

ATTENDING

AllCare Alan Burgess Natalie Case Laura McKeane	Health Share Chandra Elser Jetta Moriniti (Providence)	Trillium DR Garrett	OHA Sarah Bartelmann Jon Collins Jen Davis Anona Gund Rusha Grinstead Kate Longborg Milena Malone Kian Messkoub Adrienne Mullock Frank Wu
Cascade Angela Leach Amanda Blodgett	IHN Ellen Altman Steve Hadachek Eryn Womack	Umpqua Nikki Martin Rose Rice Debbie Standridge	Guests Victoria Demchak (OPCA) Lynn Knox (OFB) Stephanie Renfro (OHSU)
CareOregon Nicole Merrithew	Jackson	WOAH Anna Warner	Dental Gary Allen (Advantage)
ColumbiaPacific	PacificSource Beth Quinlan Laura Walker Coco Yackley Tyler Nass (Mosaic) Ken House (Mosaic)	WVCH Greg Fraser	
Eastern Oregon Nathan Trenholme Lenore Diaz del Castillo		Yamhill	
FamilyCare Kevin McLean	PrimaryHealth Jennifer Johnston	Acumentra Sara Hallvik Q Corp Cindi McElhanev	

UPDATES

Sarah Bartelmann provided the following updates:

METRICS & SCORING COMMITTEE

- Applications for membership are being accepted until May 13; more information is on the Committee webpage.
- TAG members are encouraged to participate in the stakeholder survey, which available online and is also open until May 13.

HOSPITAL METRICS COMMITTEE

The Committee met April 22nd to continue discussing future program structure and Year 4 specifications for the new opioid prescribing and revised EDIE measures. The Oregon Perinatal Collaborative presented on potential Year 4 measures for the proposed maternal health domain.

TRANSFORMATION CENTER TECHNICAL ASSISTANCE

Adrienne Mullock and Anona Gund provided this update:

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Colorectal cancer screening: CCOs are also invited to join the next webinar in a series as part of the technical assistance for colorectal cancer screening. The next webinar will be May 4 from 11-noon. More information and registration is online at: www.oregon.gov/oha/Transformation-Center/Documents/CRC-Webinar.Series.pdf.

Adolescent well-care visits: The Oregon Pediatric Improvement Project (OPIP) will provide a webinar series between May and September to address adolescent well-care visits. More information and registration is available online at www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx.

Childhood immunizations: The Transformation Center will be reaching out to a CCO to pilot a root-cause analysis for childhood immunizations and in May or June, and may then reach out to other CCOs who are interested. CCOs have also expressed interest in regional community meetings on this measure; more information to come.

Cigarette smoking cessation: CCOs noted the need for cessation counseling training for providers. Transformation Center will put together targeted training and communication materials. If CCOs have questions or would like more details, please email metrics.questions@state.or.us.

STRATEGIC PLAN FOR HEALTH CARE DATA COLLECTION

SB 440 charged the Oregon Health Policy Board with developing a strategic plan for health care data collection in Oregon. OHA has contracted with Q Corp to develop a data inventory and gap analysis, and stakeholder engagement to inform development of the strategic plan. CCOs may be contacted in the near future for participation in focus groups and an online survey will be distributed in May.

CY 2015 VALIDATION PROCESS / TIMELINE

Jen Davis explained that the dashboard being released April 29 will reflect CY 2015 results with claims processed through April 8. OHA is also providing auxiliary files for several measures. A refreshed dashboard incorporating any missing diagnosis codes from adjusted claims will be released in mid-May; any changes are expected to be minor.

Also in May, CCOs will receive notification of approval of data submission for EHR-based measures; and CAHPS measure results will be released. Questions regarding CY 2015 validation are due to OHA no later than May 31 and should be sent to metrics.questions@state.or.us. Metrics staff will also provide office hours by phone on May 12; call-in information can be found in the meeting slides online.

All final 2015 measure results and quality pool payment amounts will be released to CCOs June 23, and CCO Metrics 2015 Final Report will be released publicly on June 24. CCOs will receive quality pool payments no later than June 30. Also on June 30, a dashboard with rolling window March 2015 – February 2016 will be available to CCOs. This will be the first dashboard with new 2016 incentive measures included.

SBIRT CODING

OHA noted a large increase in SBIRT numerator compliance beginning in October 2015 and believes this is due to the switch from ICD-9 to ICD-10. Frank Wu explained that, specifically, the change from diagnosis code v79.1 (ICD-9) to z13.89 (ICD-10) led to an average 79% increase in claims per month.

This new ICD-10 code lacks specificity -- it is only for "screening - other" -- and is very likely picking up non-SBIRT screenings. However, when z13.89 is combined with 99420, the increase in claims during measurement period Oct-Dec (i.e. ICD-10) compared with Jan-Sep (i.e. ICD-9) is only 16% instead of 79%. Staff believes this is a reasonable change that will reduce the likelihood that the SBIRT numerator is over-counting and picking up non-SBIRT services, and proposes removing the standalone coding option for CY 2016.

Staff is seeking TAG feedback on this matter; discussion included:

- Staff also found that the ICD-9 code v79.1 was very often paired with 99420 already, so coding in this combination for SBIRT is likely already a common practice.
- Concern about over-manipulating this measure. Ultimately SBIRT is not measured well with claims and whether SBIRT is still on track to become an EHR-based metric in 2017. It is unlikely to be fully implemented in 2017.
- 99420 is also a generic code (completion of a standardized screening tool) and this combination still doesn't guarantee the screening was SBIRT.
- Concern about the timeline, since we are already well into CY 2016.
- Can we look to other states for best practices? (No, we developed the measure.)
- Even with the pairing, SBIRT numerator compliance is still up. However that increase could be due to legitimate improvement in the measure and not to problems with coding (there is no way to know for sure).
- Have any CCOs done chart review to see whether the standalone code indeed wasn't for SBIRT? (No, but that would be interesting and helpful information, if any CCOs have capacity to do so.)
- Perhaps this change can be implemented beginning in July 2016 rather than retroactively to January. It was also suggested that the Metrics & Scoring Committee be informed and asked about potentially suspending payment for SBIRT for CY 2016, given this known issue.

TAG members agreed to table this discussion until the next meeting, allowing time to investigate further, look at data, and talk with providers or staff. Staff made clear that discussion is not about changes to 2015.

MEASURE SPECIFICATION DEVELOPMENT

FOOD INSECURITY SCREENING

At the March TAG meeting, the group discussed denominator and continuous enrollment criteria. Today, staff have provided updated draft specifications for final review and feedback. Specifically, staff are concerned that the draft specifications allow for too much flexibility and results will not be comparable across CCOs, and are seeking TAG guidance on ways to make the specifications more ... specific in terms of

who is being measured, and for precisely what. The data source should then be decided upon in support of those bigger-picture guidelines. Discussion included:

The group had a difficult time not framing the discussion based on the data source. Sarah reminded everybody that food insecurity screening is not on the list to become a CCO incentive measure; the purpose of these specifications is to have a standardized way to measure food insecurity screening should CCOs wish to pursue it as a performance improvement project (PIP).

Some members stated that population-level results are more difficult to act upon than clinic-level. Others countered this is dependent upon what type of intervention the CCO wishes to pursue. The TAG proposed taking a bifurcated approach and writing two versions of the measure specifications: one population-based, and one clinic- or provider-based. Both versions could be compared benchmarked against county-level data. CCOs would be encouraged to provide feedback on the specifications to foster continuous improvement as part of the PIP. Staff agreed to move forward with two version of the specifications.

Staff also asked TAG for input on the screening tool that should be used. Should CCOs be allowed flexibility to choose from multiple tools, or should the USDA screening tool be the standard? The group preferred flexibility. In addition to the list provided, there is a six-question BRFSS screening tool that allows responses to be stratified by severity (i.e. food insecure, very food insecure, etc.).

HEALTH EQUITY INDEX

Staff presented the health equity index development work to date, as well as several alternative options to the index to the Metrics and Scoring Committee at its April 22 meeting (below) and asked for further direction.

1. Select specific measure(s) of disparities and adopt into the measure set / challenge pool.
2. Require one (or more) of the new menu measures be related to disparities, allowing CCO flexibility to identify disparities within their own populations and prioritize measures that make the most sense based on local needs, data, etc.

After robust discussion, the Committee requested additional information for continued discussion at their May 20 meeting:

1. A crosswalk of the current 33 state performance and CCO incentive measures compared to the NQF disparities-sensitive measures report.
2. A proposal with options to more highly incentivize equity, without being limited to a single measure or Index: 1) "Must" pass model (similar to EHR adoption in the current quality pool distribution, CCOs would have to meet specific disparities-sensitive measures in order to achieve 100% of the quality pool); and 2) Granular payment model.
3. Additional suggestions from TAG

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Brief discussion included concern about a granular payment model due to small denominators and variation among CCO populations. Members also discussed the idea of a potential menu option and suggested menu choices could be tied to CCO Transformation Plans.

No additional development work on the Health Equity Index needed at this time.

NEXT MEETING: MAY 26TH FROM 1-3 PM

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