Metrics & Scoring Committee

February 21, 2014

Oregon Health Authority

Consent Agenda

Committee Bylaws

Updates

Oregon Health Authority

Health System Transformation Quarterly Progress Report – Feb 2014

New in this report:

- ✓ Progress data (Jan – Sept 2013) for 10 of the 17 CCO incentive metrics.
- ✓ Progress data (Jan – Sept 2013) for 25 of the 33 state performance metrics.
- ✓ CCO-level progress data (Jan – Sept 2013) compared to 2011 baseline.
- ✓ Cost and utilization data by CCO.

www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf

Oregon Health Authority

DHS Custody – Progress

- February 10th Learning Collaborative session with Medical Directors and Quality Improvement Coordinators was cancelled.

  Will be rescheduled as a webinar.

- OHA will provide CCOs with their 2013 denominators in mid-March.

Oregon Health Authority

Year One Technology Plans

- All CCOs submitted their Year One Technology Plans on time.
- OHA has completed the initial review (for completeness) and notified CCOs of the initial review results.
- OHA is now working on the secondary (detailed) review.
- Approval of secondary review will result in early payment of 75 percent of 3/17th of quality pool.

Oregon Health Authority

Colorectal Cancer Screening
2014 Benchmark

Oregon Health Authority

January Recap

- In January, the Committee considered three options for setting the colorectal cancer screening benchmark (see handout).
- The Committee agreed that the benchmark options converge around 40%, which seems appropriate given what is known about the range of screening rates across 26 clinics.
- Held decision for February meeting.

Staff Recommendation

OHA recommends the Metrics & Scoring Committee adopt a benchmark of 47 percent for the colorectal cancer screening measure for 2014.

This would be a Committee consensus benchmark (like developmental screening), based on limited available data, but not directly based on any of the adjusted NCQA percentiles or CDC data.

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SBIRT Measure Specifications for 2014

Oregon Health Authority

January Recap

- In January, the Committee discussed the modification to the SBIRT measure specifications proposed by the SBIRT workgroup:

  allowing use of v79.1 diagnosis code as a standalone indicator of SBIRT screening, without requiring use of CPT 99420.

- The Committee asked for additional information on how widespread these issues are and a staff recommendation.

- Held decision for February meeting.

Oregon Health Authority

SBIRT Billing: Addition of V79.1

ADVANTAGES

- More easily allows documentation of screening portion without billing for services. It may be fraud to bill for services for Medicaid but not commercial.
- Some EHRs are set up so that 99420 cannot be billed at the time of an office visit and providers must submit an extra encounter which is burdensome.
- Doesn't require a time period (15 mins) for screening or intervention.
- May aid in capture of services that are currently under-counted and makes the coding easier.

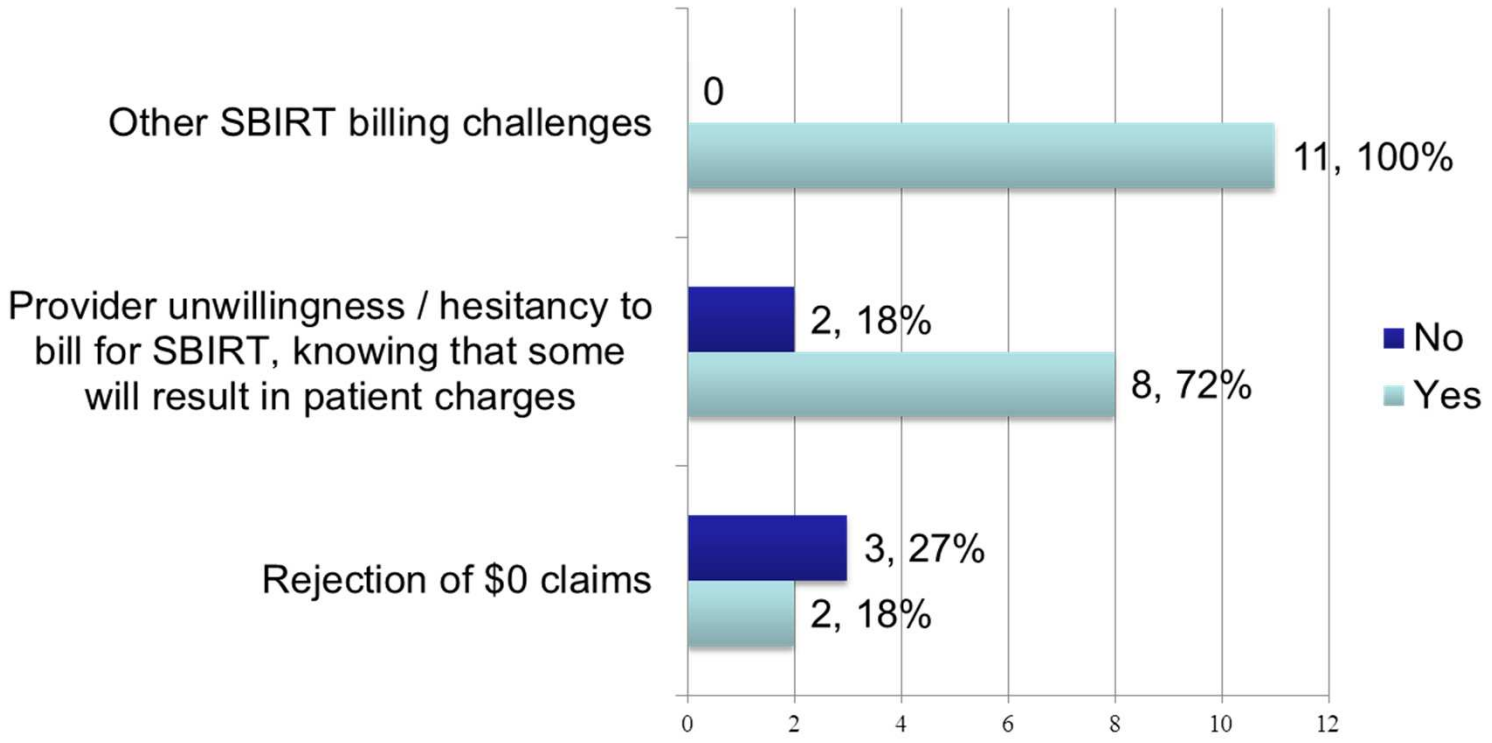
SBIRT Billing: Addition of V79.1

DISADVANTAGES

- Practices could document using V79.1 for universal, 3 item screening instead of secondary screening making the measurement less specific.
- Would change the specifications from 2013 and could be confusing to early adopters who have already changed their work flows.
- Some practices want to be reimbursed for SBIRT services and would continue to use 99420 with V79.1

SBIRT Issues - Workgroup Survey

OHA surveyed the SBIRT Workgroup on any billing challenges they might be experiencing as a CCO or clinic (see handout).



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SBIRT Billing - $0 claims rejection

- Only 2 survey respondents indicated issues with $0 claims.
- Mosaic Medical reports submitting $0 claims for other procedures/visits successfully with OCHIN, but has not submitted any $0 SBIRT claims. CareOregon is working with OCHIN on retaining claims with $0.
- Health Share – Providence health plan retains $0 claims; however, OHSU has expressed concern with billing patients and does not have work flow to bill $0.
- WOAH – Providers concerned with billing Medicaid but not commercial.

Staff Recommendation

Adopt the addition of V79.1 to be included with any CPT code for credit for SBIRT.

Rationale:

- Broaden the net for capturing SBIRT services by offering an additional method for data capture

- Improve under-counting of measure

Continue to work on an EMR based approach for 2015

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2014 Quality Pool

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2014 Quality Pool Methodology

Very similar to 2013 Quality Pool:

- CCOs earn the quality pool by meeting the benchmark or improvement target on 13 of the 17 measures.
- PCPCH Enrollment is still based on a sliding scale, using the tiered formula.
- CCOs earn the quality pool for the 3 clinical measures by submitting the Year Two Technology Plan and expanded proof of concept data.
- CCOs can only earn 90% of the total quality pool if they do not meet the EHR adoption measure.

2014 Challenge Pool

Quality pool funds not earned by CCOs meeting the benchmarks or improvement targets or reporting requirements are distributed based on CCO performance on 4 of the 17 measures:

Incentive Measure	Challenge Pool Earned By
SBIRT	Meeting the benchmark or improvement target
Depression Screening and Follow Up Plan	Meeting the benchmark*
Diabetes: HbA1c Poor Control	Meeting the benchmark*
PCPCH Enrollment	Sliding scale; all CCOs earn these challenge pool funds.

*New for 2014; added at CMS requirement to not wait until 2015 to pay for performance on clinical measures.

Measurement Framework & Proposed Measure Criteria

Oregon Health Authority

January Recap

The Committee reviewed the seven quality improvement focus areas from the waiver and eight drivers from the CoverOregon metrics committee.

The Committee identified a number of purposes for establishing a measurement framework and/or criteria for evaluating proposed measures against.

The Committee asked for additional information on existing state health goals and priorities.

Summary of State Priorities

- Improved health status of Oregonians (chronic disease management, tobacco cessation, obesity, and prevention)
- Improved health care delivery (care coordination, avoidable ED and re-hospitalizations, access)
- Improved access to behavioral health services.
- Payment reform / cost containment
- Increased transparency

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Proposed Measure Selection Criteria

I. Technical Measure Criterion (tests that each measure should meet)				
Potential criterion	Description	Include	Consider	Exclude
1. Evidence-based and scientifically acceptable	The measure will produce consistent (reliable) and credible (valid) results. The measure has been endorsed by the NQF or by another national body with a rigorous method for review and endorsement of measures (e.g., NCQA).			
2. Has a relevant benchmark	State, regional or national level performance data are available for the same measure.			

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Dental Metrics for 2015: Accountability for Oral Health

Oregon Health Authority

Integrated Oral Health

From Oregon's 1115 Medicaid Demonstration Waiver's Coordinated Care Model:

- Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care.

Oral Health and Accountability Plan

- Dental visits for children (after 2014) will meet or exceed national Medicaid averages: Listed as a specific objective for access in the Waiver (Attachment H, p. 194)

- Total eligible who received dental treatment services (ages 1-20): Listed as a measure for consideration in the Waiver for improving access and timely care (Attachment H, p. 324)

www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf

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Adopting Dental Metrics

Metrics & Scoring Committee charge (from SB 1580):

The committee shall use a public process to identify objective outcome and quality measures, including measures of outcomes and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care, and all other health services provided by coordinated care organizations.

Quality measures adopted by the committee must be consistent with existing state and national quality measures.

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Foundations of Accountability

- Adopting dental metrics will begin to hold CCOs and the dental community accountable.
- These first measures deal with fundamental issues of access and prevention. The first question, “Is the dental community delivering on the fundamentals?”
- The effort is to engage the dental community
- Start with the basics:
  - Access to dental care
  - Early prevention

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Dental Quality Metrics Workgroup Presentation

Oregon Health Authority

Public Testimony

Oregon Health Authority

Next Meeting

April 18th

9:00 am - Noon

Wilsonville Training Center

Oregon Health Authority

Oregon Metrics & Scoring Committee
Minutes
January 31, 2014
1:00 – 3:00 PM

ITEM
Welcome Committee members present: Maggie Bennington-Davis, Gloria Coronado, Robert Dannenhoffer, David Labby, Jeff Luck, R.J. Gillespie, Not attending: Phil Greenhill, Bob Joondeph, Jeanine Rodriguez OHA Staff: Lori Coyner, Sarah Bartelmann, Tracy Hulett Consultants: Michael Bailit, Bailit Health Purchasing
Consent Agenda The Committee approved the December 13, 2013 meeting minutes with one correction: R.J. Gillespie did not attend the meeting.
Committee Bylaws Lori Coyner introduced the proposed bylaws for the Committee's consideration. The bylaws will clarify Committee term-lengths, duties of the chair and vice-chair, and decision making processes. The draft bylaws are available in the meeting materials online here: www.oregon.gov/oha/MetricsMeetingMaterials/January%2031,%202014%20Materials.pdf The Committee agreed to submit any questions or proposed modifications on the draft bylaws to staff in advance of the February 21st meeting. The Committee will vote to adopt the bylaws in February. Committee members interested in the chair or vice-chair positions should notify Lori Coyner prior to the February meeting.
Updates Lori Coyner and Sarah Bartelmann provided updates on the dental quality metrics workgroup process and the availability of the measure specification sheets for 2014 and revised guidance documents.
SBIRT Workgroup / Specifications Lori Coyner provided an overview of the new SBIRT workgroup and their recent discussion of billing challenges providers and practices are facing with this measure. Challenges include provider hesitancy to code for SBIRT because patients may be charged, rejection / exclusion of claims with $0 charges, and inconsistencies of billing processes across payer types. The workgroup proposes a modification to the SBIRT measure specifications for 2014 which would allow for use of the v79.1 diagnosis code as a standalone service, without also requiring use of one of the CPT codes, to document SBIRT screenings. The Committee discussed positives and negatives of the proposed modification and requested additional information on how widespread these issues are across the state. Staff will collect additional information from the SBIRT workgroup and provide a recommendation for the Committee's consideration and final decision at the February meeting.

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Oregon Metrics & Scoring Committee
Minutes
January 31, 2014
1:00 – 3:00 PM

2014 Benchmarks

The Committee revisited benchmark setting for the three incentive measures that were not addressed in the December 2013 meeting: colorectal cancer screening, diabetes: HbA1c poor control, and depression screening. The diabetes and depression screening benchmarks are needed only for the challenge pool distribution in 2014; CCOs will still "meet" these measures by submitting year two technology plans and expanded electronic clinical data. The Committee requested more information on the 2014 challenge pool distribution methodology for the February meeting.

- *Colorectal Cancer Screening*
  Michael Bailit presented three benchmark options: adjusting or estimating a Medicaid-specific benchmark using other NCQA benchmarks, and utilizing national data from the Centers for Disease Control and Prevention. Options are in the meeting materials available online here: www.oregon.gov/oha/MetricsMeetingMaterials/January%2031,%202014%20Materials.pdf

  The Committee agreed that the benchmark options converge around 40%, which seems appropriate given what is known about the range of screening rates across 26 clinics, but will make a final decision at the February meeting.

- *Diabetes: HbA1c Poor Control*
  The Committee agreed to adopt the national 2013 Medicaid 75th percentile (34% of patients with poorly controlled diabetes / 66% of patients in good control) as the 2014 benchmark.

- *Depression Screening and Follow Up Plan*
  Michael Bailit provided information on other states using depression screening as a measure; however, no data from other states are currently equivalent to our measure specifications and population.

  The Committee agreed to wait to set the 2014 benchmark for this measure until the year one proof of concept data is available to provide context about Oregon's performance. The Committee will revisit this benchmark in June.

Measurement Framework

The Committee reviewed the CCO incentive measures listed by the seven quality improvement focus areas and considered the modified drivers as adopted by the HB 2118 (CoverOregon) metrics committee. The Committee then discussed the following purposes for establishing a measurement framework:

- Criteria or tool for selecting future measures;
- Identifying gaps and opportunities (e.g., specific populations not represented)
- Statewide alignment on measures where possible;
- Alignment with established state health priorities / desired outcomes;
- Codifying Committee work / decisions for future Committee members;

Staff will prepare draft criteria / tool for evaluating measures for the Committee's continued discussion in February. Staff will also provide additional information on existing state health goals and priorities as

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established in the 1115 waiver with CMS and other policy for the February meeting.
Public Testimony No public testimony was provided.

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Oregon Metrics & Scoring Committee
Draft By-Laws

ARTICLE I
The Committee and its Members

- The Metrics & Scoring Committee ("Committee") is established by Oregon's 2012 Senate Bill 1580, Section 21. The Committee's function is to identify objective outcome and quality measures and benchmarks for health services provided by coordinated care organizations, consistent with the Committee's Charter, and as further determined by the Oregon Health Authority.

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Director of the Oregon Health Authority. Committee members will be appointed by the Director for an initial 2-year term. Committee members may be re-appointed at the discretion of the Director for 1-year terms, for a total of 4 years on the Committee.

- Members of the Committee are not entitled to compensation for services but shall be reimbursed for actual and necessary travel expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair from among its members. The Chair will serve for 12-months from the date of their election.

- Duties of the Chair are:
  - Preside at all meetings of the Committee.
  - Coordinate meeting agendas after consultation with Committee staff.
  - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
  - Be advised of all presentations or appearances before legislative committees that relate to the work of the Committee.
  - The Chair may designate other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- The Committee shall select a Vice-Chair from among its members. The Vice-Chair will serve for 12-months from the date of their election.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;

- Perform any other duties assigned by the chair.

ARTICLE III
Committee Meetings

- The Committee shall meet at least quarterly and more frequently at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws.

- The preliminary agenda will be available from the Committee staff and posted on the Committee website [*http://www.oregon.gov/oha/Pages/metrix.aspx*] at least two working days prior to the meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- As a general rule, the Committee will conduct its business through discussion and consensus. In cases where consensus cannot be achieved, a vote may be used. Use of a vote and its results will be recorded in the meeting minutes. Official action by the Committee requires the approval of a majority of a quorum of Members.

- When voting on motions, resolutions, or other matters, a voice or electronic vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair, Vice-Chair, or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

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- The by-laws in this section apply to the full Committee and any subcommittees or designated workgroups.

ARTICLE IV

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Committee.

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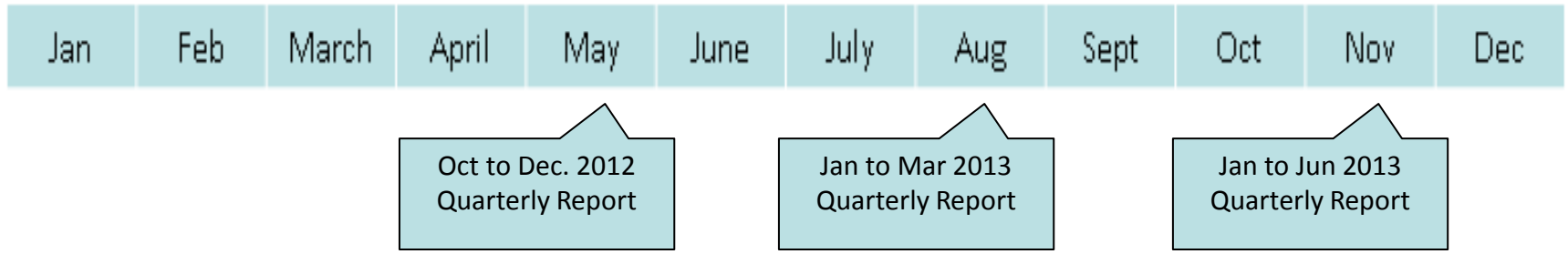
Health System Transformation Quarterly Progress Report February 2014

Oregon Health Policy Board
February 4, 2014

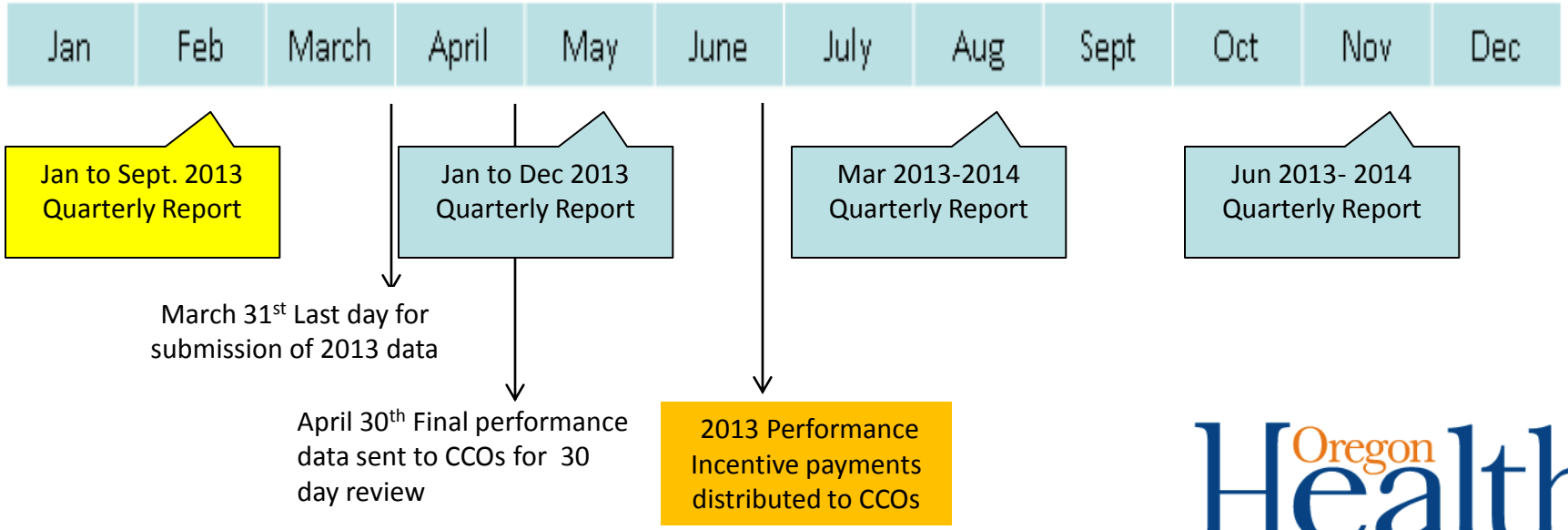
Lori Coyner
Director of Accountability and Quality

Accountability and Transparency Timeline 2013-2014

2013



2014



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Oregon Health Authority Accountability

State Performance Measures

- Annual assessment of statewide performance on 33 measures
- Financial penalties to the state if quality goals are not achieved

CCO Incentive Measures

- Annual assessment of CCO performance on 17 measures
- Will compare performance in 2013 to 2011 baseline
- Monthly data shared with CCOs so data can be validated and progress can be monitored throughout the year
- 2013 quality pool funds allocated to CCOs in June 2014

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What is new in this progress report

- ✓ Progress data (Jan to September 2013) for 10 of the 17 CCO incentive metrics.
- ✓ Progress data (Jan to September 2013) for 25 of the 33 state performance metrics.
- ✓ CCO-level progress data (Jan to September 2013) compared to 2011 baseline
- ✓ Cost and utilization data by CCO

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Progress data show: Improved Developmental Screening

- ✓ Connecting health and early learning provides timely opportunities for improving children's outcomes.
- ✓ The percentage of children who were screened for the risk of developmental, behavioral and social delays increased from a 2011 baseline of 21% to 32% in the first nine months of 2013.

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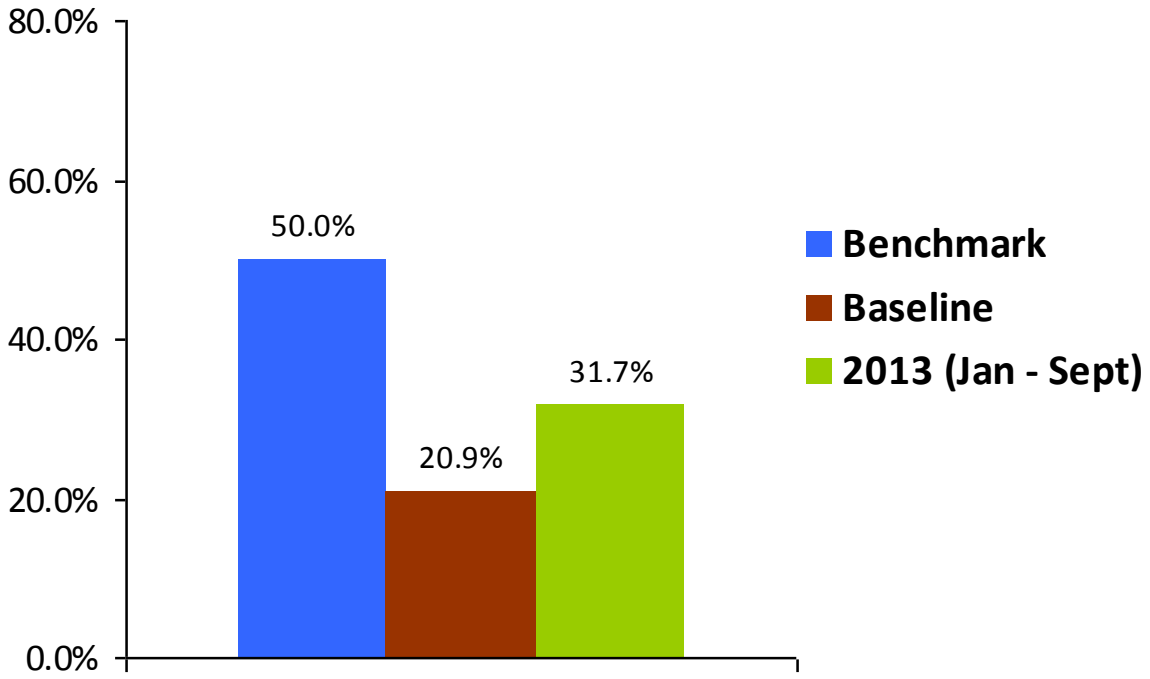
What progress data indicate -

- ✓ **Developmental Screening is up. First nine months indicate that developmental screenings are up by 52% since 2011.**



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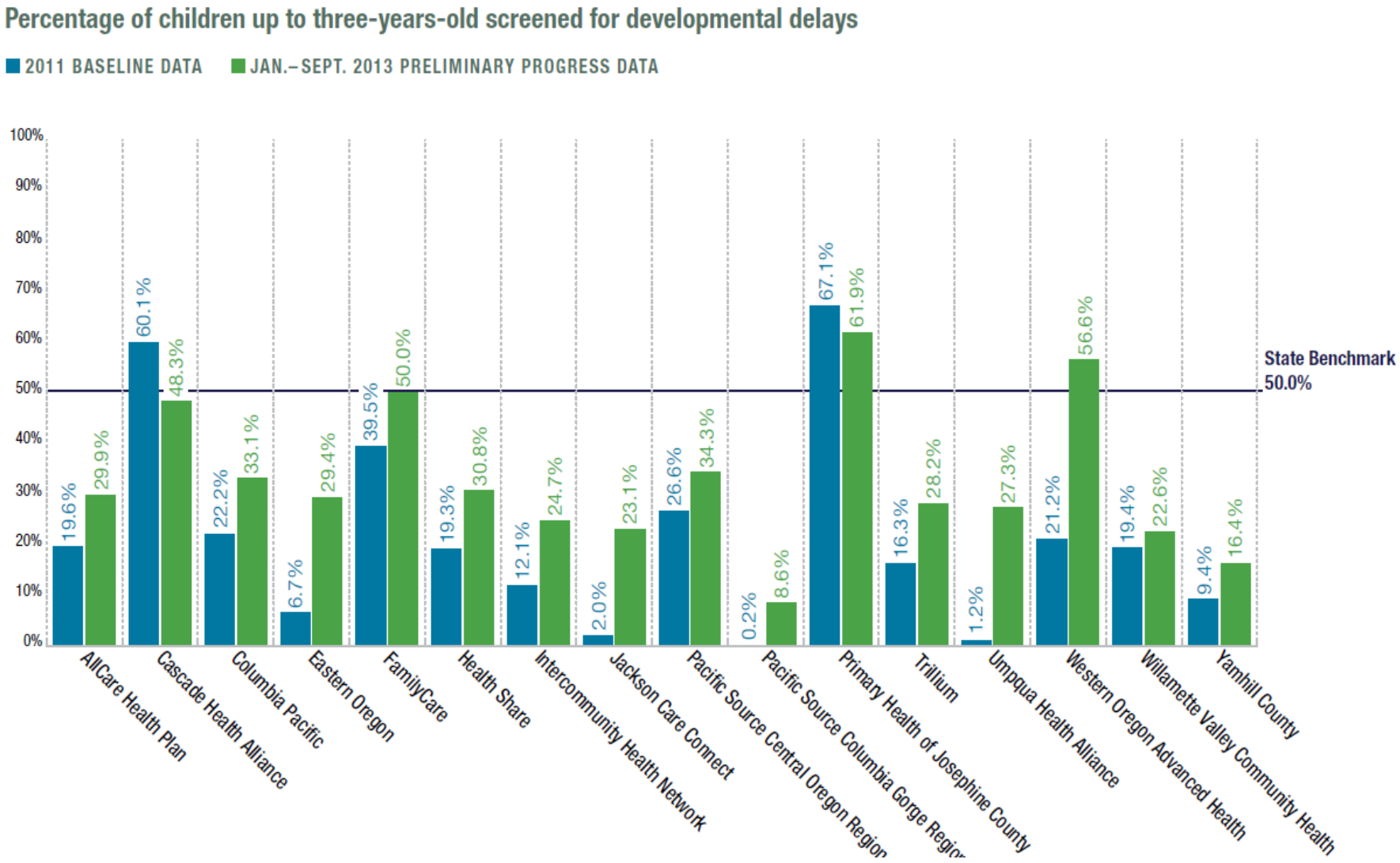
What progress data indicate

- ✓ **Developmental Screening is up. Some CCOs show large improvements and three are at or over the benchmark for 2013**



Progress data show: Primary Care Increases

- ✓ Outpatient primary care visits for CCO members' increased and spending for primary care is up.
- ✓ Enrollment in patient-centered primary care homes has increased by 51% since 2012, the baseline year for that program.

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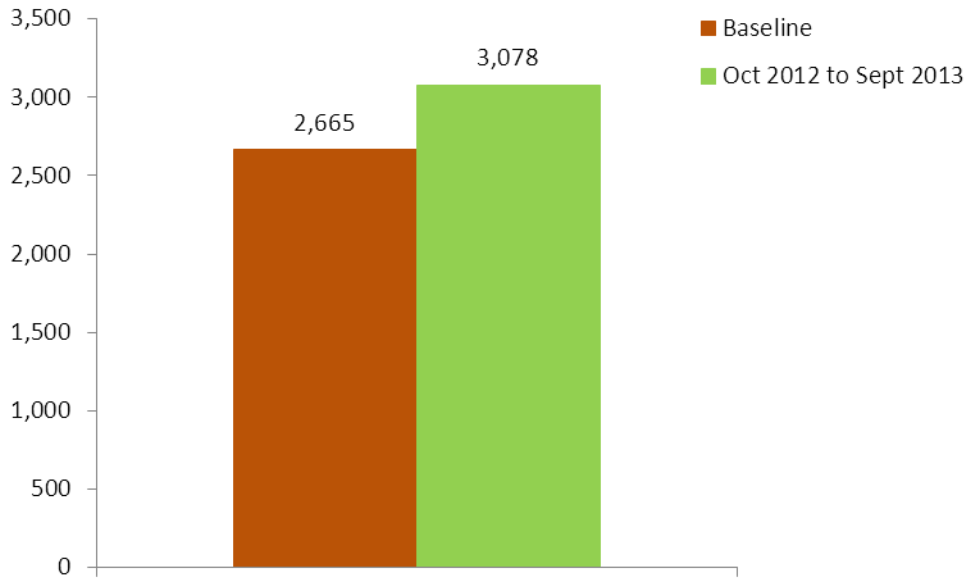
What progress data indicate

- ✓ **CCO primary care visits are up nearly 16% from 2011 baseline.**

Ambulatory Care: Primary care medical visits (includes immunizations/injections)

Rate primary care visits per 1,000 members



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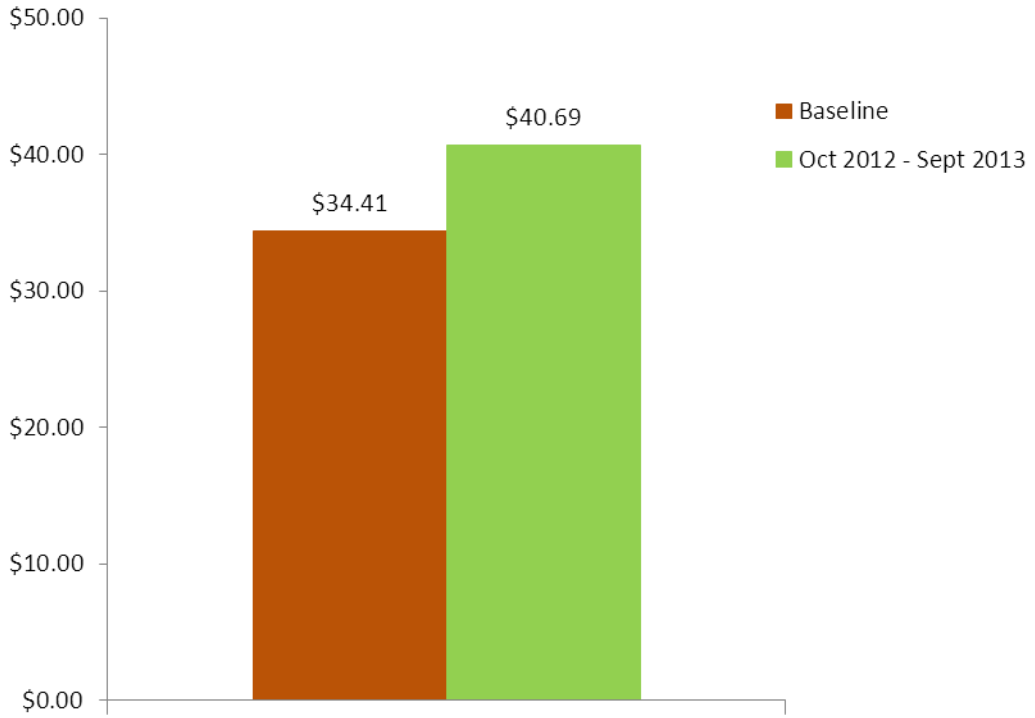
What progress data indicate - Change

- ✓ **CCO primary care costs are up over 18% from 2011 baseline.**

CCO primary care cost per member per month (pmpm)



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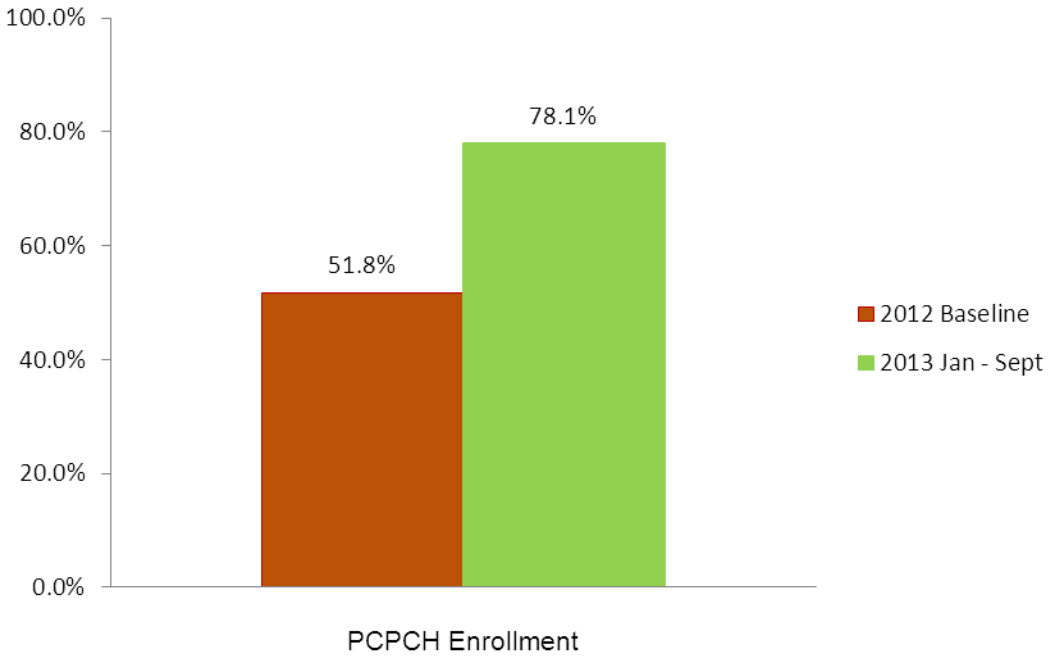
What progress data indicate

- ✓ **Enrollment in Patient-Centered Primary Care Homes (PCPCH) has increased markedly.**
  Over 75% of members are enrolled in a PCPCH.

Percentage of patients who were enrolled in a recognized patient-centered primary care home



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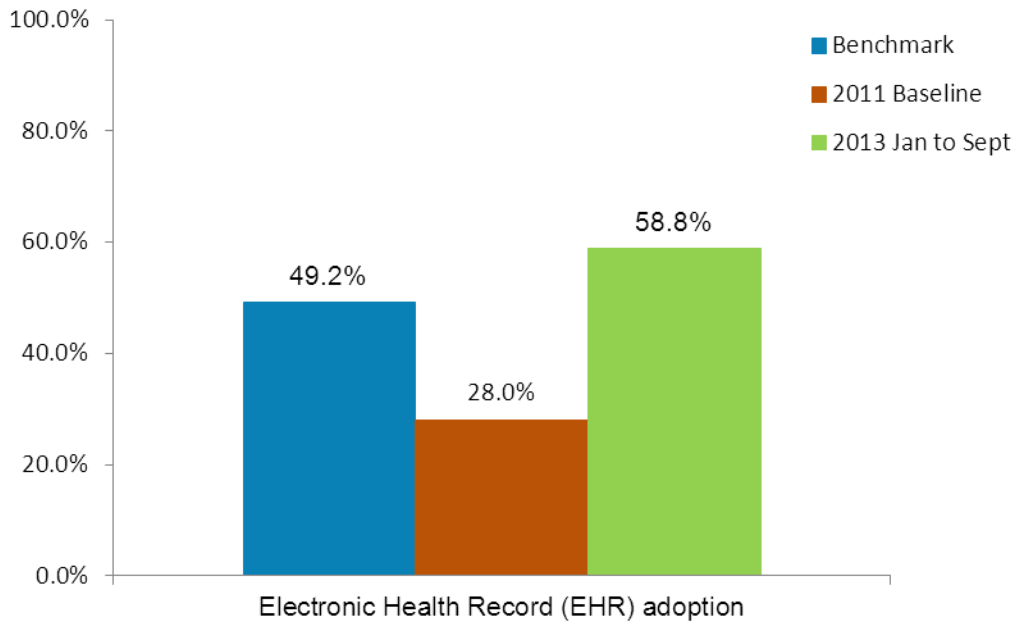
What progress data indicate

✓ **Adoption of electronic health records (EHR) has dramatically increased since 2011.**

Percentage of eligible individual providers within a CCO's network and service area who qualify for an EHR incentive payment from Medicaid or Medicare.



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Progress data show: Better care, lower costs

- ✓ Data continues to show reduced ED visits and spending.
- ✓ This data shows we are lowering unnecessary hospitalizations for conditions that can better be treated elsewhere.
- ✓ Data shows improvements in hospital readmissions due to community efforts to achieve the highest quality care.

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What progress data indicate

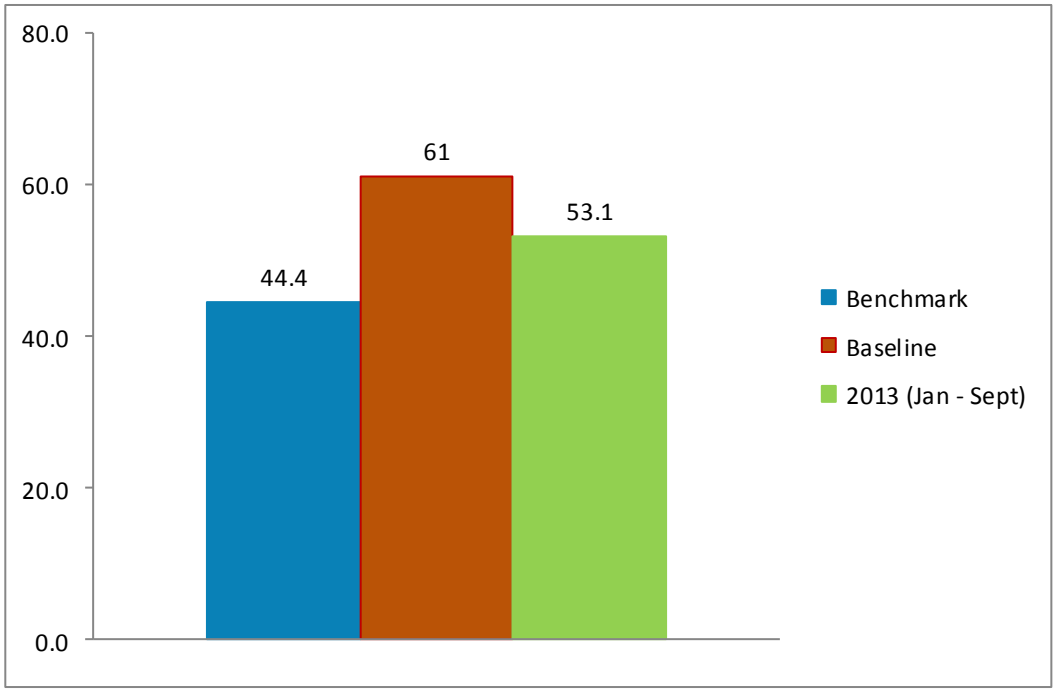
- ✓ **Emergency department (ED) utilization is down. First nine months indicate that ED utilization is down 13% from rate in 2011.**

Ambulatory Care:
ED utilization

Rate of patient visits to the ED per 1,000 member months

Lower is better

Benchmark: 2012 national Medicaid 90th percentile.



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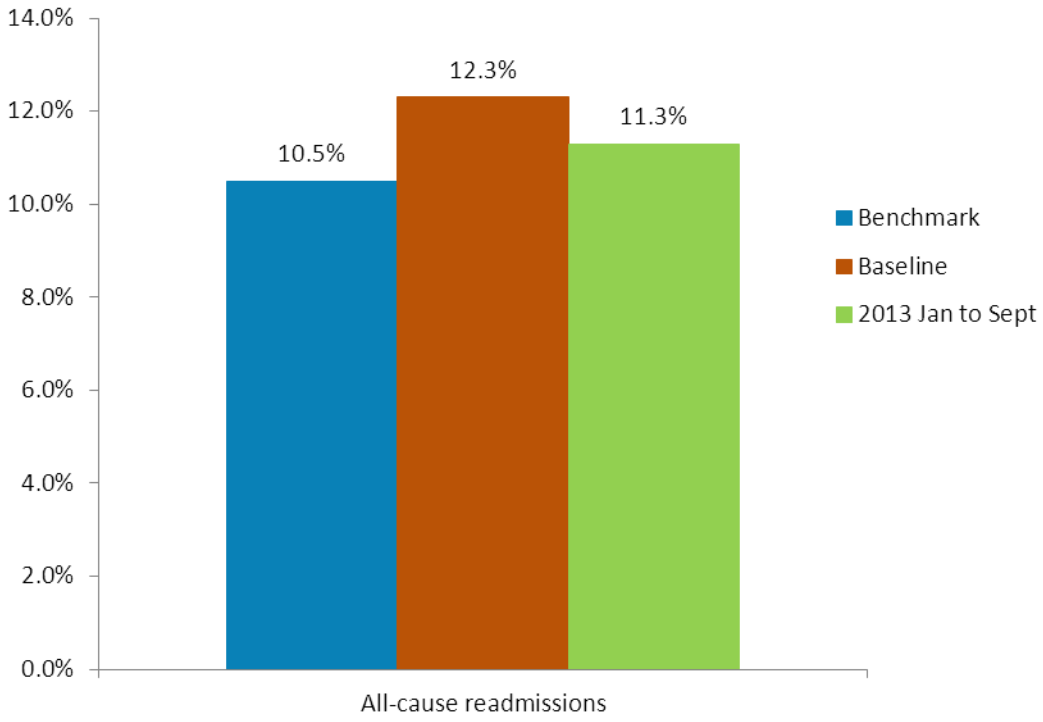
What progress data indicate

✓ **All-cause readmissions are currently down by 8%.**

Percentage of adults who had a hospital stay and were readmitted for any reason within 30 days of discharge.



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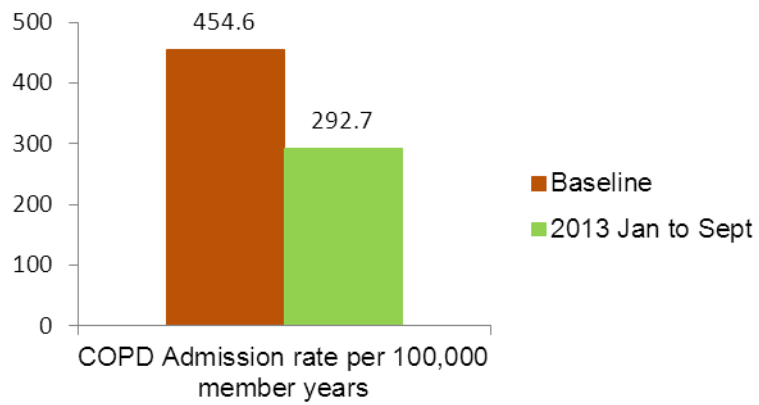
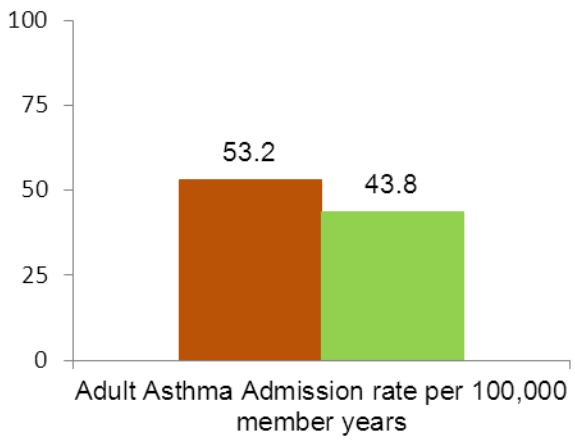
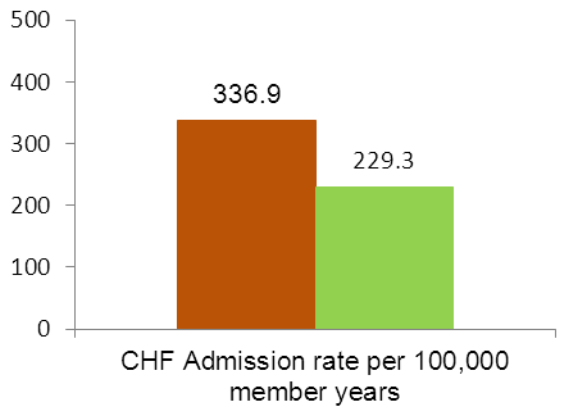
What progress data indicate

- ✓ **Potentially avoidable hospitalizations for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and adult asthma are currently down.**



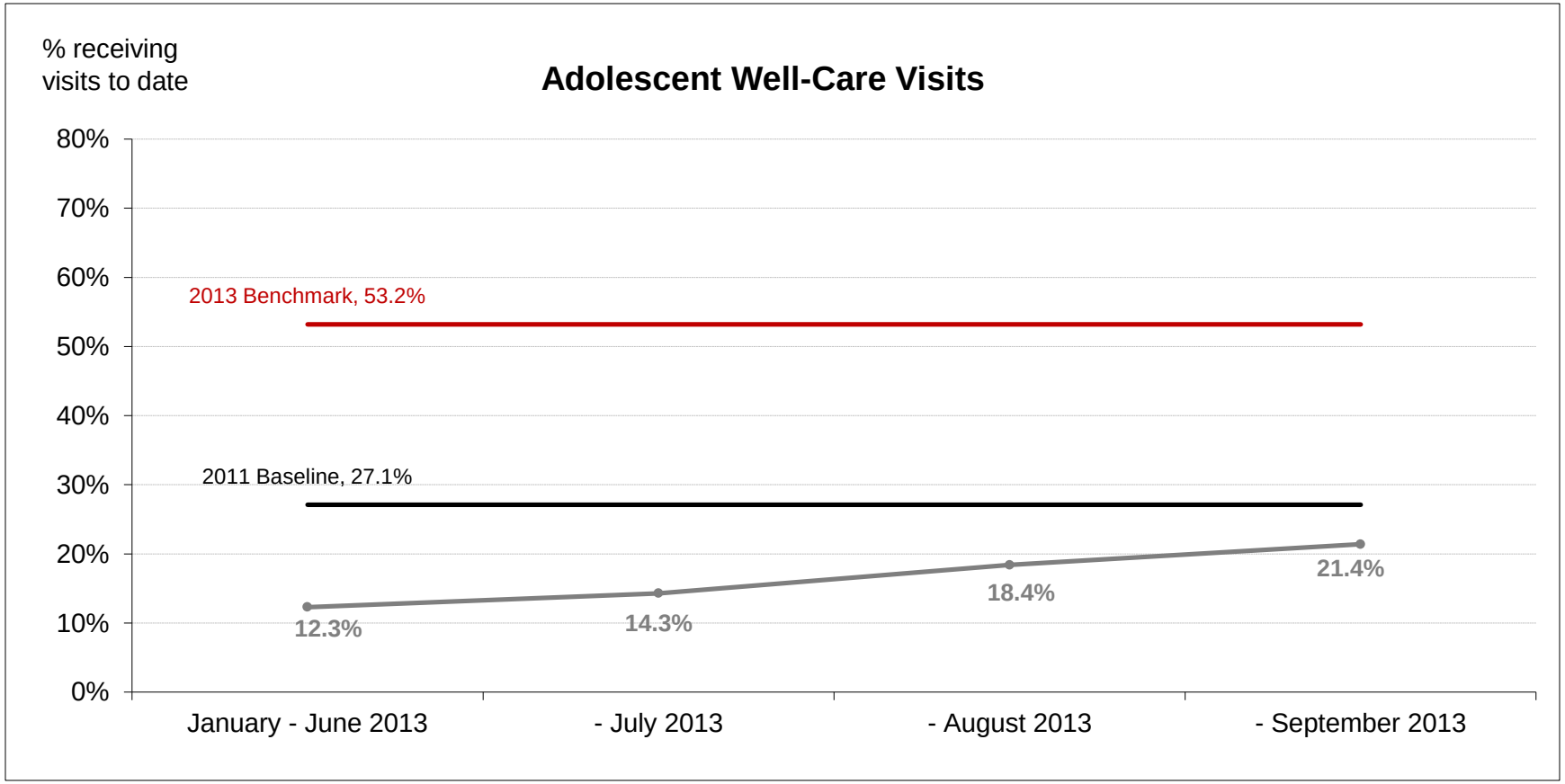




Caveats for selected metrics

- ✓ **Adolescent well-care visits:** Current data shows a lower rate than baseline, but data does not include the fall months when many adolescent well-child visits occur. The percentages have been increasing with time and will be indicative of care with a full year of data.

Statewide Adolescent Well-Care Visits Over Time



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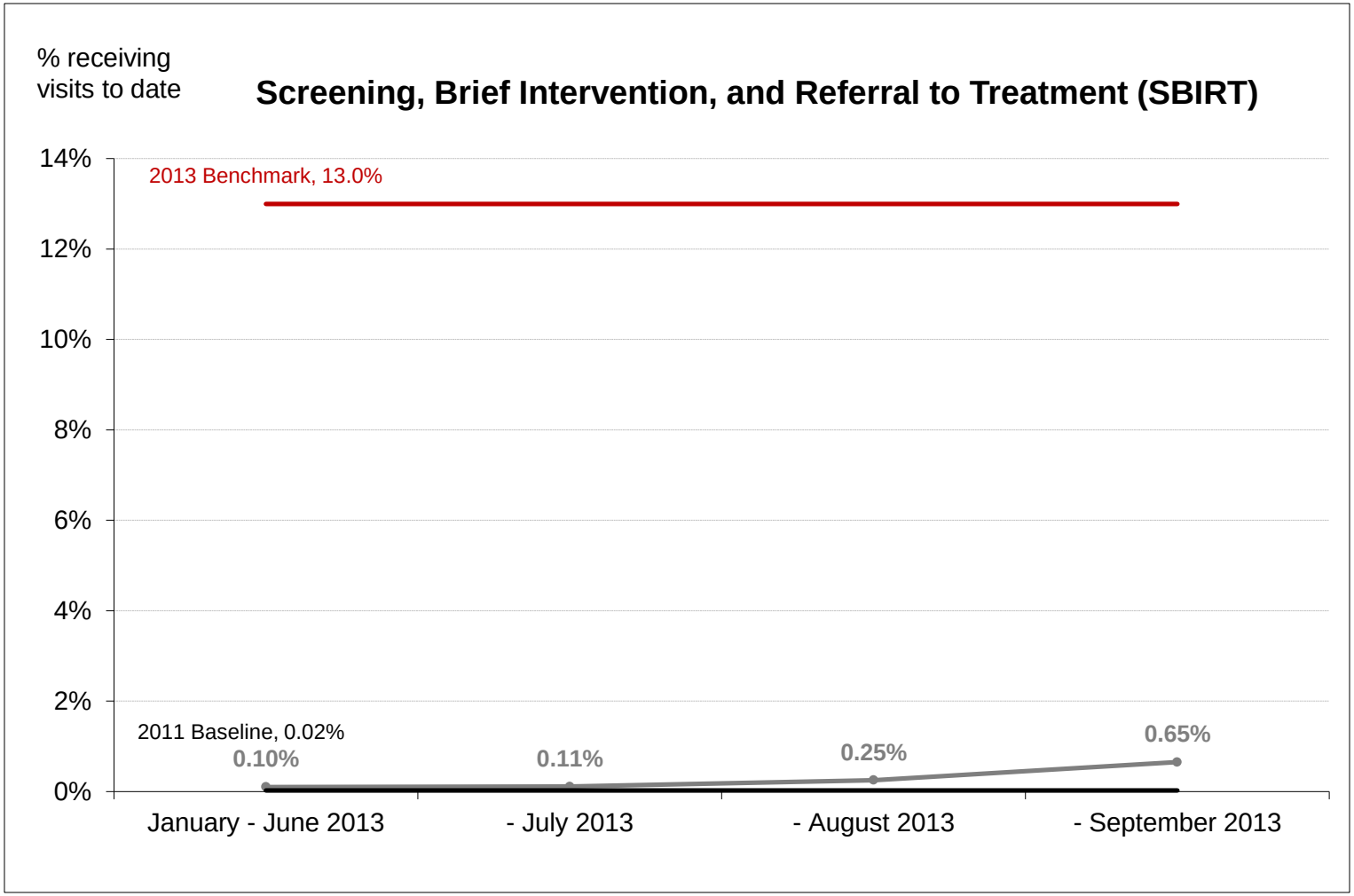
Caveats for selected metrics

- ✓ **Screening, brief intervention and referral to treatment (SBIRT)** was effectively zero at baseline. Some CCOs have shown significant improvement over baseline. We expect to see continued increases in SBIRT data in the next report with a full year of data.

Statewide SBIRT Over Time



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Caveats

- **Progress data includes dates up through September 2013, which is only nine months of the measurement year. Progress will not be linear. Data can and will change due to:**
  - **Claims lag.** Much of this data comes from billing information and bills may be submitted long after the date on which the service was provided.
  - **Seasonality.** Health conditions and health care-seeking behaviors are seasonal (e.g., cold and flu season impacts on COPD, CHF and asthma)
  - **Improvement efforts.** These data are from the first nine months of the year when CCOs were just beginning to impact the Medicaid delivery system and implement quality improvement activities. Some metrics (for example, SBIRT) represent changes in work flow and patterns that aren't likely to be reflected in the earlier months of implementation.

Next Steps

- Continue to aggregate and produce state-level data for each of the state's 33 performance measures.
- Prepare and publicly report CCO-level progress reports all performance metrics, including quality, utilization and cost data.
- Prepare and publicly report performance metrics by race and ethnicity for CY 2013.
- **Full data for calendar year 2013 will be included in the next report.**

Oregon Health Authority

For More Information

Current quarterly progress report and all data and technical specifications are posted online at Health.Oregon.gov

Contact

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Director of Accountability and Quality

lori.a.coyner@state.or.us

Oregon Health Authority

bailit health PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Oregon Health Authority
FROM: Michael Bailit and Kate Bazinsky
DATE: January 22, 2014
RE: Colorectal Cancer Screening Measure Adjustment Factor Options-Revised

This memo serves as a revision to that previously sent on January 10, 2014. It incorporates HEDIS 25th and 50th national percentile values into Options 1 and 2.

Introduction

Oregon Health Authority (OHA) included the HEDIS Colorectal Cancer Screening measure in its CCO incentive measure year for CY 2013. However, HEDIS does not define the Colorectal Cancer Screening measure for use with the Medicaid population. As a result, OHA did not have a HEDIS national comparison benchmark readily available for the quality incentive pool. For CY 2013 OHA only defined a 3% improvement target for the CCOs.

For CY2014 OHA is again considering using the commercially-insured population benchmark that NCQA publishes annually to calculate a performance target for Colorectal Cancer Screening and requested that Bailit provide options for constructing such a target.

Options for Constructing a Performance Target for Colorectal Cancer Screening

We have identified three potential approaches to creating a Medicaid benchmark for the Colorectal Cancer Screening measure.

1. Create an adjustment factor to apply to commercially-insured population data that is based on the average difference between Medicaid and commercial rates for cancer screening measures.
2. Create an adjustment factor to apply to commercial data that is based on the average difference between Medicaid and commercial rates for a subset of measures focused on patient populations similar to that targeted by the Colorectal Cancer Screening measure.
3. Set a benchmark using data from the Centers for Disease Control and Prevention.

We note that all of three of the identified approaches have limitations that OHA will have to acknowledge if it chooses to set a benchmark using one of the aforementioned methodologies.

Option 1: Create an adjustment factor to apply to the commercially-insured population data that is based on the average difference between Medicaid and commercial rates for cancer screening measures. There are currently two other HEDIS cancer screening measures that are used in both the commercial and Medicaid populations: Breast Cancer Screening and Cervical Cancer Screening. Two approaches may be used to calculate the

adjustment factor: it may be calculated by taking the average of the average differences across all of the percentiles or by considering only the average difference at the 75th percentile, the 50th percentile and the 25th percentile. The adjustment factors are provided in Table 1 below.

Table 1: Adjustment factors calculated using Option 1

Approach	Adjustment Factor (% points)	2013 HEDIS rate	Potential Benchmark
Average across all percentiles (75th percentile)	12.059	75th: 66.46%	54.401%
Average across all percentiles (50th percentile)	12.059	50th: 59.44%	47.381%
Average across all percentiles (25th percentile)	12.059	25th: 53.97%	41.911%
Average difference at the 75th percentile	9.825	75th: 66.46%	56.635%
Average difference at the 50th percentile	12.345	50th: 59.44%	47.095%
Average difference at the 25th percentile	15.875	25th: 53.97%	38.095%

Limitations of Option 1:

1. The populations are not the same. The populations included in these screening measures are limited to women who fall within wider age ranges.
2. Colorectal Cancer Screening has a much longer "look back" period than do either Breast or Cervical Cancer Screening.
3. The average difference between Medicaid and commercial varies greatly by measure. There is a much larger discrepancy (more than twice as large at some percentiles) between the commercial and Medicaid population rates for Breast Cancer measure than for the Cervical Cancer measure. Bailit would feel more confident using this adjustment factor if the rates were similar across both measures.

Option 2: Create an adjustment factor to apply to the commercial data that is based on the average difference between Medicaid and Commercial rates for a subset of measures with populations similar to the Colorectal Cancer Screening measure. Bailit created a subset of HEDIS measures based on the following criteria:

1. The measure must be reported for both the Medicaid and commercial populations.
2. The age range for the measure must overlap with the age range for the Colorectal Screening measure (e.g., no Childhood Immunizations and Chlamydia Screening).
3. The measure must be clinically-focused (e.g., no utilization or patient experience measures).
4. The measure must be collected through either administrative or hybrid method (e.g., no survey-based measures).

Applying these criteria to all of the HEDIS measures reported in 2013, Bailit identified 34 measures for inclusion and calculated the average difference between the Medicaid and commercial populations using two different approaches: taking the average of the average differences across all of the percentiles and by taking the average difference at the 75th percentile, the 50th percentile and the 25th percentile. The adjustment factors a across the three benchmarks vary far less than those considered for Option 1. The adjustment factors are provided in Table 2 below.

Table 2: Adjustment factors calculated using Option 2

Approach	Adjustment Factor (% points)	2013 HEDIS rate	Potential Benchmark
Average across all percentiles (75th percentile)	6.376	66.46%	60.084%
Average across all percentiles (50th percentile)	6.376	59.44%	53.064%
Average across all percentiles (25th percentile)	6.376	53.97%	47.594%
Average difference at the 75th percentile	5.566	66.46%	60.894%
Average difference at the 50th percentile	6.373	59.44%	53.067%
Average difference at the 25th percentile	6.440	53.97%	47.530%

Limitations of Option 2:

1. The measures included in the subset vary widely by clinical purpose. They are not just limited to cancer screening measures or even prevention-focused measures.
2. Colorectal Cancer Screening has a much longer "look back" period than do any of the other measures.
3. The average difference between Medicaid and commercial varies greatly by measure. While on the whole, the commercial rates are still generally higher than the Medicaid rates, on specific measures (e.g., Annual Monitoring for Patients on Persistent Medications) Medicaid plans outperform health plans serving the commercial population. This suppresses the average difference and reduces Bailit's confidence in the adjustment factor.

Option 3: Set a benchmark using data from the Centers for Disease Control and Prevention (CDC). The CDC published rates of adults aged 50-75 who received colorectal cancer screenings by income family level in 2010.[1] For those individuals at or

[1] Centers for Disease Control and Prevention. QuickStats: Percentage of Adults Aged 50–75 Years Who Received Colorectal Cancer Screening,* by Family Income Level† — National Health Interview Survey, United States, 2010§. Morbidity and Mortality Weekly Report. November 23, 2012 / 61(46); 955. Accessed online on January 8, 2014 at

below 138% of FPL, and therefore eligible for Medicaid in Oregon, the rate of screening is approximately 48%.

Family Income Level	Potential Benchmark
Below federal poverty level (FPL)	38.7%
100%-199% FPL	47.5%
200%-399% FPL	57.4%
400%-599% FPL	63.9%
>=600% FPL	72.9%

Limitations of Option 3:

1. The CDC data is collected through a survey tool whereas the HEDIS data and the rates that will be collected in the context of the CCO incentive program rely on claims data.
2. The CDC data uses 2010 data which is several years old at this point.
3. The CDC data do not match exactly with Medicaid eligibility and therefore my slightly overstate the benchmark.

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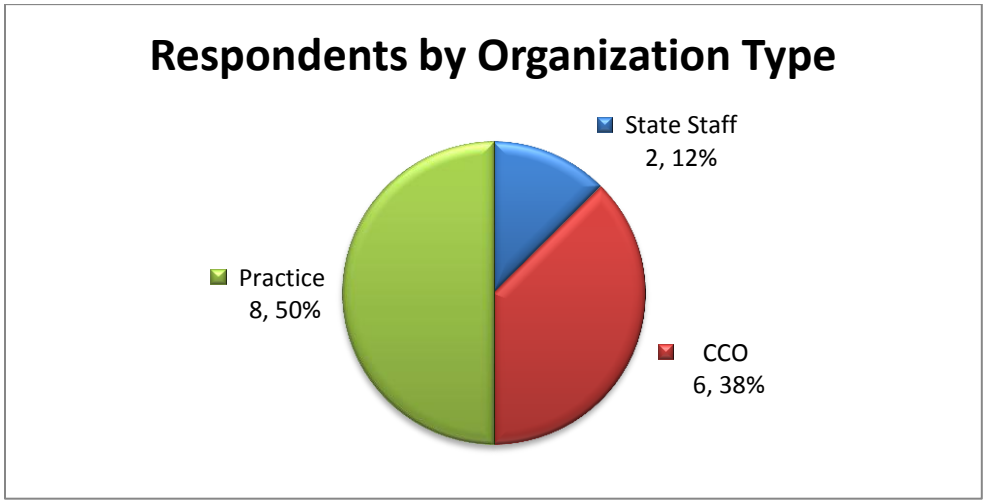
www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a10.htm. Also, personal communication with David T. Huang, CDC, National Center for Health Statistics, January 9, 2014.

SBIRT Workgroup Next Steps Survey

OHA surveyed the SBIRT Workgroup on challenges they are experiencing and next steps. This document summarizes the survey responses.

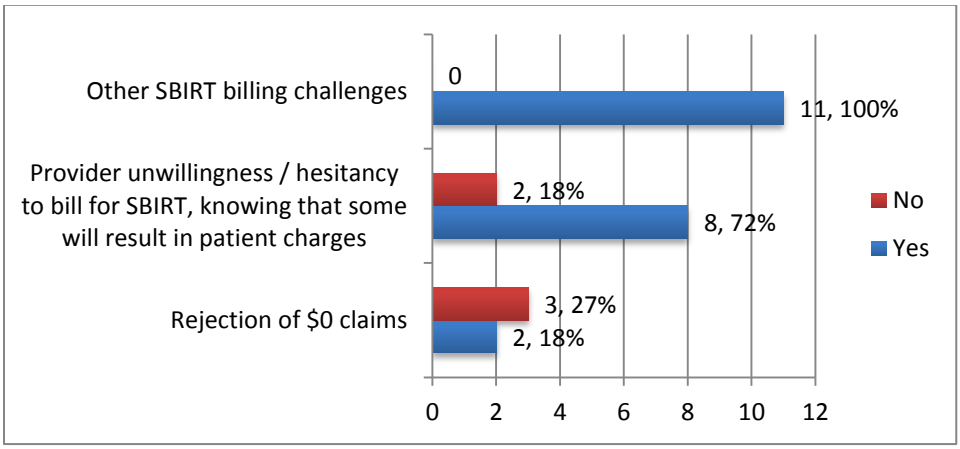
Respondents

17 workgroup members responded to the survey. Respondents by organization type include:



SBIRT Billing Information

Respondents were asked to identify whether their clinic or CCO was experiencing any of the following challenges:



100 percent of respondents answering this question experienced other SBIRT billing challenges. Explanations of those other challenges, which were also presented as barriers for providers, can be grouped into broad themes, including:

Overall Complexity

- Complexity of the billing is a perceived obstacle for practitioners.
- SBIRT is occurring, but not showing up in claims.
- Multiple codes required for different scenarios.
- Inconsistency of coding acceptance / requirements across payors.
- Limitations on provider types who can bill or bill incident-to for SBIRT services.

Time Requirements

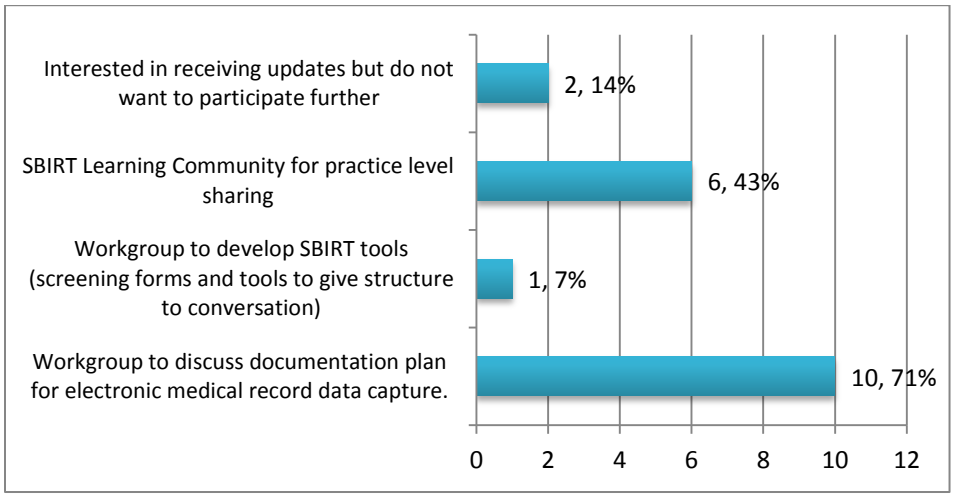
- The required time [i.e., 15 minutes or more] to deliver and bill CTP 99408 / 99409
- No evidence saying a Brief Intervention should take 15 minutes; usually not possible and not necessary.

Process / Workflows

- Inconsistent clinic processes that capture the billing.
- Complex process of finding and using seldom used billing codes.
- EMRs preventing providers from billing SBIRT codes
- The term "screen" is used for both brief and secondary processes.

Next Steps

Workgroup members were asked if they or their organization were interested in participating in additional SBIRT activities:



Respondents were most interested in developing electronic medical record data capture moving forward, followed by a Learning Community for practice level sharing.