Metrics Technical Advisory Workgroup

June 23, 2016

PLEASE DO NOT PUT YOUR PHONE ON HOLD – IT IS BETTER IF YOU DROP OFF THE CALL AND REJOIN IF NEEDED

Today's Agenda

- Updates
- 2016 Cessation Benefit Requirement Clarification
- SBIRT Coding Decision
- Food Insecurity Screening Specifications: Revisited
- EHR-Based Measure: Year 4 Reporting Requirements
- Tobacco Prevalence Reporting Roundtable

Transformation Center Incentive Measure Technical Assistance Overview for TAG

June 23, 2016

Oregon Health Authority

Colorectal Cancer Screening TA

CCO medical directors, providers, quality improvement staff and other partners working to improve colorectal cancer screening rates are welcome to participate in the last webinar of this series entitled **Operationalizing Direct-Mail Interventions in Practice: EMR Tools and Practice Readiness Assessment** on **July 20th from 11-noon**.

For more information and to register for the webinars visit: https://www.oregon.gov/oha/Transformation-Center/Documents/CRC-Webinar-Series.pdf

Oregon Health Authority

Colorectal Cancer Screening TA

- Thank you to all CCOs who submitted consultation intake forms and took advantage of this additional TA opportunity.
- The Transformation Center will be reconvening with Gloria Coronado, PhD (Kaiser) and Melinda Davis, PhD (OHSU/ORPRN) on July 14th to discuss these calls and to determine the next steps for TA to support colorectal cancer screening rates. More details will be shared once they are available.

Adolescent Well Visit TA

The Oregon Pediatric Improvement Partnership (OPIP) will provide the following three webinar series to address the adolescent well visit at the Coordinated Care Organization (CCO).

Series 1: Adolescents –What, Why, and How You Educate About Adolescent Well-Visits

- September 29

Series 2: From Recommendations to Implementation: Key Learnings Related to Implementing Adolescent Well-Visits and Documenting in a Way that is Aligned with the CCO Incentive Metrics

- **June 30**, July 7, July 27, & September 8

Series 3: Going to Them! Leveraging Partnerships with School Based Health Centers

- August 18 & September 20

For more information and to register for these series, visit: http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx

Oregon Health Authority

2015 Final Report

- Published this morning!

www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

- CCOs received payment notification and final CY 2015 dashboard on Wednesday, June 22nd.

- Presentation and deeper discussion of results at:
  - July 11th QHOC
  - July 15th Metrics & Scoring Committee
  - July 28th TAG

2016 Improvement Targets

- Are being calculated now using the final 2015 data.
- Will be included in an upcoming dashboard (June / no later than July).

Immunization Data

- OHA provided ALERT immunization files for *all* CCO enrollees <18 on Wednesday, June 15th.

- Will provide on a quarterly basis going forward, schedule TBD.

Dashboards

- Next dashboard will be released June 30th
- Rolling 12-month period: March 2015 – Feb 2016
- 2016 specifications

Metrics & Scoring Committee

- Met June 17th and agreed to keep the measure set the same for 2017 – **will not add or drop any measures.**

- Will begin selecting 2017 benchmarks on July 15th.

- Will now turn their focus to 2018 measure selection, to ensure time for development and testing. Interested in:
  - Kindergarten Readiness
  - Obesity
  - Alternate patient experience measures
  - Dental measures
  - Medical therapy / pharmacy measures

2016 Specification Updates

During 2015 validation, a number of questions came up and OHA will be adding clarification and reposting several 2016 specifications in the next few weeks.

2016 Cessation Benefit Requirement Clarification

Background

- Several CCOs submitted benefit survey as trial run.
- Upon reviewing and additional conversation with CCOs, we identified several places where the 2016 specifications are unclear.
- To not penalize any CCOs (by providing clarification 7 days before the deadline), we will allow some flexibility for 2016, and will tighten requirements for 2017.

Requirement: # of Quit Attempts

Original Intent	CCO must cover two quit attempts per year. This should apply to both cessation medications AND counseling.
2016 Flexibility	CCOs must cover at least two quit attempts per year for cessation medications, and at least one quit attempt for counseling.
2017 Requirement	CCOs must cover two quit attempts per year for both cessation medications and counseling.

Requirement: Duration of Counseling

Original Intent	CCOs must cover 4 sessions of at least 10 minutes for each type of counseling (individual, group, telephonic) per quit attempt (and two quit attempts per year).
2016 Flexibility	CCOs must cover 4 sessions of at least 10 minutes for at least <u>one</u> type of counseling, and some coverage for the other two types of counseling.
2017 Requirement	CCOs must cover 4 sessions of at least 10 minutes for <u>each</u> type of counseling (individual, group, telephonic) per quit attempt and two quit attempts per year.

Clarification: Quit Line Counseling

- CCOs must cover telephone counseling to meet cessation benefit requirement. Either:
  - In-house staff
  - Quit Line contract
- The state (public health division) contract with the Quit Line <u>does not</u> meet this requirement.
- All other requirements re: # of attempts and duration must be met.

TA from Public Health

- Strategies to promote QL services to members
- Help with tobacco-free campus policies
- Help making connections with local partners

https://www.oregon.gov/oha/analytics/CCOData/Strategies%20for%20Reducing%20Tobacco%20Use%20(revised%20Dec%202015).pdf

SBIRT Coding Revisited

Recap

- OHA noted large increase in SBIRT numerator compliance post ICD10.
- A more detailed look indicated that standalone coding (Z13.89) was driving the increase (79% change after ICD10).
- OHA proposed removing the standalone ICD10 option from the SBIRT measure for CY 2016.
- TAG discussion in May indicated that it would be better to make the change for CY 2017.

CCO experiences (shared @ May TAG)

- 82% of standalone codes were for SBIRT – remainder for brief screening or depression.
- Most standalone codes were for depression, not SBIRT.
- Increase in standalone codes due to providers beginning to bill for SBIRT.
- Increase in standalone codes due to pediatric practices beginning to implement SBIRT.
- Did not find many providers using standalone codes.
- May be influenced by EPIC removing 99420 + Dx option.

Final Decision

Proposal: remove ICD10 standalone coding option from the measure specifications for CY 2017.

Allow time to communicate change to providers.

Close out 2016 as is, but recalculate 2016 without the standalone code to set 2017 improvement targets.

Food Insecurity Screening Specifications

Recap

After several months of reviewing draft specifications and discussing intent for the proposed PIP measure, in April TAG suggested a bifurcated approach and writing two versions of the measure specifications:

- Population-based
- Provider / clinic-based

Either version could be benchmarked against county-level data, allowing CCOs flexibility in their interventions and measurement approach.

Population-Based

Data Source	Health risk assessment implemented at CCO level? Survey implemented at CCO level?
Denominator	All CCO members who were continuously enrolled with the CCO for at least 6 months during the measurement period. No anchor date? Sampling?
Denominator exclusions	CCO members who refused to participate in survey / health risk assessment
Numerator	CCO members who: (1) Were screened for food insecurity during the measurement year, using age-appropriate, standardized screening questions; and (2) Among those who screened positive, received an intervention or referral to community / health plan resources. *CCOs may choose to phase in part 2.*

Provider / Clinic-Based

Data Source	Electronic Health Records? Survey implemented at the clinic level?
Denominator	All CCO members assigned to the clinic / empaneled with the provider who had a qualifying visit with the provider. How to define qualifying visit? (Use tobacco /depression specs)
Denominator exclusions	Patients who refused to participate or in urgent or emergent situations (Patient Reason Refused / Medical or Other Reason Not Done value sets)
Numerator	CCO members who: (1) Were screened for food insecurity during the measurement year, using age-appropriate, standardized screening questions; and (2) Among those who screened positive, received an intervention or referral to community / health plan resources. *CCOs may choose to phase in part 2.*

EHR-Based Measures: Year 4 Requirements

Kate Lonborg

Today's Objectives

- Provide a high-level overview of 2016 requirements that are anticipated to be included in the Guidance Documentation
- Provide an opportunity for comments from CCO Metrics TAG to inform development of the Guidance Documentation
  - Feedback on Draft Year 4 Data Proposal Template

Guidance Documentation

- As in previous years, Guidance Documentation will outline the reporting requirements for the EHR-based measures in 2016
- Guidance Documentation will be published in late July http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx
- Template for Patient Level Data Test Submission
  - Distribute draft for feedback in July
  - Finalize for publication in August

Summary of Changes in 2016

- Population threshold increases from 50% to 65% for three measures:
  - Screening for Clinical Depression and Follow-up Plan
  - Diabetes HbA1c Poor Control, and
  - Controlling High Blood Pressure-Hypertension

Summary of Changes in 2016

- Reporting is required for Cigarette Smoking Prevalence measure
  - Required reporting in 2016 after optional reporting in 2015
  - Minimum population threshold of 25%
  - Payment is not tied to performance in 2016 – to earn payment, CCOs must meet cessation benefit requirements and submit EHR-based data in the Data Submission
- Anticipated population threshold glide path for new measures: 25%, 50%, current population threshold

Summary of Changes in 2016 – Report Types

- Meaningful Use Attestation Reports from 2011 certified EHR technology (CEHRT) will no longer be accepted
  - In Year 3, only one clinic in one CCO used 2011 CEHRT MU attestation report
- Attestation reports from 2014 Edition or 2015 Edition CEHRT will be accepted

Summary of Changes in 2016 – Test Submission of Patient Level Data

- CCOs will be required to test submission of patient level data (PLD), **limited to CCO Medicaid beneficiaries only**
  - Test data will be submitted from a practice for each measure
  - Different practices can submit the PLD test data for different measures
  - A practice with a zero denominator for a measure cannot be used for the PLD test for the measure
- Anticipate that data submission will have two components:
  - Data Submission Template similar to Year 3 for aggregated data
  - PLD Test Template – plan to distribute draft template in late July
- A practice submitting PLD test data will be included in both the Data Submission Template (aggregated) and the PLD Test Template

Summary of Changes in 2016 – Minimum Population Threshold

- New guidance about hardship exceptions – anticipated
  - Intended to allow for flexibility if extreme circumstances (e.g., natural disaster, EHR vendor bankruptcy) prevent a CCO from meeting population threshold requirements
  - Not intended to cover planning failures
- Clarifications on reporting zero denominators in the Data Submission so minimum population threshold can be accurately calculated
  - If an organization/ practice has no patients who met criteria and thus generates reports with a zero denominator, the Data Submission should include those reports
  - If an organization/ practice did not generate a report for a measure, it should not be included in the Data Submission for that measure

2016 Reporting Requirements – Minimum Population Threshold Summary

- A percentage of CCO membership must be included in reporting on all measures
  - For depression screening, diabetes, and hypertension, population threshold increases to 65%
  - For cigarette smoking prevalence, population threshold is 25%
- Membership count should be:
  - Inclusive of adults and children
  - Inclusive of members with physical health benefits (i.e., CCO-A and CCO-B members)
  - Accurate as of the end of the measurement period (i.e., a date sometime within December 2016; preferably toward the end of the month)

2016 Reporting Requirements - Components

1. Data Proposal -- similar to 2015, but moving to an Excel format
   - Aligning formats so Data Proposal can be used to populate columns in the Data Submission
   - Break down by measure for questions about report type, level of data aggregation, and payer type
     - Accounts for possibility that, for example, a practice may use an MU attestation report for one measure and custom query for another
   - Due to OHA no later than 5pm on December 31, 2016
2. Data Submission
   - Due to OHA no later than 5pm on April 1, 2017

2016 Reporting Requirements – Specifications

- OHA's specifications for the EHR-based measures can be found on the CCO Incentive Metrics webpage: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx
- OHA's specifications are aligned with the CMS Meaningful Use specifications found in the eCQM Library --https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html -- for the depression screening, diabetes, and hypertension measures

Next Steps

- Year Four Guidance Documentation is anticipated to be published by July 31
- Template for Patient Level Data Test Submission
  - Draft template will be distributed for feedback in July
  - Finalized template anticipated to be published in August
- Please email any feedback to Kate Lonborg katrina.m.lonborg@state.or.us

Tobacco Prevalence Reporting Roundtable

Next TAG meeting

- July 28, 2016 from 1-3 pm