

Oregon Metrics Technical Advisory Workgroup Meeting  
March 26, 2015 Minutes DRAFT

**Attending:**

<b>AllCare</b> Alan Burgess Natalie Case Laura McKeane	<b>Health Share</b>	<b>WOAH</b>	
<b>Cascade</b> Angela Leach	<b>IHN</b> Ellen Altman Roxanna Neuhaus Eryn Womack	<b>WVCH</b> Greg Fraser Stuart Bradley	
<b>CareOregon</b> Christine Castle Bethany Hollister	<b>Jackson</b>	<b>Yamhill</b>	
<b>Columbia Pacific</b>	<b>PacificSource</b> Jeff Stevens Laura Walker	<b>Acumentra</b> Sara Hallvik	
<b>DCOs</b>	<b>PrimaryHealth</b> Sharon Merfeld	<b>Quality Corp</b> Cindi McElhaney	
<b>Eastern Oregon</b>	<b>Trillium</b> Katharine Carvelli DR Garrett	<b>Guests</b> Stephanie Renfro (OHSU)	
<b>FamilyCare</b> Emileigh Canales Kari Benjamin	<b>Umpqua</b> Rose Rice Debbie Standridge Christine Seals Kelley Richardson Nikki Martin		

**OHA Staff:** Crystal Nielson, Jon Collins, Milena Malone, Frank Wu, Sarah Bartelmann, Lisa Bui, Sheila Clauson, Angela Kimball, Stacey Schubert, Scott Montegna, Mike Morris, Cissie Bollinger.

**Updates**

Sarah Bartelmann provided the following updates:

- The March dashboard was released on Tuesday, March 24<sup>th</sup>. The next dashboard will be released on April 30<sup>th</sup>, beginning the final CY 2014 validation period. Please contact Jen Davis or Sarah with any questions.

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- 2014 Quality Pool: staff discussed the January 15<sup>th</sup> revised estimates at the February TAG meeting. However after that meeting, leadership met and agreed to reinstate the hospital reimbursement adjustment (HRA) dollars into the 2014 quality pool. On February 27<sup>th</sup>, the Director of OHA sent a memo and revised estimates by CCO were posted online. Final quality pool amounts will be released on April 30<sup>th</sup>.
- Legislative update: Three bills are currently in session that would affect OHA's metrics program:
  - HB 2027 – requires Metrics & Scoring Committee to adopt at least two oral health care measures.
  - SB 832 – requires Metrics & Scoring Committee to adopt a measure based on the percentage of CCOs participating in Patient-Centered Primary Care Homes (PCPCHs) that offer integrated behavioral health care.
  - SB 440 – sunsets Metrics & Scoring Committee in 2017 and replaces it with a multi-payer Health Quality Metrics Committee.

Once session is complete, staff will take any new requirements to the Metrics & Scoring Committee as needed.

- Nominations: OHA is currently accepting applications for both the Metrics & Scoring Committee and the Hospital Performance Metrics Advisory Committee. Applications are due April 10<sup>th</sup>. Additional information can be found on the respective Committee webpages.

#### **April 2015 USDOJ Report**

Cissie Bollinger and Mike Morris from OHA's Addictions and Mental Health unit presented draft tables from the April 2015 United States Department of Justice (USDOJ) report for TAG review and feedback. OHA and the USDOJ are collaborating on a settlement agreement related to an investigation of the State's treatment of people with severe and persistent mental illness (SPMI).

- The Letter of Agreement covers four years: Year 1 – collect data; Year 2 – use data to identify gaps; Year 3 – benchmarks / target setting; Year 4 – Evaluate progress on meeting those targets.
- We are in year 3. There are discussions with USDOJ regarding targets both parties can agree upon to represent evidence that the state is improving integration of people with SPMI into the community.

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- Year 1 was marked by struggles with collecting the data. Operationalizing collection of the data surfaced a lot of information, not all of which was helpful. OHA agreed with USDOJ in July 2014 on a revised method of data collection, which was first reported in the October 2014 report.
- This is the third quarterly report with the new method. This report also includes narrative to highlight some of the crucial data points and illustrate what is happening (earlier reports were only Excel spreadsheets and interpretation was challenging). April report includes five quarters worth of data, can begin to look at trends.
- Staff is working with USDOJ to use existing data rather than identifying new data elements. Data in this report are organized by county (geographic boundaries, not program services areas). USDOJ has difficulty understanding that multiple CCOs may cover the same county and/or partial counties. Some data cover individuals, some cover services, some cover capacity.
  - Data are mix between Medicaid and MOTS. Until new system is in place, OHA is collecting data regarding unfunded individuals through a survey of the community mental health programs. Lots of vetting.
- At a glance, some metrics appear to have low performance. However when looking at the bigger picture, compared to performance across the country, Oregon performs reasonably well.
- Discussion:
  - Figure 2(f) in the packet (available on the TAG webpage) - Is this an absolute number of ED visits by adults with mental illness enrolled in Medicaid, not rate per 1,000 enrollees. With the expansion, how did this change? OHA added figure 2(g) with the rate per 1,000 Medicaid member months, provides better picture of utilization post expansion.
  - FUH for SPMI – not counting same day follow up for 2014. Will next year, will see increase. TAG recommends including a comment in the report.
  - If workgroup members have additional comments, feedback, or questions, please email [Cissie.M.Bollinger@state.or.us](mailto:Cissie.M.Bollinger@state.or.us).
  - The October and January reports and additional information about the USDOJ agreement can be found online at:  
<http://www.oregon.gov/oha/amh/Pages/doj.aspx>

### **Summary of March Metrics & Scoring Committee Meeting**

OHA staff provided an overview of the discussion related to a tobacco prevalence measure to date, including the TAG suggestion to utilize EHR-based data rather than CAHPS survey data, to the Metrics & Scoring Committee. Committee discussion included:

- Developing a bundled tobacco measure: CCOs must meet a comprehensive cessation benefit ‘floor’ before they could participate in the prevalence (or process) measure.
- Cessation benefit guidance is currently being developed by the Health Evidence Review Commission (HERC) and could be used for the ‘floor’ in the bundled measure concept.
- How representative will an EHR-based measure be, if only capturing the smoking status of members who have established care and have a visit?
- Whether or not adolescents can be incorporated into a prevalence measure.

The Committee agreed to ask TAG to explore a tobacco prevalence measure based on the Meaningful Use objective for documenting smoking status, as well as developing a bundled measure.

OHA is waiting for draft guidance from HERC before addressing the bundled measure; will put on the TAG agenda for April. Today’s meeting is to summarize the 2014 cessation benefit survey report findings and begin discussing options for EHR-based reporting of tobacco prevalence.

### **2014 CCO Cessation Benefits Survey**

Scott Montegna from the Public Health Division provided an overview of the 2014 cessation benefits report, which can be found at:

[http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tob\\_cessation\\_services\\_2014\\_survey\\_report.pdf](http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_services_2014_survey_report.pdf). Key points of the presentation included:

- This is the third time OHA has assessed cessation benefits for CCO members (2011, 2012, and 2014). Did not field in 2013 due to all changes going on. Latest survey is first reflection of CCO benefits rather than Managed Care Organizations (MCOs).
- In May 2014, US Department of Health and Human Services clarified what a comprehensive benefit includes under the Affordable Care Act. Insurer is in compliance if plan:
  - Screens for tobacco use, and if positive:
    - ✓ Offers minimum two quit attempts per year;
    - ✓ At least four counseling sessions of ten minutes each (telephone, group, or individual)

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- ✓ All seven FDA approved medications
- ✓ Elimination of barriers (no prior authorization to access, provided at no cost to patient)
  
- Strong relation between number of counseling sessions and successful quit; ACA requires at least four sessions. Report found all CCOs offer individual counseling, 15 offer group, 14 offer telephone counseling (of that 14, 10 have direct contract with same quit line vendor as OHA uses).
  
- Barriers to accessing benefits:
  - All CCOs require prior authorization for at least one of the covered medications.
  - Most CCOs do not require some kind of enrollment in counseling to access medications.
  
- The survey matters because tobacco is the leading cause of death and disability in Oregon. Tobacco prevalence among OHP members is significantly higher than the general population; according to BRFSS 2013 data, 38% of OHP members use tobacco, compared to 12% of commercially insured Oregon residents.
  
- Overall, report provides strong foundation for CCOs to work on both prevention and cessation efforts. Each CCO has room for improvement; but also each CCO is offering a variety of counseling and medications.

Questions:

- How were data collected? Last spring, Innovator Agents fielded the survey to each CCO, collected results and sent to Public Health.
  
- Any variations / changes since 2011/2012 surveys? Some improvements, but variation in benefits across CCOs is still surprising. Variations on type of counseling provided, medications offered, amount of medications offered (courses offered per year), and variation across prior authorizations.
  - Much of Oregon is rural – issue is less likely to be benefit package and more likely to be what services are available? Note there is still variation in benefit packages across CCOs.
  - TAG suggests HERC weighs in on the course length, not just which medications are covered.
  
- ACA definition for comprehensive benefit package – commercial insurers need to get their benefits in line with Medicaid plans, but is there expectation that Medicaid plans

will also be in line? All insurance plans (including commercial plans), are required to provide comprehensive cessation benefits, except grandfathered in plans. The ACA requires non-grandfathered health insurance plans to cover without cost sharing all preventive services that have received “A” or “B” ratings from the US Preventive Services Task Force (USPSTF), which includes, 1) screening for tobacco use, 2) tobacco cessation counseling, and 3) all FDA-approved tobacco cessation medications. In regards to Medicaid plans the programs that are grandfathered in are only required to provide a comprehensive tobacco cessation benefit to pregnant women.

### **Discussion: Tobacco Measure Options**

A Meaningful Use measure (Core Measure #9) exists that records the percentage of patients ages 13 and older who had smoking status recorded in the EHR. To turn this into a tobacco use prevalence measure, we would look at those patients who had their smoking status recorded and add a third step (i.e., of members who had their smoking status recorded, *how many are smokers*).

In addition, there is a clinical quality measure (NQF 0028) within Meaningful Use related to screening for tobacco use and providing cessation services. TAG discussion included:

- Important question to consider: is it possible to report data for the CCO membership only?
- We have learned from existing Clinical Quality Measures not to assume that all EHRs are set up to capture these data. OHA seeks feedback from CCOs and practices on whether smoking status data is accessible within EHRs and how challenging it would be to extract it.
- Is it possible to determine prevalence using both parts of NQF 0028 (i.e., percentage of patients 18+ who have been identified as tobacco users divided by all patients who have had an office visit)? Perhaps; staff will explore further.
- CCOs have talked with clinics and learned that almost all do track tobacco use in their EHRs, but in very different ways.
- All of these measure options only track members who have visited the doctor’s office.

OHA will create online survey to collect information from CCOs and practices on how smoking status is recorded as structured data within EHRs and how accessible it is. Survey results will be discussed at the April TAG meeting.

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If members have additional insights or questions, please email [Sarah.E.Bartelmann@state.or.us](mailto:Sarah.E.Bartelmann@state.or.us) before the next meeting.

**Wrap up / next meeting**

Thursday, April 23rd  
1:00-3:00 pm

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