CareOregon®

2021

Quality Metrics Toolkit

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The CareOregon Quality Metrics Toolkit was created to support our network partners in caring for our members. Our goals are to share knowledge about Oregon Health Authority's Coordinated Care Organization Incentive Metrics and the CMS Medicare Stars Measures; help create a better understanding of the quality health metrics and why they are important; assist with the implementation of workflows and best practices; and assist with tracking and monitoring of quality performance.

CareOregon Quality Metrics Toolkit Measure Sheet Definitions

Performance Measure Set:

CCO Incentive Metric: The Coordinated Care Organization (CCO) Incentive Metrics are determined by the Oregon Metrics& Scoring Committee, which was established in 2012 by Senate Bill 1580 to create outcomes and quality measures for CCOs. The measures are negotiated with the Centers for Medicaid and Medicare Services (CMS) as part of Oregon's 1115 waiver agreement. The CCO has then individualized improvement targets that are designed to decrease the distance between current performance and the OHA-established benchmark each year.

Medicare Star Measure: The Medicare Stars Measures are determined by CMS. The Star Rating System measures the performance of Medicare Advantage and Part D plans by comparing them against the rest of the country. There are over 40 measures which constitute the Star Rating System, with plans scored on a 5 Star scale for each. The individual measures are scored and weighted to determine a plan's overall Stars score. 5 Star plans have a special enrollment period and earn increased reimbursement from CMS.

Quality Measurement Type:

Structural Measures: Gives consumers a sense of a health care provider's access capacity, systems, and processes to provide high-quality care, e.g., whether the health care organization uses electronic medical records or medication order entry systems.

Process Measures: Indicates what a provider does to maintain or improve health of patients. They are typically generally accepted recommendations for clinical practice. They are the parts/steps in the system which measures whether it was performed as planned, e.g., for diabetes: percent of patients whose hemoglobin A1c level was measured twice in the past year.

Outcome Measures: Reflect the impact of the health care service or intervention on the health status of patients. How does the system impact the clinical values of patients, e.g., for diabetes: average hemoglobin A1c level for the population of patients with diabetes?

Patient Experience: Captures a person's perception of their experience with healthcare service using surveys, e.g., access and ability to navigate services, or time spent waiting.

Data Source/Type:

These data types refer to how measurement information is collected for performance monitoring.

Claims: An invoice a provider sends to a health plan for services of care provided to a plan member. CPT and diagnosis codes contained in the invoice serve to capture care outlined in quality improvement CCO Incentive Metrics and Medicare Star Measures.

Chart Documentation: How clinical care providers and staff record a patient's health status and care services received during a visit. This information is critical when conducting a comprehensive medical record review. When looking for evidence of care (not reflected through claims or diagnosis), if care is given but it is not reflected in a patient chart, it didn't happen.

eCQMs: Clinical Quality Measures (CQM) are a mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. Electronic CQMs are reported using electronic specifications from an electronic health record (EHR) in the form of a report.

Survey: survey instruments capture self-reported information from patients about their health care experience and outcome. Surveys are typically administered to a sample of patients by mail, by telephone, or via the intranet.

Other: Data source not addressed via claim, chart documentation, eCQM, or survey.

Part One
CCO Incentive Metrics

- Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)
- Child and Adolescent Well-Care Visits
- Childhood Immunization Status (Combo 2)
- Cigarette Smoking Prevalence
- Diabetes HbA1c Poor Control (>9.0%)
- Disparity Measure: Emergency Department Utilization among Members with Mental Illness
- Immunizations for Adolescents (Combo 2)
- Initiation and Engagement of Alcohol and Other Drug Use Treatment
- Meaningful Language Access to Health Care Services
- Members Receiving Preventive Dental Services, ages 1-5 and 6-14
- Mental, Physical, and Oral Health Assessments for Children in DHS Custody
- Oral Evaluation for Adults with Diabetes
- Screening for Depression and Follow-Up Plan
- Timeliness of Prenatal & Postpartum Care

Alcohol and Drug Misuse: Screening, Brief Intervention and Referral to Treatment (SBIRT)

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other

State Benchmark: N/A. 2021 is considered a reporting only year for this measure.

Who: All patients aged 12 and older.

Why: Screening for alcohol and drug misuse is important for early detection and prevention of substance use disorder.

What: Percent of all patients aged 12 years and older who are screened for alcohol and drug misuse using an age-appropriate screening tool, and received appropriate follow-up as clinically indicated.

How: Two rates are reported for this measure using EHR-based data:

1. Screening Rate: of the patients aged 12 years and older who had a visit during the year (including telehealth visits), what percentage received age-appropriate screening for alcohol and drug misuse and had either a brief screen with a negative result or a full screen.
   a. The denominator for rate 1 uses the same denominator criteria as the depression screening and follow-up measure (NQF0418e/CMS2v10).
2. Follow-up Rate: of those patients who had a positive full screen during the year, what percentage of patients received a brief intervention, referral to treatment, or both that is documented within 48 hours of the date of the full screen.
   a. The denominator for rate 2 includes those patients in the rate 1 numerator who had a positive full screen (i.e. subset of rate 1 numerator).

Example:

Scenario	Rate 1		Rate 2	
	Denom	Num	Denom	Num
Patient refuses screening any point before required screening is completed.	No	No	No	No
Patient completes brief screen that is positive but refuses to complete full screen.	Yes	No	No	No
Patient completes brief screen that is negative.	Yes	Yes	No	No
Patient completes brief screen that is positive and completes full screen that is also positive. Results are discussed, and brief intervention or referral is completed.	Yes	Yes	Yes	Yes
Patient completes full screen that is positive but refuses brief intervention or referral to treatment.	Yes	Yes	Yes	No

Exclusions: Any of the following criteria remove people from the denominator:

- SBIRT services received in an emergency department or hospital setting;
- Patients with an active diagnosis for alcohol or drug dependency, engagement in treatment, dementia or mental degeneration;
- limited life expectancy, palliative care or hospice;
- situations where the patient's functional capacity or motivation to improve impact the accuracy of results of standardized assessment tools;
- Patient refuses to participate;
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Reporting: This is an EHR-based measure and does not require billing codes or claims data. CareOregon must receive data pulled from each clinic's EHR for this measure; the data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred.
- Final reporting must be for the full 2021 calendar year; mid-year reports preferred in a rolling 12-month timeframe.
- Data must be formatted in Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Alcohol and Drug Misuse (SBIRT) FAQ

Q: Does a brief screen count toward the measure?

A: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is not numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant for Rate 1, regardless of the result.

Q: What score counts as a "positive" screening result?

A: The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418e/ CMS2v9. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.

Q: What counts as a brief intervention? Is there a time requirement?

A: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources. A brief intervention of less than 15 minutes can count towards this measure.

Q: How can an integrated behavioral health counselor support SBIRT?

A: Through collaborative appointments and follow-up engagement and support. Establish standard workflows where a BHC sees patients who score positive on SBIRT. BHC provides brief intervention to patients. BHC facilitates referrals to those who qualify for substance use treatment.

Q: Does the referral to treatment need to be completed?

A: No, a referral to treatment is counted when the referral is made and documented in the EHR. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Q: What screening tools are recommended?

A: Approved Evidence-Based Screening Resources/Tool are located here: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx

We recommend that you check this list to ensure your screening tool is OHA-approved.

Q: Do I need to screen patients at every visit?

A: Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Child and Adolescent Well-Care Visits (WCV)

formally known as Well Child Visits in the Third, Fourth, Fifth and Sixth Years of LIFE(W34)

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Measure Quality Measurement Type: ☐Structure ☐Process ☐Outcome ☐Patient Experience ☒Other Specify: HEDIS-like. OHA has deviations outside of the HEDIS allowable adjustment rules. Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other State Benchmark: 78.5% for children age 3-6 (Original 2020 benchmark)

Who: Children who are 3–21 years-old as of December 31 of the measurement year.

Why: Regular check-ups during the preschool and early school-age children are important for detection of vision, speech and language problems. Early intervention can help a child improve communication skills and avoid or reduce language and learning problems. Annual well-care visits are recommended for those age 2-21 year-olds. "as they are a strong vehicle to deliver screening, anticipatory guidance, and health education to support healthy development now and in the future (source: OHA Guidance Document).

What: The percentage of members 3–21 years of age who had one or more well-child visits during the measurement year. There are four age stratifications and a total rate which must be reported; however ONLY the age group 3-6 is incentivized for this measure:

- *3-6 Years
- 7-11 Years
- 12-17 Years
- 18-21 Years
- Total

How: At least one well-child visit, which can be completed via telemedicine (see codes below), by any provider type during the measurement year. Some ideas to improve Well Care visits include:

- Regularly pull member lists for outreach
- Create well-child visit reminders
- Build relationships with community organizations to reinforce the importance of the well-child visit
- Collaborative Appointment: BHC meets with families before PCP comes into appointment to assess for psycho-social issues needing to be addressed during WCC. BHC can help complete Ages and Stages tool for those who did not complete the tool ahead of time. BHC can help create a robust appointment that assures that all aspects of care are addressed, while allowing PCP to focus on physical health issues. Any concerns can lead to follow up appointments.

Exclusions: Members in hospice are excluded from this measure.

Coding: Diagnosis codes do not have to be primary.
CPT: 99381-99385, 99391-99395, 99461, G0438, G0439, S0302
ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z02.5, Z76.1, 276.2

Child and Adolescent Well-Care Visits (WCV)

Q: What are the required elements of a well child visit?

A:

- **A health history.** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history**. Physical developmental histories assess specific age- appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history**. Mental developmental histories assess specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam.** Include height and weight measurements as well as condition of gums and teeth among others.
- **Health education/anticipatory guidance**. Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Q: Do school-based clinic visits count for this measure?

A: Yes, as long as the visit meets the requirements of a well child visit, and the documentation is available in the medical record or administrative system in the time frame specified by the measure.

Q: Does the patient need to be seen by their PCP for it to count for the metric?

A: No, the provider does not have to be the assigned PCP. However, OHA does not use Emergency Department or Inpatient claims for identifying well-visits.

Q: What telehealth codes count for this measure?

A: G0438-G0439 per the ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES published by OHA as of February 21, 2021.

Please note that while this measure is telehealth eligible as the qualifying numerator services do not require in-person place of service codes in claims data, we recommend scheduling an in-person physical health exam as medically appropriate and safe to do so considering COIVD-19 precautions.

Childhood Immunization Status (Combo 2)

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☐Survey ☒Other: ALERT IIS Registry

State Benchmark: 80.8% for 2021 Benchmark (2019 National Medicaid 90th percentile)

Who: Children who turn two years of age in 2021.

Why: Despite the effectiveness of vaccines to prevent disease and reduce unnecessary costs to the health care system, immunization rates for children in Oregon remain well below national Healthy People 2020 goals. Much attention is given to those who choose not to vaccinate their children; however, these families and communities represent the minority in Oregon. Most parents do intend to vaccinate their children according to the American Academy of Pediatrics schedule and as recommended by their health care provider. Thus, providers play a key role in immunization rates among their patients (Source: *CCO Resource Guide–Strategies to Improve Immunization Rates*, OHA July 2017).

What: This measure reports the percentage of children who turn two-years-old in 2021 and receive all the following immunizations before their second birth date:

- 4 DTaP (Diphtheria, Tetanus, and Pertussis)
- 3 IPV (Inactivated Polio Vaccine)
- 1 MMR* (Measles, Mumps, Rubella)
- 3 HiB (Haemophilus Influenzae Type B)
- 3 Hepatitis B
- 1 VZV* (Varicella Zoster Vaccine)

Please note that multiple vaccines within the same type must have different dates of service to count toward requirement (i.e. to meet the four required DTaP vaccines there must be at least four dates of service on which a DTaP was provided).

*1 MMR and 1VZV must have a date of service on or between the child's first and second birthdays.

How: Some ideas to improve Childhood Immunization Status rate:

- Ensure that immunization records in ALERT IIS are up to date and that all patient information is correct (e.g., name spelled correctly, correct date of birth, etc.).
- Schedule immunizations visits months before their second birthday.
- Ensure that patient decision-aid tools and catch-up schedules are available for all parents when deciding to vaccinate their children (see resources for more information).
- Schedule subsequent vaccine visits before parents leave the office.
- Implement patient recall workflows.
- Behavioral Health Support: BHC asks families and/or scrubs their schedule to identify children in need of immunization when they're in clinic for BHC appointment. Those who need immunizations are connected for scheduling or same-day appointment. Support families through discussions of vaccine hesitancy.

Exclusions: Members who are deceased at the time of metric reporting or in hospice during the measurement year.

Childhood Immunization Status (Combo 2) FAQ

Q: What immunization combination does this metric follow?

A: HEDIS® MY2020/2021 Combination 2.

Q: Are disease histories considered if the child had not received a vaccination?

A: No. ALERT IIS data currently does not reliably capture disease history and OHA does not integrate disease histories when calculating performance for this measure.

Q: How do I know which members are due for vaccinations?

A: A child's immunization history in ALERT should be checked before each visit. Additionally, CareOregon prepares and distributes member gap lists using ALERT data provided by OHA on a quarterly basis. If parents decline the vaccine, the child remains in the measure denominator. Please reach out to your Primary Care Innovation Specialist for additional resources.

Q: Who is included in the denominator for this measure?

A: Members whose second birthday is within 2021 and have had physical health coverage with the CCO continuously for the 12 months prior to their second birthday are included in the denominator.

Q: If parents refuse to have their child vaccinated, are they excluded from the metric?

A: No. If the child does not receive immunizations, they will remain in the denominator but not the numerator.

Resources

CDC recommended schedule for immunizations for children:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Cigarette Smoking Prevalence

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other
Benchmark: 26.6% (2018 CCO Statewide Average)

Who: All members aged 13 years and older.

Why: Tobacco dependence is a chronic condition known to have a negative impact on overall health. Effective treatments exist and research shows that 70% of tobacco users report wanting to quit. Many have had at least one failed attempt and believe advice from a health care provider is important.

What: Three rates are reported for this measure using EHR-based data: rate of screening for smoking and/or tobacco use (rate 1), prevalence of cigarette smoking (rate 2), and prevalence of tobacco use (rate 3). However, only cigarette smoking prevalence (rate 2) is incentivized.

> Rate 1: Of all patients with a qualifying visit during the measurement year, how many have their cigarette smoking or tobacco use status recorded as structured data? (This value will be your numerator for Rate 1 and the denominator for Rate 2 and Rate 3.)
>
> Rate 2: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current cigarette smokers?
>
> Rate 3: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current smokers and/or tobacco users?

Exclusions: e-cigarettes, marijuana, and nicotine replacement therapy products do not qualify as cigarette or tobacco use. However, if a patient is using nicotine replacement therapy products and also using cigarettes and/or other tobacco products, they will be counted in the numerator.

How: To reduce the prevalence rate, clinics should:

- Ask their CareOregon Primary Care Innovation Specialist or Provider Relations Specialist about CareOregon smoking cessation benefits.
- Encourage members to call the State Quit Line, 800-QUIT-NOW or 1-800-784-8669 English, or 855- DEJELO-YA (1-855-335356-92) for Spanish and identify that they have CareOregon coverage for expanded services.
- Refer members using Oregon Tobacco Quit Line Fax Referral Form via fax 1-800- 483-3114.
- Follow the 5A's model for treating tobacco use and dependence.
- Ask about cigarette smoking and/or tobacco use status at every visit and provide counseling and/or recommend nicotine replacement therapy.
- Behavioral Health Follow Up Engagement and Support: BHC sees patients identified as tobacco users to help engage in quit plans via motivational interviewing techniques. BHC can aid in connecting to resources like quit lines. Connect BHC to anyone asking for NRT.

Data reporting: This measure is similar to but **does not directly align with NQF 0028e/CMS 138v9** (which looks for patients aged 18 or older). If your reporting is based on NQF 0028e/CMS 138v9, you will need to incorporate adolescents aged 13-17 through custom query. Please note that clinics must report the three prevalence rates regardless whether they are using custom query reporting or NQF 0028e/CMS 138v9.

CareOregon must collect data from each clinic's EHR for this measure. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred
- Reporting must be for the full calendar year of 2021; monthly reports in a rolling 12-month timeframe are preferred
- Data must be formatted in Excel

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Cigarette Smoking Prevalence FAQs

Q: What supports does the CCO provide to members who want to quit smoking?

A: CareOregon covers tobacco cessation counseling, nicotine replacement therapy products such as gum and lozenges with no prior authorization, and other pharmacotherapy options with a prior authorization. CareOregon also covers cessation counseling through Quit For Life.

Q: What is the difference between the Oregon Tobacco Quit Line and Quit For Life?

A: CareOregon contracts for cessation counseling services with the same vendor that staffs the Oregon Tobacco Quit Line. The state's Tobacco Quit Line provides free counseling to anyone who calls. However, after identification of CareOregon coverage, the individual is transferred to a Quit For Life representative for additional, expanded counseling services. Please note that while the state's Tobacco Quit Line accepts individuals aged 13 and older, the age requirement for CareOregon's Quit For Life contract is 18 and older.

Q: Is it required to ask about cigarette smoking status at every visit?

A: No. Although, while cigarette smoking and/or tobacco use status is not required at every visit, it is important to ensuring that an accurate status is captured for each patient. If a patient's status is recorded during multiple visits in the measurement year or year prior, only the most recent screening will be used.

Q: What if a patient quits smoking after a visit to PCP?

A: They will need to come back in so that their new status is recorded. That is why it's important to ask
about cigarette smoking and/or tobacco use status at every visit.

Q: Does the smoking status need to be recorded during the calendar year to count for the measure?

A: No. Cigarette smoking and/or tobacco use recorded status must be recorded within the previous 24 months.

Diabetes Care: HbA1c Poor Control

Performance Measure Set: ☒CCO Incentive ☒Medicare Star Rating
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Medicaid Data Type: ☐Claims ☐Chart Documentation ☒ eCQM ☐Survey ☐Other
Medicare Data Type: ☐Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other
Medicaid State Benchmark: 23.4% or lower (2018 CCO statewide average)
HEDIS Benchmarks National Percentile: 86.25% (75th), 88.81% (90th)

Who: All patients aged 18–75-years-old with a diagnosis of type 1 or type 2 diabetes during, or any time prior to, the calendar year. Medicaid members must receive a qualifying outpatient service during the measurement period; this is not a requirement for Medicare.

Why: People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. HbA1c testing helps clinicians identify potential need for further intervention to ensure that all patients with a diagnosis of diabetes receive appropriate and comprehensive care.

What: Percentage of patients with a diabetes diagnosis, whose most recent HbA1c level is above 9.0%.
Note: If a diabetic patient has a visit but does not have a HbA1c result documented in the measurement period, their diabetes is considered in poor control and they will enter the numerator.

Note that only patients with a Type 1 or Type 2 diabetes diagnosis are included. Members with a diagnosis of gestational diabetes, steroid-induced diabetes or pre-diabetes are excluded.

How: Best practices to improve Diabetes Poor Control include

- Educating patients about healthy lifestyle choices through motivational interviewing
- Employing diabetes educators, clinical pharmacists, or registered dietitians in the care management team
- Using an evidence-based diabetes care pathway for medication management and other care options
- Collaborative appointment with integrated behavioral health and follow-up engagement and support: Establish standard workflow that BHC sees patients who are newly diagnosed with diabetes, and patients with A1C over 9. BHCs work with patients on behavior change to help better manage lifestyle requirements that support diabetes control. BHCs can assess and support risk factors (e.g. binge eating, substance use, mood disorders) that can contribute to poor control.
- BHC asks patient and/or scrubs their schedule to assure those who need labs are connected for scheduling or same-day appointment. Those who have

been working on improving DM management and/or are close to 9% can be identified as good candidates for being retested.

Exclusions:

- Patients in hospice or using hospice services during the calendar year
- Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period
- Patients 66 and older with advanced illness and frailty

Medicaid Data Reporting: This measure aligns with **CMS122v9.** CareOregon must collect data from each clinic's EHR for this measure. Data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12- month time frame
- Data must be formatted in Excel

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Medicare reporting: Comprehensive diabetes care (CDC) measures use the HEDIS HbA1c poor control specifications, however, the reverse of poor A1c control is reported as blood sugar control.

Diabetes Care: HbA1c Poor Control FAQs

Q: Why are the targets for Medicaid and Medicare so different?

A: The Medicare Star measure is reporting patients with diabetes who have an A1c test during the measurement year and that their blood sugar is in control, therefore a higher number indicates more patients are in control. CareOregon dashboards, performance reporting, and targets for Medicare members reflect this rate of A1c control, the reverse score/target of poor control as reported for Medicaid The HEDIS national percentile also reflects the benchmark for poor control.

Q: What if the member didn't have an A1c test completed in the measurement year?

A: A member is considered in *poor control* if they have a diagnosis of diabetes and do not have an A1c test in the measurement year***. It is highly beneficial to complete HbA1c testing in the first and second quarter of the measurement year*** to allow time for intervention, regaining control of blood glucose levels, and retesting A1c before the end of the year if necessary because the last A1c in the measurement year is the value reported for both line of business. It is also **important to ensure the A1c results from specialists are recorded as structured data** (and therefore captured in the EHR reporting) and not simply attached to the patient's chart as a pdf.

Q: Is prior authorization required for GLP1 diabetes pharmaceuticals?

A: CareOregon covers exenatide (BYETTA/BYDUREON) and liraglutide (VICTOZA), however, a prior authorization is required for Medicaid patients.

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SPMI)

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

Medicaid State Benchmark: 86.5/1000-member months or lower (2018 CCO 90th Percentile)

Who: All patients 18 years of age or older enrolled in the CCO who have had at least two mental illness diagnoses in the last 36 months are included in this measure (i.e. from January 2020 through December 2020). In general, the mental illness code set includes schizophrenia, bipolar, major depressive disorder, manic episodes, obsessive compulsive disorder, post-traumatic stress disorder, and borderline personality disorder (see FAQ on next page for more detail).

Why: This measure aims to reduce the disproportionally higher emergency department utilization among those experiencing mental illness by increasing awareness and engagement with appropriate points of primary and mental health care.

What: This measure reports the total number of all emergency department visits that do not result in an inpatient stay as a factor of how many months patients in the denominator have had active coverage with the CCO during the year.

How: Some ideas to improve ED Utilization rates:

- Use Collective to identify when patients visit the ED and quickly follow up with each patient after their ED visit to prevent future avoidable ED use.
- Ensure patients are connected to behavioral health provider and that there is an effective communication loop between mental health and primary care.
- BHCs can utilize Collective to provide outreach and support to patients who have gone to the ED. Through tracking of the measure, we know certain sub populations are at greater risk. BHCs can be proactive in supporting these populations through providing anticipatory guidance and psycho-social interventions (address the thoughts/feelings that drive ED use). Subpopulations include those with diagnoses of: depression, PTSD, asthma, chronic pain, hypertension, diabetes, and COPD.

Exclusions: ED visits for mental health and chemical dependency services are excluded from the numerator **if the principle diagnosis** identifies it as such. Members with hospice claims in the measurement year are excluded from the measure.

NOTE: OHA applies the exclusions at the claim line level and keeps all paid ED claim lines that do not have the exclusion codes, i.e., unless the entire claim was denied or all claim lines qualify for exclusion, the remaining paid lines without mental health and chemical dependency services would pass through the algorithm.

Coding: ED visits are identified by claims with at least one of the following claims:

CPT: 99281-99285; UB Revenue Codes: 0450, 0451, 0452, 0456, 0459, 0981; or most claims with place of service code 23.

See separate Mental Illness Value Set handout for codes that identify members for inclusion in this measure.

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SPMI) FAQ

Q: What do you mean by "ED visits that do not result in an inpatient stay?"

A: When an ED or observation visit and an inpatient stay are billed on separate claims, the ED visit is considered to result in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or on the next calendar day. Also, an ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Q: What if a patient visited more than one ED on the same day?

A: Only one ED visit per day is counted for the metric.

Q: What if the patient was seen at Unity Center for Behavioral Health's Psychiatric Emergency Service?

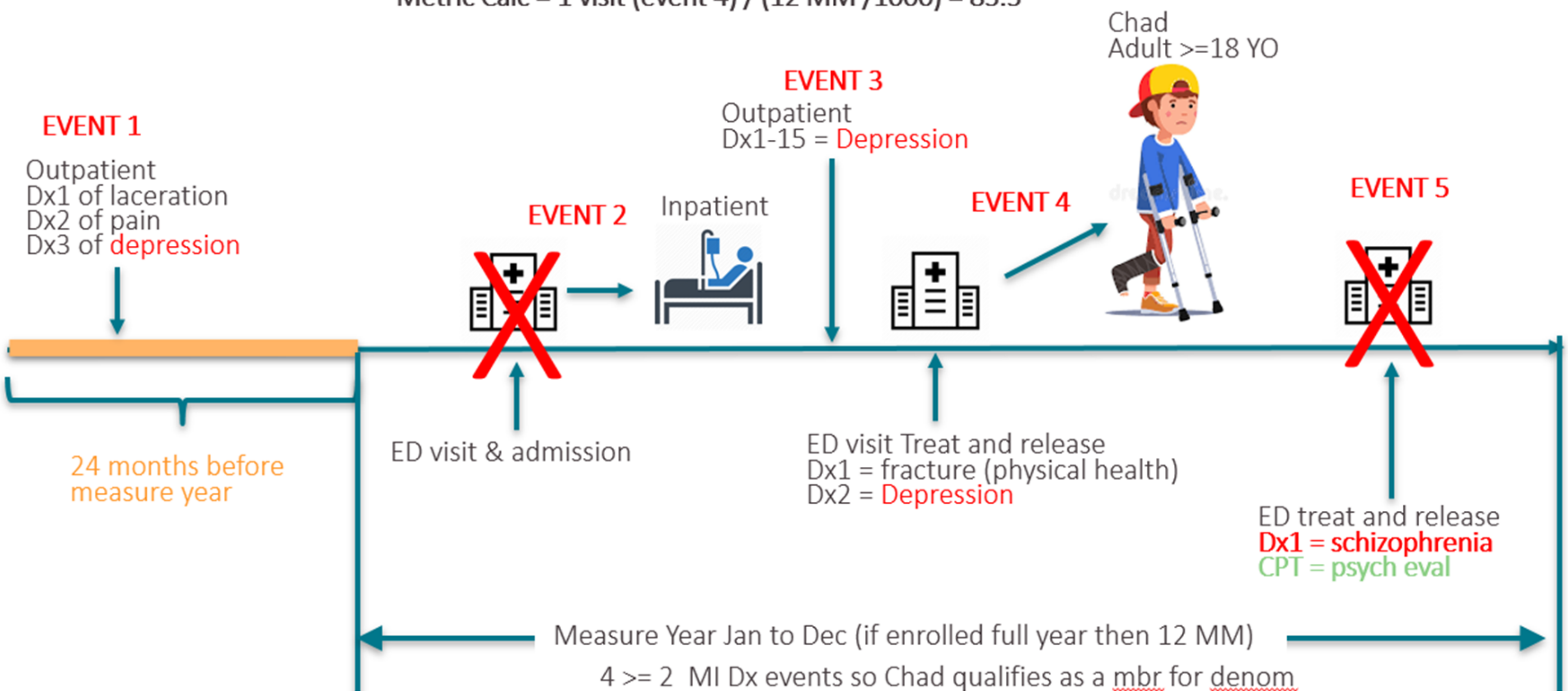
A: Visits to Unity do not qualify for the metric.

Q: What if the patient was seen at the ED for a mental health or substance-use related condition?

A: Only visits to the ED for physical health conditions count for the measure. However, sometimes mental health conditions present through physical symptoms. For example, anxiety can present as shortness of breath, and depression as pain. **Only claims with a principle mental or behavioral health diagnosis code are excluded.** Following the previous example, anxiety that presents as, and is coded with a principle diagnosis code for, shortness of breath would count towards the numerator for this measure. Exclusions for mental health or substance use diagnosis codes are applied at the claim line level meaning all lines of a claim with a principle mental health or substance use diagnosis code will be excluded.

What is measured

Metric Calc = 1 visit (event 4) / (12 MM /1000) = 83.3



Diagnosis Definitions for *Members Experiencing Mental Illness* Value Set

The below list corresponds to the diagnosis codes required for inclusion in the Disparity Measure: ED Utilization for Individuals Experiencing Mental Illness per OHA specifications updated January 2020.

Schizophrenia	F200 – Paranoid Schizophrenia F201 - Disorganized schizophrenia F202 - Catatonic schizophrenia F203 - Undifferentiated schizophrenia F205 - Residual schizophrenia F2081 - Schizophreniform disorder F2089 - Other schizophrenia F209 - Schizophrenia, unspecified
Schizotypal disorder	F21 - Schizotypal disorder
Psychotic disorder	F23 - Brief psychotic disorder F24 - Shared psychotic disorder
Schizoaffective disorders	F250 - Schizoaffective disorders F251 - Schizoaffective disorder, depressive type F258 - Other schizoaffective disorders F259 - Schizoaffective disorder, unspecified
Other and unspecified	F28 - Other psychotic disorder not due to a substance or known physiological condition F29 -Unspecified psychosis not due to a substance or known physiological condition

Manic Episode	F3010 - Manic episode without psychotic symptoms, unspecified F3011 - Manic episode without psychotic symptoms, mild F3012 - Manic episode without psychotic symptoms, moderate F3013 - Manic episode, severe, without psychotic symptoms F302 – Manic episode, severe with psychotic symptoms F303 – Manic episode in partial remission F304 – Manic episode in full remission F308 – Other manic episodes F309 - Manic episode, unspecified
Bipolar Disorder	F310 - Bipolar disorder, current episode hypomanic F3110 - Bipolar disorder, current episode manic without psychotic features, unspecified F3111 - Bipolar disorder, current episode manic without psychotic features, mild

	F3112 - Bipolar disorder, current episode manic without psychotic features, moderate F3113 - Bipolar disorder, current episode manic without psychotic features, severe F312 - Bipolar disorder, current episode manic severe with psychotic features F3130 - Bipolar disorder, current episode depressed, mild or moderate severity, unspecified F3131 - Bipolar disorder, current episode depressed, mild F3132 - Bipolar disorder, current episode depressed, moderate F314 - Bipolar disorder, current episode depressed, severe, without psychotic features F315 - Bipolar disorder, current episode depressed, severe, with psychotic features F3160 - Bipolar disorder, current episode mixed, unspecified F3161 - Bipolar disorder, current episode mixed, mild F3162 - Bipolar disorder, current episode mixed, moderate F3163 - Bipolar disorder, current episode mixed, severe, without psychotic features F3164 - Bipolar disorder, current episode mixed, severe, with psychotic features F3170 - Bipolar disorder, currently in remission F3171 - Bipolar disorder, in partial remission, most recent episode hypomanic F3172 - Bipolar disorder, in full remission, most recent episode hypomanic F3173 - Bipolar disorder, in partial remission, most recent episode manic F3174 - Bipolar disorder, in full remission, most recent episode manic F3175 - Bipolar disorder, in partial remission, most recent episode depressed F3176 - Bipolar disorder, in full remission, most recent episode depressed F3177 - Bipolar disorder, in partial remission, most recent episode mixed F3178 - Bipolar disorder, in full remission, most recent episode mixed F3181 - Bipolar II disorder F3189 - Other bipolar disorder F319 - Bipolar disorder, unspecified
Depressive Disorder	F320 - Major depressive disorder, single episode, mild F321 - Major depressive disorder, single episode, moderate F322 - Major depressive disorder, single episode, severe without psychotic features F323 - Major depressive disorder, single episode, severe with psychotic features F324 – Major depressive disorder, single episode, in partial remission

	F325 - Major depressive disorder, single episode, in full remission F328- Other depressive episodes F329 - Major depressive disorder, single episode, unspecified F330 - Major depressive disorder, recurrent, mild F331 - Major depressive disorder, recurrent, moderate F332 – Major depressive disorder, recurrent severe without psychotic features F333 - Major depressive disorder, recurrent, severe with psychotic symptoms F3340 - Major depressive disorder, recurrent, in remission, unspecified F3341 - Major depressive disorder, recurrent, in partial remission F3342 – Major depressive disorder, recurrent, in full remission F338 - Other recurrent depressive disorders F339 - Major depressive disorder, recurrent, unspecified
Affective disorder	F348 - Other persistent mood [affective] disorders F3481 - Disruptive mood dysregulation disorder F3489 - Other specified persistent mood disorders F349 – Persistent mood [affective] disorder, unspecified F39 - Unspecified mood [affective] disorder
OCD	F42 - Obsessive-compulsive disorder F422 - Mixed obsessional thoughts and acts F423 - Hoarding disorder F428 - Other obsessive-compulsive disorder F429 - Obsessive-compulsive disorder, unspecified
PTSD	F4310 - Post-traumatic stress disorder, unspecified F4311 - Post-traumatic stress disorder, acute F4312 - Post-traumatic stress disorder, chronic
Schizoid personality disorder	F603 - Schizoid personality disorder

Immunizations for Adolescents (Combo 2)

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☐Survey ☒Other: ALERT IIS Registry

State Benchmark: 40.4% (2019 National Medicaid 75th percentile)

Who: Children who turn 13 years of age in 2021.

Why: Despite the effectiveness of vaccines to prevent disease and reduce unnecessary costs to the health care system, immunization rates for children in Oregon remain well below national Healthy People 2020 goals. Much attention is given to those who choose not to vaccinate their children; however, these families and communities represent the minority in Oregon. Most parents do intend to vaccinate their children according to the American Academy of Pediatrics schedule and as recommended by their health care provider. Thus, providers play a key role in immunization rates among their patients (Source: *CCO Resource Guide–Strategies to Improve Immunization Rates*, OHA July 2017).

What: This measure reports the percentage of adolescents who turn 13-years-old in 2021 who receive all the following immunizations before their 13th birth date:

- Meningococcal: At least one meningococcal serogroups A, C, W, Y vaccine on or between the member's 11th and 13th birthdays.
- Tdap: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the member's 10th and 13th birthdays.
- HPV: At least two HPV vaccines with different dates of service, at least 146 days apart, occurring on or between the member's 9th and 13th birthdays.

  OR

  At least three HPV vaccines with different dates of service on or between the member's 9th and 13th birthdays.

How: Some ideas to improve Immunizations for Adolescents performance:

- Ensure that immunization records in ALERT are up to date and that all patient information is correct (e.g. name spelled correctly, correct date of birth, etc.).
- Schedule immunizations visits months before their 13th birthday.
- Ensure that patient decision-aid tools and catch-up schedules are available for all parents when deciding to vaccinate their children (see resources for more information).
- Discuss HPV vaccinations in the context of cancer prevention rather that sexual education. Ensure evidence-based resources on HPV vaccinations and cancer prevention are available for both adolescents and parents.
- Schedule subsequent vaccine visits before parents leave the office.

- Implement patient recall workflows.
- Behavioral Health Support: BHC asks families and/or scrubs their schedule to identify children in need of immunization when they're in clinic for BHC appointment. Those who need immunizations are connected for scheduling or same-day appointment. Support families through discussions of vaccine hesitancy.

Exclusions: Members who are deceased at the time of metric reporting or in hospice during the measurement year.

Coding: OHA relies on ALERT IIS data and does not directly rely on claim/encounter codes.

Immunizations for Adolescents (Combo 2) FAQ

Q: What immunization combination does this metric follow?

A: HEDIS® MY2020/2021 Combination 2.

Q: How do I know which members are due for vaccinations?

A: An adolescent's immunization history in ALERT should be checked before each visit. Additionally, CareOregon prepares and distributes member gap lists using ALERT data provided by OHA on a quarterly basis. If parents decline the vaccine, the adolescent remains in the measure denominator. Please reach out to your Primary Care Innovation Specialist for additional resources.

Q: Who is included in the denominator for this measure?

A: Members whose thirteenth birthday is within 2021 and have had physical health coverage with the CCO continuously for the 12 months prior to their thirteenth birthday are included in the denominator.

Q: If parents refuse to have their adolescent vaccinated, are they excluded from the metric?

A: No. If the adolescent does not receive immunizations, they will remain in the denominator but not the numerator.

Resources

CDC recommended schedule of immunizations for adolescents:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET)

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating
Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience
Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
State Benchmark: Initiation for Age 18+ – 46.8% (2019 National Medicaid 75th percentile) Engagement for Age 18+ – 18.5% (2019 National Medicaid 75th percentile) *Must meet both components to achieve measure.*

Who: Members aged 18 years and older with a new diagnosis of alcohol or other drug use between January 1, 2021–November 14, 2021. A diagnosis is considered "new" if the member has not had a diagnosis of (or received medication for) alcohol or other drug use in the previous 60 days.

Why: Access to treatment for substance use disorder is a critical aspect of a person's health and their journey through recovery. The IET metric is a tool to encourage coordination across the network of care providers for substance use treatment and helps ensure people have timely access to appropriate care.

What: Two rates are reported for this measure: Initiation and Engagement. Both measures use the same denominator.

1. Initiation – For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 60 days), this metric measures the percentage of those who initiated treatment within 14 days through either medication dispensing or a SUD visit with a provider.
   a. Initiation of treatment can be on the same day as the new alcohol or other drug use diagnosis if the services are with different providers.
2. Engagement - For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 60 days), this metric measures the percentage of those who had two treatment events, either medication dispensing or a SUD visit with a provider, within 34 days from their initial treatment event.
   a. If treatment was initiated through a medication dispensing event, only one of the two required engagement events can be through medication and the other must be through a SUD visit with a provider.
   b. Both engagement events can be on the same day if the services are with different providers; the exception being if one event is for medication-assisted treatment there is no requirement that they be different providers.

How: There are over 230 codes that count toward numerator criteria through a visit with a provider; **please see IET Guide for Primary Care on the following pages for additional details.** In general, initiation and engagement events can be through medication dispensing events, inpatient, outpatient, observation, or telemedicine visits.

NOTE: Methadone is not included in the medication lists for this measure because Methadone for opioid use disorder does not show up in pharmacy claims data. However, Methadone for opioid use disorder treatment **does count as treatment for this metric** and would be captured on medical claims.

Exclusions: Hospice during any point in the year.

Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET) FAQs

Q: Is tobacco use included in this metric?

A: No. While we do consider tobacco use disorder to be included in the continuum of substance use disorders from a clinical perspective, it is not considered as one of the diagnosis codes that would qualify someone for the IET metric.

Q: What is considered as "other drugs" in this metric?

A: The IET measure is looking for substance use disorder diagnosis including alcohol, opioid and other drugs such as cocaine, cannabis, methamphetamine, hypnotics, sedatives, inhalants, etc. See OHA specifications for full list.

Q: How are initial alcohol or other drug use diagnoses identified?

A: Alcohol or other drug use disorder diagnosis codes are identified using claims for services that occurred in the following visit types:

- Outpatient visits
- Telehealth
- E-visit of virtual check-in
- Intensive outpatient visits
- Partial hospitalization
- Detoxification visits
- ED visits or Observation
- Acute or non-acute inpatient admits
- Online assessment
- Opioid treatment services

IET Guide for Primary Care

This guide includes 4 sections:

1) Billing and Coding
2) BHC engagement
3) Collective Medical - IET cohort, useful tips
4) Person centered practice to increase engagement

1. Billing and Coding

Initiation in Primary Care

Your patient must have **one or more** of these visit types **within 14 DAYS** of the initial diagnosis to meet the measure.

For patients with all types of SUD:

Type of Visit	Common Codes
In-Person Office Visit with a SUD Dx *Substance must match the member's initial Dx type	**E&M Codes** 99211-99215, 99203-99205 **BH Services Integrated in Primary Care** 90971, 90972, 90832, 90837, 90840, 90847, 90849, 90853 H0001, H0002, H0031
Telephone Visit with a SUD Dx *Substance must match the member's initial Dx type	98966, 98967, 98968 99441, 99442, 99443
E-Visit/ Virtual Visit with a SUD Dx *Substance must match the member's initial Dx type	99421, 99423, 99444 G0071, G2012

For patients with OUD (in addition to codes listed for all substance types):

Type of Visit/Claim	Medication list
OUD Medication Prescription	**Naltrexone** (oral or injectable) **Buprenorphine** (sublingual tablet, injection, implant) **Buprenorphine/Naloxone** (sublingual tablet, buccal film, sublingual film)

For patients with AUD (in addition to codes listed for all substance types):

Type of Visit/Claim	Medication list
AUD Medication Prescription	**Disulfiram** (oral) **Naltrexone** (oral or injectable) **Acamprosate** (oral; delayed-release tablet)

Engagement in Primary Care

A patient must have the right combination of visit types **within 34 DAYS of initiation** to be considered engaged in treatment. How a patient can become engaged depends on their type of treatment initiation:

Initiation Type	Meet criteria for 'Engaged' in Metric	
Patients who initiated treatment **WITH** medication	One Medication Event + One Engagement Visit	Two Engagement Visits
Patients who initiated treatment **WITHOUT** medication	One Medication Event	Two Engagement Visits

Medication event in primary care setting

Type of Claim	Medication list
OUD Medication Prescription	**Naltrexone** (oral or injectable) **Buprenorphine** (sublingual tablet, injection, implant) **Buprenorphine/Naloxone** (sublingual tablet, buccal film, sublingual film)
AUD Medication Prescription	**Disulfiram** (oral) **Naltrexone** (oral or injectable) **Acamprosate** (oral; delayed-release tablet)

Engagement visit in primary care:

Type of Visit	Common Codes
In-Person Visit with an SUD Dx *Substance must match the member's initial Dx type	**E&M Codes** 99211-99215, 99203-99205 **BH Services Integrated in Primary Care** 90971, 90972, 90832, 90837, 90840, 90847, 90849, 90853 H0001, H0002, H0031
Telephone Visit with an SUD Dx *Substance must match the member's initial Dx type	98966, 98967, 98968 99441, 99442, 99443
E-Visit/ Virtual Visit with an SUD Dx **Substance must match the member's initial Dx type*	99421, 99423, 99444 G0071, G2012

**These codes count as a medication event AND an engagement event for members in the OUD cohort, so they meet the engagement metrics on their own.*

2. BHC Services in Primary Care

Behavioral Health Consultants (BHC) can help create an environment in primary care that supports an open door for recovery. Ensure patients know that the BHC is a resource, the BHC should be introduced to patients who are diagnosed with a substance use disorder, receive medication for substance use, or receive a follow up from ED visit for substance use

Key Services

- Preventative medicine counseling
- Psychotherapy
- Health and Behavior (for SBIRT)

Key BHC Workflows

- Utilize BHC for SBIRT, this is the start of **initiation/identification;** BHC can screen during BHC and PCP appointments
- BHC can help facilitate referrals and coordinate care if outside referrals are the best course of treatment
- Introduce BHC to patients who are diagnoses with any use disorder

3. Collective Medical

Real time knowledge of SUD inpatient and emergency department admissions allow us to coordinate in the moment to best meet our members' needs.

- Set up alerts/notifications to know when your patients end up in the ED for SUD related issues so you can follow up quickly to provide support
- Consider utilizing Collective IET cohort (details in chart below)
- Utilize reports as an additional resource for scrubbing/reviewing records before visits
- Create watch lists of patients whom you've seen in the clinic for better monitoring
  - Include those who you're referring to behavioral health and those who are going to follow up with you in primary care
  - If patients go to ED for behavioral health related issues (substance use or not), reach out for quick follow up

Collective Medical Cohort Criteria

The specifications below are suggested cohort criteria based on CareOregon's Collective onboarding support for health care providers. Some providers/organizations may choose to adjust criteria to best meet their organization's resources, needs, and existing workflows.

SUD-IET—Any Encounter Event

- Triggering Event: *Any visit activity in ED, Inpatient, Observation settings*
- Physical Age above 18+
- Exclusions:
  - Discharge code does not equal 20 (to indicate Patient 'Expired')
  - F17 Nicotine related
- Diagnosis Phrase:
  REGEX-(?i)alcohol.*|dependence.*|withdrawal.*|abuse.*|drug use.*|heroin.*|opiate.*|opioid.*|adverse.*|overdose.*|tremens.* |Intoxication.*|poison.*|hallucinogen.*|Illicit.*|detox.*

And/OR:

- Diagnosis Code:
  - Include the following ICD -10 codes with all subtypes if there is an asterisk:
  - F10* Alcohol related
  - F11* Opioid related
  - F13* Sedative, hypnotic or anxiolytic related
  - F14* Cocaine related
  - F15* Other Stimulant related (this will capture methamphetamine use)
  - F16* Hallucinogen related
  - F18* Inhalant related
  - F19 Other Psychoactive substances
  - O9931* / O9332* Alcohol related, pregnancy Drug use complicating, childbirth, and the puerperium
  - T401* Poisoning by Heroin
  - T402* Poisoning by Opioid
  - T404* Poisoning by synthetic narcotics
  - T409* Poisoning by hallucinogens
  - T42 Poisoning by, adverse effect of and underdosing of antiepileptic, sedative- hypnotic and antiparkinsonism drugs
  - T51.91XA Toxic effect of unspecified alcohol, accidental (unintentional), initial encounter

4. Person-Centered Best Practice

- Use a trauma informed, person-centered approach to educate and care for your patient
  - Use this opportunity to establish a supportive and trusting relationship with your patient with phrases such as "I'm so glad you are here", "I care so much about your safety"
  - Language Matters! By using positive, person-centered language, you are more likely to keep people engaged in care. Feeling stigmatized can reduce the willingness of individuals with SUD to seek treatment.
- Prescribe naloxone for any person who has a substance use disorders; ensure your patient has naloxone in-hand
- Discuss Medication for Opioid Use Disorder (MOUD) with any person diagnosed with Opioid Use Disorder (OUD).
  - Prescribe MOUD when indicated.
  - MOUD is the gold-standard, best-practice for the treatment of OUD.
- Connect your patient with syringe access, wound care supplies, and community supports as needed
- Query the Prescription Drug Monitoring Program (PDMP) to identify all prescribers/prescriptions
  - Coordinate care with any outside providers
- Ask your patient to sign a Release of Information to access substance use treatment records

Links to Helpful Documents:

Words Matter: Terms to Use and Avoid When Talking About Addiction

Recovery Oriented Language Guide

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☒Survey ☒Other: OHA-developed

2021 State Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 46

Component 2 – N/A

2022 State Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 56

Component 2 – Must hybrid quantitative report on sample of eligible population.

2023 State Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 77

Component 2 – TBD percentage of interpreter services provided by certified or qualified interpreters (benchmark based on 2022 results); will report on full eligible population.

Who: Members who self-identify with the OHA as having interpretation needs, spoken or sign language, and had a health care visit in the measurement year.

Why: Communication problems present a significant barrier for individuals with Limited English Proficiency (LEP) to achieve their best health potential. Lack of access to quality oral and sign language interpretation results in decreased quality of care, increased medical errors, and widens existing gaps in disparities. Professional interpretation services are associated with improved clinical care in terms of comprehension, utilization, clinical outcomes and satisfaction for both patients and clinicians. Increasing access to spoken and sign language services are critical tools for advancing equity and meaningful access to health care services (Source: *Health Equity Measure Proposal, submitted to Health Plan Quality Metrics Committee,* OHA, May 2019.)

What: There are two components to this measure. A CCO language access self-assessment survey and a quantitative language access report.

<u>Component 1: CCO language access self-assessment survey</u> – The survey has four domains and a maximum of 89 total points. The CCO must (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum total points required for each measurement year.

The four domains of the survey are:

1. Identification and assessment of communication needs
2. Provision of language assistance services
3. Training of staff on policies and procedures
4. Providing notice of language assistance services

Component 2: Quantitative language access report – This component reports the percentage of member visits with interpretation need in which interpreter services were provided.

- Denominator: Number of physical, mental, or dental health visits for members in the eligible population.
- Numerator: Number of those visits in which interpretation service was provided **by an OHA-certified/qualified interpreter**.

How: To help members have meaningful language access:

- Ask member's their preferred spoken language and record this in their permanent record.

- Have a clear process and train staff to offer interpretation services to members. When a language need is identified, best practice is to have an interpreter discuss the process, availability, and benefits of having interpretation services with the member.

- Interpretation is an essential service that requires advance planning. Have a process for scheduling interpreters as soon as members make their appointment.

- Have a process for documenting the provision of interpreter services in the EHR as structured data (not as a note). Documentation should include what language, the modality (In-person, telephone, video), who provided the interpretation, whether their certified or qualified, or if the member declines interpretation services.

- Interpretation should be provided by certified or qualified interpreters. Interpreters can be clinic staff who are certified, or through a contracted interpretation vendor. The measure will be incentivized based on an increasing proportion of interpretation services provided by OHA-certified/qualified providers.

- CareOregon contracts with three language service agencies. To arrange for an interpreter to be present during an appointment, complete the CareOregon Interpreter Request form on the CareOregon website at http://careoregon.org/providers/support/interpreters.

Exclusions: None.

Data Reporting:

- Component 1: The CCO is responsible for completing the language access self-assessment survey.
- Component 2:
  - Eligible population is identified by having an interpretation need documented in MMIS. A member will not enter the measure if they have not informed the OHA that they have an interpretation need.
  - Denominator: Visits are identified by claims submitted to the CCO.
  - Numerator: Any information the CCO has available on interpretation service provision can be used for reporting: invoice from interpretation vendor, chart documentation, EHR data report, claims, etc.

Frequently Asked Questions

Q: Are clinics responsible for reporting?

A: For 2021, the CCO is responsible for reporting on the first component of the measure. CareOregon will work with clinics on collecting sources of interpretation data for future reporting.

Q: Do clinics need to proactively work on this measure?

A: Yes, clinics should work to identify members with language needs and schedule interpretation services for their appointments.

Q: What if a member declines interpretation service or insists on using a family member?

A: Explain the process and benefits of using qualified/certified interpretation services. If a member still declines, then document that services were offered and declined in the EHR.

Q: What if a provider or staff member (non-qualified/certified) is bilingual?

A: Explain the process and benefits of using qualified/certified interpretation services. If a member still declines, then document that services were offered and declined. Services provided bilingual staff or providers who are not OHA-certified/qualified will not count towards this measure.

Q: If a member does not have an interpretation need listed in MMIS, will they be in the measure?

A: No. However, the goal is to provide meaningful access to language services to everyone regardless of whether they are in the measure. Please follow the same process for connecting members with interpretation even if their interpretation need is not in MMIS.

Resources:

https://www.oregon.gov/oha/HPA/ANALYTICS/MeetingDocuments/2019-05-02-Health-Equity-Measure-Proposal.pdf

CareOregon Provider Interpreter Service Handout

https://www.careoregon.org/providers/support/interpreters

Guidelines for medical providers for working with interpreters

http://delamorainstitute.com/wp-content/uploads/ALL-COURSE-CONTENTS-WITH-PAGE-NUMBERS.pdf

Best practice for using over-the-phone interpretation

https://blog.cyracom.com/best-practices-for-using-phone-interpretation-in-a-healthcare-setting

Helping patient express their preferred language https://www.oregon.gov/oha/OEI/Documents/Preferred%20Language%20Cards%20Instructions%20for%20External%20Partners%2010_2017.pdf

Preventive Dental Services for Children aged 1-5 and 6-14

Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

State Benchmark: Preventive Dental Services age 1-5 – 45.4% Preventive Dental Services age 6-14 – 65.5% (CCO 75th percentile from two years prior)

CCOs must meet benchmark or improvement target for both age groups to achieve measure.

Who: All patients who will turn age 1–14 years old during the calendar year.

Why: Poor oral health has been linked to chronic pain, lost school days, and avoidable visits to the emergency department. Oral health can also affect speech, nutrition, growth and function, social development. Ensuring all children have access to dental health care during these formative years is important to their overall health and quality of life.

What: All patients who will be age 1–14 years by the end of the 2021 calendar year who are continuously enrolled with the CCO for at least 6 months and have at least one preventive dental service with either a dental or non-dental provider.

This measure is reported using two separate age stratification: patients aged 1–5 years and 6–14 years, who received a preventive dental service during the measurement year. Both age stratification groups must meet either the state benchmark or CCO improvement target to comply with this incentive measure.

How:

- Discuss the importance of dental health during all physical health wellness visits
- Include dental visits in your existing referral coordination workflow
- Use CareOregon's dental referral process in the OneHealth Portal to easily connect CareOregon members to a dental care coordinator who can help them schedule with a dental provider
- Behavioral Health Support: 30% of children are afraid to go to the dentist--BHC can support family for a successful dental visit.
    - Inreach: BHC asks families and/or scrubs their schedule to identify children in need of dental appointment when they're in clinic for BHC appointment. Those who need appointment are connected for scheduling.
    - Follow Up Engagement and Support: BHC provides supports for family implementing healthy behaviors (e.g. brushing routine) and can support family in connecting dental referral.

Exclusions: N/A

Coding:

Preventive Dental Services: CDT codes D1000 – D1999 billed by dental providers, Federally Qualified Health Centers, or Rural Health Centers.

Preventive Oral Health Services: CDT codes D1000 – D1999 or CPT code 99188 billed by non-dental providers.

Members Receiving Dental Services FAQ

Q: Can a member qualify for the denominator for two separates CCOs?

A: Yes, if the member switched from one CCO to another and had continuous enrollment for at least 180 days (i.e. 6 months) in the same year with both CCOs. The numerator services are attributed independently to the CCOs that paid and submitted the claim; thus, the member would not automatically count in the numerator for both CCOs, but only that CCO which paid the claims for the preventive service.

Q: Will services provided by dental hygienists count if they are not under supervision of a dentist?

A: Yes. Although the technical specifications state that "services provided by dental hygienists should only be counted when they are under supervision of a dentist," the OHA does not adopt this requirement because administrative claims data generally do not indicate supervision between health care providers.

Q: Does a First Tooth visit count as a preventive dental service for this measure?

A: CPT code 99188 (topical fluoride varnish) billed with a First Tooth visit on a medical claim does count towards the metric numerator.

Q: Do Telehealth visits count toward the metric?

A: This measure is eligible for telehealth/teledentistry. Some qualifying services such as D1310 'nutritional counseling' and D1330 'oral hygiene instructions' may be delivered in a teledentistry visit but are subject to providers' determination whether required components can be provided equivalent to an in-person visit.

Assessments for Children in DHS Custody

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure
Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience
Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
State Benchmark: 90%; from Metrics & Scoring Committee consensus.

Who: Children and adolescents aged 0–17 years newly placed in DHS custody between November 1, 2020, and October 31, 2021. Note the cut-off date of notification is on October 31st so the health assessment period can occur by the end of the year.

Why: OHA developed these specifications based on requirements for physical, mental, and dental health assessments for children who enter foster care. Children in foster care are among the most vulnerable that CCOs serve. This measure ensures that they receive necessary care during a challenging transition.

What: Completion of the following health assessments within 60 days after the CCO is notified that the child has entered DHS custody, or within the 30 days prior to notification.

	Required assessments for children entering DHS custody		
Age on CCO Notification Date	**Physical**	**Dental**	**Mental**
Less than 12 months old	YES	NO	NO
1 to 3 years old	YES	YES	NO
4 to 17 years old	YES	YES	YES

How: The CCO coordinates with dental, mental, and physical health providers to schedule necessary assessments, and providers agree to prioritize foster children for appointment scheduling.

Exclusions: Children will be excluded from the final measure denominator if:

- The CCO does not receive notification from OHA within 30 days of the child entering DHS custody.
- The child does not remain in DHS custody and enrolled with the CCO for 60 days after notification.

See OHA technical specifications for a complete list of other exclusions handled on a case-by-case basis.

Coding:

Physical Health Assessment	Mental Health Assessment	Dental Health Assessment
99201 – 99205 (can count for mental health assessment as well if mental health dx code is included on claim) 99212 – 99215, 99381 – 99384, 99391 – 99394, G0438, G0439	90791, 90792, 96130, 96131, 96136, 96137, 96138, 96139 H0031, H1011 H2000 – TG (***need modifier***) H0019, H2013, H0037	D0100 – D0199
	Mental Health dx codes on 99201-99205: F03, F20–F53, F59–F69, F80-F99	

Assessments for Children in DHS Custody FAQs

Q: Do clinics need to proactively work on this measure?

A: No, if clinic help is required for a child in this measure, CCO staff contact the clinic directly.

Q: How does the CCO coordinate this measure?

A: CCO staff maintain a list of children in foster care and points of contact with local DHS offices. They work with physical, mental, and dental health plan staff to outreach to foster parents and facilitate the scheduling of needed services.

Oral Evaluation for Adults with Diabetes

Performance Measure Set: ☒CCO Incentive ☐Medicare Star Rating

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐ Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

Medicaid State Benchmark: 26.8% (2018 CCO 75th Percentile)

Who: All patients aged 18 years or older with type 1 or type 2 diabetes during the measurement year or the year prior to the measurement year (i.e. a diabetes dx since January 1, 2020) identified through medial or pharmacy claims.

Why: Efforts to promote whole-person care include bringing together physical and oral health. This is especially true for adults with diabetes. Diabetes increases the risk of gum disease, and untreated gum disease can worsen blood sugar control. Lack of oral health care has also been linked to costly emergency department visits, where prescription pain medication may be the only treatment available.[1]

What: Percent of members who received a comprehensive, periodic or periodontal oral evaluation in the measurement year.

How:

- Ask whether diabetic patients are regularly engaged with a dental provider.
- Request dental outreach for patients through CareOregon's provider portal or another internal referral processes.
- Discuss the need for routine oral health care with all diabetic patients.
- Behavioral Health Follow Up Engagement and Support: approx. 50% of dental patients have anxiety. BHC can evaluate barriers to attending referral to dental, such as anxiety. BHC can follow up with patients after dental appointment should have occurred to see if appointment was completed and if it wasn't, help problem solve and follow up to help patient try again. After completing dental appointment, BHC can help with implementation of healthy behaviors.

Exclusions: Patients identified with gestational diabetes or steroid-induced diabetes but who do not have a diagnosis of Type 1 or Type 2 diabetes in any care settings. Patients in hospice or palliative care. Patients 66 and older as of December 31 of the measurement year enrolled in an institutional SNP (I-SNP), or living long-term in an institution, or who meet the criteria for frailty and advanced illness.

Coding:

CDT codes: D0120, D0150, or D0180.

[1]NASHP (National Academy for State Health Policy): https://nashp.org/wp-content/uploads/2017/09/DentaQuest-Brief.pdf

Note on teledentistry: This measure may be eligible for teledentistry. While the intent of the measure is to ensure that members with diabetes had a touchpoint with the dental delivery system and had diagnoses and treatment planning, these activities as documented in the claims data by the dentist/ dental health provider is based on their clinical judgment. If the rendering provider documents a qualifying CDT code (D0120, D0150 or D0180) in the claims form, the visit will be counted in the measure, irrespective if the visit was virtual (Teledentistry) or in person.

[1]NASHP (National Academy for State Health Policy): https://nashp.org/wp-content/uploads/2017/09/DentaQuest-Brief.pdf

Screening for Depression and Follow-Up Plan

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Rating
Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience
Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐ Survey ☐Other
State Benchmark: N/A. 2021 is considered a reporting-only year for this measure.

Who: All patients aged 12 and older with at least one eligible encounter during the year.

Why: Major depression is a serious mental illness affecting millions of adults and children each year with impacts on health outcomes, quality of life, and cost of care. Comprehensive screening in primary care may help clinicians identify undiagnosed depression, earlier in the course of depression, and initiate appropriate treatment (Source: OHA Guidance Document, 2014).

What: This measure includes all members aged 12 and older who have at least one visit during the year (including telehealth visits). It reports those who were screened for clinical depression using an age appropriate standardized tool, and, if positive, have a follow-up plan documented on the same day as the positive screening result. Therefore, there are two ways to meet numerator:

1. members received an initial depression screening and it was negative
2. members received an initial depression screening and it was positive, AND they received appropriate follow up documented on the same date

NOTE: PHQ-9 no longer counts as follow-up to a positive PHQ-2 screening and additional follow-up options need to be completed and documented. Please see FAQ page below for detail on the changes.

How: Some ideas to improve Depression Screening and Follow-Up performance:

- Standardized, age appropriate, annual screening tools should be used for screening patients at least once per measurement period; ideally integrated in EHR workflows.
- Workflows that include front desk staff, MAs, and providers are necessary to ensure each patient receives the appropriate screening, correct scoring, review, and documentation during at least one encounter per year.
- Staff should be prepared to discuss your clinic's confidentiality practices and the importance of screening with each patient.
- Collaborative Appointment: Set a standard workflow where BHC sees patients who score positive on the depression screening (e.g. PHQ-9 of 10+). BHC can see patient before PCP to assess for safety and develop follow up plan. BHC can inform PCP of the plan during warm hand off, which allows PCP to address additional issues during visit.

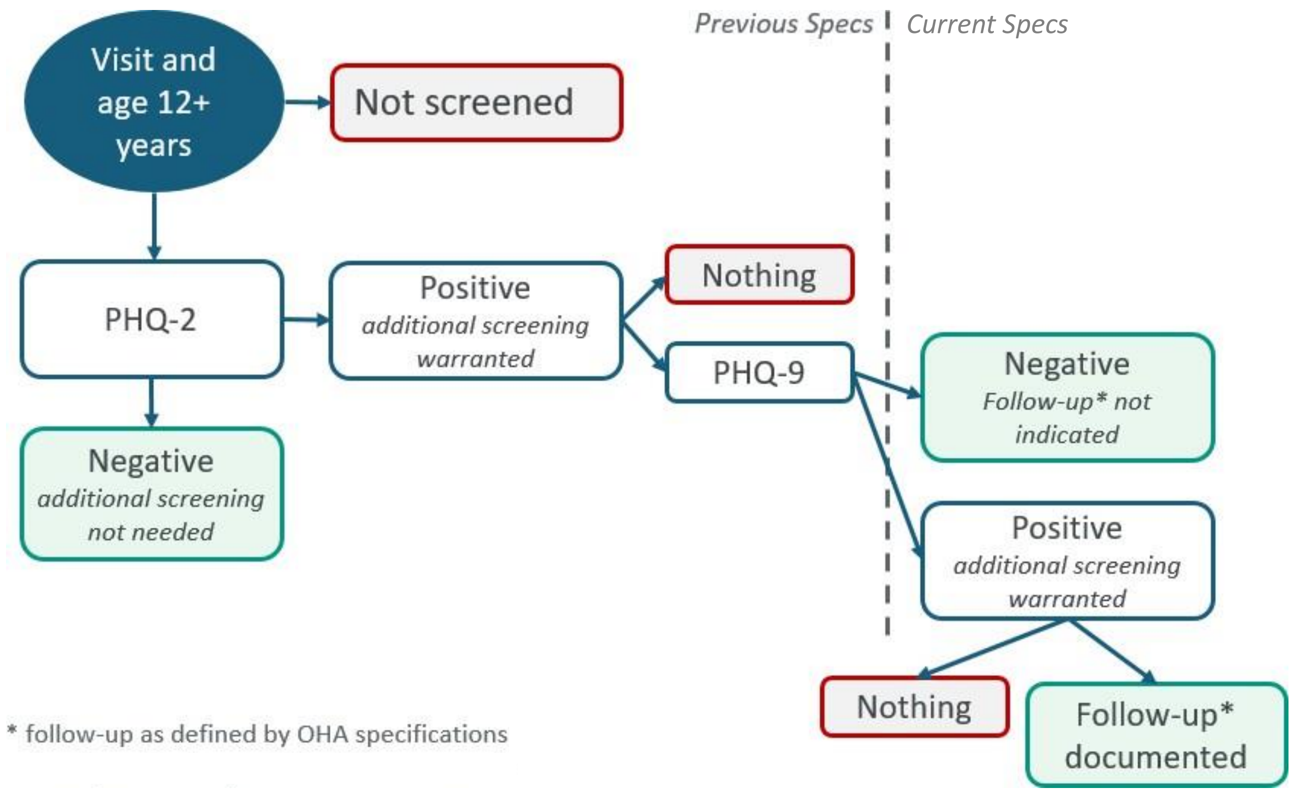
Exclusions: Patients with a current or historical diagnosis for depression or bipolar disorder, patients who refuse to participate in screening, if there is a medically urgent reason to delay screening, or if the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results.

Reporting: This measure aligns with **NQF 0418e/CMS 2v10**. CareOregon must collect data from each clinic's EHR for this measure. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12- month timeframe
- Data must be formatted in Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Recommend Workflow and Reporting Logic:



Screening for Depression and Follow-up Plan FAQ:

Q: Does the depression screening need to happen on the same date as the visit encounter?

A: No. Depression screenings performed 14 days prior to the encounter are accepted to allow alternative methods of screenings, such as pre-screenings within EHRs. However, follow-up plans for a positive initial screening must be documented on the date of the encounter.

Q: What counts as a "positive" score?

A: Determination of a "positive" score is up to the clinical discretion of each provider and will be dependent on the screening tool used. CareOregon does not provide clinical guidance and defers to the best clinical judgement of providers to interpret the screening results and identify appropriate follow-up plans.

Q: What types of "follow-up" are sufficient for this measure?

A: Documented of at least one of the following:

- **Referral to a practitioner or program** for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. This can be an internal or external referral, and either type should be documented in a way that is captured in reporting.
- **Physical therapy evaluation**
- **Other interventions designed to treat depression** such as psychotherapy, pharmacological interventions, or additional treatment options.
    - Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Q: What screening tools are recommended?

A: OHA does not require use of specific screening tools, only that screening tools are normalized, validated, and age appropriate. Implementation of tools is at the provider or clinic's discretion. Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)

- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

- Patient Health Questionnaire (PHQ9)
- Beck Depression Inventory (BDI or BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)
- Computerized Adaptive Diagnostic

Screener (CAD-MDD) Perinatal Screening Tools

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory
- Beck Depression Inventory-II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-Rating Depression Scale

Timeliness of Prenatal and Postpartum Care

Performance Measure Set: ☒CCO Incentive Metric ☐Medicare Star Measure
Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience
Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other
State Benchmark: Postpartum Care – 61.3% (2018 CCO statewide average)

Note: Although CCOs must submit data for timeliness of both prenatal and postpartum care, the 2021 CCO incentive measure and quality pool payments are tied to the Postpartum Care rate. Starting in 2020 services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates, however it is up to each clinic to determine how they handle telehealth visits.

Prenatal Care

Who: Members who had a live delivery with estimated delivery date (EDD) between October 8 of the year prior to the measurement year and October 7 of the measurement year who meet continuous enrollment criteria (i.e. October 8, 2020 – October 7, 2021).

Why: Appropriate perinatal service and education are crucial components of a healthy birth. Preventing complications that can affect the health of both parent and baby before, during and after pregnancy is equally important. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend at least one exam during the first trimester for prenatal care in an uncomplicated pregnancy and one exam approximately 4–6 weeks after delivery for postpartum care.[1]

What: A prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment, to an OB/GYN or other prenatal care practitioner, or PCP.

How: A prenatal visit with an OB/GYN practitioner or midwife, family practitioner or PCP can satisfy this measure. Visits with a PCP require a diagnosis of pregnancy. Documentation of prenatal care in the medical record must include a note indicating the date of the prenatal care visit and *at least one* of the following:

1. Documentation indicating the woman is pregnant or references to the pregnancy.
2. A basic physical obstetrical examination that includes auscultation for the fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.
3. Evidence that a prenatal care procedure was performed such as:
    - Screening test in the form of an obstetric panel
    - TORCH antibody panel alone, or
    - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
    - Ultrasound of a pregnant uterus.

Postpartum Care

Who: Members who had a live delivery between October 8, 2020–October 7, 2021.

What: A postpartum visit for a pelvic exam or postpartum care on or between 7–84 days (1–12 weeks) after delivery.

How: A postpartum visit with an OB/GYN practitioner or midwife, family practitioner or other PCP can satisfy this measure. Postpartum care provided in acute inpatient settings does not count towards this measure. Documentation of postpartum care in the medical record must include the date of the postpartum care visit and *at least one* of the following:

4. Pelvic exam.
5. Evaluation of weight, blood pressure, breasts and abdomen.
6. Notation of postpartum care, including, but not limited to:
   - Notation of “postpartum care,” “PP care,” “PP check,” or “6-week check;”
   - A preprinted “Postpartum Care” form in which information was documented during the visit.
7. Perineal or cesarean incision/wound check.
8. Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
9. Glucose screening for women with gestational diabetes.
10. Documentation of any of the following topics:
    - Infant care or breastfeeding;
    - Resumption of intercourse, birth spacing or family planning;
    - Sleep/fatigue;
    - Resumption of physical activity and attainment of healthy weight.

Exclusions: Non-live birth and patients in hospice.

[1] (NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Timeliness of Postpartum Care FAQ

Q: My clinic does not provide prenatal care, does this measure affect us?

A: Yes, you should still encourage patients to seek timely prenatal care from a prenatal provider. In addition, some of the services that qualify as "prenatal care" are appropriate for primary care and may even improve the quality of the referral to OB/GYN.

Q: We only offer RN visits during the first trimester; will that count for the measure?

A: An RN visit on its own does not count for the measure. However, if a provider signs off on the RN visit note and/or the claim is billed under the provider we would consider this compliant, as the provider is evaluating the visit information and is ultimately responsible for the assessment.

Q: Will a Pap test alone count for the postpartum care visit?

A: Yes. Although a Pap test alone does not count as a prenatal care visit for the Timeliness of Prenatal Care rate, it will count for the Postpartum Care measure.

Part Two
Medicare Stars Metrics

- Breast Cancer Screening
- Care for Older Adults - Medication Review
- Care for Older Adults - Pain Assessment
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Diabetes Care - Eye Exam
- Diabetes Care - Kidney Disease Monitoring
- Diabetes Care - Blood Sugar Controlled
- Medicare Health Outcomes Survey - Improving Bladder Control
- Medicare Health Outcomes Survey - Monitoring Physical Activity
- Medicare Health Outcomes Survey - Risk of Falling
- Medicare Medication - Adherence for Cholesterol - Statins
- Medicare Medication - Adherence for Diabetes Medications
- Medicare Medication - Adherence for Hypertension
- Osteoporosis Management in Women who had a Fracture
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Use in Persons with Diabetes

Breast Cancer Screening (BCS)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality

Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 79.98% (75th), 85.59% (90th)

Who: Female patients between the ages of 52 and 74 as of December 31 of measurement year.

Why: Preventative screenings for breast cancer help detect breast cancer in women who have no signs or symptoms of the disease. Early detection and treatment of breast cancer can greatly improve patient outcomes.

What: The percentage of women who had at least one mammogram any time between October 1 of the two years prior to the measurement year through December 31 of the measurement year. For example, for the 2021 measurement year, the qualifying period is October 1, 2019 – December 31, 2021.

How: Methods of mammograms that qualify include primary screening, film, digital or digital breast tomosynthesis.

Exclusions: Women 66 years of age and older enrolled in an institutional SNP (I-SNP) or living in long-term in an institution any time during the measurement year; members with advanced illness and frailty; women receiving palliative care or in hospice; women who have had a bilateral mastectomy or history of a bilateral mastectomy; or evidence of a right and a left unilateral mastectomy.

Tip: For women who have a bilateral mastectomy or history of a bilateral mastectomy, be sure to document in the Problem List and Health Maintenance sections to ensure that they will be excluded from the measure.

Coding:

CPT: 77055-77057, 77061–77063, 77065-77067, HCPCS: G0202, G0204, G0206

Breast Cancer Screening (BCS) FAQs

Q: Do biopsies, breast ultrasounds, MRIs or tomosynthesis (3D mammography) count as a primary mammography screening?

A: No. Although diagnostic procedures are sometimes performed as an adjunct to mammography for women at higher risk of breast cancer, MRIs, ultrasounds, or biopsies alone do not count.

Q: Is a physician order required for a mammography screening?

A: No. A physician can refer a member for a screening based on age criteria and health status, but a member can schedule a mammogram without a physician's order.

Q: How do I close the referral loop?

A: Check to see that the mammogram report is in the medical record and update the Health Maintenance Summary section.

Care for Older Adults (COA): Medication Review

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 98.46% (75th), 100% (90th)

Who: Adult patients 66 years of age or older as of December 31 of the measurement year.

Why: Older adults are at risk for adverse drug events due to multiple medications and complex medication regimens. Medication review helps increase communication between patient and prescriber to minimize medication duplication and complexity, resolve discrepancies, and increase patient adherence.

What: The percentage of patients with at least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year.

How: This measure can be satisfied using CPT/HCPCS codes or through medical record review during HEDIS review. Both the medication list and the review must be in the encounter to be compliant.

If submitting a claim, the CPT/HCPCS codes for the medication review and med list must be on the same claim.

Exclusions: Patients in hospice or using hospice services during the measurement year.

Coding:
CPT/HCPCS: 90863, 99483, 99605, 99606, 99495, 99496, G8427
CPT-CAT-II: 1160F, 1159F

Care for Older Adults (COA): Medication Review FAQs

Q: Are over-the-counter medications and herbal supplemental therapies included in the medication review?

A: Yes.

Q: Does notation of a review of side effects for a single medication at the time of prescription count?

A: No. A medication review includes all prescription medications, OTC medications and herbal or supplemental therapies.

Q: Is an outpatient visit required to meet criteria?

A: No. A clinical pharmacist or provider can review medications with a patient via a phone conversation. The reviewed medication list signed by the clinical pharmacist or provider is evidence that the medications were reviewed.

Q: If the patient is not taking any medications or herbal supplements is a notation still required?

A: Yes. Notation that the patient is not taking any medication and the date when it was noted are needed to count.

Q: Does it count if a CMA reviews the medication list at the beginning of the encounter?

A: Yes, if the medication list is in the encounter and the provider or clinical pharmacist states that the medications were reviewed.

Care for Older Adults (COA): Pain Assessment

Performance Measure Set: ☐ CCO Incentive Metric ☒Medicare Stars Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks Nat'l Percentile: 98.54% (75th), 99.71% (90th)

Who: Adults 66 years of age or older as of December 31 of the measurement year.

Why: As the population ages physical and cognitive function can decline, and pain becomes more prevalent. This is one of four important measures to help ensure that older adults receive the care they need to optimize quality of life.

What: Percentage of patients with a pain assessment and pain management plan during the measurement year.

Update for MY 2020 & MY 2021: Please note that services provided during a telephone visit, e-visit, or virtual check-in meet criteria for Pain Assessment indicators.

How: This measure can be satisfied using CPT codes or through medical record review during HEDIS review.

At least one pain assessment or pain management plan documented with the date the assessment was performed in the medical record.

Standardized pain assessment tools include: Numeric rating scales (verbal or written); Face, Legs, Activity, Cry, Consolability (FLACC) scale; Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory); Pain Thermometer; Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale); Visual analogue scale; Brief Pain Inventory; Chronic Pain Grade; PROMIS Pain Intensity Scale; Pain Assessment in Advanced Dementia (PAINAD) Scale.

Exclusions: Patients in hospice or using hospice services during the measurement year. Services provided in an acute inpatient setting are excluded.

Coding: CPT-CAT-II: 1125F, 1126F

Care for Older Adults (COA): Pain Assessments FAQs

Q: Will notation of a pain management plan or pain treatment plan alone in the record meet criteria?

> **A:** No. Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Q: Does screening for chest pain or documentation in the medical record of chest pain alone meet criteria?

> **A:** No. Patients coming in for chest pain or who have chest pain as a chief complaint typically get elevated to a more specific level of systems assessment that could potentially lead to something more serious.

Q: Do I need to document negative findings when screening for pain?

> **A:** Yes. To meet criteria, documentation must include that the patient was assessed for pain and the results, positive or negative.

Q: Who can document the pain assessment?

> **A:** CMA, RN, PT/OT, Pharmacist, and Provider.

Q: Does whole body pain need to be assessed?

> **A:** No. Pain assessment can originate from a chief complaint, reason for visit, or question of overall how well the patient is feeling.

Q: Is an outpatient visit required to meet criteria?

> **A:** No. A CMA, nurse clinical pharmacist, or provider can assess pain with a patient via a phone conversation. For example: asking how the patient is feeling or asking follow-up questions from a previous visit for leg pain, etc.

Colorectal Cancer Screening (CRC)

Performance Measure Set: ☐CCO Incentive Metric ☒CCO Non-Incentive Medicaid Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

Medicare HEDIS Benchmark National Percentile: 79.57% (75th), 83.94% (90th)

CCO 2019 Benchmark: 61.1%, 2018 national commercial 50th percentile

Who: All members aged 51–75 years old as of December 31 of the measurement year.

Why: Screening saves lives, but only if people get tested. Routine colorectal cancer screening can save lives through early diagnosis and depending on screening type detect and remove pre-cancerous polyps.

What: Percentage of patients who have received at least one of the following colorectal cancer screenings in the specified timeframes:

- Fecal occult blood test (FOBT) in 2021
- FIT-DNA test in 2019 – 2021
- Flexible sigmoidoscopy in 2017 – 2021
- CT Colonography in 2017 - 2021
- Colonoscopy in 2012 - 2021

Please note: do not count digital rectal exam (DRE), in-office FOBT tests or test performed on a sample collected via DRE. In office FOBT is not a USPSTF recommended procedure.

How: Some ideas to improve Colorectal Cancer Screening rates:

1. Participate in **CareOregon's BeneFIT Program** (CareOregon Members Only). CareOregon will mail FIT kits directly to members on behalf of your primary care clinic. Clinic staff will work directly with the CareOregon program administrator to determine program initiation and planning. Activities include determination of timing of the mailing, creation of member mailing list, and development of materials. For more information, please email Kelly Coates, Program Administrator(coatesk@careoregon.org).
2. Implement the **STOP CRC Program** (Entire Clinic Population) in your clinic. Refer to the STOP CRC Implementation Guide to determine your capacity and required technical resources. STOP CRC Guideline.
3. Other Clinic Activities.
   - Distribute FIT kits to patients during their annual wellness exam.
   - Have culturally appropriate decision guides readily available for your patients.
   - Offer FOBT when patients refuse other screening procedures.
   - Use health maintenance alerts or chart scrubbing prior to scheduled visits to identify members that are due for a screen and address during visit

Exclusions: Patients aged 66 or older who are living long-term in an institution or are enrolled in an I-SNP; members with colorectal cancer, or who have had a total colectomy; patients 66 or older with frailty and advanced illness, patients with advanced illness who had telephone, e-visits, or virtual check-ins; patients in palliative care, and patients in hospice or using hospice services during the measurement year.

Coding: Colorectal Cancer Screenings are identified through claims with at least one of the following codes, or through chart review (see documentation on next page).

CPT: 82270, 82274, 44388-44394, 44397, 44401-44408, 45330-45335, 45337-45342, 45345-45347, 45349, 45350, 45355, 45378-45393, 45398, 74261, 74262,74263, 81528

HCPCS: G0328, G0104, G0105, G0121, G0464

Colorectal Cancer Screening (CRC) FAQs

Q: What is the difference between the BeneFIT program and the STOP CRC program?

A: Both programs are designed for mailed FIT kit outreach to eligible patients in a clinic. The BeneFit program is only for CareOregon members and the STOP CRC program is for the entire clinic population. The BeneFIT program is administered completely by CareOregon staff; they manage all correspondence with the print vendor, pull the eligibility lists, and track on program performance. Clinic staff help by reviewing and approving mailed materials, scrubbing the mailing list of CareOregon members who are eligible for the screening, and conducting follow-up calls to patients after the mailing has gone out. The STOP CRC program is administered internally by clinic staff.

Q: What should we think about if we are interested in using the BeneFIT program in our clinic?

A: To succeed, clinic leadership needs to be committed to Colorectal Cancer Screening and clinics should have a clinician champion who is experienced with this topic and influential. Beyond that foundation, the following questions can help you check your clinic's readiness to implement BeneFIT. You don't necessarily need to have answers to these questions, but it is helpful to be thinking about these things.

- What is the size of your eligible population?
- Are you already using a FIT kit?
- Are FIT processes standardized and are staff trained?
- Is your staff trained to provide FIT kits opportunistically in clinic and answer questions?
- How will completed kits arrive at the lab you're using for testing? How are the lab orders placed and who puts in the orders?

Q: What documentation is needed in the medical record for a colorectal cancer screening?

A: Documentation in the medical record must include a note indicating the date and type of screening performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

Q: Why are FIT tests an acceptable screening?

A: Screening by Fecal Immunochemical Test (FIT) every year has a comparable mortality reduction rate to screening by colonoscopy every 10 years. FIT screening also helps reduce the capacity burden of screening by colonoscopy-only which allows for greater screening access. (Source: Microsimulation Screening Analysis; Ann Intern Med 2008; 149:659-669).

Q: How do I know which members are due for screening?

A: A list of members assigned to your clinic, and which metric related screenings they are due for, can be found on the Metrics Dashboard in CareOregon's FIDO Portal. If you do not have access, please email your Provider Relations Specialist to set it up.

Q: What if patients are showing as due for screening on the FIDO gap lists but I know they have had appropriate screening?

A: Member/patient lists on COBI are based on claims data; if a patient had a screening before their CareOregon coverage began it is likely that they will still show as due for screening as the claim was paid by another payer. But don't fret! Simply send (via secure email) the chart documentation to your Quality Improvement Analyst and we can upload a historical claim for the screening so the patient will correctly reflect on your member list. Please email your Provider Relations Specialist if you have any questions about this process.

Q: What if a patient declines colorectal cancer screening?

A: Members who decline screening will fall into the gap for this measure (i.e. remain in the denominator and will not be numerator compliant). We understand that this will happen with some members and the OHA benchmark is determined accordingly. FOBT should be offered and screening should be discussed in the following measurement year.

Controlling High Blood Pressure

Performance Measure Set: ☐CCO Incentive Metric ☒ CCO Non-incentivized Medicaid Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Medicaid Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other

Medicare Data Type: ☐Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

Medicaid State Benchmark: N/A

HEDIS Benchmarks National Percentile: 76.40% (75th), 81.27% (90th)

Who: All members age 18–85 years who had an essential hypertension diagnosis and at least one PCP visit in 2021.
Medicare Star Measure: All members age 18–85 years with a diagnosis of hypertension, who had at least two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the prior year.

Why: Monitoring blood pressure for control has been shown to significantly reduce the probability of undesirable outcomes, such as heart disease, stroke, and death. High blood pressure and hypertension are the leading cause of death for Americans.

What: Percentage of members with an essential hypertension diagnosis whose most recent blood pressure reading is below 140/90 mmHg. Please note:

- only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.
- If a member does not have a blood pressure reading recorded during 2021, their blood pressure is considered out of control and not numerator compliant.
- ***Medicare Star Measure:*** The blood pressure reading must occur on or after the date of the second diagnosis visit (only one of the two visits can be a telephone visit, an online assessment or a telehealth visit.)

How: Some ideas to improve Controlling High Blood Pressure rates:

- Re-take blood pressure at the end of each visit if the initial reading is elevated and document repeat values in vital flowsheets.
- Ensure training of clinical staff to maintain skills and accurate readings.
- Ensure the members whose blood pressure is above 140/90 mmHg have a scheduled follow-up visit with a care team member to work toward controlled blood pressure.

Exclusions: Members with end-stage renal disease, chronic kidney disease, dialysis or renal transplant, are pregnant, or in hospice or using hospice services are excluded. Additionally, members age 66 or older who are living long-term in an institutional or enrolled in an I-SNP, or those with frailty and advanced illness are excluded, and members 81 years or older with frailty.

Medicaid Data reporting: This measure aligns with **NQF 0018/CMS 165v9**. Even though the measure is not incentivized for 2021, CareOregon must still collect data from each clinic's EHR to submit to OHA as required in the state's Medicaid Demonstration Waiver from CMS. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred.
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12-month timeframe.
- Data must be formatted in Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Controlling High Blood Pressure FAQ

Q: How do I pull the necessary EHR-based reports?

A: This measure follows the eCQM specifications used by CMS. To find out how to pull this report from your EHR please visit: https://chpl.healthit.gov/#/search and search for your EHR product, or reach out to your Primary Care Innovation Specialist.

Q: How do I submit EHR-based reports to CareOregon?

A: Reports are generally submitted to the CareOregon by SFTP or secure email. Reach out to your Quality Improvement or Primary Care Innovation Specialist for more information.

Q: What if I can't report with the necessary specifications?

A: Unfortunately, we cannot accept data that doesn't align with the eCQM or HEDIS specifications. Reach out to your Primary Care Innovation Specialist if you are concerned about reporting or have questions about the specifications.

Q: What if a patient has more than one blood pressure reading on a single day?

A: Use the lower of the two readings.

Q: The Medicaid measure doesn't align with JNC 8 recommendations for the treatment of hypertension. What if I have a large population of patients over 60 years old?

A: Although we understand the JNC 8 guidelines represent best practices and that sometimes best practices and metrics don't always align, we are accountable to the guidelines and specifications that OHA requires. We cannot provide clinical recommendations and can only provide support in reporting measures that are outlined by OHA. Reach out to your Primary Care Innovation Specialist for assistance with population reporting.

Q: What if a patient doesn't have a blood pressure recorded during the measurement period?

A: The patient's blood pressure is assumed "not controlled" if there are no blood pressure reading during the measurement year and will fall into the gap for this measure (i.e. remain in the measure denominator but not numerator compliant).

Diabetes Care: Eye Exam

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality

Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience Data

Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 82.05% (75th), 85.33% (90th)

Who: All patients aged 18-75 years with a diagnosis of type 1 or type 2 diabetes during the measurement year.

Why: Ensure that all patients with a diagnosis of diabetes receive appropriate care. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death.

What: Percentage of patients who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

How: Screening or monitoring for diabetic retinal disease (retinal or dilated eye exam) performed by an ophthalmologist or optometrist.

Some ideas to capture retinal eye exams:

- During an office visit, ask if the member has had a retinal eye exam.
- Check retinal eye exam results in referrals and update chart.
- If patient indicates they had an exam, request results and update chart.

Exclusions: Patients in hospice or using hospice services are excluded. Patients who had a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior, and members with two unilateral eye enclucleations and unilateral eye enucleation with a bilateral modifier are also excluded. Members aged 66 or older who are living long-term in an institutional or enrolled in an I- SNP, and patients 66 years of age and older with frailty and advanced illness.

Coding: HCPC/CPT: 67028, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112-67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227-67228, 92002, 92004, 92012,92014, 92018- 92019,92134, 92225-92228,92230, 92235, 92240, 92250, 92260, 99203-99205,99213-99215,99242-99245, S0620- S0621, S3000, 2022F, 2024F, 2026F, 3072F, 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Diabetes Care: Eye Exam FAQs

Q: Is a physician order required for a retinal eye exam?

A: No. Although a retinal eye exam for patients with a diagnosis of diabetes is routine and a best practice, a physician order is not required.

Q: How do I close the referral loop?

A: Check to see that the eye exam report is in the medical record and update the Health Maintenance Summary section.

Q: How do I identify the population of patients with diabetes?

A: If your office uses OCHIN, check with your site specialist for reports or member lists. If your office uses another EHR system check with your data specialists.

Diabetes Care: Nephropathy Monitoring

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 97.09% (75th), 98.30% (90th)

Who: All patients aged 18–75 years with a diagnosis of type 1 or type 2 diabetes during the measurement year.

Why: Ensure that all patients with a diagnosis of diabetes receive appropriate care. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death.

What: Percentage of patients with who had a nephropathy screening or monitoring test OR evidence of nephropathy during the measurement period.

How: Conduct a urine test for albumin or protein; document ACE inhibitor/ARB therapy, renal transplant, or nephrectomy; document visit with a nephrologist; document medical attention for ESRD, dialysis, or renal failure.
Some ideas to improve nephropathy screenings include:

- Diabetes population management/registry
- Chart scrubbing
- Create health maintenance alerts
- In-reach and outreach to diabetics

Exclusions: Patients in hospice or using hospice services are excluded. Patients who had a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year are excluded. Members aged 66 or older who are living long-term in an institution or enrolled in an I-SNP, and patients 66 years of age and older with frailty and advanced illness.

Coding: HCPC/CPT: CPT: 81000 – 81003, 81005, 82042, 82043, 82044, 84156, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 36147, 36800, 36810, 36815, 36818-36821, 36831—36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512, S2065, S9339, G0257

CPT-CAT-II: 3060F, 3061F, 3062F, 3066F, 4010F, OR diagnosis codes for nephropathy treatment, ESRD, or kidney transplant

Diabetes Care: Nephropathy Monitoring FAQs

Q: How do I identify the population of patients with diabetes?

A: If your office uses OCHIN, check with your site specialist for reports or member lists. If your office uses another EHR system check with your data specialists.

Diabetes Care: HbA1c Poor Control

Performance Measure Set: ☒CCO Incentive ☒Medicare Star Rating
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Medicaid Data Type: ☐Claims ☐Chart Documentation ☒ eCQM ☐Survey ☐Other
Medicare Data Type: ☐Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other
Medicaid State Benchmark: 23.4% or lower (2018 CCO statewide average)
HEDIS Benchmarks National Percentile: 86.25% (75th), 88.81% (90th)

Who: All patients aged 18–75-years-old with a diagnosis of type 1 or type 2 diabetes during, or any time prior to, the calendar year. Medicaid members must receive a qualifying outpatient service during the measurement period; this is not a requirement for Medicare.

Why: People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. HbA1c testing helps clinicians identify potential need for further intervention to ensure that all patients with a diagnosis of diabetes receive appropriate and comprehensive care.

What: Percentage of patients with a diabetes diagnosis, whose most recent HbA1c level is above 9.0%.
Note: If a diabetic patient has a visit but does not have a HbA1c result documented in the measurement period, their diabetes is considered in poor control and they will enter the numerator.

Note that only patients with a Type 1 or Type 2 diabetes diagnosis are included. Members with a diagnosis of gestational diabetes, steroid-induced diabetes or pre-diabetes are excluded.

How: Best practices to improve Diabetes Poor Control include

- Educating patients about healthy lifestyle choices through motivational interviewing
- Employing diabetes educators, clinical pharmacists, or registered dietitians in the care management team
- Using an evidence-based diabetes care pathway for medication management and other care options
- Collaborative appointment with integrated behavioral health and follow-up engagement and support: Establish standard workflow that BHC sees patients who are newly diagnosed with diabetes, and patients with A1C over 9. BHCs work with patients on behavior change to help better manage lifestyle requirements that support diabetes control. BHCs can assess and support risk factors (e.g. binge eating, substance use, mood disorders) that can contribute to poor control.
- BHC asks patient and/or scrubs their schedule to assure those who need labs are connected for scheduling or same-day appointment. Those who have

been working on improving DM management and/or are close to 9% can be identified as good candidates for being retested.

Exclusions:

- Patients in hospice or using hospice services during the calendar year
- Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period
- Patients 66 and older with advanced illness and frailty

Medicaid Data Reporting: This measure aligns with **CMS122v9.** CareOregon must collect data from each clinic's EHR for this measure. Data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail for CareOregon members only is preferred
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12- month time frame
- Data must be formatted in Excel

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Medicare reporting: Comprehensive diabetes care (CDC) measures use the HEDIS HbA1c poor control specifications, however, the reverse of poor A1c control is reported as blood sugar control.

Diabetes Care: HbA1c Poor Control FAQs

Q: Why are the targets for Medicaid and Medicare so different?

A: The Medicare Star measure is reporting patients with diabetes who have an A1c test during the measurement year and that their blood sugar is in control, therefore a higher number indicates more patients are in control. CareOregon dashboards, performance reporting, and targets for Medicare members reflect this rate of A1c control, the reverse score/target of poor control as reported for Medicaid The HEDIS national percentile also reflects the benchmark for poor control.

Q: What if the member didn't have an A1c test completed in the measurement year?

A: A member is considered in *poor control* if they have a diagnosis of diabetes and do not have an A1c test in the measurement year***. It is highly beneficial to complete HbA1c testing in the first and second quarter of the measurement year*** to allow time for intervention, regaining control of blood glucose levels, and retesting A1c before the end of the year if necessary because the last A1c in the measurement year is the value reported for both line of business. It is also **important to ensure the A1c results from specialists are recorded as structured data** (and therefore captured in the EHR reporting) and not simply attached to the patient's chart as a pdf.

Q: Is prior authorization required for GLP1 diabetes pharmaceuticals?

A: CareOregon covers exenatide (BYETTA/BYDUREON) and liraglutide (VICTOZA), however, a prior authorization is required for Medicaid patients.

Medicare Health Outcomes Survey (HOS) – Improving Bladder Control

Performance Measure Set: ☐CCO Incentive ☒Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient

Experience Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☒Survey

Who: Adults aged 65 or older as of December 31 of the measurement year who had a problem with urine leakage in the past six months, who discussed the issue and treatment options with their doctor during the year.

Why: 51% of women and 14% of men in the U.S. experience urinary incontinence. Adults who experience urinary incontinence report worse physical health, mental health and quality of life. For older adults, it can potentially reduce independence and the ability to socialize. Discussing urinary incontinence with patients can help address and reduce symptoms with evidence-based treatment.

What: Percentage of patients 65-years-old or older with a urine leakage problem in the past 6 months who discussed treatment options with a provider.

How: This is a patient-reported measure which surveys a random sample of Medicare beneficiaries. The Health Outcomes Survey is administered annually; the same member cohort is surveyed again two years later to account for baseline and follow-up results. Health Outcomes Survey quality measures include two functional health measures and three HEDIS Effectiveness of Care measures used in the annual Medicare Part C Star Ratings.

Improving Bladder Control is based on two survey questions:

1) In the past six months, have you experienced leaking of urine?
2) Have you discussed treatment options with a doctor or other health care provider?

Medicare Health Outcomes Survey (HOS) – Monitoring Physical Activity

Performance Measure Set: ☐CCO Incentive ☒Medicare Star Rating

Quality Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation ☐eCQM ☒ Survey ☐Other

Who: Adults aged 65 or older as of December 31 of the measurement year.

Why: The Health Outcomes Survey gathers valid, reliable, and clinically meaningful health status data about a patient's physical activity. This tool initiates the conversation between physician and patient about the importance of physical activity and any activity limitations the patient may present with.

What: Percentage of patients 65 years or older who had a doctor's visit in the past 12 months and received advice to start, increase, or maintain their level of exercise or physical activity.

How: This is a patient-reported measure which surveys a random sample of Medicare beneficiaries. The Health Outcomes Survey is administered annually; the same member cohort is surveyed again two years later to account for baseline and follow-up results. Health Outcomes Survey quality measures include two functional health measures and three HEDIS Effectiveness of Care measures used in the annual Medicare Part C Star Ratings.

Monitoring Physical Activity is based on two survey questions:

1) In the past 12 months, did you talk with a doctor or provider about your level of exercise of physical activity?
2) In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

Medicare Health Outcomes Survey (HOS) – Reducing the Risk of Falling

Performance Measure Set: ☐ CCO Incentive ☒Medicare Star Rating

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Data Type: ☐Claims ☐Chart Documentation eCQM ☒ Survey ☐ Other

Who: Adults aged 65 or older as of December 31 of the measurement year.

Why: The Health Outcomes Survey for Reducing the Risk of Falling was developed to help identify patients that may be at risk of falling. By identifying patients who may be at risk, physicians and other providers can initiate appropriate interventions to prevent injuries resulting falls.

What: Percentage of patients aged 65 years or older who were seen by a practitioner in the past 12 months for a fall or problems with balance or walking and received a fall-risk intervention.

How: This is a patient-reported measure that surveys a random sample of Medicare beneficiaries. The survey is administered annually to a random sample of plan members. The same member cohort is surveyed again two years later to account for baseline and follow-up results. Health Outcomes Survey measures include two functional health measures and three HEDIS Effectiveness of Care measures used in the annual Medicare Part C Star Ratings.

Reducing risk of falling is based members' response to four questions:

1) In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking?
2) Did you fall in the past 12 months?
3) In the past 12 months have you had a problem with balance or walking?
4) Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

Medication Adherence for Cholesterol (Statins)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Stars Measure
Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient
Experience Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
HEDIS Benchmarks National Percentile: 83% (75th), 87% (90th)

Who: Patients aged 18 years and older.

Why: One of the most important ways people with high cholesterol can manage their health is by taking medication as directed. It is important for the patient, doctor, and the health plan to work together to manage the patient's high cholesterol.

What: Percent of members with at least two prescription fills on unique dates of service for statin medication(s) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

How: This measure is calculated using the number of member-years of enrolled beneficiaries (see below) with a proportion of days covered (PDC) at 80% or higher for statin cholesterol medication(s) during the measurement period.

The measure is weighted based on the total number of member-years for each Medicare Part D member. For instance, if a member is enrolled for a three-month episode, does not have coverage for a six-month episode, then reenrolled for a three-month episode, they will count as "0.5 member years" in the rate calculation (3/12 + 3/12 = 6/12).

Exclusions: Hospice or ESRD diagnosis or dialysis coverage

Statin Medications:

Lovastatin, simvastatin, pravastatin, atorvastatin, or rosuvastatin.

Medication Adherence for Diabetes Medications

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality
Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience
Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
HEDIS Benchmarks National Percentile: 81% (75th), 85% (90th)

Who: Patients 18 years of age and older.

Why: Taking medication as directed is one of the most important ways people with diabetes can manage their health. It is important for the patient, doctor, and the health plan to work together to manage the patient's diabetes.

What: Percent of members with at least two prescription fills on unique dates of service for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

How: This measure is calculated using the number of member-years of enrolled beneficiaries with a proportion of days covered (PDC) at 80% or higher across the classes of diabetes medications during the measurement period.

The measure is weighted based on the total number of member-years for each Medicare Part D member. For instance, if a member is enrolled for a three-month episode, does not have coverage for a six-month episode, then reenrolled for a three-month episode, they will count as "0.5 member years" in the rate calculation (3/12 + 3/12 = 6/12).

Exclusions: Patients who take insulin are excluded. Hospice or ESRD.

Diabetes Medications:
Biguanides, sulfonylureas, thiazolidinediones, dipeptidylpeptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.

Medication Adherence for Hypertension (RAS Antagonists)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality

Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 86% (75th), 88% (90th)

Who: Patients 18 years of age and older.

Why: One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. It is important for the patient, doctor, and health plan to work together to help manage the patient's blood pressure.

What: Percent of members with at least two prescription fills on unique dates of service for blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

How: This measure is calculated using the number of member-years of enrolled beneficiaries with a proportion of days covered (PDC) at 80% or higher for RAS antagonist medications during the measurement period.

The measure is weighted based on the total number of member-years for each Medicare Part D member. For instance, if a member is enrolled for a three-month episode, does not have coverage for a six-month episode, then reenrolled for a three-month episode, they will count as "0.5 member years" in the rate calculation (3/12 + 3/12 = 6/12).

Exclusions: Patients in hospice, with a diagnosis of ESRD or coverage dates, or received one or more prescriptions for sacubitril/valsartan anytime during the measurement year.

Blood Pressure Medications:
Renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.

Osteoporosis Management in Women Who had a Fracture (OMW)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality

Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐ Survey ☐Other

HEDIS Benchmarks National Percentile: 61.49% (75th), 76.77% (90th)

Who: Female patients aged 67–85 years who suffered a fracture in the measurement year.

Why: Osteoporosis is referred to as the silent disease because there are no symptoms with bone loss. A bone mineral density (BMD) test can identify osteoporosis, determine risk for future fractures, and help measure an individual's response to treatment. Early detection and treatment can help preserve quality of life.

What: Percentage of women who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months of the fracture.

How: Appropriate testing **(BMD)** or treatment **(Medication)** for osteoporosis **within 6 months** of the fracture.

Note that women who had a fracture during the measurement period are excluded if:

- They had a pharmacy claim for osteoporosis medications 12-months prior to fracture; or
- They had BMD imaging in 2 years or less prior to fracture.

Exclusions: Fractures of finger, toe, face and skull are excluded. Patients in hospice or using hospice services as well as those patients age 66 and older who are living long term in an institutional setting or enrolled in an I-SNP are excluded. Patients 66–80 years of age and older diagnosed with frailty and advanced illness or patients 81 years of age and older with diagnosed with frailty are excluded.

Coding:

BMD Test CPT/HCPCS: 76977, 77078, 77081-77082, 77085-77086, G0130
Medications HCPCS: J0630, J0897, J1740, J3110, J3487, J3488, J3489, Q2051
Medications Long-Acting HCPCS: J0897, J1740, J3487, J3488, J3489, Q2051

Osteoporosis Management FAQs

Q: Do I need to include women who had a second qualifying fracture in the measurement period?

A: No. If a patient had more than one fracture, include only the first fracture.

Q: How do I correct a misdiagnosis of a fracture for a patient?

A: If you find a patient that is in the osteoporosis measure but they did not have a fracture, bring it to the provider's attention for correction of charting and claims.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure Quality

Measurement Type: ☐Structure ☒Process ☐Outcome ☐Patient Experience

Data Type: ☒Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 83.94% (75th), 86.81% (90th)

Who: Female patients between 40–75 years of age and male patients between 21–75 years of age during the measurement period who have been identified as having clinical atherosclerotic cardiovascular disease.

Why: Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease. People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing ASCVD[1].

What: Percent of female members between 40–75 years of age and male members between 21– 75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and had at least one medication dispensing event for a high-intensity or moderate-intensity statin during the measurement period.

How: The denominator is the number of patients that have either a qualifying event (MI, CABG, PCI, other revascularization) in the year prior to the measurement year, or diagnosis of ischemic vascular disease (ICD) with a qualifying visit in both the measurement year and prior year. The numerator is the number of patients who had at least one dispensing event for a high- or moderate- intensity statin medication (listed in table below) during the measurement year.

Exclusions: Female patients with a diagnosis of pregnancy during the measurement year or year prior. All patients with ESRD or cirrhosis during the measurement year or year prior, myalgia, myositis, myopathy or rhabdomyolysis during the measurement year. Patients 66 years of age and older enrolled in an Institutional SNP or living in a long-term institution during the measurement year. Patients 66 years of age and older diagnosed with frailty and advanced illness during the measurement year or the year prior.
Patients in hospice or palliative care are also excluded.

High-intensity and Moderate-intensity Statin Medications:

High-intensity statin therapy	Atorvastatin 40-80 mg Amlodipine-atorvastatin 40-80 mg Rosuvastatin 20-40 mg Simvastatin 80 mg Ezetimibe-simvastatin 80 mg

Moderate-intensity statin therapy	Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg Ezetimibe-simvastatin 20-40 mg Pravastatin 40-80 mg Lovastatin 40 mg Fluvastatin 40-80 mg Pitavastatin 2–4 mg

[1](NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with- cardiovascular-disease-and-diabetes/

Statin Use in Persons with Diabetes (SPD)

Performance Measure Set: ☐CCO Incentive Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Data Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other

HEDIS Benchmarks National Percentile: 77.27% (75th), 80.27% (90th)

Who: Patients between 40–75 years of age with diabetes.

Why: Taking cholesterol medication can help to lower the risk of developing heart disease for most people with diabetes. It is important for patients to work with their doctor to determine the most effective cholesterol-lowering medication.

What: Percent of members with at least two diabetes medication fills who received a statin medication fill during the measurement period. Two rates are reported for this measure:

1. Received Statin Therapy: Members who were dispensed at least one statin medication during the measurement year.

2. Statin Adherence 80%: Members who remained on a statin medication for at least 80% of the treatment period (the time between their first statin medication dispensing event in the measurement year and the end of that year).

How: This measure is calculated using the number of member-years of enrolled beneficiaries with a statin medication fill during the measurement period.

Exclusions: Patients with ESRD, cardiovascular disease, cirrhosis, or muscular disease; patients who are pregnant; patients age 66 years of age or older in a SNP or living long-term in an institution; patients 66 years of age or older with frailty and advanced illness; and patients in palliative care or hospice are excluded.

Optional exclusion: Members who do not have a diagnosis of diabetes from any setting, ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes from any setting, during the measurement year or the year prior to the measurement year.

Statin Medications:

Any statin medication evidenced on pharmacy claims.