

Oregon Metrics and Scoring Committee

AGENDA

August 16, 2013

1:00 – 4:00 pm

Wilsonville Training Center
29353 SW Town Center Loop E
Wilsonville, OR 97070

Public Listen-Only Conference Line: Dial: 1-888-808-6929; participant code: 604851

#	Time	Item	Presenter	Action Item
1	1:00 – 1:15 pm	Welcome <ul style="list-style-type: none">• Agenda review• June 7 minutes	Bob Dannenhoffer	X
2	1:15 – 1:45 pm	Review proposed approach for diabetes, hypertension, and depression measures.	Tina Edlund Susan Otter	
3	1:45 – 3:30 pm	Review and adopt proposals to finalize incentive measures for Measurement Year #1 (CY 2013) <ul style="list-style-type: none">• SBIRT coding• Revised improvement targets• EHR adoption denominator• Elective delivery	Lori Coyner Carole Romm	X
4	3:30 – 3:45	Planning for Measurement Year #2 (CY 2014)	Lori Coyner Carole Romm	
5	3:45 – 4:00 pm	Public testimony	Bob Dannenhoffer	
		Adjourn	Bob Dannenhoffer	

Next Meeting:

October 11, 1-4 pm

Oregon Metrics and Scoring Committee

Minutes

June 7, 2013

1:00 p.m. – 4:00 p.m.

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Item

Welcome

Committee members present: Gloria Coronado, Maggie Bennington-Davis, Robert Dannenhoffer, R.J. Gillespie, Phil Greenhill, Bob Joondeph, David Labby, Jeff Luck, Jeanine Rodriguez.

Presenters: Michael Bailit, Bailit Health Purchasing

OHA Staff: Tina Edlund, Chief of Policy; Lori Coyner, Director of Accountability and Quality; Jon Collins, Program Analysis and Evaluation Manager; Sarah Bartelmann, Metrics Coordinator; Ari Ettinger, Assistant to the Health Policy Board; Denise Taray; HERC Liaison.

Consent Agenda

The Committee approved the April 5th meeting minutes.

Tina Edlund presented the first Health Systems Transformation quarterly progress report, containing 2011 baseline data on the CCO incentive and state performance measures, and thanked the Committee for their work. The report has been well received by the Oregon Health Policy Board and legislators to date. The August quarterly report will include additional CCO level data.

Review and adopt proposals from Technical Advisory Workgroup

The Technical Advisory Group (TAG) met twice in April and once in May and came up with recommendations related to several measures and methodology. David Labby presented the TAG recommendations to the Committee:

- **Colorectal Cancer Screening** – TAG recommendation for year one uses an absolute count of screened adults during a 12-month period, looking for 3 percent improvement. Hybrid data is incorporated in year two. The Committee accepted TAG's recommendation.
- **Follow Up after Hospitalization for Mental Illness** - TAG recommended adding case management codes to the numerator. The TAG did not identify any additional codes beyond what was presented to the Metrics & Scoring Committee in April. The Committee accepted TAG's recommendation with a recommendation that OHA report on both the expanded measure and to HEDIS specifications. Note the NCQA benchmark is no longer directly comparable to what is being measured.
- **SBIRT** – TAG recommendation for year one to measure the full (secondary) screening for adults age 18+, but also give credit for any brief interventions conducted and billed during the first year.

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In the second year, focus more on the brief intervention and ages 12-18. TAG recommends a 13% benchmark and a 3% improvement target. The Committee accepted TAG's recommendation and requested that TAG follow up on:

- Developing a bridge system for CCOs to include information about screenings that occurred but were not coded. Discuss concept, potential approaches at the August Metrics & Scoring Committee meeting.
- Including specifications for reporting clinical data for this measure in the data dictionary.
- Clarifying if CPT 99420 can count for both depression screening and SBIRT.
- **Small Denominators** – TAG recommendation is to omit measures with small denominators ($n < 30$) from the quality pool calculation. CCOs would still need to meet 75% of the remaining measures to get 100% of the quality pool. The Committee does not accept the TAG recommendation. Do not omit measures with small denominators from quality pool calculations. Denote small denominators in the report.
- **Measurement Period** – TAG recommendation is to leave the measurement year at the full 12 months, but to revisit the improvement targets/benchmarks for time-dependent measures. The Committee requested TAG make recommendations for adjusted improvement targets for the first year.

Review and adopt final measure specifications

Lori Coyner and Michael Bailit presented the proposed measure specifications for the 6 remaining incentive measures:

- **Mental and Physical Health Assessments for Children in DHS Custody** – OHA proposed combining the assessments into one composite measure where CCOs receive credit if a child receives both assessments within 60 days. Children age 0-4 only need to receive the physical health assessment for full credit. The benchmark would remain at 90%. The Committee accepted this recommendation, and asked TAG follow up on:
 - Revised improvement target
 - Expectations for DHS to provide notification to CCOs
- **Depression Screening** – OHA proposed using CMS adult quality measure specifications, which utilize new g codes to indicate positive or negative screenings. The Committee did not accept

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this recommendation, and proposed treating depression screening as a clinical measure for the first year, where CCOs receive credit for developing systems to report on electronic clinical quality data, rather than for performance toward a benchmark. Final specifications pending OHA discussion with CMS later in June 2013.

- **Clinical Measures** – OHA proposed having the CCOs retrieve clinical information to meet minimum standards and a data dictionary developed by the TAG. CCOs may retrieve the information through a variety of approaches (e.g., EHRs, chart review), but must meet a sampling methodology to demonstrate proof of concept. OHA proposed changing the quality pool distribution for these measures (diabetes, hypertension, and depression screening) to provide CCOs with funds to support making investments in electronic clinical quality data and reporting systems.

The Committee supported the approach of some kind of up-front payment for these three measures, some data reporting, and a requirement to provide a plan for building a clinical quality data reporting system. No baseline data, benchmarks, or improvement targets for the first measurement year. The Committee will wait on CMS approval and additional development work from the TAG.

- **EHR Adoption** – OHA proposed measuring providers who have received payments from the federal EHR Incentive Program for the Medicaid or Medicare program. The proposed benchmark is the CMS assumed rate for non-hospital based EHR adoption in 2014. The Committee did not accept this recommendation, as the provider denominator does not distinguish between providers who see many Medicaid patients and those specialty providers who only see one Medicaid patient per year; CCOs may not have sufficient leverage with those providers to influence their rate of EHR adoption.

The Committee requested alternate approaches to providers included in the denominator, to be discussed at the August meeting. Suggested approaches include:

- Limit the denominator to primary care providers only.
- Weight the denominator by the number of members each provider sees in a given time period (e.g., “consequential” providers)
- Ask CCOs to report on “consequential” providers

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- Limit the denominator to providers in the service area (by zip code).

The Committee did accept the proposed benchmark and set the improvement target using the Minnesota Method with 3% floor.

- **Early Elective Delivery** – OHA calculated early elective delivery rates using the Joint Commission approach and notes this method does not exclude deliveries with spontaneous rupture of membranes. OHA proposes using this method for 2013, knowing that the rates represent an over-count, and that due to the hard stop policies set up in late 2011, CCOs will likely still see an improvement between 2011 baseline and 2013 performance.

The Committee defers this measure to the Perinatal Steering Committee, who is working with the Oregon Health Care Quality Corporation developing this measure, for a recommendation. Discuss proposed approach at the August meeting.

Review and adopt final benchmarks for measures

Lori Coyner reviewed the previously determined benchmarks and highlighted several proposed changes:

- **Ambulatory Care** – The incentive payment is based on the emergency department utilization rate only, not the outpatient utilization rate.
- **Controlling Hypertension, Diabetes Control, and Depression Screening** -- No benchmarks for year one, see proposed reporting-only approach for clinical measures.
- **Follow Up Care for Children Prescribed ADHD Medications** – The incentive payment is based on the initiation rate only, not the continuation and maintenance rate.
- **Mental and Physical Health Assessments for Children in DHS Custody** – The benchmark will remain at 90%; the improvement target may be revised in August, based on TAG recommendations.
- **PCPCH Enrollment** – Note the incentive payment is based on a sliding scale, rather than a benchmark of 100%, as previously documented. The goal is 100%.
- **Adolescent Well Care Visits, Timeliness of Prenatal Care** – The benchmarks have been reduced. The originally selected benchmarks were derived using hybrid methodology; the revised benchmarks use administrative data only.
- **Colorectal Cancer Screening** – No benchmark for the first year; Three percent improvement from baseline only.

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- **EHR Adoption** – Use federal benchmark and 3% improvement target.

The Committee accepted these benchmarks.

Public Testimony

No public testimony was provided.

Adjourn

Next Meetings:

Friday, August 16 from 1-4 p.m.

Friday, October 11 from 1-4 p.m.

Friday, December 13 from 1-4 p.m.

All meetings will be held at the Wilsonville Training Center, 29353 SW Town Center Loop E. Wilsonville.

**Metrics & Scoring Committee
August 16, 2013**



**Proposed approach for diabetes,
hypertension, and depression
measures**



Challenge Pool Considerations

The Challenge Pool currently includes:

- SBIRT
 - Depression screening
 - Diabetes control
 - PCPCH enrollment
- If CMS approves depression screening and diabetes control as “pay for reporting” measures for CY 2013 – Committee confirm that these measures remain in the challenge pool (CCOs receive credit for reporting)?



Finalize Measurement Year #1 (CY 2013)



Measurement Year #1 – Outstanding Issues



- SBIRT Coding
- Revised Improvement Targets
- EHR Adoption Denominator
- Early Elective Delivery

SBIRT Coding

H0049 and H0050 (alcohol and drug screening) are not currently included in the incentive measure specifications.

OHA has received requests to add these codes to the SBIRT incentive measure.

SBIRT Coding – EncoderPro Definitions

H0049:

Drug and alcohol screening is performed on patients in a drug and alcohol treatment program to detect the presence or absence of drugs or alcohol in the urine, blood, or breath. Screening tests are used to determine if an individual has recently ingested drugs or alcohol.

H0050:

A brief intervention for a patient in a drug and/or alcohol treatment program is performed. Professionally trained interventionists who are experts in chemical dependency meet briefly with the patient and/or family members to discuss a current treatment issue. The purpose of the intervention is to provide support and feedback related to chemical dependency issues that are currently affecting the patient and/or family members. This code is reported per 15 minute time increment spent in the intervention service.



SBIRT Coding



Revised Improvement Targets

In June, the Committee requested that TAG review selected improvement targets and determine if any of them should be revised for CY 2013.

TAG met July 31st and reviewed the improvement targets.

For more information, OHA has posted a new brief on improvement targets and their calculation:

<http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>



Revised Improvement Targets: TAG Recommendations

Measure	Existing Improvement Target	TAG Recommendation
Timeliness of prenatal care	Minnesota method (basic formula) with 3 percentage point floor.	Keep Minnesota method (basic formula), but drop the 3 percentage point floor for CY 2013. Reinstate the floor for CY 2014 to continue to incentivize meaningful improvement.



Revised Improvement Targets: TAG Recommendations

Measure	Existing Improvement Target	TAG Recommendation
Developmental screening	Minnesota method (basic formula) with no percentage point floor.	No changes.
Follow up care for children prescribed ADHD medications	Minnesota method (basic formula) with no percentage point floor.	No changes.
Follow up after hospitalization for mental illness	Minnesota method (basic formula) with 3 percentage point floor.	No changes.



Revised Improvement Targets: TAG Recommendations

Measure	Existing Improvement Target	TAG Recommendation
Mental and physical health assessments for children in DHS custody	Minnesota method (basic formula) with 3 percentage point floor.	<p>No changes for CY 2013. Keep the Minnesota method (basic formula) with 3 percentage point floor.</p> <p>TAG strongly recommends revisiting the floor for the second year (CY 2014) once DHS has revised their notification process and CY 2013 data are available.</p> <p>TAG also recommends the Committee revisit the benchmark of 90%.</p>



Revised Improvement Targets



Electronic Health Record (EHR) Adoption Denominator

In June, the Committee requested additional options for the EHR adoption measure denominator, rather than using all providers in a CCO's network.

Staff have developed several options for the denominator. The TAG reviewed these options on July 31st and voted on their recommendation.

All denominator options are based on the (old) Exhibit K/ (new) Exhibit G – Provider Network Capacity report.

EHR Adoption Option #1: Original Denominator

This approach includes all providers in a CCO's network.

Pros	Cons
Utilizes all providers in a CCO network, including specialists who are needed for coordinated care.	<p>May include providers who do not see many CCO clients, although if they do not see enough Medicaid clients, this is addressed through the adjustment factor.</p> <p>CCOs may not have equal leverage with all providers in their network.</p>



EHR Adoption Option #2: Zip Code Based Denominator

This approach only includes local providers in a CCO's network, based on the CCO's service area zip codes.

Pros	Cons
<p>CCOs may have more leverage/influence with local providers to affect EHR adoption.</p> <p>Still includes specialists, which are needed for coordinated care.</p>	<p>May still include providers who do not see many CCO clients, although if they do not see enough Medicaid clients, this is addressed through the adjustment factor.</p> <p>May discourage coordination between local and non-local providers within a network, as non-local providers engage with different health information technology and health information exchange strategies in <i>their</i> areas.</p>



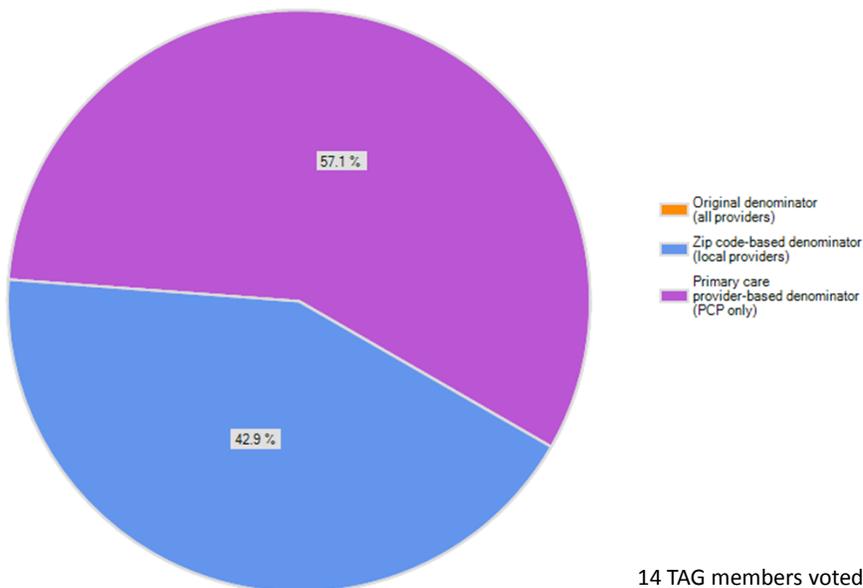
EHR Adoption Option #3: Primary Care Based Denominator

This approach only includes providers designated as primary care providers in a CCO's provider network report, regardless of location.

Pros	Cons
<p>By limiting the denominator to PCPs, the population of providers is more specific and potentially easier for the CCO to work with.</p> <p>Alignment with patient-centered primary care home (PCPCH) work and PCPCH enrollment measure.</p>	<p>Does not include specialists who will need EHRs to improve care coordination;</p> <p>Limiting the denominator to PCPs only will result in small n's for some CCOs;</p> <p>Limiting the denominator to PCPs narrows the providers that a CCO can work with on EHR adoption – additionally, many PCPs may be one or two doc shops, with limited resources to dedicate to EHR adoption and implementation.</p>



Which of the three denominator options for the EHR adoption measure do you want to recommend to the Metrics & Scoring Committee?



EHR Adoption Denominator



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Early Elective Delivery

Challenge: When calculating the measure using claims data only, rate will include some non-elective deliveries (e.g., women who present already in labor) and does not truly represent elective deliveries.

Proposal: To calculate the measure

- 1) Identify each woman in the denominator (live singleton births in 37-39 week range) by CCO.
- 2) Identify which hospital each woman delivered in.
- 3) Apply the Joint Commission's elective delivery rate for each hospital for each birth, creating a weighted average for each CCO.

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Early Elective Delivery Example

ACME CCO had 1,700 early term births in the measurement year at multiple facilities. 500 of the deliveries were at Hospital A, 700 were at Hospital B, and 500 occurred at other facilities.

Apply Joint Commission elective delivery rates for each hospital:

Hospital A: 500 deliveries * 3.9% = 19.5

Hospital B: 700 deliveries * 16.7% = 117

Other: 500 deliveries * state average (assume 12% - exact TBD) = 60

Determine weighted average for ACME CCO:

$19.5 + 117 + 60 = 196.5$

$196.5 / 1,700 \text{ births} = 11.6\%$



Early Elective Delivery



Planning for Measurement Year 2 (CY 2014)



Goal

- Determine incentive measures, benchmarks and improvement targets for the second measurement year (CY 2014).
- Finalize selection and measure specifications before January 1, 2014.
- Major topic for October Metrics & Scoring Committee meeting.



Proposed Approach for Year 2

- Avoid adding more measures to measure set; Keep number of measures at 17.
- Review benchmarks and improvement targets; update where appropriate (e.g., increase benchmarks where performance is strong).
- Continue to refine measure specifications and develop alternate data submission/collection options for “bridge” measures (e.g., SBIRT, Colorectal Cancer Screening).



Other Considerations for Year 2?



Updates

DHS Notification of Children in Custody

OHA/DHS workgroup has been meeting to determine how to provide notification to CCOs directly. OHA/DHS will begin providing notification to CCOs (start date TBD) and the group is currently working on the details of generating the notification.

Dental Quality Metrics Workgroup

The DQM workgroup has met in July and August and is quickly coming to agreement on a recommended set of dental measures (for overall performance monitoring and inclusion as incentive metrics for CY 2015).

The workgroup will bring their recommendation to the Committee by the end of the year.

Online at:

www.oregon.gov/oha/Pages/DentalQualityMetrics.aspx



Public Testimony



Next Meeting

Friday, October 11, 2013

1:00 – 4:00 pm

Wilsonville Training Center

