the 2012 Medicaid 75th Percentile for adult and child rates.
Screening for clinical depression and follow up plan	0%	Improvement target only.
EHR adoption See detailed methodology online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx	19%	49.2% 2014 Federal benchmark for Medicaid.
Elective Delivery	TBD	5% or below Determined by Metrics & Scoring Committee.

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CCO Incentive Measures	Statewide Baseline (CY 2011)	Benchmark
Controlling high blood pressure Note: report only for year one.	TBD	60% 2012 National Medicaid 75th percentile
Diabetes: HbA1c poor control Note: report only for year one.	TBD	34% 2012 National Medicaid 75th percentile

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