

## Oregon Metrics and Scoring Committee

### AGENDA

September 11, 2012  
8:30 a.m. to 11:30 a.m.

Sheraton Airport Hotel  
Cascade Rooms A & B  
8235 Northeast Airport Way  
Portland, OR 97220

Public Listen-Only Conference Line: Dial 877-771-7176; participant code 273420

#	Time	Item	Presenter	Action Item
1	8:30	Welcome and agenda review	Bob Dannenhoffer	
2	8:35	Consent agenda: August minutes	Bob Dannenhoffer	X
3	8:45	Review of CMS requirements for incentive measures	Tina Edlund and Michael Bailit	
4	8:55	Potential metric domains	Michael Bailit	
5	9:15	Potential metrics for selected incentive metric domains	Michael Bailit	
6	11:10	Next steps and wrap up	Bob Dannenhoffer	
7	11:15	Public testimony	Bob Dannenhoffer	

#### Next Meeting:

September 25<sup>th</sup>  
8:30 to 11:30 a.m.  
Clackamas Community College  
29353 SW Town Center Loop E  
Wilsonville, OR 97070



**Oregon Metrics and Scoring Committee**  
**DRAFT Minutes**  
**August 22, 2012**  
**Clackamas Community College**  
**29353 SW Town Center Loop E**  
**Wilsonville, OR 97070**  
**8:30 – 11:30 a.m.**

**Item**

**Welcome and Introductions**

Committee members present: Robert Dannenhoffer, interim Chairperson (by phone), Robert Gillespie, Maggie Bennington-Davis, Bob Joondeph, David Labby, Jeff Luck, Gloria Coronado (by phone), Jeanine Rodriguez, Phil Greenhill.

Consultants (by phone): Michael Bailit, Kate Bazinsky (Bailit Health Purchasing); Michelle Mills, Steve Cha, Andy Hackbarth (Centers for Medicare and Medicaid Services - CMS)

OHA Staff: Tina Edlund, Chief of Policy; Carole Romm, Accountability and Quality Advisor; Sarah Bartelmann, Project Manager. Tina Edlund welcomed the committee and gave a brief overview of health transformation in Oregon and the development of Coordinated Care Organizations (CCOs), as well as the formation of the Metrics and Scoring Committee. She also introduced the CMS waiver and described how the Committee will work together with CMS.

Michelle Mills introduced CMS staff and outlined the key principles of the transformation work. Steve Cha discussed achieving the Triple Aim through changing and improving care delivery, with a focus on quality improvement efforts and quality metrics. She outlined the goal of moving from a payment system based entirely on capitation to one based on both capitation and payment for outcomes, with an expected reduction in capitation payments as payment for outcomes grows. Andy Hackbarth emphasized how the measures can become a feedback mechanism and management system for CCOs, as well as the Oregon Health Authority and CMS.

**Committee Charter and Overview**

Tina Edlund provided an overview of the charter, as it resides in statute and how the Committee's work ties to other OHA obligations to the federal government around mental health care, requirements outlined in the CMS wavier, etc.

**Incentive Program Framework**

Michael Bailit provided a frame for what the Committee should take into consideration to establish an incentive pool. A CCO could potentially access the incentive (or quality) pool by meeting certain benchmarks – it is budget neutral and part of the global budget, not a payment made on top of, or in addition to the global budget. Michael gave an overview of the Committee meeting schedule and tasks. He then gave a presentation on the evidence supporting quality-based incentive programs, as they apply to health plans and to providers, and recommendations for program design, performance measures, financing, and implementation.

Michael asked that any additional feedback or questions be directed to Tina Edlund.

**Waiver Requirements**

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Tina Edlund provided a high-level overview of the waiver and timeline:

- The CMS waiver is a contract with the federal government through which the state has committed to reducing the growth trend in per capita Medicaid spending by 2 percentage points while not degrading quality.
- Oregon has committed to a focus on accountability and quality through several mechanisms: the creation of a 1% capitation withhold for timely and accurate reporting of encounter data; a bonus incentive pool that rewards both absolute and relative performance on quality and outcomes; and through establishing learning collaborative and Innovator Agents.

### **Core Measures**

Carole Romm introduced the principles the external stakeholder group used in evaluating potential measures and the list of all performance measures, examples of access measures, and suggested quality improvement focus areas. She also introduced the core measures matrix and asked the Committee to review this document before the next meeting.

The seven Quality Improvement Focus Areas (PIPs) include:

1. Reducing preventable re-hospitalizations.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily- costly utilization by super-utilizers.
4. Integrating primary care and behavioral health.
5. Ensuring appropriate care is delivered in appropriate settings
6. Improving perinatal and maternity care
7. Improving primary care for all populations through increased adoption of the Patient-Centered Primary Care Home model of care throughout the CCO network.

The list of performance and access measures is attached and the core measures matrix is included in the meeting materials, available online at:

<http://cms.oregon.gov/oha/Documents/MetricsScoringCommitteeMaterials120822.pdf>

### **Next Meeting Agenda**

- Looking at the potential domains from which metrics can be drawn.
- Discussing potential metrics for each domain, including selecting, timing, collection, benchmarks, and data analysis,
- Discussing potential metrics for access.

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**Other Discussion**

- Tina Edlund introduced the Oregon Action Plan for Health document and recommended it to the Committee as background. The Action Plan for Health can be accessed online at: <http://cms.oregon.gov/oha/pages/action-plan/index.aspx>
- Carole Romm introduced the ideal CCO behaviors document drafted in conjunction with the CMS team and asked Committee for feedback. The document is attached below.
- Tina Edlund will send out a list with Committee member contact information.
- All meeting information and documents are publically available and can be shared with stakeholders.

**Public Testimony**

The Committee heard testimony from Richard Katz, Executive Director of the Northwest Rehab Alliance / Care Connections, encouraging the Committee to look at existing national measures, consider focusing on administrative simplification and to consider alternate payment methodologies.

**Adjourn**

**Next Meeting:**

September 11, 2012  
8:30 am – 11:30 am  
Sheraton Airport Hotel

## Oregon Metrics and Scoring Committee PERFORMANCE MEASURES

### *Medicaid Adult Core Set*

1. Member/patient experience of care (CAHPS tool or similar);
2. Health and functional status among CCO enrollees;
3. Rate of tobacco use among CCO enrollees;
4. Obesity rate among CCO enrollees
5. Outpatient and emergency department utilization;
6. Potentially avoidable emergency department visits;
7. Ambulatory care sensitive hospital admissions;
8. Medication reconciliation post discharge;
9. All-cause readmissions;
10. Alcohol misuse-screening, brief intervention, and referral for treatment;
11. Initiation & engagement in alcohol and drug treatment;
12. Mental health assessment for children in DHS custody;
13. Follow-up after hospitalization for mental illness;
14. Effective contraceptive use among women who do not desire pregnancy;
15. Low birth weight;
16. Developmental screening by 36 months; and
17. Reduction of disparities: differences in these metrics among race and ethnicity categories

### *Additional Year 1 Measures*

18. Planning for end-of-life care
19. Screening for clinical depression and follow-up plan
20. Timely transmission of transition record
21. Care plan for members with long-term care benefits

## Access Measures

1. Based on CCO data (examples):
  - a. Percentage of children in particular age groups with a preventive visit in prior year (see CHIP quality measures).
  - b. Percentage of adults with any outpatient visit.
  - c. Percentage of adults with a chronic disease w/any outpatient visits in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).
  - d. Percentage of adults with a chronic disease in the prior year, w/any outpatient visits this year.
  - e. Percentage of children with at least one dental visit.
  - f. Fraction of physicians (by specialty) participating in the Medicaid program.
  - g. Change in the number of physicians (by specialty) participating in Medicaid
  - h. Proportion of primary care provider sites recognized as Patient-Centered Primary Care Homes (PCPCH) in CCO network and proportion certified as Tier 3 (the highest level).
  - i. Percentage of CCO enrollees with access to a PCPCH.
  
2. Based on state survey data (examples):
  - a. Percent of beneficiaries with a usual source of care.
  - b. Percent of beneficiaries with a preventive visit in past year.
  - c. Percent of beneficiaries with a dental visit in past year.
  - d. Percent of beneficiaries with any unmet needs.
  - e. Percent of beneficiaries delaying/deferring care due to cost.
  - f. Percent of beneficiaries delaying/deferring care due to lack of available provider.
  - g. Percent of beneficiaries delaying/deferring care due to provider office being closed at time of illness.
  - h. Percent of beneficiaries experiencing difficulty obtaining necessary referrals.

## Quality Improvement Focus Areas (PIPs)

1. Reducing preventable re-hospitalizations.
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
3. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by super-utilizers.
4. Integrating primary care and behavioral health.
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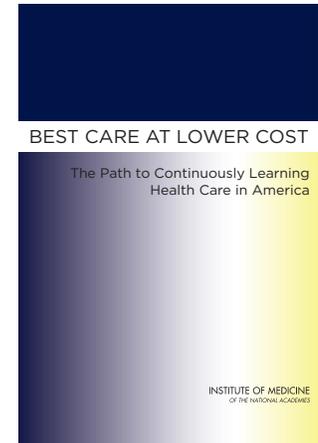
## Ideal CCO Behaviors

- Be innovative with aligning provider financial incentives to achieve the triple aim. E.g.,
  - Global payments for physical health, behavioral health, and dental health;
  - Encouraging the creation of patient-centered medical homes, and encouraging the transition of lower “tier” PCMHs to higher tiers;
  - Value-based purchasing (perhaps using surveys of member perception of care coordination as one dimension of value);
  - Bundled payment models
  - Shared savings models
- Encourage providers to do a better job with care coordination (e.g., including mental and physical health coordination)
- Care about and take actions to guarantee strong member outcomes and access
- Take meaningful action to reduce administrative waste
- Encourage providers to exceed benchmarks for meaningful use
- Encourage providers to participate in health information exchanges (HIE), particularly because HIEs would provide useful data to the CCO that can contribute to better, more coordinated care
- Be creative with deploying flexible services when appropriate
- Be creative with deploying caregivers directly when appropriate (e.g., care teams for super-utilizers)
- Have a CCO management system that is focused on learning, improvement, etc.
- Engage meaningfully with community to address its needs (e.g., have an active community advisory committee)
- Take action to engage members to become more active in their own care
- Focus on health equity
- Participate meaningfully in at least 3 quality improvement focus areas (PIPs)

# Best Care at Lower Cost

## The Path to Continuously Learning Health Care in America

The *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* report offers findings, conclusions, and recommendations for implementation by key stakeholders to achieve a health care system that is consistently reliable and that constantly, systematically, and seamlessly improves.



### Foundational Elements

#### Recommendation 1: The Digital Infrastructure

**Improve the capacity to capture clinical, care delivery process, and financial data for better care, system improvement, and the generation of new knowledge.** Data generated in the course of care delivery should be digitally collected, compiled, and protected as a reliable and accessible resource for care management, process improvement, public health, and the generation of new knowledge.

##### Strategies for progress toward this goal:

- Health care delivery organizations and clinicians should fully and effectively employ digital systems that capture patient care experiences reliably and consistently, and implement standards and practices that advance the interoperability of data systems.
- The National Coordinator for Health Information Technology, digital technology developers, and standards organizations should ensure that the digital infrastructure captures and delivers the core data elements and interoperability needed to support better care, system improvement, and the generation of new knowledge.
- Payers, health care delivery organizations, and medical product companies should contribute data to research and analytic consortia to support expanded use of care data to generate new insights.
- Patients should participate in the development

of a robust data utility; use new clinical communication tools, such as personal portals, for self-management and care activities; and be involved in building new knowledge, such as through patient-reported outcomes and other knowledge processes.

- The Secretary of Health and Human Services (HHS) should encourage the development of distributed data research networks and expand the availability of departmental health data resources for translation into accessible knowledge that can be used for improving care, lowering costs, and enhancing public health.
- Research funding agencies and organizations, such as the National Institutes of Health, the Agency for Healthcare Research and Quality (AHRQ), the Veterans Health Administration (VHA), the Department of Defense (DoD), and the Patient-Centered Outcomes Research Institute (PCORI), should promote research designs and methods that draw naturally on existing care processes and that also support ongoing quality improvement efforts.

#### Recommendation 2: The Data Utility

**Streamline and revise research regulations to improve care, promote the capture of clinical data, and generate knowledge.** Regulatory agencies should clarify and improve regulations governing the collection and use of clinical data to ensure patient privacy but also the seamless use of clinical data for better care coordination and

management, improved care, and knowledge enhancement.

**Strategies for progress toward this goal:**

- The Secretary of HHS should accelerate and expand the review of the Health Insurance Portability and Accountability Act and institutional review board policies with respect to actual or perceived regulatory impediments to the protected use of clinical data, and clarify regulations and their interpretation to support the use of clinical data as a resource for advancing science and care improvement.
- Patient and consumer groups, clinicians, professional specialty societies, health care delivery organizations, voluntary organizations, researchers, and grantmakers should develop strategies and outreach to improve understanding of the benefits and importance of accelerating the use of clinical data to improve care and health outcomes.

## Care Improvement Targets

### Recommendation 3: Clinical Decision Support

**Accelerate integration of the best clinical knowledge into care decisions.** Decision support tools and knowledge management systems should be routine features of health care delivery to ensure that decisions made by clinicians and patients are informed by current best evidence.

**Strategies for progress toward this goal:**

- Clinicians and health care organizations should adopt tools that deliver reliable, current clinical knowledge to the point of care, and organizations should adopt incentives that encourage the use of these tools.
- Research organizations, advocacy organizations, professional specialty societies, and care delivery organizations should facilitate the development, accessibility, and use of evidence-based and harmonized clinical practice guidelines.
- Public and private payers should promote the adoption of decision support tools, knowledge management systems, and evidence-based clinical practice guidelines by structuring payment and contracting policies to reward effective, evidence-based care that improves patient health.
- Health professional education programs should teach new methods for accessing, managing, and applying evidence; engaging in lifelong learning; understanding human behavior and social science; and delivering safe care in an interdisciplinary environment.
- Research funding agencies and organizations should promote research into the barriers and

systematic challenges to the dissemination and use of evidence at the point of care, and support research to develop strategies and methods that can improve the usefulness and accessibility of patient outcome data and scientific evidence for clinicians and patients.

### Recommendation 4: Patient-Centered Care

**Involve patients and families in decisions regarding health and health care, tailored to fit their preferences.**

Patients and families should be given the opportunity to be fully engaged participants at all levels, including individual care decisions, health system learning and improvement activities, and community-based interventions to promote health.

**Strategies for progress toward this goal:**

- Patients and families should expect to be offered full participation in their own care and health and encouraged to partner, according to their preference, with clinicians in fulfilling those expectations.
- Clinicians should employ high-quality, reliable tools and skills for informed shared decision making with patients and families, tailored to clinical needs, patient goals, social circumstances, and the degree of control patients prefer.
- Health care delivery organizations, including programs operated by the DoD, VHA, and Health Resources and Services Administration, should monitor and assess patient perspectives and use the insights thus gained to improve care processes; establish patient portals to facilitate data sharing and communication among clinicians, patients, and families; and make high-quality, reliable tools available for shared decision making with patients at different levels of health literacy.
- AHRQ, partnering with the Centers for Medicare & Medicaid Services (CMS), other payers, and stakeholder organizations, should support the development and testing of an accurate and reliable core set of measures of patient-centeredness for consistent use across the health care system.
- CMS and other public and private payers should promote and measure patient-centered care through payment models, contracting policies, and public reporting programs.
- Digital technology developers and health product innovators should develop tools to assist individuals in managing their health and health care, in addition to providing patient supports in new forms of communities.

## Recommendation 5: Community Links

**Promote community-clinical partnerships and services aimed at managing and improving health at the community level.** Care delivery and community-based organizations and agencies should partner with each other to develop cooperative strategies for the design, implementation, and accountability of services aimed at improving individual and population health.

### Strategies for progress toward this goal:

- Health care delivery organizations and clinicians should partner with community-based organizations and public health agencies to leverage and coordinate prevention, health promotion, and community-based interventions to improve health outcomes, including strategies related to the assessment and use of web-based tools.
- Public and private payers should incorporate population health improvement into their health care payment and contracting policies and accountability measures.
- Health economists, health service researchers, professional specialty societies, and measure development organizations should continue to improve measures that can readily be applied to assess performance on both individual and population health.

## Recommendation 6: Care Continuity

**Improve coordination and communication within and across organizations.** Payers should structure payment and contracting to reward effective communication and coordination between and among members of a patient's care team.

### Strategies for progress toward this goal:

- Health care delivery organizations and clinicians, partnering with patients, families, and community organizations, should develop coordination and transition processes, data sharing capabilities, and communication tools to ensure safe, seamless patient care.
- Health economists, health service researchers, professional specialty societies, and measure development organizations should develop and test metrics with which to monitor and evaluate the effectiveness of care transitions in improving patient health outcomes.
- Public and private payers should promote effective care transitions that improve patient health through their payment and contracting policies.

## Recommendation 7: Optimized Operations

**Continuously improve health care operations to reduce waste, streamline care delivery, and focus on activities that improve patient health.** Care delivery organizations should apply systems engineering tools and process improvement methods to improve operations and care delivery processes.

### Strategies for progress toward this goal:

- Health care delivery organizations should utilize systems engineering tools and process improvement methods to eliminate inefficiencies, remove unnecessary burdens on clinicians and staff, enhance patient experience, and improve patient health outcomes.
- CMS, AHRQ, PCORI, quality improvement organizations, and process improvement leaders should develop a learning consortium aimed at accelerating training, technical assistance, and the collection and validation of lessons learned about ways to transform the effectiveness and efficiency of care through continuous improvement programs and initiatives.

## Supportive Policy Environment

### Recommendation 8: Financial Incentives

**Structure payment to reward continuous learning and improvement in the provision of best care at lower cost.** Payers should structure payment models, contracting policies, and benefit designs to reward care that is effective and efficient and continuously learns and improves.

### Strategies for progress toward this goal:

- Public and private payers should reward continuous learning and improvement through outcome- and value-oriented payment models, contracting policies, and benefit designs. Payment models should adequately incentivize and support high-quality team-based care focused on the needs and goals of patients and families.
- Health care delivery organizations should reward continuous learning and improvement through the use of internal practice incentives.
- Health economists, health service researchers, professional specialty societies, and measure development organizations should partner with public and private payers to develop and evaluate metrics, payment models, contracting policies, and benefit designs that reward high-value care that improves health outcomes.

## Recommendation 9: Performance Transparency

**Increase transparency on health care system performance.** Health care delivery organizations, clinicians, and payers should increase the availability of information on the quality, prices and cost, and outcomes of care to help inform care decisions and guide improvement efforts.

### Strategies for progress toward this goal:

- Health care delivery organizations should collect and expand the availability of information on the safety, quality, prices and cost, and health outcomes of care.
- Professional specialty societies should encourage transparency on the quality, value, and outcomes of the care provided by their members.
- Public and private payers should promote transparency in quality, value, and outcomes to aid plan members in their care decision making.
- Consumer and patient organizations should disseminate this information to facilitate discussion, informed decision making, and care improvement.

## Recommendation 10: Broad Leadership

**Expand commitment to the goals of a continuously learning health care system.** Continuous learning and improvement should be a core and constant priority for all participants in health care—patients, families, clinicians, care leaders, and those involved in supporting their work.

### Strategies for progress toward this goal:

- Health care delivery organizations should develop organizational cultures that support and encourage continuous improvement, the use of best practices, transparency, open communication, staff empowerment, coordination, teamwork, and mutual respect and align rewards accordingly.
- Leaders of these organizations should define, disseminate, support, and commit to a vision of continuous improvement; focus attention, training, and resources on continuous learning; and build an operational model that incentivizes continuous improvement and ensures its sustainability.
- Governing boards of health care delivery organizations should support and actively participate in fostering a culture of continuous improvement, request continuous feedback on the progress being made toward the adoption of such a culture, and align leadership incentive structures accordingly.
- Clinical professional specialty societies, health professional education programs, health professions specialty boards, licensing boards, and accreditation organizations should incorporate basic concepts and specialized applications of

continuous learning and improvement into health professions education; continuing education; and licensing, certification, and accreditation requirements. 

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# Metrics for Incentivizing Performance: CMS Requirements, Domains and Measures

Oregon Metrics and Scoring Committee  
Michael Bailit  
September 11, 2012



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## Agenda

- Review of Committee's Charge/  
Parameters for Incentive Measures
- Incentive Measures Domain Framework
- Quality Improvement Focus Areas
- Criteria for Selecting Incentive Measures
- Incentive Measures Discussion and  
Selection
- Wrap Up/ Next Steps



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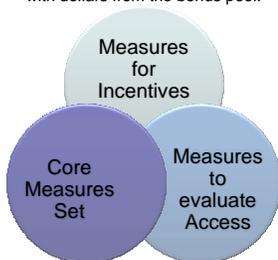
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## CCOs Must Report on Three Potentially Overlapping Measures Sets

This Committee will determine the  
measures used to incentivize the CCOs  
with dollars from the bonus pool.

The Core  
Measures set  
has already been  
defined.



This Committee  
will determine the  
Measures to  
evaluate Access  
using a list  
developed by  
CMS as guidance.



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## Committee Charge per Waiver Terms

- "The Committee will:
  - review data and the relevant literature,
  - determine which measures will be included in the CCO incentive program,
  - establish the performance benchmarks and targets to be used in this incentive program,
  - endorse/develop specifications for each measure." (p61)

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## CMS Parameters for Incentive Measures (1)

- CCO "Success will be measured by and incentives paid based upon:
  1. decreased rate of per capita Medicaid expenditure growth;
  2. increased patient satisfaction with, and involvement in, care planning and quality of care; and
  3. overall population health improvement." (p59)
- "Incentives must be designed to:
  - reduce costs and
  - improve health care outcomes." (p60)
- "When developing the bonus pool, the State will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases in order to reduce the incentive for volume-based billing." (p60)

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## CMS Parameters for Incentive Measures (2)

- "In order for CCOs to fully realize years 2-3 performance incentives, the State **must require that CCOs successfully surpass benchmarks for widespread adoption and meaningful use of EHRs for eligible providers.**
- The related incentives must take into account the costs incurred in order to facilitate adoption and meaningful use of EHRs, as well as the existing incentives available to eligible providers." (p52)

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### CMS Parameters for Incentive Measures (3)

#### 40. Additional Quality Measures and Reporting at the CCO Level.

“CMS developed an **additional list of requirements** [i.e., access measures and PIPS] for the Metrics and Scoring Committee that should be incorporated into the measurement planning and financial incentive determinations.”

“This should not supplant the work of this committee, but rather provide some strategic direction to reach the two goals of this Demonstration.” (p62)

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### CMS Requirements Regarding Methodology

- “The whole bonus incentive pool amount will be at risk.
- The State will provide larger incentive awards for CCOs with **higher absolute performance on the quality and access metrics** compared to an appropriate benchmark,
- and provide larger incentive awards to CCOs that **improve performance over time** compared to their own past performance.” (p61)
- “Incentives must be correlatively reflected in the CCO/provider agreements to ensure that the incentives are passed through to providers to reflect the arrangement with the State-CCO contract.” (p61)

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### Future Work of the Committee

- “In future years, the Committee will review earlier decisions and make adjustments as needed.
- A transitional Metrics and Scoring Committee recommended a set of metrics for the first program year, which were described in CCO RFA contracts.
- Going forward, the permanent Metrics and Scoring Committee will recommend metrics that will be used to determine financial incentives for CCOs.” (p61)
- “Each subsequent DY rates and incentives will be set in the DY preceding the implementation in order to apply program experience as the program matures (e.g., DY 13 rates and incentives will be set in DY 12). The State will incorporate the changes into the CCO contracts and submit the changes to CMS for review and approval prior to implementation.” (p61)

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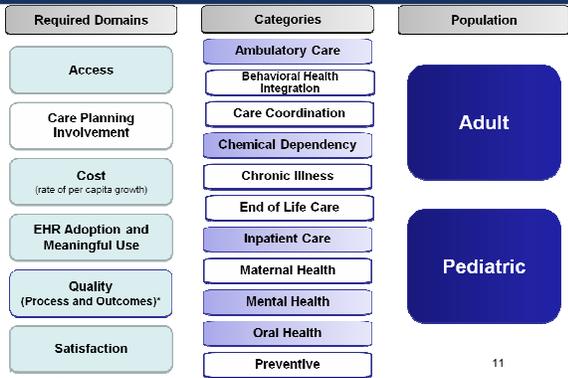
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## Incentive Measures Domain Framework



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## What Domains are Missing?

- Health Disparities
  - Efficiency
  - Administrative Services
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- Would you like to add any of these domains?
  - Are there any other measure domains that are missing from this list that you think would be important to add?

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## The Quality Improvement Focus Areas (aka Performance Improvement Projects or "PIPs")

- CMS outlined seven quality improvement areas within the terms and conditions document.
  1. Reducing preventable re-hospitalizations.
  2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs, etc.
  3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers.
  4. Integrating primary care and behavioral health.
  5. Ensuring appropriate care is delivered in appropriate settings
  6. Improving perinatal and maternity care
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## The Quality Improvement Focus Areas (PIPs)

- The state has selected "integrating primary care and behavioral health" as a statewide measurement topic required of all CCOs.
- CCOs are required to pick three other areas of the seven upon which to focus, two of which can serve as PIPs.
- While not required, the Committee may wish to consider measures in these various focus areas when selecting incentives measures.

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## Transitional M&S Committee Criteria for Selecting Incentive Measures

- At a minimum, any selected performance measure selected should meet standard scientific criteria for reliability and face validity.
- Other criteria to consider:
  - Transformative potential
  - Consumer engagement
  - Relevance
  - Consistency with existing state and national quality measures with room for innovation when needed
  - Attainability
  - Accuracy
  - Feasibility of measurement
  - Reasonable accountability
  - Range/diversity of measures

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## Proposed Incentive Measure Selection Criteria

1. Representative of the array of services provided and beneficiaries served by the CCOs
2. Use valid and reliable performance measures,
3. Rely on measures from national measure sets whenever possible
4. Focus on outcomes to the extent possible
5. Exclude measures that would be expected to be heavily influenced by patient case mix
6. Control for the effects of random variation
  - Measure type
  - Denominator size

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## What is the Right Number of Incentive Measures?

- How many measures would you like to include in the incentive measures set?
- Factors to consider:
  - With 5 required domains, the minimum number of measures within the set is 5.
  - Whether the set reflects the diversity of services provided and beneficiaries served by the CCOs.
  - The amount of influence given to each individual measure if the measurement set is small.
  - The number of measures that a CCO can focus upon at one time in order to make improvements.

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## Incentive Measures Selection Methodology

- We have compiled a list of potential measures within each domain and category previously identified.
  - Committee members will be given the opportunity to add measures for consideration if they would like the Committee to consider something not on the original list.
- Members will review each measure and discuss its value as an incentive measure.
- With each measure members will decide whether to recommend inclusion in the incentive measure set, exclusion, or decision postponement until the next meeting.
- At the next meeting we will conduct a “second pass” through the included and “maybe” measures to finalize the list.

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## Agenda



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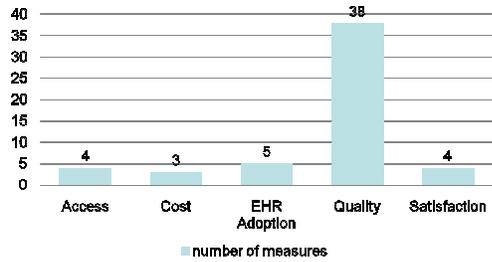
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## Number of Potential Measures by Domain




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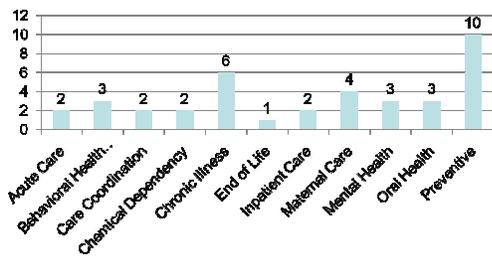
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## Number of Measures within Each Category in the Quality Domain




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## Color Key

Color	Meaning
Green	Core Measure Set for Year 1 and 2
Orange	Oregon Performance Measures for Medicaid Managed Care Plans
Yellow	National Measures Set
Purple	OR Health Insurance Exchange Measure
Blue	CMS-recommended Access Measure

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### Potential Incentive Measures: Access (1)

The Committee must choose at least one Access measure for inclusion in the incentive measures set

#	Pop.	Measure Name	Data Source	Source
151	Adult	In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	Survey	CAHPS 4.0H Adult Questionnaire (Q 6)
152	All	In the last 12 months, how often was it easy to get appointments with specialists?	Survey	CAHPS 4.0H Adult Questionnaire (Q 23)
93	Adults	% of adults with a chronic disease w/any outpatient visit in past year (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia)	Claims	CMS recommended access reporting measure

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### Potential Incentive Measures: Access (2)

#	Pop.	Measure Name	Data Source	Source:
272	pediatric	In the last 12 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?	Survey	CAHPS 4.0H Child Questionnaire

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### Potential Incentive Measures: Cost (1)

#	Pop.	Measure Name	Data Source	Source:
96	All	All-cause readmissions (% stays followed by a readmission for any reason within 30 days; (also report separately for psychiatric))	Oregon All-Payer All-Claims data system; MMIS	Core Measure Set for Year 1 and 2
103	All	Potentially avoidable ED visits (Specific metric to be determined (NYU algorithm or CMS PQI applied to ED visits))	Oregon All-Payer All-Claims data system; MMIS	Core Measure Set for Year 1 and 2

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Potential Incentive Measures:  
Quality: Acute Care

#	Pop.	Measure Name	Data Source	Source:
97		Appropriate Imaging for Low Back Pain (The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis)	Administrative claims, Electronic Clinical Data, Paper Medical Records	HEDIS, NQF# 0052
99		Appropriate Treatment for Children with Pharyngitis (The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate	Administrative claims, Electronic Clinical Data, Paper Medical Records	HEDIS, NQF# 0002

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Potential Incentive Measures:  
Quality: Behavioral Health Integration

#	Pop.	Measure Name	Data Source	Source:
180	Adult	Whether a patient with a behavioral health diagnosis has a release in the chart allowing conversations with (other) MH/SA providers	Medical Record	MA PCMH Behavioral Health Integration Work Group
218	Adult	% of patients screened annually for depression in primary care	Administrative Data; Medical Record	Veterans Health Administration/Department of Defense
72	Adult	Screening for Clinical Depression and Follow-up Plan (% of members patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented)	Medical Record	ACO 18 (ACO-Prev-12), CMS Focus Area (PIP)

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Potential Incentive Measures:  
Quality: Care Coordination

#	Pop.	Measure Name	Data Source	Source:
43	Adult	Medication reconciliation post-discharge (% patients 65+ discharged from acute or non-acute inpatient facility who had discharge meds reconciled with current med list in the medical record within 30 days).	Oregon All-Payer All-Claims data system	Core Measure Set for Year 1 and 2, NQF: 0054
44	Adult	Timely transmission of transition record (% of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours)	Admin data or medical record or hybrid	HEDIS, NQF: 0648, CMS Focus Area (PIP)

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Potential Incentive Measures:  
Quality: Chemical Dependency

#	Pop.	Measure Name	Data Source	Source:
28	Adult	Alcohol misuse - screening, brief intervention, referral for treatment (SBIRT) (% members 18+ with routine visit in the measurement year screened for alcohol misuse, and referred as necessary)	Oregon All-Payer All-Claims data system; MMIS	Core Measure Set for Year 1 and 2
69	Adult and adolescent	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. b. Engagement of AOD Treatment.	Administrative claims, Electronic Health Record, Paper Records	HEDIS, NQF: 0004

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Potential Incentive Measures:  
Quality: Chronic Illness: Asthma

#	Pop.	Measure Name	Data Source	Source:
47	members 5-64 years of age	Asthma Medication Management (The percentage of during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.	Administrative claims, Electronic Health Record, Paper Records	HEDIS, NQF: 1799, Partner for Quality Care Round 3* Measures
276	(four age groups)	Asthma Care Measures	Administrative claims, Electronic Health Record, Paper Records	Oregon Performance Measures for Medicaid Managed Care Plans

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Potential Incentive Measures:  
Quality: Chronic Illness: Diabetes

#	Pop.	Measure Name	Data Source	Source:
261	Adult	Optimal Diabetes Use (D5) (You achieve the D5 when you meet all five goals: 1. Your blood pressure is less than 140/90 mmHG 2. Your bad cholesterol, LDL, is less than 100 mg/dl 3. Your blood sugar, A1c, is less than 8% 4. You are tobacco-free 5. You take an aspirin as appropriate)	Electronic Clinical Data, Electronic Health Record, Paper Records Registry	MN Health Scores, NQF: 0729
262	Adult	Diabetes Hemaglobin A1c Poor Control (>9.0%) (Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control))	Administrative claims, Electronic Health Record, Laboratory, Paper Records	HEDIS, NQF: 0059

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Potential Incentive Measures:  
Quality: Chronic Illness: Other

#	Pop.	Measure Name	Data Source	Source:
55	Adult	Controlling High BP (The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.)	Administrative claims, Electronic Clinical Data, Medical Records	HEDIS, NQF: 0018
263	Adult	IVD: Complete Lipid Profile and LDL Control <100	Administrative claims, Electronic Clinical Data, Medical Records, Lab Data	HEDIS, NQF: 0075

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Potential Incentive Measures:  
Quality: End of Life Care

#	Pop.	Measure Name	Data Source	Source:
265	Adult	Advance Care Plan (Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker)	Administrative claims, Electronic Health Record, Registry	HEDIS, NQF: 0326

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Potential Incentive Measures:  
Quality: Inpatient Care

#	Pop.	Measure Name	Data Source	Source:
115	Adult	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	Administrative claims, Electronic Clinical Data, Electronic Health Record, Paper Medical Records	NCQA, NQF: 0068
267	Adult	Leapfrog Composite Measure (the percentage of hospitals participating in the CCO that have achieved substantial progress on the following Leaps: 1) Heart Attack 2) Pneumonia 3) Normal Deliveries 4) Steps to Avoid Harm)		The Leapfrog Group

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Potential Incentive Measures:  
Quality: Maternal Health

#	Pop.	Measure Name	Data Source	Source:
127	Adult	Elective Delivery Before 39 Weeks	Administrative claims, Electronic Clinical Data, Paper Medical Records	Joint Commission, NQF: 0469
184	Adult	PC-02 C-Section Rate	Vital Statistics	NQF: 0471/Obstetrics Dept. at OHSU
251	Adult	Post-Partum Care: % of deliveries that had a postpartum visit on or between 3-8 weeks after delivery.	Administrative claims, Paper Medical Records	NQF: 1517, Qcorp/ OR Health Insurance Exchange
250 a	Adult	Prenatal Care % of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment.	Administrative claims, Paper Medical Records	HEDIS- NQF: 1517, Qcorp/ OR Health Insurance Exchange

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Potential Incentive Measures:  
Quality: Mental Health (1)

#	Pop.	Measure Name	Data Source	Source:
42	Adult	Follow-up After Hospitalization for Mental Illness (% of members with follow-up visit within 7 days after hospitalization for mental illness)	Oregon All-Payer All-Claims data system; MMIS	NCQA, NQF: 0576, Core Measure Set for Year 1 and 2
68	Adult	Antidepressant Medication Management (The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. b) Effective Continuation Phase Treatment.	Administrative claims	HEDIS, NQF: 0105

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Potential Incentive Measures:  
Quality: Mental Health (2)

#	Pop.	Measure Name	Data Source	Source:
71	Pediatric	Mental Health Assessment for Children in DHS Custody (% children who receive a mental health assessment within 30 days of DHS custody)	Child welfare case system data + claims/encoder data from MMIS or All-Payer All-Claims data system	Core Measure Set for Year 1 and 2

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Potential Incentive Measures:  
Quality: Oral Health

#	Pop.	Measure Name	Data Source	Source:
162	Pediatric	Percentage of continuously enrolled children, 2-18 years of age with one or more restorations who received a topical fluoride or sealant.	Administrative claims, medical record	
163	Pediatric	Percentage of continuously enrolled children, 2-18 years of age enrolled for two years who received an annual oral evaluation/prophylaxis.	Administrative claims, medical record	
268	Pediatric	Annual Dental Visit (The percentage of members 2-21 years of age who had at least one dental visit during the measurement year.)	Administrative claims	HEDIS, NQF: 1388, Oregon Performance Measures for Medicaid Managed Care Plans

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Potential Incentive Measures:  
Quality: Preventive Care: Screening

#	Pop.	Measure Name	Data Source	Source:
76	Pediatric	Developmental screening by 36 months	Oregon All-Payer All-Claims data system MMIS	NQF: 1448, Core Measure Set for Year 1 and 2, NCCA and CAHMI
86	Adult	Chlamydia screening	Administrative claims, Electronic Health Record, Pharmacy	NQF: 0033, Oregon Performance Measures for Medicaid Managed Care Plans, Partner for Quality Care Round 3* Measures
91	Adult	Cervical Cancer Screening	Administrative claims, Electronic Clinical Data, Electronic Health Record, Paper Records	HEDIS, NQF: 0032 Transparency Measures, Partner for Quality Care Round 3* Measures
278	Adult	Colorectal Cancer Screening	Administrative claims, Imaging/Diagnostic Study, Laboratory, Paper Records	HEDIS/ Oregon Performance Measures for Medicaid Managed Care Plans

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Potential Incentive Measures: Quality:  
Preventive: Well Care: Immunizations

#	Pop.	Measure Name	Data Source	Source:
85	Pediatric	Childhood Immunization Status Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Administrative claims, Paper Records Registry	HEDIS, NQF: 0038 Oregon Performance Measures for Medicaid Managed Care Plans
269	Pediatric	Immunizations for Adolescents (The percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday)	Administrative claims, Paper Records Registry	HEDIS, NQF: 1407

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Potential Incentive Measures: Quality:  
Preventive: Well Care Visits

#	Pop.	Measure Name	Data Source	Source:
83	Pediatric	Well-child Visits: the first 15 months of life, 6 or more	Administrative claims, Paper Medical Record	HEDIS, NQF: 1392, Partner for Quality Care Round 3* Measures
84	Pediatric	Well-Child Visits: the Third, Fourth, Fifth and Sixth Years of Life	Administrative claims, Paper Medical Record	HEDIS, NQF: 1516, Partner for Quality Care Round 3* Measures
277	Adolescent	Adolescent Well-Care Visits	Administrative claims, Paper Medical Record	Oregon Performance Measures for Medicaid Managed Care Plans

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Potential Incentive Measures: Quality:  
Preventive: Resource Distribution

#	Pop.	Measure Name	Data Source	Source:
135	All	Ratio of primary care spending to specialty & hospital spending over time	Administrative claims	CMS Focus Area (PIP)

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Potential Incentive Measures: Satisfaction  
(1)

#	Pop.	Measure Name	Data Source	Source:
177	Adult	In the last 12 months, how often did your health plan's customer service give you the information or help you needed?	CAHPS 4.0H Adult Questionnaire (Q 35)	OR Health Insurance Exchange, Oregon Performance Measures for Medicaid Managed Care Plans
178	Adult	In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?	CAHPS 4.0H Adult Questionnaire (Q 36)	OR Health Insurance Exchange, Oregon Performance Measures for Medicaid Managed Care Plans

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## Potential Incentive Measures: Satisfaction (2)

#	Pop.	Measure Name	Data Source	Source:
279	Adult	Satisfaction with Behavioral Health Services: question(s) to be selected from the OR-modified MHSIP survey for adults	Survey	OHA Addictions and Mental Health Division, Oregon Performance Measures for Medicaid Managed Care Plans
167	Adult	In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	CAHPS 4.0H Adult Questionnaire (Q 20)	CAHPS, Oregon Performance Measures for Medicaid Managed Care Plans

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## Agenda

- Review of Committee's Charge/ Parameters for Incentive Measures
- Incentive Measures Domain Framework
- Quality Improvement Focus Areas
- Criteria for Selecting Incentive Measures
- Incentive Measures Discussion and Selection
- Wrap Up/ Next Steps

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## Wrap Up/ Next Steps

- Next Meeting (#3): Tuesday, September 25<sup>th</sup> 8:30am
  - Continue incentive measures discussion and selection
  - Discuss metric data sources, collection timing, benchmarks options and data analysis process

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Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/outcome)	Data type, source	Specifications
include	151	Access	Access	In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a	adult	Oregon Performance Measures for		survey	CAHPS 4.0H Adult Questionnaire (Q 6)	In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for
include	152	Access	Access	In the last 12 months, how often was it easy to get appointments with specialists? 1☐ Never	adult	Oregon Performance Measures for		survey	CAHPS 4.0H Adult Questionnaire (Q 23)	In the last 12 months, how often was it easy to get appointments with specialists? 1☐ Never
include	272	Access	Access	In the last 12 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed? 10 Never 20 Sometimes	pediatric	Oregon Performance Measures for Medicaid Managed Care Plans		survey	CAHPS 4.0H Child Questionnaire	In the last 12 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?
include	93	Access	Chronic Illness	<b>% of adults with a chronic disease w/any outpatient visit in past year</b> (specific chronic diseases could include diabetes, COPD/asthma, coronary artery disease, HTN, schizophrenia).	adult	CMS: Access improvement measures based on CCO data.	Unknown	Process	Access improvement measures based on CCO data.	
include	96	Cost	Efficiency	<b>All-cause readmissions</b> (% stays followed by a readmission for any reason within 30 days; (also report separately for psychiatric))	all	Core Measure Set for Year 1 and 2	n/a	Outcome	Oregon All-Payer All-Claims data system; MMIS	
include	103	Cost	Efficiency	<b>Potentially avoidable ED visits</b> (Specific metric to be determined (NYU algorithm or CMS PQI applied to ED visits))	all	Core Measure Set for Year 1 and 2	Unknown	Outcome	Oregon All-Payer All-Claims data system;	
include	104	Cost	Efficiency	<b>Primary-Care Sensitive Hospital Admissions</b> (Prevention Quality Indicators, PQIs)	all	CMS: Core set of quality		Outcome	Oregon All-Payer All-Claims	PQI 01 Diabetes Short-Term Complications Admission Rate PQI 02 Perforated Appendix

<u>Status</u>	<u>Library #</u>	<u>Domain</u>	<u>Category</u>	<u>Measure and description</u>	<u>Population</u>	<u>Currently used by:</u>	<u>NQF #</u>	<u>Type (process/out come)</u>	<u>Data type source</u>	<u>Specifications</u>
include	140	EHR Adoption	EHR Adoption	<b>Implement drug-drug and drug-allergy interaction checks</b> (The EP has enabled this functionality for the entire EHR reporting period.)	all	CMS EHR incentive program		Process		Attestation Requirements YES / NO Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.
include	142	EHR Adoption	EHR Adoption	<b>Generate and transmit permissible prescriptions electronically (eRx)</b> (More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.)	all	CMS EHR incentive program		Process		Definition of Terms Permissible Prescriptions – The concept of only permissible prescriptions refers to the current restrictions established by the Department
include	146	EHR Adoption	EHR Adoption	<b>Implement one clinical decision support rule</b> relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	all	CMS EHR incentive program		Process		Definition of Terms Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general
include	259	EHR Adoption	Meaningful Use	<b>Professional Meaningful Use Composite</b> (The percent of practices in the CCOs network that meet the performance requirements of the Eligible Professional Meaningful Use Core set (some or all measures.))				Process		
include	260	EHR Adoption	Meaningful Use	<b>Hospital Meaningful Use Composite</b> (The percent of hospitals in the CCOs network that meet the performance requirements of the Hospital Meaningful Use Core set (some or all measures.))				Process		

Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/outcome)	Data type, source	Specifications
include	97	Quality	Acute Care	<b>Appropriate Imaging for Low Back Pain</b> (The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis)	adult	HEDIS, Transparency Measures	Yes: 0052	Process	Administrative claims, Electronic Clinical Data, Paper Medical	Numerator Statement:  Patients who received an imaging study (plain x-ray, MRI, CT scan) conducted on the Episode Start Date or in the 28 days following the Episode Start Date.
include	99	Quality	Acute Care	<b>Appropriate Treatment for Children with Pharyngitis</b> (The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better) performance (i.e., appropriate	Pediatric	HEDIS, Transparency Measures	Yes: 0002	Process	Administrative claims, Electronic Health Record, Paper Medical	Measure Description: The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate
include	180	Quality	Behavioral Health Integration	Whether a patient with a behavioral health diagnosis has a release in the chart allowing conversations with (other) MH/SA providers	Adult	MA PCMH Behavioral Health Integration Work Group		Process		
include	218	Quality	Behavioral Health Integration	% of patients screened annually for depression in primary care	Adult	<a href="#">Veterans Health Administration</a>		Process	Administrative Data; Medical	Denominator:  All patients seen at least 3
include	72	Quality	Behavioral Health Integration	<b>Screening for Clinical Depression and Follow-up Plan</b> (% of members patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented)	Adult (CMS ACO version is for ages 12 and up)	CMS Attachment E: Menu Set of Quality Improvement in Focus Areas	NQF #/Steward: 0418 (Could not locate on NQF web site) but is	Process	Medical record or hybrid; potentially sample-based (following	DESCRIPTION: Percentage of patients ages 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/out come)	Data type, source	Specifications
include	43	Quality	Care Coordination	<b>Medication reconciliation post-discharge</b> (% patients 65+ discharged from acute or non-acute inpatient facility who had discharge meds reconciled with current med list in the medical record within 30 days).	Adult	Core Measure Set for Year 1 and 2	NQF #/Steward: 0554	Process	Oregon All-Payer All-Claims data system (using administrative	Measure Description: The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.
include	44	Quality	Care Coordination	<b>Timely transmission of transition record</b> (% of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours)	Adult	CMS Attachment E: Menu Set of Quality Improvement in Focus Areas, American Medical	NQF#: 0648	Process	Admin data or medical record or hybrid	Measure Description: Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a
include	28	Quality	Chemical Dependency	<b>Alcohol misuse - screening, brief intervention, referral for treatment (SBIRT)</b> (% members 18+ with routine visit in the measurement year screened for alcohol misuse, and referred as necessary)	Adult	Core Measure Set for Year 1 and 2	n/a	Process	Oregon All-Payer All-Claims data system; MMIS	Metrics that CMS has asked Oregon to use: <b>**NOT YET FINALIZED**</b> b. x.
include	69	Quality	Chemical Dependency	<b>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</b> (The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate	Adult and adolescent	HEDIS	Yes: 0004	Process	Administrative claims, Electronic Health Record, Paper Records (renamed	Numerator Statement: a) Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization
include	47	Quality	Chronic Illness: Asthma	<b>Asthma Medication Management</b> (The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications	Adult and Pediatric	NCQA/ Partner for Quality Care Round 3* Measures	Yes: 1799	process	Administrative claims, Electronic Clinical Data	Numerator Statement: Numerator 1: The number of members who achieved a PDC* of at least 50% for their asthma controller medications

<u>Status</u>	<u>Library #</u>	<u>Domain</u>	<u>Category</u>	<u>Measure and description</u>	<u>Population</u>	<u>Currently used by:</u>	<u>NQF #</u>	<u>Type (process/outcome)</u>	<u>Data type, source</u>	<u>Specifications</u>
include	276	Quality	Chronic Illness: Asthma	<b>Asthma Care Measures</b> (four age groups) percentage of: <ul style="list-style-type: none"> <li>• Members with persistent asthma</li> <li>• Members with persistent asthma who had an outpatient visit for asthma</li> <li>• Members with persistent asthma who had a hospital visit for asthma</li> <li>• Hospital visits for asthma with an outpatient visit within 30 days</li> <li>• Members with persistent asthma</li> </ul>	Adult and Pediatric	Oregon Performance Measures for Medicaid Managed Care Plans				<ul style="list-style-type: none"> <li>• Members with persistent asthma</li> <li>• Members with persistent asthma who had an outpatient visit for asthma</li> <li>• Members with persistent asthma who had a hospital visit for asthma</li> <li>• Hospital visits for asthma with an outpatient visit within</li> </ul>
include	261	Quality	Chronic Illness: Diabetes	<b>Optimal Diabetes Use (D5)</b> (You achieve the D5 when you meet all five goals: 1. Your blood pressure is less than 140/90 mmHG 2. Your bad cholesterol, LDL, is less than 100 mg/dl 3. Your blood sugar, A1c, is less than 8% 4. You are tobacco-free 5. You take an aspirin as appropriate)	Adult	MN Health Scores	Yes: 0729	outcome	Electronic Clinical Data, Electronic Health Record, Paper Records	Measure Description: The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic
include	262	Quality	Chronic Illness: Diabetes	<b>Diabetes Hemaglobin A1c Poor Control (&gt;9.0%)</b> (Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control))	Adult	NCQA	Yes: 0059	outcome	Administrative claims, Electronic Health Record, Laboratory, Paper Records	Denominator Statement: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).
include	55	Quality	Chronic Illness: Hypertension	<b>Controlling High BP</b> (The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.)	Adult	NCQA	Yes: 0018	Outcome	Electronic administrative data/claims (renamed to "Administrative	Numerator Statement: The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic

Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/outcome)	Data type, source	Specifications
include	263	Quality	Chronic Illness: Ischemic Vascular Disease	<b>IVD: Complete Lipid Profile and LDL Control &lt;100</b> (The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1–November 1 of the year prior to the measurement)	Adult	NCQA	Yes: 0075	Outcome	Electronic administrative data/claims (renamed to "Administrative	Numerator Statement: A complete lipid profile performed during the measurement year. A LDL-C control result of <100mg/dL using the most recent LDL-C screening test during the measurement year.
include- no benchmark	265	Quality	End of Life	<b>Advance Care Plan</b> (Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker)	Adult	NQF	Yes: 0326	process	Administrative claims, Electronic Health Record.	Measure Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or
need to confirm that this is a medicare hospital compare measure- a number- not	115	Quality	Inpatient Care	<b>Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic</b> (The percentage of patients 18 years and older with ischemic vascular disease who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1-	Adult	NCQA: <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1229#k=Acute%2520myo">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1229#k=Acute%2520myo</a>	yes: 0068	process	Electronic administrative data/claims (renamed to "Administrative	Measure Description: The percentage of patients 18 years and older with ischemic vascular disease who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI)
include	267	Quality	Inpatient Care	<b>Leapfrog Composite Measure</b> (the percentage of hospitals participating in the CCO that have achieved substantial progress on the following Leaps: 1) Heart Attack 2) Pneumonia 3) Normal Deliveries 4) Steps to Avoid Harm)	Adult	The Leapfrog Group				
include	127	Quality	Maternal Health	<b>Elective Delivery Before 39 Weeks</b> (This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures	Adult	Joint Commission	Yes: 0469	Process	Administrative claims, Electronic Clinical Data, Paper	Numerator Statement: Patients with elective deliveries with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the

Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/outcome)	Data type, source	Specifications
include	184	Quality	Maternal Health	<b>PC-02 C-Section Rate</b> (This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address	Adult	NQF/ Obstetrics Dept. at OHSU	Yes: 0471	Outcome	vital statistics	Numerator Statement: Patients with cesarean sections with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for cesarean section as defined in Appendix A, Table
include	251	Quality	Maternal Health	<b>Post-Partum Care</b> (The percentage of deliveries that had a postpartum visit for a pelvic exam or postpartum care on or between 3-8 weeks after delivery.)	Adult	Qcorp/ OR Health Insurance Exchange	Yes: 1517 Rate 2	Process	Administrative claims, Paper Medical Records	Measure Description: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For those
include	250a	Quality	Maternal Health	<b>Prenatal Care</b> (The percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan.)	Adult	Qcorp HEDIS/ OR Health Insurance Exchange	Yes: 1517 Rate 1	Process	Administrative claims, Paper Medical Records	Measure Description: The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the
include	42	Quality	Mental Health	<b>Follow-up After Hospitalization for Mental Illness</b> (% of members with follow-up visit within 7 days after hospitalization for mental illness)	Adult	Core Measure Set for Year 1 and 2	NQF #/Steward: 0576	Process	Oregon All-Payer All-Claims data system; MMIS	Measure Description: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and
include	68	Quality	Mental Health	<b>Antidepressant Medication Management</b> (The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant	Adult	HEDIS	105	unknown	Administrative claims	Numerator Statement: a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant
include	71	Quality	Mental Health	<b>Mental Health Assessment for Children in DHS Custody</b> (% children who receive a mental health assessment within 30 days of DHS custody)	Pediatric	Core Measure Set for Year 1 and 2	No	process	Child welfare case system data + claims/enc	

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include	162	Quality	Oral Health	Percentage of continuously enrolled children, 2-18 years of age with one or more restorations who received a topical fluoride or sealant.	Pediatric					
include	163	Quality	Oral Health	Percentage of continuously enrolled children, 2-18 years of age enrolled for two years who received an annual oral evaluation/prophylaxis.	Pediatric					
include	268	Quality	Oral Health	<b>Annual Dental Visit</b> (The percentage of members 2-21 years of age who had at least one dental visit during the measurement year.)	Pediatric	HEDIS/ Oregon Performance Measures for Medicaid	1388	Process	Administrative claims	Measure Description: Percentage of members 2-21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental
include (mention in the slide	91	Quality	Preventive Care: Screening	<b>Cervical Cancer Screening</b>	Adult	HEDIS/ Transparenc y Measures,	yes: 0032	Process	Administrative claims,	Measure Description: Percentage of women 21–64 years of age received one or
include	278	Quality	Preventive Care: Screening	<b>Colorectal Cancer Screening</b>	Adult	HEDIS/ Oregon Performance Measures	yes: 0034	Process	Administrative claims,	Measure Description: The percentage of members 50–75 years of age who had
include	86	Quality	Preventive Care: Screening	Chlamydia screening	Adult	Oregon Performance Measures for Medicaid Managed Care Plans	Yes: 0033	Process	Administrative claims, Electronic Health Record, Physician	Measure Description: Assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year
include	76	Quality	Preventive Care: Screening	Developmental screening by 36 months	Pediatric	Core Measure Set for Year 1 and 2, NCQA and CAHMI	Yes: 1448	Process	Oregon All-Payer All-Claims data system (using the administrative	Measure Description: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life.

Status	Library #	Domain	Category	Measure and description	Population	Currently used by:	NQF #	Type (process/outcome)	Data type, source	Specifications
include HEDIS version of this	85	Quality	Preventive Care: Well Care Immunizations	<b>Childhood Immunization Status</b> (Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio	Pediatric	HEDIS/ Oregon Performance Measures	yes: 0038	Process	Administrative claims, Paper	Numerator Statement:  Children who have evidence showing they received
include	269	Quality	Preventive Care: Well Care Immunizations	<b>Immunizations for Adolescents</b> (The percentage of adolescents 13 years of age who had recommended	Pediatric	HEDIS	yes: 1407	Process	Administrative claims	Numerator Statement:  Adolescents who had one dose
include	277	Quality	Preventive Care: Well Visits	Adolescent Well-Care Visits	Adolescent	Oregon Performance Measures	No	Process		
include	83	Quality	Preventive Care: Well Visits	<b>Well-child Visits:</b> the first 15 months of life, 6 or more	Pediatric	HEDIS, Partner for Quality Care	Yes: 1392	Process	Administrative claims	Measure Description: Percentage of members who turned 15 months old during
include	84	Quality	Preventive Care: Well Visits	<b>Well-Child Visits:</b> the Third, Fourth, Fifth and Sixth Years of Life	Pediatric	HEDIS, Partner for Quality Care	Yes: 1516	Process	Administrative claims,	Measure Description: Percentage of members 3–6 years of age who received one
include	135	Quality	Preventive: Resource Distribution	Ratio of primary care spending to specialty & hospital spending over time	All	CMS Attachment E: Menu Set				
include	177	Satisfaction	Administrative Service	In the last 12 months, how often did your health plan's customer service give you the information or help you needed? 1 <input type="checkbox"/> Never	Adult	OR Health Insurance Exchange, Oregon Performance		survey	CAHPS 4.0H Adult Questionnaire (Q 35)	In the last 12 months, how often did your health plan's customer service give you the information or help you needed?
include	178	Satisfaction	Administrative Service	In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? 1 <input type="checkbox"/> Never	Adult	OR Health Insurance Exchange, Oregon Performance		survey	CAHPS 4.0H Adult Questionnaire (Q 36)	In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? 1 <input type="checkbox"/> Never
include	279	Satisfaction	Behavioral Health	<b>Satisfaction with Behavioral Health Services</b> (question(s) to be selected from the OR-modified MHSIP survey for adults - greatest opportunities in connectedness, functioning and outcomes domains - or from the Youth Services Survey)	Adult	OHA Addictions and Mental Health Division, Oregon Performance Measures for		survey		

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include	167	Satisfaction	Care Coordination	In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? 15 Never	Adult	Oregon Performance Measures for Medicaid Managed		survey	CAHPS 4.0H Adult Questionnaire (Q 20)	In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?