

Oregon Metrics and Scoring Committee

AGENDA

November 25, 2013

1:00 – 3:00 pm

BY PHONE:

Dial in: 1-888-808-6929
Committee and staff code: 275474
Public listen only line: 915042

IN PERSON (optional)

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#	Time	Item	Presenter	Action Item
1	1:00 – 1:15 pm	Welcome <ul style="list-style-type: none">• Consent Agenda• 2014 Meeting Schedule• 2014 Meeting Agendas	Bob Dannenhoffer	X
2	1:15 – 1:30 pm	Updates <ul style="list-style-type: none">• CMS decision on technology plan	Tina Edlund	
3	1:30 – 2:45 pm	Changes for Measurement Year #2 <ul style="list-style-type: none">• Review TAG feedback and CCO comments• Identify any specification changes for 2014	Lori Coyner Michael Bailit	X
4	2:45 – 3:00 pm	Public testimony	Bob Dannenhoffer	
		Adjourn	Bob Dannenhoffer	

Next Meeting:
December 13, 2013
1:00 – 4:00 p.m.

Oregon Metrics and Scoring Committee

Minutes

October 11, 2013

1:00 – 4:00 p.m.

29353 SW Town Center Loop E

Wilsonville, OR 97070

Item
<p>Welcome</p> <p>Committee members present: Maggie Bennington-Davis, Gloria Coronado, Robert Dannenhoffer, R.J. Gillespie, Phil Greenhill, Jeff Luck, David Labby, Bob Joondeph.</p> <p>Not attending: Jeanine Rodriguez.</p> <p>OHA Staff: Tina Edlund, Susan Otter, Susan Arbor, Denise Taray, Sarah Bartelmann, Ari Ettinger.</p> <p>Consultants: Michael Bailit, Bailit Health Purchasing.</p>
<p>Consent Agenda</p> <p>The Committee approved the August 16, 2013 meeting minutes. The Committee agreed to add a November phone meeting.</p>
<p>Updates</p> <p><i>CMS approval of clinical measures proposal</i> - OHA meeting with CMS was postponed due to the federal government shutdown. No approval yet. As a backup plan, OHA is proposing including language on the technology plan and proof of concept data in the 2014 CCO contracts and reference documents, but will not release any of the quality pool funds tied to the three clinical measures until CMS approves the proposal.</p> <p><i>Notification feed for children in foster care</i> – OHA launched a weekly notification feed on October 2, 2013. This is a short term solution until OHA / DHS can develop a more robust solution.</p> <p><i>Dental Quality Metrics Workgroup</i> - the workgroup has met every month since July and will be ready to present recommended dental metrics for CY 2015 to the Committee in December. Note OHA is not accountable to CMS for any dental care measures.</p> <p><i>Measure specifications and guidance documents</i> – OHA has published measure specifications online for EHR adoption and early elective delivery, as well as guidance documents for prenatal care, depression screening, and SBIRT.</p>
<p>Proposed Year One Technology Plan Guidance</p> <p>OHA is proposing that CCOs submit a year one technology plan to OHA no later than February 1, 2014 and proof of concept data for the three clinical measures (depression screening, diabetes control, and hypertension control) no later than May 1, 2014.</p> <p>CCOs will earn 75 percent of the quality pool funds tied to these measures (e.g., 75 percent of 3/17ths of the quality pool) for the technology plan and the remaining 25 percent upon OHA's acceptance of the proof of concept data.</p>

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OHA is working with the Technical Advisory Group (TAG) to finalize the year one technology plan guidance document and plans to release it to CCOs the first week of November.

Susan Otter provided an update on the Transformation Fund / HIT proposal: OHA will leverage \$3 million from the \$30 million Transformation Funds awarded by the legislators to draw down \$27 million in federal match to develop six priorities:

- Statewide provider directory;
- Incremental development of a patient index;
- Statewide hospital notifications;
- On-ramp - connecting all members of a care team;
- Clinical quality metrics registry; and
- Developing technical assistance for Medicaid providers.

CCOs agreed this is the right direction and OHA will be setting up a technical advisory group to guide the development of these areas and the use of the Transformation Funds.

Measurement Periods

Three of the CCO incentive measures require look back periods, which for CY 2013 measurement, require looking back into 2012 prior to when CCOs were established. OHA brought alternate measurement period proposals to the TAG for their discussion and recommendation for the Committee.

Mental and physical health assessment for children in DHS custody – The Committee agreed to modify the measurement period for 2013 to include assessments for children entering custody between October 1 – December 31, 2013 only.

Follow up care for children prescribed ADHD medications - The Committee agreed to modify the measurement period for 2013 and 2014 to align with the calendar year. The measure will look for children prescribed ADHD medications between January 1 – December 31, 2013.

Timeliness of prenatal care – The Committee agreed to modify the measurement period for 2013 to include live deliveries between September 6, 2013 – February 2014, and prenatal care provided between January – August 2013.

The Committee asked the Technical Advisory Workgroup to discuss options for improving data for this measure at their October 30th meeting.

Planning for Measurement Year #2 (CY 2014)

OHA proposed that all measure specifications, benchmarks, and improvement targets will be identified, approved, and operationalized by the end of December 2013, so CCOs know exactly what to expect for the second measurement year.

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Michael Bailit outlined six potential sources of information to inform Committee decisions for CY 2014 and beyond:

- Changes the Committee have already committed to, or noted in previous meetings;
- Changes the TAG has already recommended;
- CCO performance (Jan – June 2013) compared to baseline and benchmarks;
- Changes proposed by CCOs;
- Changes proposed by community members / stakeholders;
- Changes proposed by OHA.

Overall feedback from CCOs and partners to date is a request to let the dust settle on the existing measures and specifications: keep them the same for at least one more year so health plans, practices, and providers can adjust and have an opportunity to improve the delivery of care.

The Committee agreed to invite CCOs, stakeholders, and the Technical Advisory Workgroup to submit thoughts and suggestions on the measures and specifications for CY 2014 and beyond. This feedback will be considered by the Committee in November and December meetings.

The Committee reviewed changes that have already been suggested. The Committee agreed to pose these questions to the CCO CEO meeting on October 17th and to the TAG on October 30th.

- *Colorectal cancer screening* - move from administrative data only, to a hybrid measure for CY 2014. Is this reasonable and attainable for CCOs?
- *Early elective delivery* – no easy solutions for improvement measurement from the Perinatal Collaborative yet. Should we keep the weighted average methodology or modify for CY 2014?
- *SBIRT* – is it too soon to expand the measure to include adolescents, measure brief interventions, referrals to treatment, etc...?
- *Prenatal care* – The Committee previously agreed to drop the 3 percent floor requirement for the CY 2013 improvement target. Should the 3 percent floor be reinstated for CY 2014?
- *Mental and physical health assessments for children in DHS custody* – Should the benchmark and improvement targets be modified for CY 2014?

The Committee also requested blinded 2013 progress data to review at the November meeting.

Public Testimony

No public testimony was provided.

Metrics & Scoring Committee

November 25, 2013



Consent Agenda

2014 Meeting Schedule & Agendas

Updates

CMS Approval!

OHA received approval from CMS for the proposed approach of paying for measurement and reporting for 2013 and 2014 for the 3 clinical quality metrics: diabetes control, hypertension control, and depression screening.

- The year one technology plan guidance document : <http://www.oregon.gov/oha/CCOData/Technology%20Plan%20Guidance.pdf>
- A detailed description of the revised quality pool distribution : <http://www.oregon.gov/oha/CCOData/ReferenceInstructions.pdf>



Dental Quality Metrics Workgroup

The DQM workgroup met again in November and will present their final recommendations at the December 13th Metrics & Scoring Committee meeting.

SBIRT Workgroup

At the November 18th QHOC meeting, CCO Medical Directors and OHA agreed to convene an SBIRT workgroup to establish a community standard for SBIRT workflow and coding practice.

The workgroup will convene by early January.

2013 Progress Report Data

OHA is providing CCOs with monthly progress report files for the claims-based incentive measures to help with data validation and quality improvement efforts.

As requested in October, blinded progress data is available for the Committee's review.

Changes for Measurement Year 2 (CY 2014)



In October

The Committee asked OHA to systematically collect proposed changes to the incentive measures for 2014 and answers to specific questions from all CCOs and community stakeholders.

OHA brought the questions to the CCO CEOs, the TAG, and made an online survey available to all CCOs for their input.

Survey Results

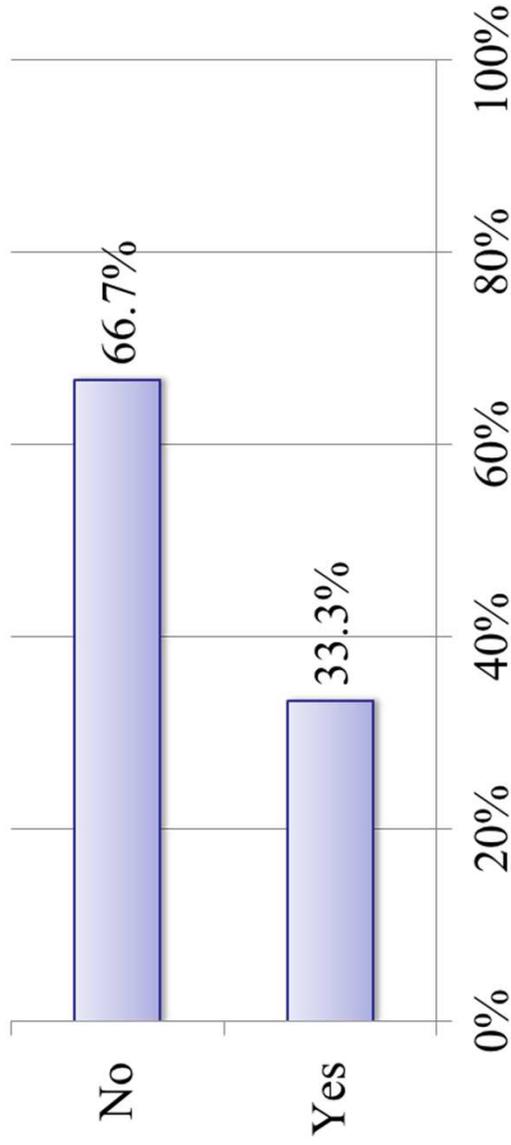
OHA received extensive feedback online and via email from:

- 10 CCOs
- 3 provider groups / practices
- 2 partner organizations

Full survey results and all comments available in the [handout](#).

CCO Capacity to Collect Medical Record Data

Does your CCO have the capacity (staff, time, resources) to collect medical record data and submit to OHA to supplement administrative data for hybrid measures such as colorectal cancer screening?



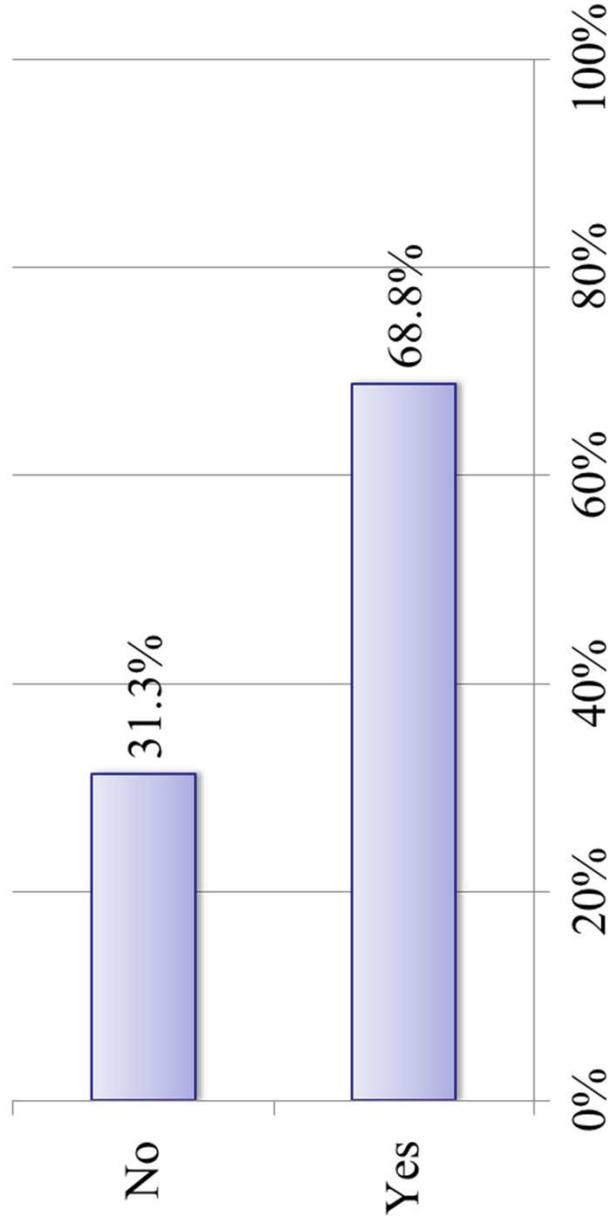
N = 15

CCO Capacity to Collect Medical Record Data

- Our personnel resources are stretched to the max trying to implement other changes related to health system transformation.
- It depends on the sample size and specifications for each measure.
- If there was appropriate remuneration for CCO's to assume this responsibility our organization would be receptive to the change, but we would need to ensure that we have adequate training and procedures in place.
- The time involved in collecting the needed data for hybrid measures will be prohibitive until an aggregate HIE is available, at which time we will be better able to handle a wide variety of reporting issues.
- In office record review requires FTE.

Hybrid Measure Specifications

Are hybrid measure specifications reasonable and attainable for CY 2014?



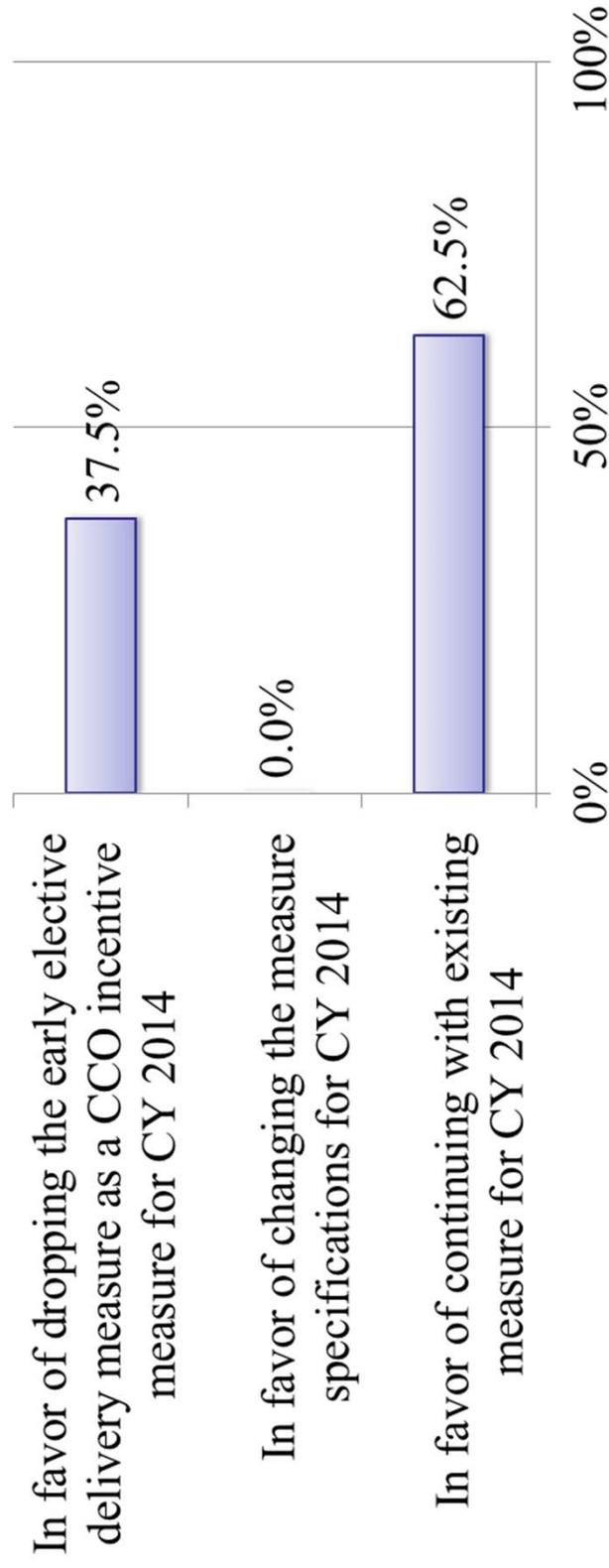
N = 16

Hybrid Measure Specifications

- Hybrid measures that would allow us to pull clinical data from an EMR report would be reasonable. Manual chart review is not the way we should be going.
- Hybrid measures will be more accurate than simply using administrative billing data.
- The hybrid specifications are attainable, provided each organization is given sufficient time to prepare. The issue, however, is that such an approach would deviate from the information we have previously been using to guide our strategic planning.

Early Elective Delivery

How does your CCO feel about continuing with the EED measure as it currently stands (collecting EED rates from hospitals and creating a weighted average for each CCO) for CY 2014?



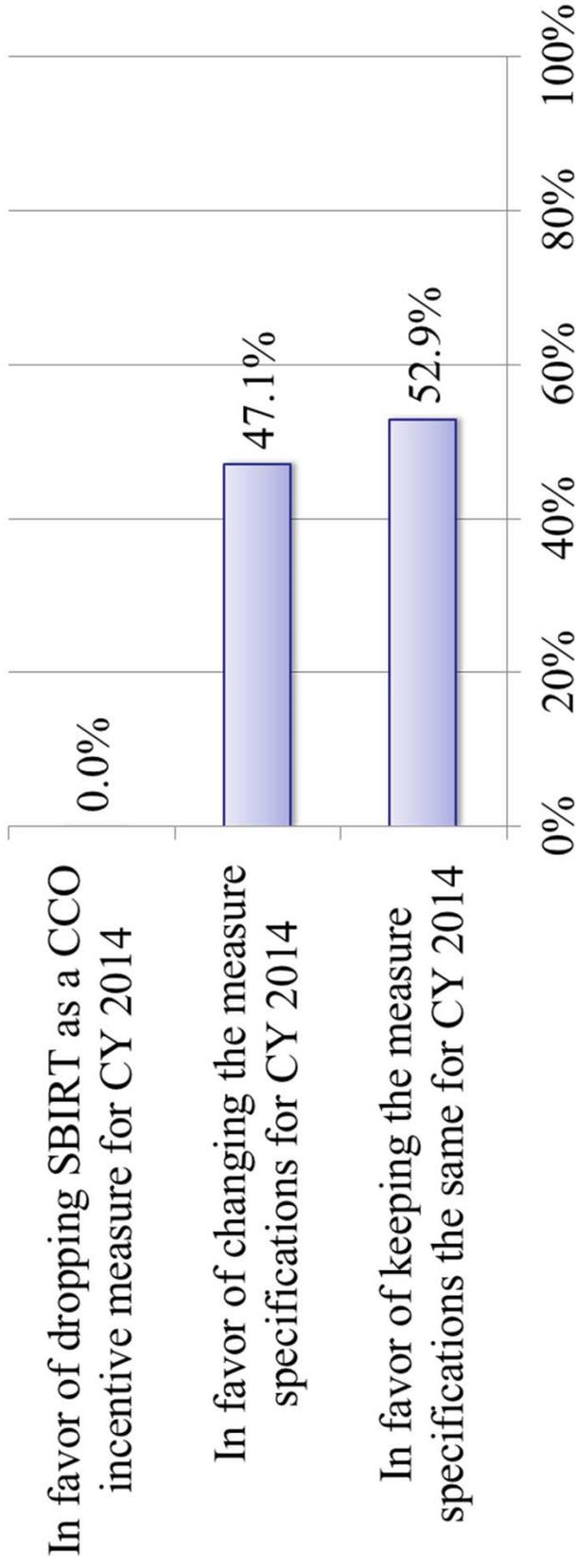
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Early Elective Delivery

- Even though we appear to be doing well (~2% state average in 2013), I don't think we should drop this measure yet. I think that this is worth monitoring for a year or two to make sure that this is trending in the right direction, and that we don't have a bounce-back to old practices.
- The C-section rate would be a better measure for CY2014. Most hospitals have a hard stop policy against EEDs.
- Hospitals are tracking this, no need to duplicate.

Alcohol and Drug Misuse (SBIRT)

How does your CCO feel about changing the SBIRT measure specifications again for 2014, or continuing with the 2013 measure specifications for another year?



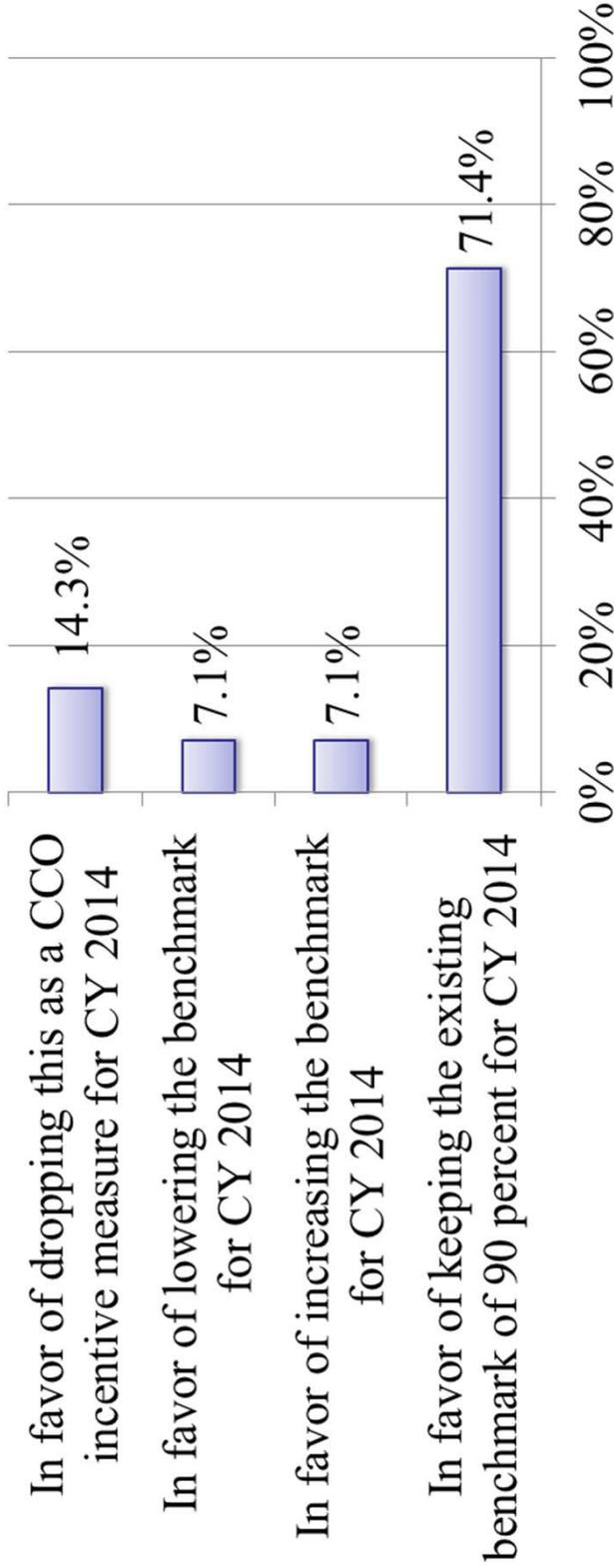
N = 17

Alcohol and Drug Misuse (SBIRT)

- The intention behind the measure is good so would prefer to keep measure and change/clarify measure specifications.
- Ultimately, I think that we will have to either change the way we capture the data or dramatically adjust the benchmark, recognizing that very little of this activity actually shows up in claims data.
- I don't favor adding adolescents until the USPSTF supports this as a recommended intervention. I believe that they still list this as having insufficient evidence.
- Need to reach adolescents since they are the medium term method to improving adult metrics.

Mental and Physical Health Assessments for Children in DHS Custody

Is your CCO comfortable with the existing benchmark of 90 percent? Do you have thoughts about modifications for CY 2014?



N = 14

Mental and Physical Health Assessments for Children in DHS Custody

- Can't comment on where we should be in 2014 until we know where we are in 2013. If we are at 85% for 2013, keep it at 90%. If we are at 50% for 2013, 90% is probably unrealistic.
- The benchmark is fine. The challenge is in getting the correct children for this measure and in working out the challenges across the systems.
- Best Practice, these kids depend on the adults to keep them healthy. 90% seems reasonable to me. 100% would be our goal!

Staff Recommendations

These recommendations are based on the CCO survey results, CMS input, CCO feedback on monthly progress reports, preliminary 2013 data, and experience.

No Changes Recommended to Measure Specifications

- Adolescent Well Care Visits
- Alcohol and Drug Misuse (SBIRT)
- Ambulatory Care: Outpatient and Emergency Department Utilization
- CAHPS: Access to Care
- CAHPS: Satisfaction with Care
- Developmental Screening
- Electronic Health Record (EHR) Adoption
- Follow Up after Hospitalization for Mental Illness
- Follow Up Care for Children Prescribed ADHD Medications
- Patient Centered Primary Care Home Enrollment
- 3 clinical measures: depression, diabetes, hypertension.

We will discuss benchmarks in December.

Early Elective Delivery

Rate of providers in a CCO's service area that qualified for incentive payments under the federal Medicaid, Medicare, or Medicare Advantage Incentive Program for EHR adoption.

Options:

- 1) Keep the measure the same, continue to monitor for 2014.
- 2) Drop measure and replace with PC-02 Cesarean Section for 2014.

Mental and Physical Health Assessments for Children in DHS Custody

Rate of children entering DHS custody between October 1 – December 31, 2013, who received required mental and physical health assessments. Measured from date of notification, not date of custody.

- Keep the measure the same for 2014, but measure for the full CY year.
- Continue to measure from date of notification, rather than date of custody.

Colorectal Cancer Screening

Absolute rate of Medicaid members ages 50-75 who received a colorectal cancer screening during the measurement year.

Options:

- 1) Keep the measure the same, no changes for 2014.
- 2) Adopt HEDIS specifications for hybrid methodology.

Note CCO concerns regarding cost, staff time, and resources required to collect medical record data.

Timeliness of Prenatal Care

Rate of women who received timely prenatal care (first trimester, or within 42 days of enrollment) for live deliveries between Sept 2013 – Feb 2014.
Administrative data only.

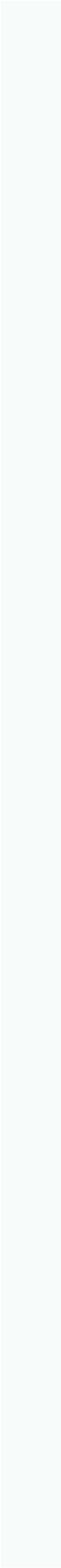
Options:

- 1) Keep the measure the same, no changes for 2014.
- 2) Adopt HEDIS specifications for hybrid methodology.

Note CCO concerns regarding cost, staff time, and resources required to collect medical record data.

Public Testimony





Next Meeting

December 13, 2013

1:00 – 4:00 pm

Wilsonville Training Center

CCO Survey Results

The Metrics & Scoring Committee asked OHA to systematically collect proposed changes to the incentive measures for 2014 and answers to specific questions from all CCOs and community stakeholders.

OHA brought the following questions to the CCO CEOs, the TAG, and made an online survey available to all CCOs for their input in November. OHA received responses from:

- 10 CCOs;
- 3 provider groups / practices; and
- 2 partner organizations.

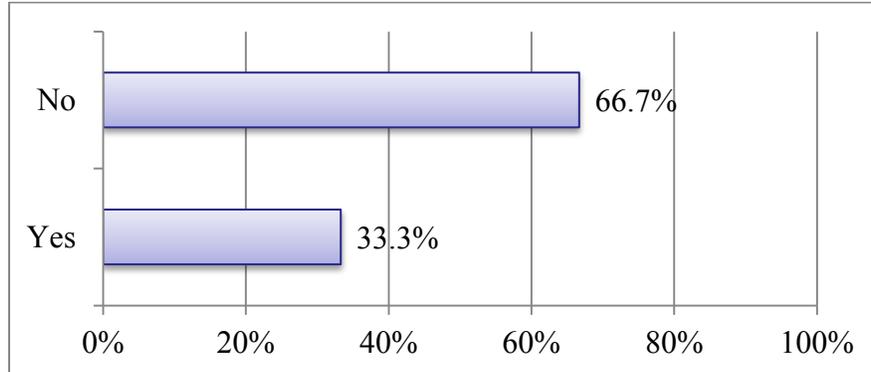
The survey results and full comments received are included in this document. OHA has edited the responses slightly to correct typos and to remove any identifying information.

Survey Questions

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CCO Capacity to Collect Medical Record Data

Does your CCO have the capacity (staff, time, resources) to collect medical record data and submit to OHA to supplement administrative data for hybrid measures such as colorectal cancer screening?



N = 15

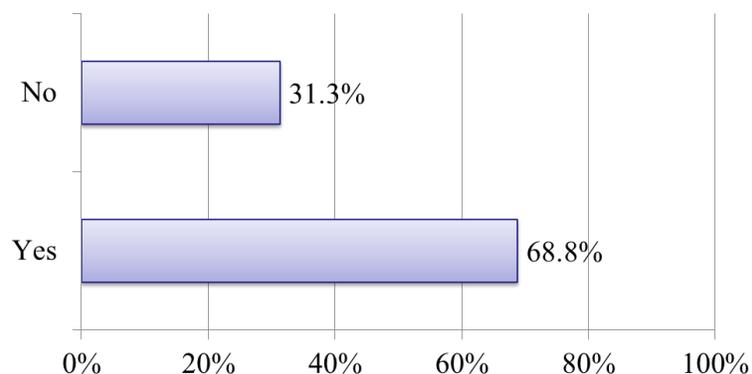
Comments

- Our personnel resources are stretched to the max trying to implement other changes related to health system transformation. We are expanding our staff as fast as we can, but it takes time to train reviewers AND it takes support and buy in from the clinics whose records we would need to audit. I would consider it if we were using the HEDIS measure, but to have to check every member in the screening age group yearly is overly burdensome. I would very much prefer to use the HEDIS administrative measure only, and set benchmarks according to the known limitations of our data.
- It depends on the sample size and specifications for each measure.
- Our organization has been operating under the assumption that individual CCO's would not be responsible for performing chart chases and medical record reviews. OHA has repeatedly stated that CCO's would not be responsible for this activity and our organization used that information to allocate staff resources accordingly. If there was appropriate remuneration for CCO's to assume this responsibility our organization would be receptive to the change, but we would need to ensure that we have adequate training and procedures in place.
- We would incur additional staffing cost and/or cost for record collection.
- If a sample is the same as HEDIS for Medicare. We would also have the capability to supplement exclusion information if that could be provided by practices in a standard format.

- If [CCOs] do, they aren't providing clinic and provider-based data so [providers] can improve on the front lines.
- Depends on the format required - patient level detail or aggregate numerators and denominators.
- I believe that the time involved in collecting the needed data for hybrid measures will be prohibitive until an aggregate HIE is available, at which time we will be better able to handle a wide variety of reporting issues.
- Obviously with the huge influx and request for measures demanded over less than a year, and no the sudden withdrawal of any funding to offset costs from the OHA/ACA qualified MH patients, this is an unfunded mandate. [Identifying information redacted] It is impossible to justify extra staff to meet these mandates. And this is not Kaizen-slow methodical and sustainable change. The colorectal cancer screening measure is poorly conceived and constructed, as it puts patients at risk who might have been screened more than 2 years previous with a colonoscopy, and then have a false positive FOBT or repeat colonoscopy-which only increases the risk of harm and even death. Why not pick one or two measures to improve upon, and back them up with intelligent designs and EBM.
- In office record review requires FTE. [Identifying information redacted].
- We have the resources and ability. We would need to re-prioritize some of those resources with report writing.
- No, and varies with each CCO and each clinic system in each CCO. Plan is to really address [this type of reporting] through the OHA expected technology plan, but in reality a big ask for clinics. [Identifying information redacted].

Hybrid Measure Specifications

Are hybrid measure specifications reasonable and attainable for CY 2014?



N=16

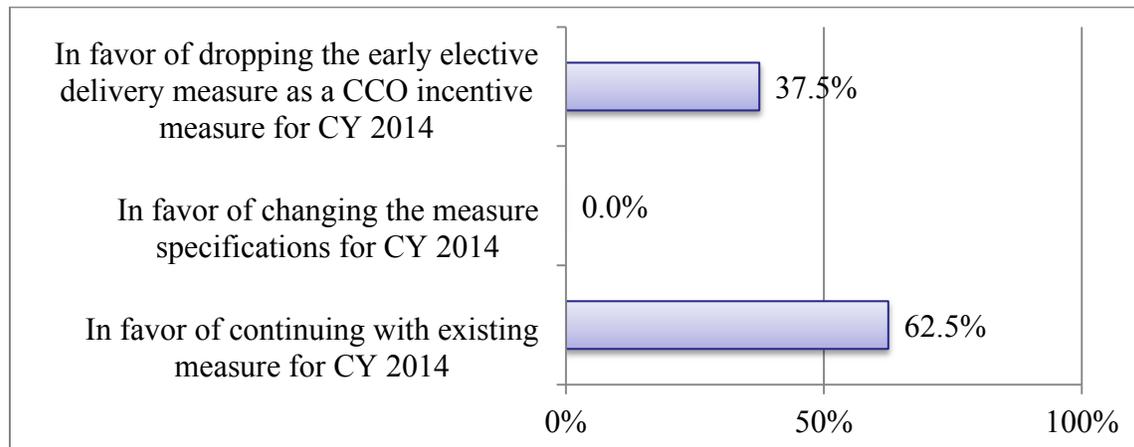
Comments

- Hybrid measures that would allow us to pull clinical data from an EMR report would be reasonable. Manual chart review is not the way that I think we should be going. Again, benchmarks and improvement targets would have to take into account the limitations of the data.
- I think the hybrid measures will be more accurate than simply using administrative billing data. Colorectal Cancer Screening is a good example of how chart reviews in addition to billing data will more accurately reflect the CCOs performance.
- The hybrid specifications are attainable, provided each organization is given sufficient time to prepare. The issue, however, is that such an approach would deviate from the information we have previously been using to guide our strategic planning. The resources used by each CCO to perform these medical record reviews would need to be taken into account in any decision that is made.
- Timeliness of Prenatal Care should be a Hybrid measure and should allow for more meaningful data collection that tells the true story about the patient's entry into care.
- Maybe.
- [Hybrid measures are] preferable to claims only measures.
- I do [believe hybrid measure specifications are reasonable and attainable for CCOs]; HOWEVER, I do NOT believe that significant progress will be made without transformation projects in place (including case management software and HIE) and it may not be as simple as it seems to REPORT on the improvement and progress.
- After one year of CCO function we will be well prepared.

Early Elective Delivery

The Metrics & Scoring Committee initially proposed deferring to the Perinatal Collaborative on how to measure / collect data for the Early Elective Delivery measure in CY 2014. However, the group has not yet had their first meeting; it seems unlikely that there will be a solution from the Collaborative before December 2013. Note that the hospital quality metrics group has committed to using EED, and that the 2013 rate has dropped to 2 percent (according to OHHA).

How does your CCO feel about continuing with the EED measure as it currently stands (collecting EED rates from hospitals and creating a weighted average for each CCO) for CY 2014?



N = 16

Comments

- Data being collected from the hospitals reflects the state-wide rate and not the individual CCO rate.
- I think that using the JCAHO measure seems to be the best way to capture this. I have some concern that we need to be able to show that OHP members are not disproportionately represented in that 2% of early elective deliveries, but I don't know how best to capture that.

I will need to check with my local hospital to see if they plan to report this measure for 2014. Even though we appear to be doing well, I don't think we should drop this measure yet. I think that this is worth monitoring for a year or two to make sure that this is trending in the right direction, and that we don't have a bounce-back to old practices.

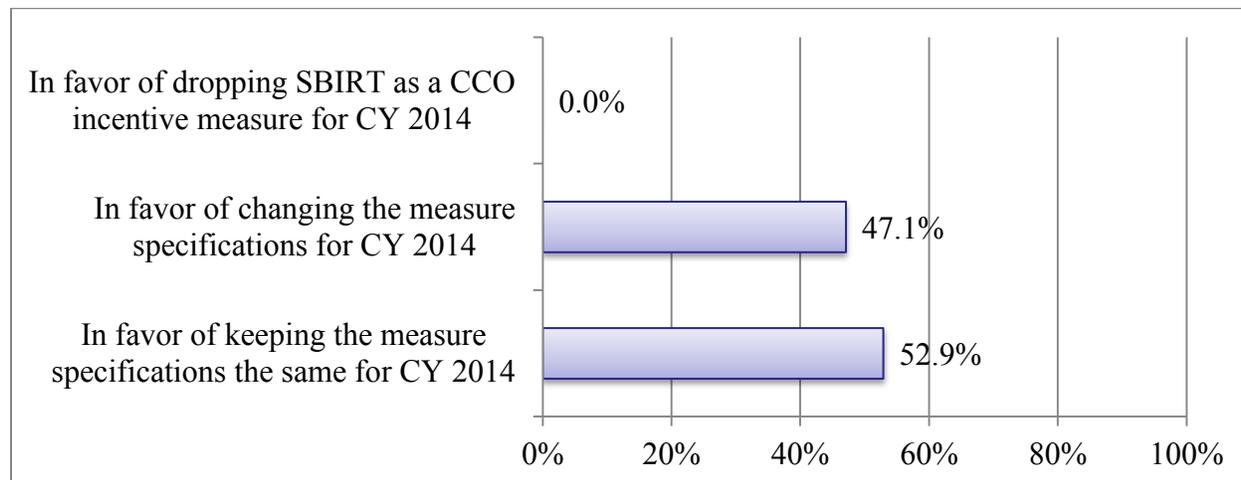
- I think the C-section rate would be a better measure for CY2014. Most hospitals have a hard stop policy against EEDs.

- If the rate is down to 2% in 2013, I am not sure of the usefulness of this as a measure in 2014. Any change in the data specifications would require a recalculation for 2013 so that there could be a meaningful comparison and opportunity for improvement.
- Look at a different metric for this population. This one does not seem to apply any longer. Something meaningful would make more sense.
- We believe our rate is low enough that we will be fine for CY2014.
- Our local hospital is tracking, no need to duplicate.
- Unsure any other alternative and we have only heard that this measure is not an issue as all indication is that it is being met.
- I feel we should continue this metric, but more so because it will help our hospital sites standardize the reporting. Our initial data for this measure is very low due to the fact that our sites are not consistently tracking/reporting early elective delivery data. We have started some early preliminary discussions regarding this.

Alcohol and Drug Misuse (SBIRT)

A number of changes have been suggested for the SBIRT measure (e.g., including adolescents, figuring out ways to measure brief screenings, or referral to treatment, or capacity of treatment system). OHA has also received feedback that CCOs and practices are still working to try to implement SBIRT and would prefer to not make any changes that could cause more confusion for another year.

How does your CCO feel about changing the SBIRT measure specifications again for 2014, or continuing with the 2013 measure specifications for another year?



N = 17

Comments

- Need to address coding issues identified in the November QHOC meeting and need to clarify the specifications on who can do the screening. The intention behind the measure is good so would prefer to keep measure and change/clarify measure specifications.
- I don't favor adding adolescents until the USPSTF supports this as a recommended intervention. I believe that they still list this as having insufficient evidence:
<http://www.uspreventiveservicestaskforce.org/uspstf/uspdrin.htm>

I would like to consider whether a risk-screening tool such as the Opioid Risk Tool might be considered one of the accepted validated tools. It is not primarily for the purpose of screening for active alcohol or drug use, but does address these issues and we are trying to encourage our providers to use this on anyone being considered for chronic opioid therapy.

Ultimately, I think that we will have to either change the way we capture the data or dramatically adjust the benchmark, recognizing that very little of this activity actually shows up in claims data due to the fact that CCI edits do not allow the use of the codes in the measure

with other commonly used codes. Perhaps if we could capture diagnosis codes for screening OR CPT codes, our capture would improve.

- Minor modifications to the SBIRT technical specifications could help improve the measure. Some clinics, for instance, are experiencing claims denials for dual eligible members screened for 99420 since the required Medicare G code is not included on the list of acceptable codes. On a larger level, clinics are struggling to create uniform SBIRT policies across payers. Many feel that the codes used to drive the CCO incentive measures place an unfair burden on the rest of their patient population who may not expect their responses from the two question screening to ultimately result in billed service (AUDIT/DAST etc.).
- I would not want to add adolescents at this time. There are significant issues with confidentiality and collecting this as a billing code when someone admits to alcohol or substance use. Ideally, the measure would somehow move into the technology plan and not be claim dependent. There should be credit given for doing the initial screen and then appropriate intervention, such as likely will happen with depression screening. It is too confusing for practices and in no one's best interest to collect Depression screening one way and Alcohol/Substance Abuse screening a different way.
- Keep SBIRT as a measure, but create tracking tool/registry to capture universal, annual screen.
- Adding adolescents, finding ways to measure brief screenings, and ensuring that the measure correctly incentivizes screenings over brief intervention and treatment.
- Need to reach adolescents since they are the medium term method to improving adult metrics etc...
- Including Brief Screenings and allowing either Hybrid or EHR based methodology - the claims based part is the most awkward and difficult part because it's not how most of the clinics we work with recording SBIRT. It is in other (reportable) places in the EHR.
- I personally believe that we are initiating enough SBIRT changes that will be in effect for CY 2014 that we will see a significant improvement toward the benchmark and certainly meet our goal for the year.
- Just adding a relatively poorly supported measure (not as robust SCIENTIFIC evidence as say the CAGE etc.) and then changing it is not smart. DO not change something that is just getting off the ground - many practices struggled to design an implementation measure and recording methodology with searchable data to query SBIRT compliance. And the billing parameters and charges are confusing at best. Although not the proper screen for adolescents, there is far less evidence that intervention in that age group is useful. And for many clinics, the access to

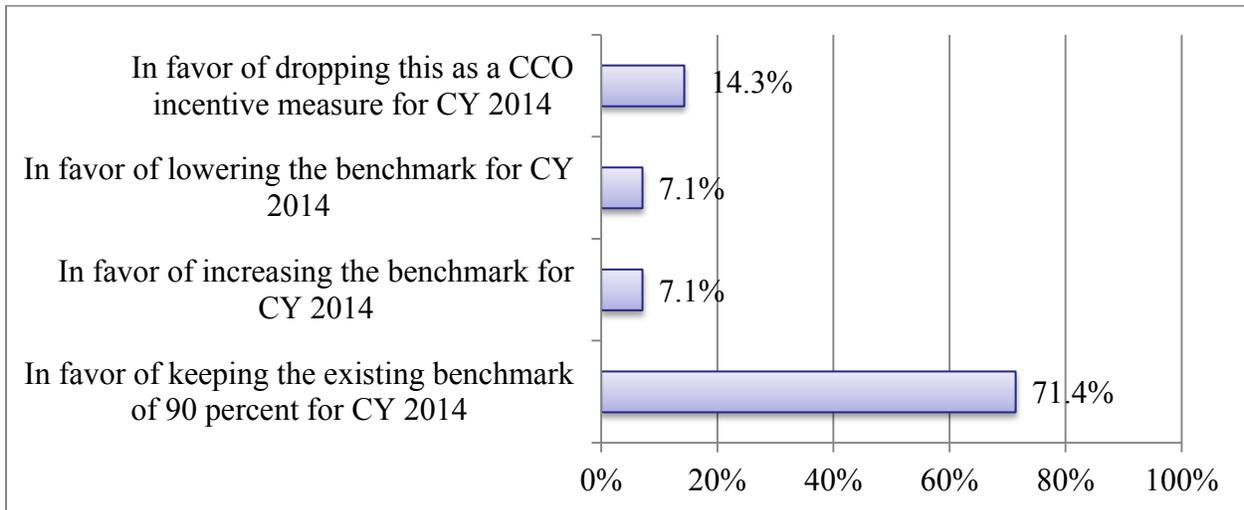
appropriate counseling after a positive screen is pie in the sky. There are not enough BH or ETOH/substance counselors in the OHP/contracted and available in a timely manner to intervene. DO NOT MEASURE WHAT YOU CANNOT TREAT.

- The requirement to have a physician review the SBIRT has greatly limited the use of this tool. We have looked at this tool being used in the field during crisis or face to face contact but delivering them to the MD for review creates an issue with billing. Billing and paying both are not functional.
- We need to stick with it as tremendous effort to get to this measure itself (specifications, etc but more importantly workflow redesign). I believe this measure was too narrowly focused and not mirror clinical practice (universal screening for all respective population cohorts) but to redo measure will be so hard on everyone (prefer leave it and can build “correct” workflow in clinics as opposed to a measure dictating workflow).
- Recommend continuing with 2013 measure specs for another year due to the work that has already been done.

Mental and Physical Health Assessments for Children in DHS Custody

The benchmark for the “mental health and physical health assessments for children in DHS custody” measure is currently set at 90 percent. There have been suggestions to modify the benchmark for CY 2014, although lowering the benchmark is likely not negotiable with CMS.

Is your CCO comfortable with the existing benchmark? Do you have thoughts about modifications for CY 2014?



N = 14

Comments

- Until we get the DHS list sent regularly and accurately this will be hard. Also, the interaction, workflows with DHS is really complicated in setting of coordinating between PH, BH, and DHS. We do not even really know what baseline is. Think lowering the baseline is great for getting the money, not great for intent, and agree CMS will not alter.
- I can't comment on where we should be in 2014 until we know where we are in 2013. If we are at 85% for 2013, keep it at 90%. If we are at 50% for 2013, 90% is probably unrealistic.
- I am comfortable with the 90% benchmark.
- CCOs are only required to hit the improvement target. Would this change in 2014? Another option would be to loosen the specifications a bit to ensure 90% is attainable.
- The benchmark is fine. My understanding is that there are federal requirements around the 90%. The challenge is in getting the correct children for this measure and in working out the challenges across the systems.

- So far I have not seen any data about this on the front lines in a clinic with likely a high number of this population. I am flying blind at my level.
- Best Practice, these kids depend on the adults to keep them healthy. 90% seems reasonable to me. 100% would be our goal!
- We are concerned that due to the low number of children that stay in the county after being taken into custody that there might be issues for us being responsible for the appropriate screening.
- We cannot control the behavior of the county or the DHS workers who are overburdened with case load as it is, nor control the no-show rates for follow up of DHS custody kids. The DHS is underfunded or at least disorganized enough that many of the workers are busy doing their job IE keeping kids out of danger, that this is a pretty meaningless effort anyway.

Other Feedback

Please provide any other feedback, comments, or suggestions about measure selection, specifications, benchmarks, etc... for CY 2014.

- Depression screening specifications need further clarification on who can do screening especially the requirement for supervision of the person doing the screening. Also would need clarification on reporting of screenings done in non-provider based settings. On potentially using a hybrid methodology on measures this may not be doable by many of the CCOs without significant burden.
- Please turn the colorectal cancer screening measure back to the HEDIS administrative measure.
- We need to be aware of other forces at work for 2014 that will affect our numbers. I think a number of the measures will be adversely affected by the increase in enrollment. I expect an increase in the number of ER visits due to pent-up demand and new enrollees overwhelming the medical system. I am concerned that cancer and other screenings will be less prioritized as patients are dealing with acute issues that bother them now. I anticipate that the CAHPS access to care measure may be adversely affected, as people realize that they can't get seen immediately when they come onto the plan. I don't think that this means we should abandon the measures, but we should expect that several will be adversely affected.
- Our organization has been operating under the assumption that individual CCO's would not be responsible for performing chart chases and medical record reviews. OHA has repeatedly stated that CCO's would not be responsible for this activity and our organization has used that information to allocate staff resources accordingly. If there was appropriate remuneration for CCO's to assume this responsibility our organization would be receptive to the change, but we would need to ensure that we have adequate training and procedures in place.
- Our organization has been frustrated with the lack of communication surrounding the incentive measure technical specifications. The measure specifications were released for too late in the year to allow CCO's to create the type of robust system-wide strategies necessary for true transformation. Furthermore, the even following their release, the measure specifications have remained so fluid that it has significantly hindered substantive planning and provider outreach.

We appreciate the fact that the OHA has been receptive to the comments and concerns raised by our CCO thus far, and are aware of the burdens the state employees are facing. Our primary concerns at this point in time is that the 2014 technical are finalized as soon as possible, and hope that this survey contributes to achieving that objective.

- Mental Health F/U visit should include Same Day f/u visits because HEDIS specs include them.

- The PCPCH measure is still not correlating with our internal data. The data submission and format should be clarified and included in the guidance around measures. There is language about submitting this information in the contracts, but there are no specs. For the actual submission for the Incentive payment, there needs to be clarification on a date range for the submission (my suggestion is the last week of December each year), or the clarification that this will be a "random date" in a certain format.
- Your slides for SBIRT are confusing since they contradict each other re SBIRT code for 'screening' and brief intervention. Clear in written document but several slides lead to many misinterpretations.
- Are we going to maintain HEDIS 2012 as the national specifications used with the CCO metric or will we be going with the updated version for CY 2014?

Metrics & Scoring Committee

Proposed 2014 Agendas

Committee Goals for 2014

- Review CCO performance and quality pool awards for CY 2013; consider adjustments to the incentive pool methodology for CY 2015.
- Adopt at least one dental metric as a CCO incentive measure for CY 2015.
- Finalize CCO incentive measures, specifications, benchmarks and improvement targets for CY 2015 by October 2014.
- Remain informed on work in Oregon to align measures across initiatives, agencies, and payers.
- Establish new committee members by August 2014

Proposed Meeting Schedule

Month	Topic(s)
December 2013	<ul style="list-style-type: none"> • Finalize CCO incentive measures, specifications, benchmarks and improvement targets for CY 2014. • Dental Quality Metrics workgroup recommendation. • Introduce measurement framework / metrics alignment work.
February 2014	<ul style="list-style-type: none"> • Continue discussing dental measures for CY 2015. • Adopt measurement framework. • Determine requested presentations for remainder of 2014.
April 2014	<ul style="list-style-type: none"> • Adopt dental measures for CY 2015. • Begin reviewing CCO performance for CY 2013. • Presentation on measure alignment work: HB 2118 and other (Lori Coyner, OHA Director of Quality and Accountability).
June 2014	<ul style="list-style-type: none"> • Review CCO performance and quality pool distribution for CY 2013. • Begin discussing CCO incentive measures, specifications, benchmarks and improvement targets for CY 2015. • CMS waiver “test” and overall state performance presentation • Committee terms are up in August / new members.
August 2014	<ul style="list-style-type: none"> • Presentation on early learning metrics / child health dashboard. (Dana Hargunani, OHA Child Health Director) • Review CY 2014 performance to date. • Continue discussing CCO incentive measures, specifications, benchmarks and improvement targets for CY 2015.
October 2014	<ul style="list-style-type: none"> • Final agreement on CCO incentive measures, specifications, benchmarks, and improvement targets for CY 2015.
December 2014	TBD

Potential Presentations

- Population Health / Public Health Metrics – Katrina Hedburg, Public Health Division
- Perinatal Collaborative – Mylia Christensen, Oregon Health Care Quality Corporation
- Long Term Care / Shared Services Metrics – Shared Accountability Sub-Committee
<http://www.oregon.gov/dhs/cms/Pages/SharedAccountability.aspx>
- CMS waiver and SIM evaluation projects