CCO Incentive Metrics: Requirements for Reporting on EHR-Based Measures in 2018

GUIDANCE DOCUMENTATION

Oregon Health Authority
Contents

Section 1: Executive Summary .............................................................................................................. 3
  1.1 Background .................................................................................................................................. 3
  1.2 Changes in Year Six (2018) ........................................................................................................... 3
Section 2: Reporting Process ............................................................................................................... 4
  2.1 Use of Clinical Quality Metrics Registry (CQMR) ....................................................................... 4
  2.2 Data Proposal ................................................................................................................................. 4
  2.3 Data Submission ............................................................................................................................. 5
    2.3.1 QRDA I Sample ......................................................................................................................... 5
    2.3.2 Data Submission – Submission Process ................................................................................... 6
    2.3.3 Data Submission – Review Process ......................................................................................... 6
    2.3.4 Data Submission – Notifications & Communication ............................................................... 7
Section 3: Measure Specifications ......................................................................................................... 7
Section 4: Parameters ........................................................................................................................... 8
  4.1 Initial Population and Minimum Population Threshold ................................................................. 8
    4.1.1 Definitions ............................................................................................................................... 8
    4.1.2 Selection ..................................................................................................................................... 9
    4.1.3 Calculation ............................................................................................................................. 10
    4.1.4 Hardship Exceptions ............................................................................................................... 11
  4.2 Summary of Required Reporting Parameters ............................................................................... 12
  4.3 Report Type and Submission Format ............................................................................................ 12
  4.4 Payer Type .................................................................................................................................... 12
  4.5 Measurement Period ...................................................................................................................... 13
  4.6 Aggregation Level .......................................................................................................................... 13
Section 5: Projected Reporting Requirements in Future Years ............................................................. 13
  5.1 Population Threshold ..................................................................................................................... 14
  5.2 Report Type, Submission Format, and Aggregation Level ............................................................. 14
  5.3 Payer Type .................................................................................................................................... 15
  5.4 Measurement Period ...................................................................................................................... 15
  5.5 Frequency ..................................................................................................................................... 15
  5.7 Measure Selection in Future Years .............................................................................................. 16
Section 6: Contacts ............................................................................................................................... 16

Appendix A: QRDA in National Reporting Requirements ................................................................. 17
Appendix B: Data Proposal Template and Data Submission Template ........................................... 18
Appendix C: Data Proposal Review Form ............................................................................................ 19
Appendix D: Reporting Parameters by Program Year ........................................................................ 20
Section 1: Executive Summary
This document provides guidance to coordinated care organizations (CCOs) reporting clinical quality measures in measurement year six (2018). These measures are

- Controlling High Blood Pressure (CMS 165/ NQF0018)
- Diabetes HbA1c Poor Control (CMS 122/ NQF0059)
- Depression Screening and Follow-up Plan (CMS 2/ NQF0418)
- Cigarette Smoking Prevalence (state-specific measure)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155/ NQQF0024).

1.1 Background
Clinical quality measures, which use data from providers’ electronic health records (EHRs) and other health information technology systems, are valued because clinical data can provide more timely information on outcomes. For example, claims data may demonstrate that a patient with diabetes had an HbA1c test performed, but clinical data can demonstrate the resulting value of the test and whether the patient’s diabetes is controlled.

In 2018, OHA is continuing on a path of incremental progress toward regular electronic submissions of patient-level clinical measure data. OHA intends to leverage EHRs’ ability to export clinical quality measure data in Quality Reporting Data Architecture (QRDA) formats. EHRs certified to 2014 or 2015 Edition standards should be able to export data as QRDA III (aggregated data) and QRDA I (individual patient level data). Understanding that clinics face challenges with QRDA implementation, OHA is planning for a gradual glide path.

Oregon is investing in infrastructure to move to streamlined electronic reporting of clinical quality data. OHA’s goal is that Oregon providers can meet requirements for national programs such as the Promoting Interoperability Programs and the Merit-based Incentive Payment System (MIPS). OHA expects CCOs to take action to move their networked providers toward adopting and using certified health information technology.

1.2 Changes in Year Six (2018)
The following changes from prior measurement years apply to 2018:

- Year Six (2018) reporting is planned to occur in the Clinical Quality Metrics Registry (CQMR), scheduled to go live in December 2018. Please see Section 2.1 for more information.
  - As a contingency plan for unexpected delays, OHA has prepared Excel templates similar to those used in prior years.
- A QRDA I sample submission will be required. For more detail, please see Section 2.3.1.
- The Weight Assessment and Counseling measure is new to the CCO incentive measure set for 2018. The population threshold for this measure is 25%.
- For Cigarette Smoking Prevalence, the minimum population threshold increased from 30% to 35%.
- The deadline for submitting the Data Proposal is later in the year. For 2018 reporting, the Data Proposal deadline is February 1, 2019. With this change, the eligibility date used to determine if population thresholds are met will change to December 2018.
Section 2: Reporting Process

In 2018, reporting will require two components: (1) the Data Proposal and (2) the Data Submission, composed of aggregated data and a patient-level data (QRDA I) sample. OHA plans to shift collection of this information from Excel templates to the CQMR. As a contingency option, however, OHA has updated the Excel templates for 2018, so reporting will not be disrupted if the CQMR implementation is delayed.

2.1 Use of Clinical Quality Metrics Registry (CQMR)

The CQMR is a new quality reporting solution that is intended to streamline reporting across programs. Initially, the CQMR will be used for CCO incentive measures and for eCQMs for Oregon’s Medicaid EHR Incentive Program. Participants in those programs also could choose to use the CQMR to report their eCQMs to CMS to meet requirements of the Merit-based Incentive Payment System (MIPS) and Comprehensive Primary Care Plus (CPC+). Over time, additional programs may use the CQMR, so providers can report once for multiple programs.

The CQMR aligns with national standards and is designed to support timely collection of robust data. As providers build capacity to report QRDA I data and submit data more frequently, the CQMR will be ready to collect the data to support quality improvement and analytics. The CQMR includes functionality to filter QRDA I data by payer, as well as other fields, and OHA plans to add functionality to the CQMR to bring in enrollment data for more robust patient-payer attribution. With QRDA I data and filtering capabilities, OHA anticipates that the need for custom query reporting will decline, as practices will be able to export QRDA I data for standard eCQMs from their EHRs and then use the CQMR to filter to CCO Medicaid only. Reducing custom query needs is expected to decrease reporting burdens and improve data quality.

OHA recognizes that achieving that goal will take time. With that in mind, the CQMR is designed to support data submissions from end users who may start at different places; for example, methods for sending data range from a simple webform to an API. Training materials will be posted in the fall on the FAQs and Resources section of the CQMR webpage, and ongoing training opportunities will be offered. OHA also will continue to provide updates to and seek input from the CCO Metrics Technical Advisory Group (TAG) and other stakeholders.

2.2 Data Proposal

The Data Proposal is the first step in reporting and is a required reporting component. It provides an overview of the planned Data Submission and shows how reporting requirements (e.g., minimum population threshold) will be met. The Data Proposal is due no later than 5:00 p.m. Pacific Time on February 1, 2019.

OHA plans that the Data Proposal will be submitted in the CQMR. Components of the Data Proposal may be entered in the CQMR by CCO users, organization/practice users, or a combination. Regardless of who initially enters information into the CQMR, a CCO user will review the Data Proposal and decide when it is ready to be submitted to OHA.

As a backup if the CQMR implementation is delayed, the Data Proposal may be submitted in the Year Six (2018) Data Proposal Template, included in Appendix B and available on the CCO Incentive Metrics webpage. If the Data Proposal is submitted in the Excel template, it must be submitted to metrics.questions@state.or.us, with a cc to the CCO’s Innovator Agent.
Whatever the submission method, OHA will review the Data Proposal and notify the CCO of the results no later than February 22, 2019. The review criteria are outlined in the Review Form in Appendix C. If OHA requests additional information, the CCO will have 10 business days to respond or resubmit the Data Proposal. OHA will then review the resubmitted Data Proposal and notify the CCO of the results within 10 business days.

As necessary, the review process will be iterative as OHA and the CCO work collaboratively to identify and address issues in the Data Proposal. Although not anticipated, the review process may extend until the deadline for approval of the Data Proposal: 5:00 p.m. Pacific on April 1, 2019. OHA approval of the Data Proposal is required prior to the Data Submission.

2.3 Data Submission

The Data Submission is the report of measure data. OHA reserves the right to request resubmission of any files that are not submitted using the process outlined in this section.

In 2018, the Data Submission will have two components: (1) an aggregate level report of all five measures and (2) a sample of patient-level reporting (QRDA I) for select measures. Details about report types and other reporting parameters can be found in Section 4. The Data Submission is due to OHA no later than 5:00 p.m. Pacific Time on April 1, 2019.

2.3.1 QRDA I Sample

For 2018, OHA is requiring a sample submission of QRDA I data from one organization or practice per CCO. This is a proof of concept submission and will not be included in the calculation of the CCO’s overall performance. OHA intends to learn from this initial sample approach in setting requirements for 2019 and planning for any additional supports. Feedback will be solicited from the CCOs and clinics about QRDA I reporting experiences.

To help prepare for QRDA I reporting, OHA is contracting with OHSU to offer technical assistance on QRDA I implementation, including some EHR vendor-specific user guides and user groups and at-the-elbow support to clinics. OHA will work with CCOs to identify clinics to target for this technical assistance, which is expected to begin in the fall and then continue with a second wave in spring 2019.

The QRDA I sample requirement applies to these three measures only:

- Diabetes HbA1c poor control,
- Depression screening and follow-up, and
- Controlling high blood pressure.

No QRDA I sample is expected for cigarette smoking prevalence (because it is a state-specific measure) or for weight assessment and counseling (because it is new to the CCO incentive measure set in 2018).

The sample should include 25 total CCO members, and it should include at least 3 denominator hits for each of the measures. OHA anticipates that each CCO will work with its key practices to identify those that are most likely to be able to produce a QRDA I sample. As clinics use technical assistance and advance, the CCO would make the decision about which practice would report the sample and would work with that practice to identify the members to be included in the sample. The CCO would identify that practice when the CCO submits its Data Proposal.
2.3.2 Data Submission – Submission Process

OHA plans that both components of the Data Submission (the aggregate submission and the QRDA I sample) will be submitted in the CQMR. Data can be submitted in the CQMR by CCO users, organization/practice users, or a combination. Regardless of who initially submits data, a CCO user will review the Data Submission and decide when it is ready to be submitted to OHA.

As a backup, the aggregate component of the Data Submission may be submitted in the Year Six (2018) Data Submission Template, included in Appendix B and available on the CCO Incentive Metrics webpage. For consistency, columns listing organizations and practices in the Data Submission should be populated by copying from the CCO’s approved Data Proposal. If the aggregated Data Submission is submitted in the Excel template, it must be submitted to metrics.questions@state.or.us, with a cc to the CCO’s Innovator Agent. The Excel template should use the following naming convention:

\(<\text{CCOName}>\_\text{Y6DataSubmission}\_\text{<DateCreated>}\>

As a backup, the QRDA I sample may be uploaded through the CCO’s secure FTP site (ASU site). CCOs should not email the QRDA I sample to OHA. For assistance with the secure FTP site, please contact OHA at metrics.questions@state.or.us.

2.3.3 Data Submission – Review Process

Once the Data Submission is received, OHA will begin an initial review to confirm completeness, and the CCO will be notified of the results no later than April 15, 2019. If additional information is requested during the initial review, the CCO will have 10 business days to respond and/or resubmit the Data Submission as needed.

Once the initial review is complete, OHA will begin a secondary review to evaluate the content of the Data Submission. The CCO will be notified of the results within 30 business days of the date the secondary review was initiated. If additional information is requested, the CCO will have 10 business days to respond and/or resubmit the Data Submission as needed.

As necessary, both the initial and secondary review processes will be iterative, as OHA and the CCO work collaboratively to identify and address issues identified in the Data Submission. Although not anticipated, the review process may extend until the deadline for approval of the Data Submission, which is 5:00 p.m. Pacific Time on May 31, 2019.

As in previous years, OHA expects the review criteria to be similar to those noted in Table 1.

<table>
<thead>
<tr>
<th>Table 1: Expected Data Submission Review Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Review</strong></td>
</tr>
<tr>
<td>• Was submission received by the deadline?</td>
</tr>
<tr>
<td>• Was the data submitted using the required process and correctly labeled so submission could be identified?</td>
</tr>
<tr>
<td>• Was data received in the appropriate format?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
2.3.3 Data Submission – Notifications & Communication

In addition to notifications in the CQMR, OHA will email notifications, with a copy to the CCO’s Innovator Agent, to the individuals on the Data Submission distribution list at the conclusion of the initial and the secondary review. CCOs may submit questions about the Data Proposal or Data Submission at any point during this process to metrics.questions@state.or.us. Innovator Agents should be copied on communications regarding the Data Proposal and Data Submission.

Section 3: Measure Specifications

OHA aligns to the Centers for Medicare & Medicaid Services (CMS) electronic clinical quality measure (eCQM) specifications, which also are used in programs such as the Medicaid EHR Incentive Program (Promoting Interoperability, formerly Meaningful Use), the Merit-based Incentive Payment System (MIPS), and Comprehensive Primary Care Plus (CPC+). CMS has published an updated guide to reading eCQMs.

The CMS eCQM specifications have a corresponding CMS ID, as noted in Table 2.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF ID</th>
<th>CMS ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018</td>
<td>CMS165v6</td>
</tr>
<tr>
<td>Diabetes HbA1c Poor Control</td>
<td>NQF 0059</td>
<td>CMS122v6</td>
</tr>
<tr>
<td>Depression Screening and Follow-up Plan</td>
<td>NQF 0418</td>
<td>CMS2v7</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024</td>
<td>CMS155v6</td>
</tr>
</tbody>
</table>

The distinction between the CMS ID and a National Quality Forum (NQF) or other ID is important. Some technology products may report measures for quality programs that use claims-based, rather than EHR-based, reporting. In that case, despite similar names or use of the same NQF ID, the measure reporting may not align with the required specifications. Reporting must be aligned to the CMS eCQM specifications.

Typically, CMS updates eCQM specifications annually. Although OHA ordinarily accepts data submissions from previous releases of the eCQM specifications, the updates serve important purposes. They generally reflect changes in underlying evidence, code sets, or measure logic. OHA encourages using the updated eCQM specifications and expects to move to requiring use of updated specifications at some point in future reporting years.

Information on OHA’s measure specifications and benchmarks can be found on the CCO Incentive Measures webpage. The 2018 eCQM specifications can be found in the eCQI Resource Center, which is maintained by CMS and the Office of the National Coordinator for
Health IT (ONC). Oregon-specific measures, such as the cigarette smoking prevalence measure, are not available in the eCQI Resource Center.

The OHA and CMS eCQM specifications reference value sets, which are specific code sets to capture clinical concepts and patient data in the EHR and define the codes necessary to calculate the eCQM. The value sets are available from The National Library of Medicine Value Set Authority Center (VSAC). Because of usage restrictions on some code sets, access requires a free license, which may be requested through the VSAC website.

For any reporting via custom query, VSAC access will be needed for details necessary to ensure the measure logic used for reporting is aligned with required specifications. OHA reserves the right to request additional detail for any data that is submitted via a custom query.

Section 4: Parameters
In addition to the specifications outlined above, OHA requires data to be submitted according to specified parameters: a required population threshold, report type, payer type, measurement year, and aggregation level. All parameters must be met for successful reporting. For example, if a CCO does not meet the minimum population threshold, its Data Submission for that measure would be rejected unless a hardship exception were approved.

4.1 Initial Population and Minimum Population Threshold
OHA has adopted an incremental approach to increase the population thresholds for reporting. This approach is intended to account for developing capacities to support EHR-based reporting. A summary of the 2018 population thresholds is provided in Table 3:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Threshold in 2018</th>
<th>Increase from 2017?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes HbA1c Poor Control</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Depression Screening and Follow-up Plan</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Cigarette Smoking Prevalence</td>
<td>35%</td>
<td>Yes (30% in 2017)</td>
</tr>
<tr>
<td>Weight Assessment and Counseling</td>
<td>25%</td>
<td>N/A (new in 2018)</td>
</tr>
</tbody>
</table>

Information about projections for population thresholds in future program years is included in Section 5.

4.1.1 Definitions
For the EHR-based measures, each CCO must report on a specified minimum percentage of its membership with physical health benefits. This requirement is referred to as the minimum population threshold. As described in more detail below, the minimum population threshold

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1 Information on how Value Sets are adopted and used and an overview of the code systems used in the Value Sets can be found in the CMS Measures Management System Blueprint. In the August 2018 v14.0 Blueprint, this overview appears in Section 17: “Codes, Code Systems, and Datasets.”
compares the CCO’s initial population for reporting with its total physical health membership as of December of the reporting year (that is, December 2018 for Year 6).

The initial population is the count of CCO members who are empaneled at or assigned to organizations/practices that report data included in the CCO’s Data Submission. The count of these members is taken near the end of the measurement period. The initial population is inclusive of adults and children with physical health benefits (i.e., CCO-A and CCO-B). Each CCO is required to identify the initial population by providing membership counts for each organization/practice in the Data Proposal.

The Data Proposal includes counts of adults and children. In this context, “children” refers to the CCO members who are under age 18 as of the date for which the enrollment report is run. For example, if the CCO ran its report on the count of members assigned to organizations/practices as of December 29, 2018, then “children” would be members under age 18 as of that date.

OHA checks each CCO’s Data Submission against the Data Proposal to confirm that the CCO actually met the minimum population threshold. For OHA to confirm that an organization/practice was included in the Data Submission for a given measure, the Data Submission must reflect that the organization/practice reported that measure. Each organization/practice that was listed in the Data Proposal and generated a report should be included in the Data Submission, even if the report reflects a denominator of zero.

If an organization/practice generated a report and had no patients who met the denominator criteria, the Data Submission should include the zeroes reported by the organization/practice. Conversely, zeroes should not be reported in the Data Submission for an organization/practice that did not generate a report. For example, a CCO might include a pediatric clinic in its Data Proposal and indicate that the clinic would report on all four measures. When the pediatric clinic generates its report on the hypertension measure, it might not have any patients who meet the denominator criteria. If the CCO’s Data Submission does not list the pediatric clinic or has blanks in the data fields for the clinic, it would appear (incorrectly) that the clinic did not generate a report and thus should not be counted toward the minimum population threshold.

The required minimum population threshold applies to each measure. If CCO with 1,000 members, for example, submitted data from practices assigned a total of 800 members for the diabetes measure (80%) and submitted data from practices assigned a total of 600 members for the depression screening measure (60%), it would meet the 70% threshold for the diabetes measure but not for the depression screening measure.

The threshold is based on the total CCO membership, not a subset of CCO members with a specific condition. For example, a CCO must report on 70% of its total membership for the diabetes measure, but it does not need to report on 70% of its members who have diabetes.

4.1.2 Selection
Because EHR-based reporting capacity is typically supported at the organization or practice level, selection of the initial population occurs at the organization/practice level. For the purposes of this document, “organization” refers to a health system (e.g., Acme Health System) while “practice” refers to a clinic within an organization (e.g., Acme Health – West Town, Acme Health – East Town, etc.).
The CCO’s Data Submission is not required to include all practices within an organization, as long as the CCO can provide population counts for each individual practice. That is, a CCO could include Acme Health – West Town and exclude Acme Health – East Town, as long as the CCO could provide in its Data Proposal a count of the membership empaneled at Acme Health – West Town rather than total membership empaneled at Acme Health System.

If a CCO includes an organization/practice in its Data Submission, data for all the MDs, DOs, NPs, and PAs at the selected organization/practice must be included in the Data Submission. If Acme Health – West Town includes Dr. Smith and Dr. Jones, for example, a Data Submission with Acme Health – West Town could not exclude Dr. Jones. This requirement applies whether Acme Health – West Town is aggregating data at the practice level or at the provider level.

Co-located clinics may be treated as separate practices. If Acme Health – West Town Family Medicine is co-located with Acme Health – West Town Cardiology, for example, the Data Submission could include West Town Family Medicine and exclude West Town Cardiology.

OHA expects that CCOs will build upon prior program years’ reporting. For any practices that were included in the previous year but are not included in the current year, OHA will require an explanation. As the minimum population threshold increases, a CCO may need to add organizations/practices to its Data Proposal and Data Submission. Organizations/practices that meet one or more of the following criteria should be prioritized for inclusion:

- Primary care practices
- Practices that have implemented certified EHR technology
- Practices that see a high volume of Medicaid beneficiaries
- Practices where a high prevalence of the measure conditions exist
- Practices where any tailored efforts are underway to reach members with the measure conditions

OHA reserves the right to require CCOs to reevaluate an approach that omits organizations/practices that meet one or more of these criteria.

OHA expects that selection will focus on primary care providers. If a CCO wishes to include other providers, such as dental practices, the CCO must discuss its proposed approach with OHA before submitting the Data Proposal. Any request must be clearly identified in the Data Proposal, and OHA reserves the right to reject such requests.

4.1.3 Calculation

As noted above, the initial population is the count of CCO members assigned at the organizations/practices included in the Data Submission. In the Data Proposal, the CCO provides the initial population count, which should be:

- Representative of patients assigned to the selected organization/practice for primary care purposes
- 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 2018 and preferably close to the end of the month)
To identify the Total CCO Physical Health Membership, OHA staff will use the count in the *December 2018 Physical Health Service Delivery by County* report, which will be available on the [OHP Data and Reports webpage](#). OHA will use the following calculation:

\[
\text{Initial Population} = \text{Total CCO Physical Health Membership} = \text{Must be greater than or equal to applicable minimum population threshold for measure}
\]

OHA will use the count provided in the *December 2018 Physical Health Service Delivery by County* report. OHA will use the count provided by the CCO in the Data Proposal. This count includes adult and child members with physical health benefits at each practice included in the Data Submission.

### 4.1.4 Hardship Exceptions

OHA recognizes that circumstances beyond a CCO’s or practice’s control could prevent a CCO from being able to report data as planned. In appropriate circumstances, OHA will consider granting a hardship exception and accepting a CCO’s Data Submission despite a failure to meet the minimum population threshold parameter. Reasons for a hardship exception could include extreme and uncontrollable circumstances such as a natural disaster or an EHR vendor’s bankruptcy or loss of certification.

When a CCO is relying on data from a practice that is switching EHR vendors, OHA expects that the CCO and practice will plan appropriately to be ready to submit data as outlined in the CCO’s Data Proposal. If unforeseeable problems in an EHR implementation occur despite the practice’s best efforts, OHA may consider a hardship exception; this is not a blanket exception for all vendor-related delays, but would apply only in extreme circumstances.

A hardship exception request may be made by email to [metrics.questions@state.or.us](mailto:metrics/questions@state.or.us), with a cc to the CCO’s Innovator Agent. If possible, the CCO should make its request by the Data Proposal deadline: February 1, 2019. Any request must be made by the Data Submission deadline: April 1, 2019.
4.2 Summary of Required Reporting Parameters

The reporting parameters for submission format, payer type, and aggregation level depend, to some extent, on the report type used by each practice. Table 4 summarizes the reporting parameters that correspond with each report type, and more detail is provided in the following sections.

<table>
<thead>
<tr>
<th>Report Type</th>
<th>Submission Format</th>
<th>Payer Type</th>
<th>Measurement Period</th>
<th>Aggregation Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>QRDA Category III</td>
<td>• .XML files</td>
<td>• CCO Medicaid Only (preferred)</td>
<td>• Full calendar year</td>
<td>• Practice (preferred)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All Payers</td>
<td></td>
<td>• Provider</td>
</tr>
<tr>
<td>Meaningful Use Attestation</td>
<td>• .XLS file (OHA Template)</td>
<td>• CCO Medicaid Only (preferred)</td>
<td>• Full calendar year</td>
<td>• Practice (preferred)</td>
</tr>
<tr>
<td>Report</td>
<td></td>
<td>• All Payers</td>
<td></td>
<td>• Provider</td>
</tr>
<tr>
<td>Custom Query</td>
<td>• .XLS file (OHA Template)</td>
<td>• CCO Medicaid Only</td>
<td>• Full calendar year</td>
<td>• Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Organization</td>
</tr>
<tr>
<td>QRDA I sample</td>
<td>• XML files</td>
<td>• CCO Medicaid Only</td>
<td>• Full calendar year</td>
<td>• Patient level</td>
</tr>
</tbody>
</table>

4.3 Report Type and Submission Format

OHA intends to leverage federal standards for certified EHR technology (CEHRT). ONC’s 2014 Edition and 2015 Edition standards and certification regulations require a certified EHR to be able to export eCQMs in QRDA I for patient-level data and QRDA III for aggregate level data. Although the availability of the QRDA is increasing, OHA understands that some practices may yet not be able to submit data using the QRDA format. Accordingly, OHA will accept data from the following report types for the aggregate submission:

1) QRDA Category III files
2) EHR vendor-provided Meaningful Use attestation reports from EHRs certified to the 2014 Edition, 2015 Edition, or a combination of both
3) Custom Queries
4) QRDA Category I files (sample)

If a practice or CCO changes an EHR vendor-provided report solely to aggregate from the individual provider to the practice level, OHA does not consider that aggregation to be a form of custom query. Other changes, such as manipulating data from a report to filter by payer rather than using a functionality built into the EHR, are considered a form of custom query.

Meaningful Use attestation reports from 2011 CEHRT will not be accepted.

4.4 Payer Type

The payer type is the payer associated with patients included in the measure data. OHA prefers that CCOs submit data for CCO Medicaid beneficiaries only. However, the functionality to parse data by payer (i.e., filter out non-Medicaid beneficiaries) is still unavailable in many vendor-provided reports. Therefore, for data submitted in aggregate as QRDA Category III or from a Meaningful Use attestation report, OHA will accept data that includes beneficiaries of all payers.
Data reported via a custom query must be limited to CCO Medicaid beneficiaries. The 2018 QRDA I sample also will be limited to CCO Medicaid only.

OHA is attempting to identify possibilities to standardize reporting by taking advantage of the payer field in QRDA files. In response to stakeholders’ expressions of concern about the reliability of that field, OHA also is planning to add functionality to the CQMR to use enrollment data for more robust patient-payer attribution. As national standards mature, OHA intends to align with CMS eCQM specifications related to payer type. In the meantime, OHA does not require any continuous enrollment criteria for the EHR-based measures; the “eligible as of the last date of the reporting period” rule may be used to identify beneficiaries.

When a CCO that has reported on all payer data in previous years switches to reporting on CCO Medicaid only, the CCO may request rebasing of the improvement target if the CCO can submit data to support rebasing. If a CCO requested a rebase to set its 2019 improvement targets, for example, it would have to submit a report of its 2018 data that was limited to CCO Medicaid only. Rebasing will be allowed only when a CCO switches over entirely to CCO Medicaid only reporting. Questions about this policy may be sent to metrics.questions@state.or.us.

Adding new practices for reporting is not an acceptable rationale for a rebasing request.

4.5 Measurement Period
OHA requires a full calendar year of data: January 1 to December 31, 2018. An exception may be granted if a practice did not have an EHR for the full calendar year, for example, if a practice adopted an EHR for the first time or replaced its EHR during the measurement year. With OHA approval, these practices will be allowed to report a modified measurement period; exceptions must be requested by email to metrics.questions@state.or.us and should be made by the Data Proposal deadline: February 1, 2019.

4.6 Aggregation Level
The data aggregation level is the level in the network’s hierarchical structure (described above in Section 4.1.2) at which data is “sliced” and submitted to OHA. Data might be aggregated and reported at the organization, practice, or provider level.

Most reports for Meaningful Use, whether in QRDA III format or attestation reports, aggregate data at the provider level. Due to requirements in other quality reporting programs (e.g., CPC+) or application of the (c)(4) filter criterion to QRDA III reports, some practices may be able to report data from Meaningful Use reports at the practice level. OHA prefers to receive data at the practice level, when available, but will accept provider level data for practices using QRDA Category III or Meaningful Use attestation reports. Provider level data should not be submitted for data reported via a custom query.

Please see Section 5 of this document for more details about the data aggregation level OHA expects to require in future program years.

Section 5: Projected Reporting Requirements in Future Years
OHA's vision is that in the future, reporting will occur through regular electronic submissions of patient-level data to the Clinical Quality Metrics Registry (CQMR). OHA acknowledges that achieving this vision requires development of additional capacity at the CCO, practice and state
levels. OHA has adopted an approach with incremental increases to reporting requirements each year. Projected reporting requirements for future years are outlined below, and Appendix D presents a visual depiction of the incremental increases.

This information is provided to allow CCOs to plan for future reporting years; however, at the time of this document’s publication, this information represents draft requirements only. OHA reserves the right to modify the requirements as outlined in this section and in Appendix D.

5.1 Population Threshold
Organizations/practices cannot report EHR-based measures unless they have implemented an EHR. OHA does not expect that 100% of a CCO’s primary care network will be able to report. In the 2016 Health Systems Transformation Report, it was noted that 78.4% of eligible providers in CCO networks had adopted certified EHRs. Currently, OHA does not anticipate the population threshold rising above 75% in future years. As new measures are introduced, OHA anticipates using a glide path for the minimum population threshold, which would increase over the reporting years from 25% to 50% and finally to 75% (or whatever the top percentage is in that year).

For 2019, OHA anticipates maintaining the same population thresholds for most of the measures. OHA anticipates a 10% increase in the population threshold for the weight assessment and counseling measure, allowing for a gradual increase in reporting on this measure.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Draft 2019 Threshold</th>
<th>Increase from 2018?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes HbA1c Poor Control</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Depression Screening and Follow-up Plan</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Cigarette Smoking Prevalence</td>
<td>35%</td>
<td>No</td>
</tr>
<tr>
<td>Weight Assessment and Counseling</td>
<td>35%</td>
<td>Yes (2018 threshold is 25%)</td>
</tr>
<tr>
<td>Drug and Alcohol Screening (SBIRT)</td>
<td>25%</td>
<td>N/A (new in 2019)</td>
</tr>
</tbody>
</table>

5.2 Report Type, Submission Format, and Aggregation Level
OHA’s intention for EHR-based measure reporting includes leveraging functionality in 2014 and 2015 Edition CEHRT to enable electronic submission of eCQM data. Over time, OHA plans to phase out the ability to use Meaningful Use attestation reports. The option to use these reports is an interim solution while EHR vendors continue to build out the availability of quality measure data as QRDA.

As EHR vendors develop support for the QRDA format, OHA expects to move from aggregate QRDA III to patient-level QRDA I measure data. OHA’s vision for electronic reporting of EHR-based measure data is that future years will require the reporting of patient-level data, in QRDA I format, using the most recent version of the eCQM specifications for the reporting year. Given challenges with EHR vendor support, OHA does not anticipate requiring QRDA I reporting for state-specific measures (such as cigarette smoking prevalence and SBIRT).
For 2019, OHA’s draft requirements include some patient-level data submitted as QRDA I files. OHA anticipates that to some extent, custom queries and a custom reporting template or webform will continue to be necessary, particularly for state-specific measures that are not supported by EHR vendors. OHA will work with the CQMR vendor and CCO stakeholders to further assess readiness to report CMS eCQMs in QRDA I and the appropriate pace for increasing QRDA I requirements. As mentioned previously, OHA’s QRDA I technical assistance contractor, OHSU, will be available in 2018 and 2019 to help organizations or practices selected by CCOs with some EHR vendor-specific user guides and user groups and at-the-elbow support.

Because OHA intends to learn from experience with the 2018 sample submissions in setting expectations for 2019, the 2019 projections are a work in progress. OHA anticipates that it will modestly increase requirements for reporting eCQMs in QRDA I, either by establishing a minimum population threshold for QRDA I reporting or by identifying a minimum number of organizations or practices that must submit in QRDA I format. OHA expects to require QRDA I reporting on the three measures included in the 2018 sample (diabetes HbA1c poor control, controlling high blood pressure, and depression screening and follow-up). Whether the weight assessment and counseling measure will be included in the 2019 QRDA I requirement is yet to be determined.

5.3 Payer Type
OHA’s preference is that data submitted for the CCO Incentive Measures be limited to CCO Medicaid beneficiaries only. However, reporting capacities have required flexibility in allowing aggregated data to be submitted for all payer types, as many EHRs lack capability to parse the data by payer. Many CCOs have chosen to use custom queries for measure reporting, with consideration to this current lack in functionality.

As reporting transitions to QRDA I, OHA intends to use functionality in the CQMR to parse patient-level data by payer to meet appropriate program needs. In response to stakeholder concerns about the reliability of data in the payer field of QRDA I files, OHA plans to add functionality to the CQMR to incorporate member enrollment data for more robust patient to payer matching. This functionality is intended to help enable the possibility of leveraging the CQMR for organizations and practices participating in multiple quality reporting programs to “report once” and submit data for additional payer types in a single submission. Although CMS requires all-payer data for some quality reporting programs, OHA expects to use only CCO Medicaid member data for calculating CCO incentive measures in the future.

5.4 Measurement Period
OHA expects that a full calendar year will remain the required measurement period. Exceptions may be approved for practices that did not have an EHR implemented for the full calendar year.

5.6 Frequency
OHA expects that an annual submission will continue to be the required reporting frequency in 2019. The CQMR will have the capacity to receive test submissions in advance of reporting deadlines.

In addition, users have the option to submit data to the CQMR more frequently than OHA requires. For example, a CCO might use the CQMR to view data from its network of providers
on a quarterly or a monthly basis. As users gain experience submitting data to the CQMR, OHA may consider increasing reporting requirements for more frequent submission.

5.7 Measure Selection in Future Years
To enable greater use of outcomes measures, OHA anticipates that additional EHR-based measures will be collected in future years, especially for measures that are sensitive to disparities analysis. Measure selection will be dependent on decisions of the Health Plan Quality Metrics Committee and the Metrics and Scoring Committee.

Section 6: Contacts
For questions related to the content of this document or the CCO Incentive Measure Program, please contact metrics.questions@state.or.us.

For questions related to the Medicaid EHR Incentive program, please contact Oregon’s Medicaid EHR Incentive Program at 503-945-5898 or medicaid.ehrincentives@state.or.us.
Appendix A: QRDA in National Reporting Requirements

Quality Reporting Data Architecture (QRDA) is a standard HL7 format. QRDA is a Clinical Document Architecture (CDA)-based standard for reporting health care quality measurement data. QRDA Category I reports contain patient-level data, and QRDA Category III reports contain aggregated data. More information about QRDA, including CMS Implementation Guides for QRDA I and QRDA III, is available through the eCQI Resource Center.

QRDA has been adopted as a standard by ONC and CMS. ONC sets standards for electronic health records and other health IT products to receive certification. In turn, CMS uses the certification standards to define health IT requirements in programs such as the EHR Incentive Programs (Meaningful Use), the Merit-based Incentive Payment System (MIPS), and Comprehensive Primary Care Plus (CPC+).\(^2\)

For the Quality Payment Program, CMS currently proposes to require 2015 Edition CEHRT for Merit-based Incentive Payment System (MIPS) eligible clinicians for reporting in 2019. OHA will continue to monitor CMS requirements and Oregon providers’ adoption of CEHRT.

The ONC Standards and Certification Regulations include standards for data capture, calculation, and export to enable electronic submission of clinical quality measures (CQMs) in QRDA I and QRDA III formats. The ONC standards for data capture, calculation and export are sometimes referred to as (c)(1)-(3) criteria, because they appear in ONC’s 2015 Edition certification rule in § 170.315(c)(1)-(3). These standards are required in CMS’s definition of Certified EHR Technology (CEHRT) for use in various CMS programs.

In addition to those functionalities, ONC has set standards for filtering clinical quality measures, whether QRDA I or QRDA III. This filter function is sometimes referred to as the (c)(4) criterion, because it appears in ONC’s 2015 Edition certification rule in § 170.315(c)(4). The (c)(4) criterion covers multiple data elements, including the ability to filter by payer. Although the (c)(4) functionality is not required as part of CMS’s definition of CEHRT, some EHR vendors are certified as providing that functionality.

Products certified to meet ONC standards can be found on the Certified Health IT Product List (CHPL). The “Certification Criteria” filter in the Search tab can be used to find products certified to a particular criterion or combination of criteria.

Appendix B: Data Proposal Template and Data Submission Template

**Year Six (2018) Data Proposal Template**

**CCO Name:**

The Data Proposal is the narrative required prior to submission of EHR-based measure data and is intended to fulfill two specific objectives related to reporting the EHR-based measures in 2018:

1. Demonstrate that the proposed Data Submission will meet the necessary requirements.
2. Improve validity of the data by ensuring that measure data is aligned with the required specifications.

**Please be sure to complete all three of the tabs in this spreadsheet:**

*Org & Practices*  
*Cig Smoking Prev*  
*Additional info*

The completed Data Proposal is due to OHA no later than 5:00 p.m. Pacific Time on February 1, 2019. If you have questions, please submit them to metrics.questions@state.or.us and copy the CCO’s Innovator Agent.

**Organizations/Practices Tab in the Year Six (2018) Data Submission**

Please complete this tab with the information requested for each organization/practice included in the Year Six Data Submission. If all practices (i.e., physical sites) in an organization (i.e., health system) will be included in the Data Submission, a single row may be completed for the entire organization. Please note that the parameters chosen for the level of data aggregation and payer type should align with the expectations for each report type, as outlined in the Year Six (2018) Guidance Documentation.

The option ‘not reporting this measure’ may be chosen for any measures for which the organization/practice will not be submitting data.

The complete templates may be found at [http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx).
## Appendix C: Data Proposal Review Form

### CCO Year Six (2018) Data Proposal Review

<table>
<thead>
<tr>
<th>Data Submission Requirements</th>
<th>Complete</th>
<th>Reviewer Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was submission received by the deadline?</td>
<td>☐</td>
<td>Yes, submission was received on DATE.</td>
</tr>
<tr>
<td>Was data received in the appropriate format?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are all tabs and all fields in the Year Six Data Proposal complete?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are member counts provided in the Year Six Data Proposal current as of December 2018?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Based on the member counts provided, will the required population threshold be met for all measures?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Will all practices in the data submission submit data for the entire calendar year of 2018? If not, is appropriate exclusion rationale provided?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are all practices from the Year Five data submissions included? If not, is appropriate exclusion rationale provided?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are any non-primary care providers, such as dental practices, included in the proposal? If so, was this proposed approach discussed with OHA in advance of the proposal? Has an appropriate reason for inclusion been provided?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Are all primary care providers at each organization/practice included in the data submission? If not, is appropriate exclusion rationale provided?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>For each practice identified in the Data Proposal at submitting data for the Cigarette Smoking Prevalence measure, has additional detail been provided regarding the data elements used for reporting? Do the data elements align with the required specifications?</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Overall comments on data proposal:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The complete Data Proposal Review Form may be found at [http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx](http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx).
Appendix D: Reporting Parameters by Program Year

<table>
<thead>
<tr>
<th>Reporting Parameter</th>
<th>Least Complex</th>
<th>Most Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Threshold</strong></td>
<td><img src="image" alt="Graph showing population threshold for program years Y1 to Y5" /></td>
<td><img src="image" alt="Graph showing population threshold for program years Y2-Y3 to Y5-Y7" /></td>
</tr>
<tr>
<td><strong>Projected Population Threshold for Future Measures</strong></td>
<td><img src="image" alt="Graph showing projected population threshold for program years 1st to 3rd year" /></td>
<td><img src="image" alt="Graph showing projected population threshold for program years 2nd to 3rd year" /></td>
</tr>
<tr>
<td><strong>Format</strong></td>
<td><img src="image" alt="Graph showing format for program years Y1-Y3 to TBD" /></td>
<td><img src="image" alt="Graph showing format for program years Y2-Y5 to QRDA" /></td>
</tr>
<tr>
<td><strong>Data Aggregation</strong></td>
<td><img src="image" alt="Graph showing data aggregation for program years CCO, Organization, Practice, Provider" /></td>
<td><img src="image" alt="Graph showing data aggregation for program years Y1-Y6 to Y4, QRDA I" /></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td><img src="image" alt="Graph showing frequency for program years Annual to Weekly" /></td>
<td><img src="image" alt="Graph showing frequency for program years Y1-Y7 to Y4, QRDA I" /></td>
</tr>
</tbody>
</table>

**Key**
- Y1 – 2013
- Y2 – 2014
- Y3 – 2015
- Y4 – 2016
- Y5 – 2017
- Y6 – 2018
- Y7 – 2019 (draft)

*eCOM* refers to electronically specified measures with CMS e-measure IDs, such as Meaningful Use quality measures. OHA anticipates that Oregon-specific measures are unlikely to be reported in QRDA format.