

Technical Advisory Workgroup
December 4, 2013 Meeting Notes

Attending

	Cynthia Ackerman (AllCare)	x	Ray Woodmansee (PacificSource)
	Scott Munson (Cascade)	x	Jeanette Simms (PacificSource)
	Angela Leach (Cascade)		Sarah Kingston (PacificSource)
x	Amit Shah (CareOregon)		Maggie Rollins (Primary Health of Josephine)
	Hanten Day (Eastern OR)	x	Sharon Merfeld (Primary Health of Josephine)
x	Resa Bradeen (FamilyCare)	x	Frank Wu (Trillium)
x	Maureen Gaine (FamilyCare)		Lucy Zimmerelli (Trillium)
	Daniel Dean (Health Share)	x	Christine Seals (Umpqua)
	Helen Bellanca (Health Share)		John Sevier (WOAH)
	Ellen Altman (IHN)	x	Greg Fraser (WVCH)
x	Tony Stuckart (Samaritan)		
x	Jim Rickards (Yamhill)	x	Cindi McElhane (Quality Corp)
x	Ken House (Mosaic Medical)		Chantel Pelton (Quality Corp)
	Lisa Bui (Clackamas County)	x	Sara Hallvik (Acumentra)
x	Coco Yackley (Columbia Gorge Health Council)		Jody Carson (Acumentra)

OHA Staff: Lori Coyner, Sarah Bartelmann, Chris Coon, Susan Otter, Karen Hale, Denise Taray

Review Metrics & Scoring Committee 2014 Decisions

Lori and Sarah provided an overview of the Metrics & Scoring Committee's November 25th decisions for the 2014 incentive measures.

- The Committee agreed to update to the HEDIS 2013 technical specifications for CY 2014. OHA will be documenting changes in the specifications and posting them online separately for 2014.

Updates

- (1) A workgroup is forming to look at SBIRT implementation and billing issues. The focus will be on implementing the 2014 measure specifications. There is also the possibility of adding several billing codes to the measure for 2014, but the workgroup will not be focused on a complete review / overhaul of the specifications. The SBIRT workgroup is open to community partners / providers.

OHA is hoping this workgroup can meet once/month for six months. May reach resolution early – but not intending the workgroup to continue meeting indefinitely.

- (2) OHA has scheduled three webinars for December – one on the technology plan guidance, one on the revised quality pool methodology, and one on SBIRT billing. Staff will send the webinar registration links out to the TAG.

Weekly Notification Feed / DHS Custody

Chris Coon from the Office of Health Analytics provided an explanation of what is in the weekly notification feed and answered questions from the TAG.

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For the weekly notification file, DHS Child Welfare provided instructions on how to identify a child who is in foster care (“substitute care program”). OHA then looks for PERC codes to identify these children in MMIS. OHA looks to see if these children are in the CSD division, then what branch – the branch is what distinguishes foster children from others.

OHA is working from the same enrollment information CCOs have – no additional information about the child’s placement is available in MMIS. OHA is working to include guardian name and refine some start of eligibility dates for when these children enter the most current episode of foster care.

Questions

- *Many of the children are on the weekly notification list are not newly enrolled in foster care, or should not be included for a variety of reasons. When will OHA be able to generate a more accurate list?*

OHA/DHS have been having discussions about what can be produced from MMIS and from ORKIDS. There are weaknesses in both systems and a more accurate list will require reconciliation between them. For example: ORKIDS reports are not at the CCO level – they can only identify children by geographic region.

- *Which children on the weekly notification list will actually be in the measure denominator?*

The denominator will be constructed from children who are on the weekly notification files, who meet continuous enrollment criteria, who are not removed for other reasons (OHA is working on this list of criteria with DHS and will provide to CCOs in 2014).

CCOs should document what they are seeing in the weekly notification files. For example: the CCO may know a child had been in residential care for 8 months and was not “new” to foster care. This will help with the eventual reconciliation.

- *Why are some children showing up in the weekly notification files that are not new to foster care?*

The weekly notification file is not looking at history – it is looking at the most current record for each child. There have been some data errors for children in the system that OHA has been fixing as discovered. But overall, OHA is limited in what information can be pulled from MMIS. Until a child is retro’d out of foster care, they will continue to show up in MMIS. We will have to reconcile each child individually and find out what actually happened with their placement.

If CCOs have already done this tracking, it would be very helpful to provide it to OHA to compare.

- *There are more children who are new to foster care that are not showing up on the weekly notification file.*

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If CCOs have information about these children, please provide to OHA to help with the reconciliation and improvement of the weekly notification files.

- *When CCOs were first informed about the weekly notification feed, it was presented as interim until something better could be built with DHS. How much effort should we be putting into fixing the short term solution if we are only going to replace it?*

ORKIDS cannot pull information by CCO – will still need to integration information across OHA/DHS at some point. ORKIDS can only look up one child at a time and you still need to have identified which children to look up in advance. There may be options to generate reports at the field offices, so the care worker can know what CCOs are related to the children they are working with. OHA/DHS are continuing to work on overall data integration and solutions.

- *For the 2013 CCO incentive measure, which data source(s) will be used to determine CCO performance?*

OHA will integrate ORKIDS information with MMIS to construct the measure, but the measure denominator will not include children who entered foster care that CCOs did not receive notification for.

OHA is also working with DHS on some FAQs related to this measure, types of substitute care, working with field offices, etc. OHA will make sure this document includes information on eligibility and what is in the weekly notification files.

OHA will continue to work with DHS. Lori will follow up with the director of Foster Care to talk about expediting merging ORKIDS/ MMIS data so more robust information can be provided to CCOs.

The CCO incentive measure denominator for 2014 will continue to be predicated on children included in the notification files, based on date of notification, not date of custody.

Phase 1.5 HIT/HIE and Clinical Metrics Registry

Susan Otter gave an overview of Phase 1.5: the six services that all CCOs agreed to use transformation fund dollars for (to leverage federal funding to build state level systems).

Questions for CCOs (Susan would like feedback by December 10th):

- (1) Oregon is talking to other states who are building registries using QRDA III (aggregate data) first – should Oregon consider scoping smaller and building from QRDA III first? Ultimately, Oregon will build a registry for QRDA I (individual data), but would like to be realistic about capabilities from the CCO and provider community over the next two years. Should QRDA I be phased in, or out of the gate?
 - Doesn't the state require QRDA I sooner rather than later to be able to report by race/ethnicity to CMS?

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- If using QRDA III, the registry would go beyond the Medicaid population.
- 2014 certified EHRs are obligated to do this: information coming from certified EHRs to the registry would be QRDA I out of the gate.
 - This would depend on the business use / data use agreements for the registry. Most EHR systems are not connected to practice management in a way that would allow them to produce QRDA I for just their Medicaid clients – could only generate all-payer.

If sending the whole data file for all patients, all-payer, the registry will need to parse out the Medicaid-only patients for reporting. OHA will talk to Connecticut about potential legal issues.

- Don't make CCOs go back out into the field to get data: ask for all of the data wanted up front. It might delay the launch of the registry (from spring to summer), but only make one ask.
 - Negotiate specifically with OCHIN as a way to get all FQHC data in the state – do not ask FQHCs to negotiate separately.
 - Ask the state to exercise muscle with OCHIN to broker the investment in EPIC. CCOs should not have to go to each EPIC-utilizing practice individually. This should be a concerted effort (60% of population on EPIC). Contract with OCHIN and have them pull the data for all the practices they serve.
 - The functions the certified EHR vendors are implementing are tied to Medicare – specific measurement periods, specific populations, etc. Any change after this is no longer “out of the box” for EHR technology.
- (2) Would it be helpful for CCOs to get data back from the registry? And if yes, what would the data be used for?
- Supporting alternate payment methodologies.
 - Reporting in general, especially actionable reporting (e.g., which patients haven't received treatments, services, need management, etc...)
 - Economies of scale / logistics – CCOs can act as intermediaries and receive data from provider organizations that is then forwarded to OHA. Or, providers can report directly to OHA and the aggregate reporting is provided to the CCO.
 - Health Share wants all providers to report to the registry directly. Only doing it themselves because there isn't an intermediary.
 - COs can spend their time exploring data that can influence practice changes, projects, etc... rather than the nuts and bolts of data submission.
 - OHA aggregate reporting is only valuable if the data are frequent and current. We are not necessarily talking about building this functionality out of the gate.

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- If providers report directly to the registry, are there issues with eligibility (must separate out patients by payer before sending data back from the registry to a CCO to prevent HIPAA violations).
- If a single reporting mechanism allows providers to meet multiple requirements (PCPCH, CCO incentives, Meaningful Use, etc...) that's great. If the registry can then filter out data and limit results to Medicaid patients only, or CCO members by cross referencing eligibility data – that is added value for a CCO.
- Many providers are in the Medicare EHR incentive program and have to report there, also commercial PCPCH reporting. We will never get to “report once” for all requirements, but can try to align where possible.
- What is the value proposition for patients? What can they get out of this (registry for patients – like opiate medication). Is there a patient or individual care value proposition, as opposed to just administrative /reporting value?