2019 Metrics Binder

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If your clinic is not on an EMR or is not yet providing feed into the Inteligenz platform, the following would be the appropriate workflows for each CCO metric:

1. Adolescent Well-Care Visits: [CLAIM BASED: Schedule appointments]

2. Ambulatory Care: Emergency Department and Outpatient Utilization [CLAIM BASED: Count each visit to an ED that does not result in an inpatient encounter once; multiple ED visits on the same date of service as one visit]

3. Assessments within 60 Days for Children in DHS Custody [CLAIM Based: Schedule physical health appointment (0-17 years of age). Schedule appointments or refer if needed for mental health (4-17 years of age) and dental appointments (1-17 years of age)]

4. Dental Sealants [CLAIM BASED: Action required: make referral to assigned dental clinic]

5. Developmental Screening in the First Three Years of Life: [CLAIM BASED: Action: Complete screenings]

6. Effective Contraceptive Use: [CLAIM BASED: Educate patients 15-50 years of age about contraceptive use/document patients on contraceptives annually]

7. Disparity: ED Utilization with Mental Illness: [CLAIM BASED: Educate patients to see clinic before condition gets worse; Monitor Treatment Adherence]

8. Oral Evaluation for Adult with Diabetes: [CLAIM BASED: Number of unduplicated members who receive a comprehensive, periodic or periodontal oral evaluation in the measurement year]

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9. Alcohol and Drug Misuse; Screening, Brief Intervention, and Referral to Treatment (SBIRT): [EMR BASED: Give age appropriate screening, using approved SBIRT tool and follow-up measure. Record information as queryable data in EHR (see workflow)]

10. Cigarette Smoking Prevalence: [EMR Based: Rate 1- Record smoking and/or tobacco use status of unique members 13+ as structured data. Rate 2- Record any combination of “yes” responses that identifies cigarette smokers as structured data. Rate 3- Record any tobacco use as structured data within the EHR including cigars, snuff, chew, strips, sticks, gum, etc]

11. Controlling High Blood Pressure: [EMR Based: Record blood pressure readings done in office performed by a clinician or provider. Systolic blood pressure must be <140 mm Hg and diastolic blood pressure must be <90 mm Hg. If no blood pressure is recorded it is assumed not controlled]

12. Depression Screening and Follow-up Plan: [EMR BASED: Record age appropriate screening and result in EHR and if positive perform and record appropriate follow-up plan on the date of the positive screen (See workflow)]

13. Diabetes: HbA1c Poor Control: [EMR BASED: Record Patients HbA1c in EHR. Most recent HbA1c level must be >9%]

14. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: [EMR BASED: Rate 1- Record height, weight and body mass index (BMI) in EHR Rate 2- Give nutrition counseling to patients. Rate 3- Give physical activity counseling to patients]

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15. Prenatal and Postpartum Care: [HYBRID MEASURE: A first prenatal visit within the eligible timely window and required service components. A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery]

16. Colorectal Cancer Screening: [HYBRID MEASURE: Have patients 66+ years of age complete screening]

17. Patient Centered Primary Care Home (PCPCH) Enrollment: [SELF REPORT: Number of CCO members enrolled in PCPCH by tier using the formula found on page 2 of the tech specs]

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18. CAHPS: Access to Care: [STATE MEASURE: Send survey to members based on HEDIS 2019, Volume 3 Specifications]

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19. Childhood Immunization Status: [ALERT REGISTRY BASED: complete immunizations before 2 years of age]

Adolescent Well Care Visits

Overview: CCO incentive, state quality, and CMS child core set measure based off of claims data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 65.2%

Target population [Denominator]: Members age 12-21 years of age as of December 31, 2019

Goal: Minimum 1 comprehensive well care visit per measurement year for members in the target population

Process:

- Schedule[1] and complete a minimum of 1 comprehensive well care visit per measurement year for members in the target population
- Use correct ICD10 and CPT codes
    - Infant members have their own codes for well care visits

Exclusions [Denominator]: Patients on hospice care

Exclusions [Numerator]: None

[1] For clinics using Centricity EMR, you can use the meaningful use button, then population health button to see gap metrics patient is due for.

Adolescent Well Care Visits

Measure Basic Information

Name and date of specifications used: HEDIS® 2019 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: N/A

Measure Type:

HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: HEDIS-like – Computed using administrative claims only; HEDIS notes administrative data-only method should be used for the commercial population.

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ☐ CMS Child Core Set ■ Other ☐ Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

2013 Benchmark: 53.2% (administrative data only); 2011 National Medicaid 75th percentile
2014 Benchmark: 57.6% (administrative data only); 2013 National Medicaid 75th percentile
2015 Benchmark: 62.0% (administrative data only); 2014 National Medicaid 75th percentile
2016 Benchmark: 61.9% (administrative data only); 2015 National Medicaid 75th percentile
2017 Benchmark: 51.8% (administrative data only); 2016 National Medicaid 75th percentile
2018 Benchmark: 66.0% (administrative data only); 2017 National Medicaid 75th percentile
2019 Benchmark: 65.2% (administrative data only); 2018 National Medicaid 75th percentile

2019 Improvement Targets: Minnesota method with 2 percentage point floor.

Incentive Measure changes in specifications from 2018 to 2019:

- Changes to the HEDIS Well-Care Value Set: Added ICD10CM diagnosis codes Z76.1, Z76.2; deleted ICD10CM diagnosis codes Z02.79, Z02.81, Z02.83, Z02.89, Z02.9; deleted all ICD9CM diagnosis codes.
- Clarified the method used for excluding members utilizing hospice services.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

AWC	Claim from matching CCO	Denied claims included
Numerator event	Y	Y

Measure Details

Data elements required denominator: Members age 12-21 years as of December 31 of the measurement year. See HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) for details.

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

Deviations from cited specifications for denominator: None. OHA uses administrative claims only.

Data elements required numerator: At least one comprehensive well-care visit during the measurement year. See HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) for details.

Adolescent well-care visits are defined by the following codes:

Well-Care Value Set		
CPT	**HCPCS**	**ICD-10 Diagnosis***
99383-99385, 99393-99395	G0438, G0439	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
Codes in the Well-Care Value Set that only apply to infants		
99381, 99382, 99391, 99392, 99461		Z00.110, Z00.111

*Diagnosis codes do not have to be primary.

**Note: Z02.xx ICD-10 codes are not covered under OHP administrative rules or on the Prioritized List as of 10/1/2018, however this measure does include denied claims.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: HEDIS® requires well-care visits to be with a primary care practitioner or OB/GYN practitioner. OHA specifications drop this requirement and count all well-care visits by any provider types. All other HEDIS® specifications are used to define a well-care visit.

What are the continuous enrollment criteria: The measurement year.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Define Anchor Date (if applicable): December 31 of the measurement year.

For More Information: The Adolescent Well Care Visits guidance document and other supporting documents can be found at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx and http://www.oregon.gov/OHA/HPA/CSI-TC/Pages/Resources-Metric.aspx

Alcohol and Drug Misuse

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Overview: CCO Incentive Measure based off of Electronic Health Records data.

Measurement Period: January 1, 2019 - December 31, 2019

Benchmark: N/A. CCO's must report data meeting minimum population threshold for this measure

Rate 1 Target Population [Denominator]: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

Goal: To give all patients 12 years and older an age-appropriate SBIRT once per measurement year with appropriate follow-up if.

Process:

- Perform age-appropriate screening of providers choosing[1] to patient
- If positive result to brief screen, perform full screen
- If positive result to full screen, give brief intervention, referral to treatment, or both[2]

Rate 2 Target Population [Denominator]: All patients in Rate 1 who had a positive full screen during the measurement period.

Goal: To give all patients with positive results to full screenings needed interventions and/or referrals to treatment

Exclusions [Denominator]: Patients with an active diagnosis of alcohol or drug dependency, engagement in treatment, dementia or mental degeneration, limited life expectancy, and palliative care (includes comfort care and hospice)

Exceptions [Denominator]: Patient refuses to participate, patient is in an urgent or emergent situation where time is essence and to delay treatment would jeopardize the patient's health status, situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

Exclusions [Numerator]: SBIRT services received in an emergency department or hospital setting

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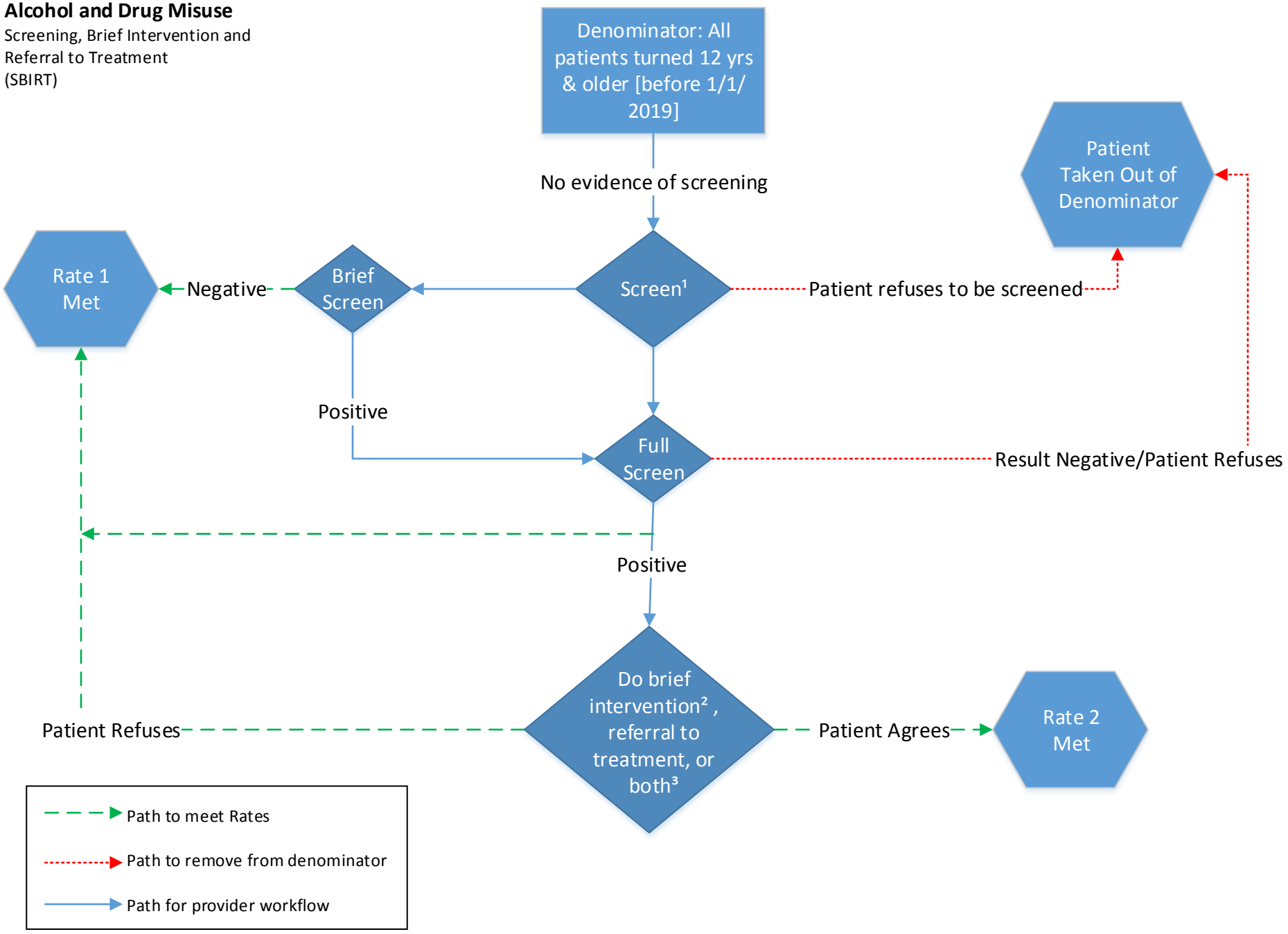
[1] A negative brief screen or a full screen regardless of the result is numerator compliant

[2] The screening(s) and result(s) must be captured as query able structured data in the EHR

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



[1] Provider decides on full screen or brief screen
[2] Brief interventions are less then 15 minutes and are one-on-one counseling sessions
[3] Must be documented within 48 hours of the date of a positive full screen
Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR

Alcohol and Drug Misuse

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a workgroup including CCOs and clinics and included clinical piloting. The measure calls for use of standardized assessment tools.

URL of Specifications: N/A. Value sets used in this measure may be accessed through the Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: OHA-developed

Measure Utility:

CCO Incentive ■ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set ☐

Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

OHA anticipates publishing the Year Seven (2019) guidance documentation for EHR-based measures in summer 2019.

2013-2018 Benchmark: N/A. Although a claims-based version of SBIRT was used in prior years, it is not comparable for benchmarking purposes.

2019 Benchmark: N/A. CCOs must report data meeting minimum population threshold for this measure in order to receive 100% of their quality pool payment. The minimum population threshold is 20%. (This is lower than the projected 25% threshold described in the Year 6 (2018) Guidance Documentation.)

Changes in Specifications from 2018 to 2019: N/A. The EHR-based version of SBIRT is a new measure.

Denied claims: n/a

Measure Details

Measure Components and Scoring

Two rates are reported for this measure:

(1) The percentage of patients who received age-appropriate screening and

(2) The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

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

Rate 1

Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

The denominator criteria for SBIRT Rate 1 are identical to the denominator criteria for the depression screening and follow-up measure (NQF0418/ CMS2). Eligible encounters are identified through the Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916).[1]

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period **AND** had either a brief screen with a negative result or a full screen.

> **Note**: 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, regardless of the result.
>
> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.
>
> 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 NQF0418/ CMS2. 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.
>
> **Note**: The screening(s) and result(s) must be captured as queryable structured data in the EHR.

[1] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

> **Note – Brief Intervention**: 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.
>
> As explained by SAMHSA:
>
> > "Brief interventions are evidence-based practices design to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.
> >
> > "In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two."
>
> https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions
>
> A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15 minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. 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.

Required exclusions for numerator: SBIRT services received in an emergency department or hospital setting.

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Active diagnosis of alcohol or drug dependency	Alcohol and Drug Dependence	2.16.840.1.113883.3.464.1003.106.12.1001
Engagement in treatment	Alcohol and Drug Dependence Treatment	2.16.840.1.113883.3.464.1003.106.12.1005
Dementia or mental degeneration	Dementia & Mental Degenerations	2.16.840.1.113883.3.526.3.1005
Limited life expectancy	Limited Life Expectancy	2.16.840.1.113883.3.526.3.1259
Palliative care (includes comfort care and hospice)	Palliative Care	2.16.840.1.113883.3.600.1.1579

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception	Grouping Value Set
Patient Reason(s) Patient refuses to participate	Patient Reason refused 2.16.840.1.113883.3.600.791
Medical Reason(s) 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.	Medical or Other reason not done 2.16.840.1.113883.3.600.1.1502

OR Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium	

Note: For this SBIRT measure, these exclusion criteria may be captured using the SNOMED-CT codes in the value sets listed below *or* otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (NQF0418/ CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

- Patient refuses brief screen. = Exception. Patient is not counted in rate 1.
- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.
- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: There are no continuous enrollment criteria required for this measure. The “eligible as of the last date of the reporting period” rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Seven (2019) guidance will be available online at: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Version Control

Ambulatory Care: Emergency Department and Outpatient Utilization

Overview: CCO Incentive, State Quality, and CMS Child Core Set based off of claims data.

Measurement Period: January 1, 2019 – December 31, 2019

Benchmark: 43.1% / 1,000 member months

Target Population [Denominator]: 1,000 member months

Goal: Accurately count member visits to the ED each month

Process [Emergency Department Visits]:

- Count each visit to an ED that does not result in an inpatient encounter once[1]
- Use correct CPT or UBREV Codes[2]

Process [Outpatient Visits]:

- Count multiple codes with the same practitioner on the same date of service as a single visit
- Count visits with different practitioners separately[3]
- Use correct CPT, HCPCS, or UBREV codes with or without the Telehealth modifier value set

Exclusions [Denominator]: Patients on hospice care

Exclusions [Numerator]: None

[1] Count multiple ED visits on the same day of service as one visit

[2] Do not count ED visits that results in an inpatient stay (inpatient stay value set)

[3] Count visits with different providers on the same date of service as different visits

Ambulatory Care: Emergency Department and Outpatient Utilization

Measure Basic Information

Name and date of specifications used: HEDIS® 2019 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: N/A

Measure Type:
HEDIS ■ PQI☐ Survey☐ Other☐ Specify:

Measure Utility:
CCO Incentive ■ (Only Emergency Department utilization) State Quality ■ CMS Adult Core Set☐
CMS Child Core Set ■ Other☐ Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

Emergency Department utilization benchmark*:
2013 Benchmark: 44.4/ 1,000 member months; 2011 National Medicaid 90th percentile
2014 Benchmark: 44.6/ 1,000 member months; 2013 National Medicaid 90th percentile
2015 Benchmark: 39.4/ 1,000 member months; 2014 National Medicaid 90th percentile
2016 Benchmark: 39.8 / 1,000 member months; 2015 national Medicaid 90th percentile
2017 Benchmark: 42.9 / 1,000 member months; 2016 national Medicaid 90th percentile
2018 Benchmark: 44.2 / 1,000 member months; 2017 national Medicaid 90th percentile
2019 Benchmark: 43.1 / 1,000 member months; 2018 national Medicaid 90th percentile

2019 Improvement Targets: Minnesota method with 2 percent floor.

*Benchmark is for the Emergency Department (ED) utilization rate only. OHA is continuing to measure and report on outpatient utilization, but CCOs receive the incentive payment based on the ED utilization rate.

Incentive Measure changes in specifications from 2018 to 2019:

- HEDIS 2019 added Telephone Visits Value Set, Telehealth Modifier Value Set, and Online Assessments Value Set to outpatient utilization.
- HEDIS 2019 moved instructions for identifying ED/observation visits that result in an inpatient stay to General Guideline 44. The method is modified to exclude any residual ED service dates may previously be identified after an inpatient admission date, but during the duration of the inpatient stay.
- HEDIS 2019 Ambulatory Outpatient Visits Value Set added CPT code 99483.

- HEDIS 2019 Mental and Behavioral Disorders Value Set added 15 ICD10CM diagnosis codes: F10.11, F11.11, F12.11, F12.23, F12.93, F13.11, F14.11, F15.11, F16.11, F18.11, F19.11, F50.82, F53.0, F53.1, F68.A. Deleted all ICD9CM diagnosis codes
- HEDIS 2019 ED Procedure Code Value Set added 42 and deleted 29 CPT codes.
- OHA clarified the method used for excluding members utilizing hospice services.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

AMB	Claim from matching CCO	Denied claims included
Numerator event	Y	N

Measure Details

Data elements required denominator: 1,000 Member Months

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

Hospice Value Set		
CPT/HCPCS	**UBREV**	**UBTOB**
99377, 99378, G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046	0115, 0125, 0135, 0145, 0155, 0235, 0650-0652, 0655-0659	0810-0815, 0817-0825, 0827-0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082O, 082X, 082Y, 082Z

Deviations from cited specifications for denominator: None.

Data elements required numerator: See HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) and Value Set workbook for details.

Numerator for Emergency Department Visits – Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit. Emergency Department visits are specified by the following codes:

ED Value Set	
CPT	**UB Revenue**
99281-99285	0450, 0451, 0452, 0456, 0459, 0981

OR

ED Procedure Code Value Set		ED POS Value Set
CPT	With	**POS**
Total of 5,790 CPT codes are included. See HEDIS 2019 Value Set Dictionary for detail		23

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

HEDIS 2019 General Guideline 44: When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Inpatient Stay Visits Value Set	
UBREV	0100, 0101, 0110 – 0114, 0116 – 0124, 0126 – 0134, 0136 – 0144, 0146 – 0154, 0156 – 0160, 0164, 0167, 0169 – 0174, 0179, 0190 – 0194, 0199 – 0204, 0206 – 0214, 0219, 1000 – 1002

Numerator for Outpatient Visits - Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits). Outpatient visits are specified by the following codes:

Ambulatory Outpatient Visits Value Set			Telehealth Modifier Value Set
CPT	92002, 92004, 92012, 92014, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99304 - 99310, 99315, 99316, 99318, 99324 - 99328, 99334 - 99337, 99341 - 99345, 99347 - 99350, 99381 - 99387, 99391 - 99397, 99401 - 99404, 99411, 99412, 99429, 99461, 99483	**With or without**	95, GT
HCPCS	G0463, T1015		
UBREV	0510 - 0517, 0519 - 0529, 0982, 0983		

OR

Telephone Visits Value Set	
CPT	98966-98968, 99441-99443

OR

Online Assessments Value Set	
CPT	98969, 99444

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the following codes. Note OHA began applying the exclusions at the claim line level in measurement year 2016. OHA keeps all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Mental and Behavioral Disorders Value Set
Principal ICD-10 CM Diagnosis
Total of 724 diagnosis codes are included. See HEDIS 2019 Value Set Dictionary for detail

OR

Psychiatry Value Set
CPT
90785, 90791, 90792, 90832 - 90834, 90836 - 90840, 90845 - 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

OR

Electroconvulsive Therapy Value Set
ICD-10 PCS Procedure
GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: None.

What are allowable gaps in enrollment: None.

Define Anchor Date (if applicable): None.

Assessments for Children in DHS Custody

Overview: CCO incentive and state quality measure based off of claims data

Measurement Period: November 1, 2018 – October 31, 2019

Benchmark: 90%

Target Population [Denominator]: Identified children/adolescents 0-17 years of age as of the first date of DHS/OHA notification and remained in custody for at least 60 days.[1]

Goal: Complete a physical, mental and dental assessment within the required timeline

Process:

- Complete physical health assessment[2] within 60 days of notification date or 30 days prior to notification date
- Complete dental assessment[3] within 60 days of notification date or 30 days prior to notification date
- Complete mental health assessment[4] within 60 days of notification date or 30 days prior to notification date

Exclusions [Denominator]:

- The CCO did not receive notification from OHA on the child, even if the CCO was informed by DHS or another source when the child entered DHS custody/substitute care.
- The child did not enroll with the CCO or did not meet the continuous enrollment criteria.
- The child entered DHS custody/substitute care more than 30 days prior to OHA notification
- If a CCO is notified more than once for the same case of a child entering DHS custody[5], only the instance in which the CCO notification date follows most closely the DHS custody date is included and the continuous enrollment and numerator assessment periods are calculated based on this date; this is typically the earliest notification date for a unique case. Any other CCO notification dates for the same child and DHS custody entry are excluded. If the earliest

[1] Only children/adolescents that DHS/OHA notified CCO's about will be included in the denominator. Include cases from November 1 of the year prior to the measurement year, to October 31 of the measurement year.
[2] On all ages 0-17
[3] On ages 1-17 or refer to assigned dentist
[4] On ages 4-17 or refer to mental health counseling
[5] Same Child Welfare Eligibility Effective Date for a child on more than one weekly notification file

notification to a CCO for a unique case is more than 30 days after the DHS custody entry date, the case is excluded.

- The child's custody was transferred to Oregon Youth Authority (OYA) during the 60 days following CCO notification. A child being in OYA detention does not create an automatic exclusion.
- The child is in a run-away status during the 60 days following CCO notification is identified from OR-Kids and excluded. The child is still in DHS custody, but they are usually dis-enrolled from the CCO and entered into Fee For Service / Open Card until their next placement (and thus can also be excluded based on continuous enrollment criteria)
- Trial reunification is not an automatic exclusion. If the child returned home and enrolled into a different CCO than the CCO they were enrolled in during the previous placement, the child could be excluded upon examination of continuous enrollment criteria. If a CCO is notified by local DHS that the case is closed or dismissed, the CCO needs to preserve communication records; OHA will review these records and determine exclusions on a case-by-case basis.
- A child placed in a rehabilitation or residential treatment facility is not an automatic exclusion, unless the placement is out of the service area for the CCO. If requested, OHA can review and determine exclusions on a case-by-case basis.

Exclusions [Numerator]: N/A

Assessments for Children in DHS Custody

Measure Basic Information

Name and date of specifications used: OHA developed these specifications based on requirements for physical, mental, and dental health assessments for children who enter DHS custody.

URL of Specifications: N/A

Measure Type:

HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: OHA-developed

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ☐ CMS Child Core Set ☐ Other ☐
Specify:

Data Source: MMIS/DSSURS and ORKIDS

Measurement Period: Notification November 1, 2018 – October 31, 2019

Note the cut-off date of notification is on October 31st so the health assessment period can occur by the end of the year.

2013 - 2019 Benchmark: 90%; from Metrics & Scoring Committee consensus

2019 Improvement Targets: Minnesota method with 3 percentage point floor

Incentive Measure changes in specifications from 2018 to 2019:

- HEDIS 2019 Mental Health Diagnosis Value Set added ICD10CM diagnosis codes: F50.82, F53.0, F53.1, F68.A.

Member type: CCO A ■ CCO B ☐ CCO G ☐

Specify claims used in the calculation:

DHS	Only use claims from matching CCO	Denied claims included
Numerator in 60-day assessment period	Y	Y
Numerator in 30-day lookback period, or when the enrollment with the notified CCO has not started	N (all MMIS/DSSURS claims for the member are used, regardless of Open Card claims, or from other CCOs)	Y

Measure Details

Data elements required denominator: Identified children/adolescents 0 – 17 years of age as of the first date of DHS/OHA notification and remained in custody for at least 60 days. Only children/adolescents that DHS/OHA notified CCOs about will be included in the denominator. Include cases notified from November 1 of the year prior to the measurement year, to October 31 of the measurement year.

Note: while OHA previously intended to transition "notification" to the dates on which CCOs receive 834 enrollment files for children, these files have proven difficult for use in constructing and validating the denominator. For the 2019 measurement year, OHA will continue to use the weekly files as the official notification for the measure. OHA will continue providing the 834 files to support validation and intends to continue working with DHS to identify additional data from OR-Kids that may be able to be shared with the CCOs to better support care coordination for children in DHS custody.

Whether a child 'remained in custody' is determined by Child Welfare discharge date, or transfer of custody (such as OYA) in the OR-Kids data. If a CCO received information from DHS for change of custody, the CCO should preserve communication records; OHA will review these records and determine exclusions from the metric on a case-by-case basis.

Required exclusions for denominator: Children will be excluded from the final measure denominator for the following reasons:

- The CCO did not receive notification from OHA on the child, even if the CCO was informed by DHS or another source when the child entered DHS custody/ substitute care.
- The child did not enroll with the CCO or did not meet the continuous enrollment criteria. See detail in the continuous enrollment and allowable gap sections.
- The child entered DHS custody/ substitute care more than 30 days prior to OHA notification; i.e., a notification date with more than 30 days delay from the DHS custody entry date is not used. The DHS custody entry date can be identified by Child Welfare Eligibility Effective Date in the weekly notification file.
- If a CCO is notified more than once for the same case of a child entering DHS custody (same Child Welfare Eligibility Effective Date for a child on more than one weekly notification file), only the instance in which the CCO notification date follows most closely the DHS custody date is included, and the continuous enrollment and numerator assessment periods are calculated based on this date; this is typically the earliest notification date for a unique case. Any other CCO notification dates for the same child and DHS custody entry are excluded. If the earliest notification to a CCO for a unique case is more than 30 days after the DHS custody entry date, the case is excluded.
- The child's custody was transferred to Oregon Youth Authority (OYA) during the 60 days following CCO notification. A child being in OYA detention does not create an automatic exclusion.
- The child is in run-away status during the 60 days following CCO notification are identified from OR-Kids and excluded. The child is still in DHS custody, but they are usually dis-enrolled from the

CCO and entered into Fee For Service / Open Card until their next placement (and thus can also be excluded based on continuous enrollment criteria).

- Trial reunification is not an automatic exclusion. If the child returned home and enrolled into a different CCO than the CCO they were enrolled in during the previous placement, the child could be excluded upon examination of continuous enrollment criteria. If a CCO is notified by local DHS that the case is closed or dismissed, the CCO needs to preserve communication records; OHA will review these records and determine exclusions on a case-by-case basis.
- A child placed in a rehabilitation or residential treatment facility is not an automatic exclusion, unless the placement is out of the service area for the CCO. If requested, OHA can review and determine exclusions on a case-by-case basis.

Deviations from cited specifications for denominator: N/A

Data elements required numerator: Depending on the age at CCO notification date, members in the denominator are required to receive a physical health assessment (all ages 0-17), a dental health assessment (age 1-17), and a mental health assessment (age 4-17), within 60 days of the notification date, or within 30 days prior to the notification date.

	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

Qualifying health assessments are identified by one of the following procedure codes:

Physical health assessment codes:

- Outpatient and office evaluation and management codes: 99201 - 99205[1], 99212 – 99215

[1] If physical health assessments as indicated in these new patient E&M codes (99201-99205) include qualifying mental health or child abuse/neglect diagnosis on the same claim (see code table below), they will count as both mental and physical health assessments. This is to reflect assessments provided by a psychiatric (nurse or physician) provider, but OHA does not apply a check of provider specialty in the calculation.

Qualifying diagnosis codes are based on the HEDIS 2019 Mental Health Diagnosis Value Set, Oregon's Prioritized List, and additional codes that may be picked up in deferred diagnosis situations. Codes include (table continues on next page):

Source	**ICD-10CM Diagnosis** (All diagnosis fields apply)
HEDIS 2019 Mental Health Diagnosis Value Set	F03, F20 – F53, F59 – F69, F80 – F99 (total of 291 codes)

- Preventative visits: 99381 – 99384, 99391 – 99394
- Annual wellness visits: G0438, G0439

Mental health assessment codes:

- Psychological assessment and intervention codes: 90791 – 90792, 96101 – 96102, H0031, H1011.
- Mental health assessment, by non-physician with CANS assessment: H2000-TG (modifier must be included).
- Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days): H0019[2]
- Psychiatric health facility service, per diem: H2013
- Community psychiatric supportive treatment program, per diem: H0037

Dental health assessment codes:

- Dental diagnostic codes (clinical oral evaluations): D0100-D0199

Required exclusions for numerator: N/A

Deviations from cited specifications for numerator: N/A

What are the continuous enrollment criteria: All cases **c**ontinuously enrolled with the notified CCO (with CCOA coverage) from the date of CCO notification through 60 days after with no gaps in coverage are included in the measure. Cases with delayed start of enrollment to the notified CCO for up to 7 days are only included if they are also numerator compliant (the CCO would receive credit on the metric). This means cases with delayed start of enrollment which did not complete all the required assessments are excluded.

What are allowable gaps in enrollment: None. Note, there is an allowable delayed start of enrollment if the case is also numerator compliant (see continuous enrollment section above), but there are no allowable gaps once the enrollment to the notified CCO has started.

Define Anchor Date (if applicable): None

For more information: The guidance document for this measure is available online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Diagnosis related to child abuse or neglect	T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.32xA, T74.32xD, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, T76.32xA, T76.32xD, T76.92xA, T76.92xD

[2] Use of this code counts as both mental and physical health assessment for children in PRTS.

CAHPS: Access to Care

Overview: CCO Incentive, State Quality, CMS Adult Set and CMS Child Core Set measure based off of state information.

Measurement Period: January 1, 2019 – December 31, 2019

Benchmark: 84.4% for adults and 92.6% for children[1]

Target population [Denominator]: The CAHPS 5.0H Getting Care Quickly Composite for this measure is based on two items from the CAHPS adult survey and two from the child survey:

- Got care right away for illness / injury / condition as soon as you / child needed.
- Got an appointment for routine care as soon as you / child needed.

Goal: Meet benchmark

Process: N/A. Survey is sent out by the state. No process is done by the clinics for this measure.

Exclusions [Denominator]: None

Exclusions [Numerator]: None

[1] Must achieve both adult and child benchmark or improvement target for metric credit

CAHPS: Access to Care

Measure Basic Information

Name and date of specifications used: HEDIS® 2019, Volume 3: Specifications for Survey Measures, Getting Care Quickly Composite

URL of Specifications: N/A

Measure Type:

HEDIS ■ PQI☐ Survey■ Other☐ Specify:

Measure Utility:

CCO Incentive■ State Quality■ CMS Adult Set■ CMS Child Core Set■ Other☐
Specify:

Data Source: OHP – Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H, Adult and Child Versions

Measurement Period: January 1, 2019 – December 31, 2019. The 2019 CAHPS survey will field in Q1 2020 and will reflect member experience during 2019.

2013 Benchmark: 87%; from the average of the 2012 National Medicaid 75th percentiles for adult and child rates.
2014 Benchmark: 88%; from the average of the 2013 National Medicaid 75th percentiles for adult and child rates.
2015 Benchmark: 87.2%; from the weighted average of the 2014 National Medicaid 75th percentiles for adult and child rates.
2016 Benchmark: 86.7%; from the weighted average of the 2015 National Medicaid 75th percentiles for adult and child rates.
2017 Benchmark: 86.5%; from the weighted average of the 2016 National Medicaid 75th percentiles for adult and child rates.
2018 Benchmarks: 2017 National Medicaid 75th percentile for (a) adults 84.5%; and (b) children 92.1% (must achieve both child and adult benchmark or improvement targets for metric credit)
2019 Benchmarks: 2018 National Medicaid 75th percentile for (a) adults 84.4%; and (b) children 92.6% (must achieve both child and adult benchmark or improvement targets for metric credit)

2019 Improvement Targets: Minnesota method with 2 percentage point floor

Incentive Measure changes in specifications from 2018 to 2019:
None.

Denied claims: Included: N/A Not included: N/A

Measure Details

Data elements required denominator: The CAHPS 5.0H Getting Care Quickly Composite for this measure is based on two items from the CAHPS adult survey and two from the child survey:

- Got care right away for illness / injury / condition as soon as you / child needed.
- Got an appointment for routine care as soon as you / child needed.

The calculation methodology for composite measures can be found here: (https://cahpsdatabase.ahrq.gov/cahpsidb/Public/Files/Doc6_CG_How_Results_are_Calculated_2012.pdf.

CAHPS 'Banner Books" provide additional information on the survey methodology, and can be found here: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CAHPS.aspx. These reports also show past survey results.

Required exclusions for denominator: None.

Deviations from cited specifications for denominator: None.

Data elements required numerator: See HEDIS® 2019, Volume 3: Specifications for Survey Measures for details. OHA includes both 'always' and 'usually' as valid responses for the numerator.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: Members must have 6 months experience with Medicaid/OHP to be eligible for the survey sample.

What are allowable gaps in enrollment: Members are allowed a total 45-day gap.

Define Anchor Date (if applicable): None.

Childhood Immunization Status (Combo 2)

Overview: CCO incentive, state quality and CMS child core set based off of ALERT Registry data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 81.9%

Target population [Denominator]: Children who turn 2 years of age during the measurement year.

Goal: Complete all 4 DTaP vaccines, at least 3 IPV vaccines, any of the allowed combination of the allowed MMR vaccines, at least 3 HiB vaccines, at least 3 Hepatitis B vaccines, and at least 1 VZV vaccine on or before the child's second's birthday.

Process:

- Confirm vaccines due for patient based off of ALERT Registry data
- Administer vaccines patient is due for, if able, on or before their second birthday
- Record vaccine with correct code in ALERT Registry and EHR

Exclusions [Denominator]: Members in hospice

Exclusions [Numerator]: None

Childhood Immunization Status (Combo 2)

Measure Basic Information

Name and date of specifications used: HEDIS® 2019 Technical Specifications for Health Plans (Volume 2)

URL of Specifications:
n/a

Measure Type:
HEDIS ■ PQI☐ Survey☐ Other☐ Specify:

Measure Utility:
CCO Incentive■ State Quality ■ CMS Adult Core Set☐ CMS Child Core Set■ Other☐
Specify:

Data Source:
MMIS/DSSURS and Public Health Division Immunization Program Registry (ALERT IIS)

See the ALERT IIS Data Use Cases document posted online for additional information about immunization data. http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Measurement Period: January 1, 2019 – December 31, 2019

2013 Benchmark: 82%, 2012 National Medicaid 75th percentile (Combo 2)
2014 Benchmark: 82% 2013 National Medicaid 75th percentile (Combo 2)
2015 Benchmark: 82% 2014 National Medicaid 75th percentile (Combo 2)
2016 Benchmark: 82% 2015 National Medicaid 75th percentile (Combo 2)
2017 Benchmark: 78.6% 2016 National Medicaid 75th percentile (Combo 2)
2018 Benchmark: 79.1% 2017 National Medicaid 75th percentile (Combo 2)
2019 Benchmark: 81.9% 2018 National Medicaid 90th percentile (Combo 2)

2019 Improvement Targets: Minnesota method with 2 percentage point floor

Incentive Measure changes in specifications from 2018 to 2019:

- HEDIS 2019 revised the MMR, VZV and HepA numerators in the administrative specification to indicate that vaccinations administered on or between the child's first and second birthdays meet numerator criteria. (MMR and VZV are included in Combo 2 for CCO incentive measure)
- HEDIS 2019 deleted all ICD9CM diagnosis codes used in the value sets for this measure. (No impact on OHA's calculation, since only ALERT IIS data with CVX codes are used.)
- OHA clarified the method used for excluding members utilizing hospice services.
- OHA deleted language regarding disease history in numerator for Hepatitis B and varicella zoster illnesses, since OHA stated in the deviation that disease histories are not used.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Measure Details

Data elements required denominator:
Children who turn 2 years of age during the measurement year. See HEDIS® 2019 Technical Specification for Health Plans (Volume 2) for details.

Required exclusions for denominator:
Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

OHA does not apply any optional exclusions to this measure.

Deviations from cited specifications for denominator: OHA excludes members who are known to be deceased at the time of metric reporting.

*Note this is a clarification of ongoing practice for OHA's immunization metrics production, given the ALERT IIS does not provide immunization records for deceased individuals.

Data elements required numerator:
OHA is using HEDIS® 2019 Combination 2 for the CCO incentive and State Quality measure: The number of children who turned 2 years of age in the measurement year and had all of the following specified vaccinations.

- DTaP – at least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child's second birthday.
- IPV – at least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child's second birthday.
- MMR – Any of the following on or between the child's first and second birthdays:
    - At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set), OR one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set), OR one measles vaccination (Measles Vaccine

Administered Value Set), OR one mumps vaccination (Mumps Vaccine Administered Value Set), OR one rubella vaccination (Rubella Vaccine Administered Value Set). OHA omits the HEDIS requirement for the combination of subcategories in the following bullet points, which compensates the effect that ALERT IIS data is unable to provide reliable disease histories.

Note: General Guideline 39 (i.e., the 14-day rule) does not apply to MMR.

- HiB – At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child's second birthday.

- Hepatitis B – At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service on or before the child's second birthday.

- VZV – At least on VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service falling on or between the child's first and second birthdays.

NOTE OHA relies on the Public Health Division Immunization Program Registry (ALERT IIS) data which provides records with CVX codes. In 2017, HEDIS incorporated CVX codes into the Value Set Directory Workbook; OHA is adopting the HEDIS numerator CVX codes, *with additional inactive and formula unspecified codes that are still in use but verified by ALERT IIS*. See table below.

In addition, ALERT IIS data currently does not reliably capture disease history, therefore OHA deviates from HEDIS and does not check the disease histories. Further improvement for ALERT IIS to indicate disease histories might be made in 2019, and OHA will revisit the deviation.

While the ALERT IIS does include MMIS claims/encounter data as one of the registry data sources[1], OHA does not directly calculate the measure from the MMIS/DSSURS claim/encounter data and the CPT/ICD codes in the table below are provided for reference only.

For more information: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Value Set Name	HEDIS CVX	OHA additional CVX	From HEDIS 2019 Value Set (reference-only)		
			CPT/HCPCS	ICD9CM-Diagnosis	ICD10 CM Diagnosis
DTaP Vaccine Administered	20, 50, 106, 107, 110, 120	01, 09, 11, 12, 22, 28, 102, 113, 115, 130, 132	90698, 90700, 90721, 90723		
Inactivated Polio Vaccine (IPV) Administered	10, 89, 110, 120	2, 130, 132	90698, 90713, 90723		
Measles, Mumps and Rubella (MMR)	Members received 03, 94		90707, 90710		

[1] For reference, ALERT IIS follows the CPT to CVX mapping from CMS: http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cpt

Value Set Name	HEDIS CVX		OHA additional CVX	From HEDIS 2019 Value Set (reference-only)		
				CPT/HCPCS	ICD9CM-Diagnosis	ICD10 CM Diagnosis
Vaccine Administered	any of these CVX codes are counted as compliant in the MMR category					
Measles/Rubella Vaccine Administered		04		90708		
Measles Vaccine Administered		05		90705		
Mumps Vaccine Administered		07	38	90704		
Rubella Vaccine Administered		06	38	90706		
Measles					055.0, 055.1, 055.2, 055.71, 055.79, 055.8, 055.9	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
Mumps					072.0-072.3, 072.71, 072.72, 072.79, 072.8, 072.9	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
Rubella					056.00, 056.01, 056.09, 056.71, 056.79, 056.8, 056.9	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Haemophilus Influenzae Type B (HiB) Vaccine Administered	17, 46 – 51, 120, 148		22, 45, 102, 132	90644, 90645-90648, 90698, 90721, 90748		
Hepatitis B Vaccine Administered	08, 44, 45, 51, 110		42, 43, 102, 104, 132	90723, 90740, 90744, 90747, 90748, G0010		
Hepatitis B					070.20-070.23, 070.30-070.33, V02.61	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
Varicella Zoster (VZV) Vaccine Administered	21, 94		36, 117	90710, 90716		
Varicella Zoster					052.x, 053.0, 053.1x, 053.20-053.22, 053.29,	B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0,

Value Set Name	HEDIS CVX	OHA additional CVX	From HEDIS 2019 Value Set (reference-only)		
			CPT/HCPCS	ICD9CM-Diagnosis	ICD10 CM Diagnosis
				053.71, 053.79, 053.8, 053.9	B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.49, B02.7, B02.8, B02.9

Required exclusions for numerator: None.

Deviations from cited specifications for numerator:

See Data elements required numerator section above, which include:

1. OHA uses CVX codes in ALERT IIS data. In addition to CVX codes in the HEDIS Value Sets, OHA keeps additional inactive and formula unspecified CVX codes that are still in use, but verified by ALERT IIS.
2. Omits the rule not to count vaccinations administered prior to 42 days after birth, due to negligible inconsistencies and occasional issues with the date of birth in eligibility data. As a result, all vaccinations through the child's 2nd birthday are used.
3. OHA counts members given any of the codes in the following value Sets compliant in the MMR category, without requiring a combination of subcategories:
    a. Measles, Mumps and Rubella (MMR) Vaccine Administered,
    b. Measles/Rubella Vaccine Administered
    c. Measles Vaccine Administered
    d. Mumps Vaccine Administered
    e. Rubella Vaccine Administered
4. OHA is not including disease histories for the numerator.

What are the continuous enrollment criteria: 12 months prior to the child's 2nd birthday.

What are allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 2nd birthday.

Define Anchor Date (if applicable): Enrolled on the child's 2nd birthday.

Cigarette Smoking Prevalence

Overview: CCO incentive EHR based measure.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 25%

Target Population [Denominator]: Unique Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period.

Goal: To record the smoking status of all patients, every day smokers, and every day smokers and/or tobacco users.

Process:

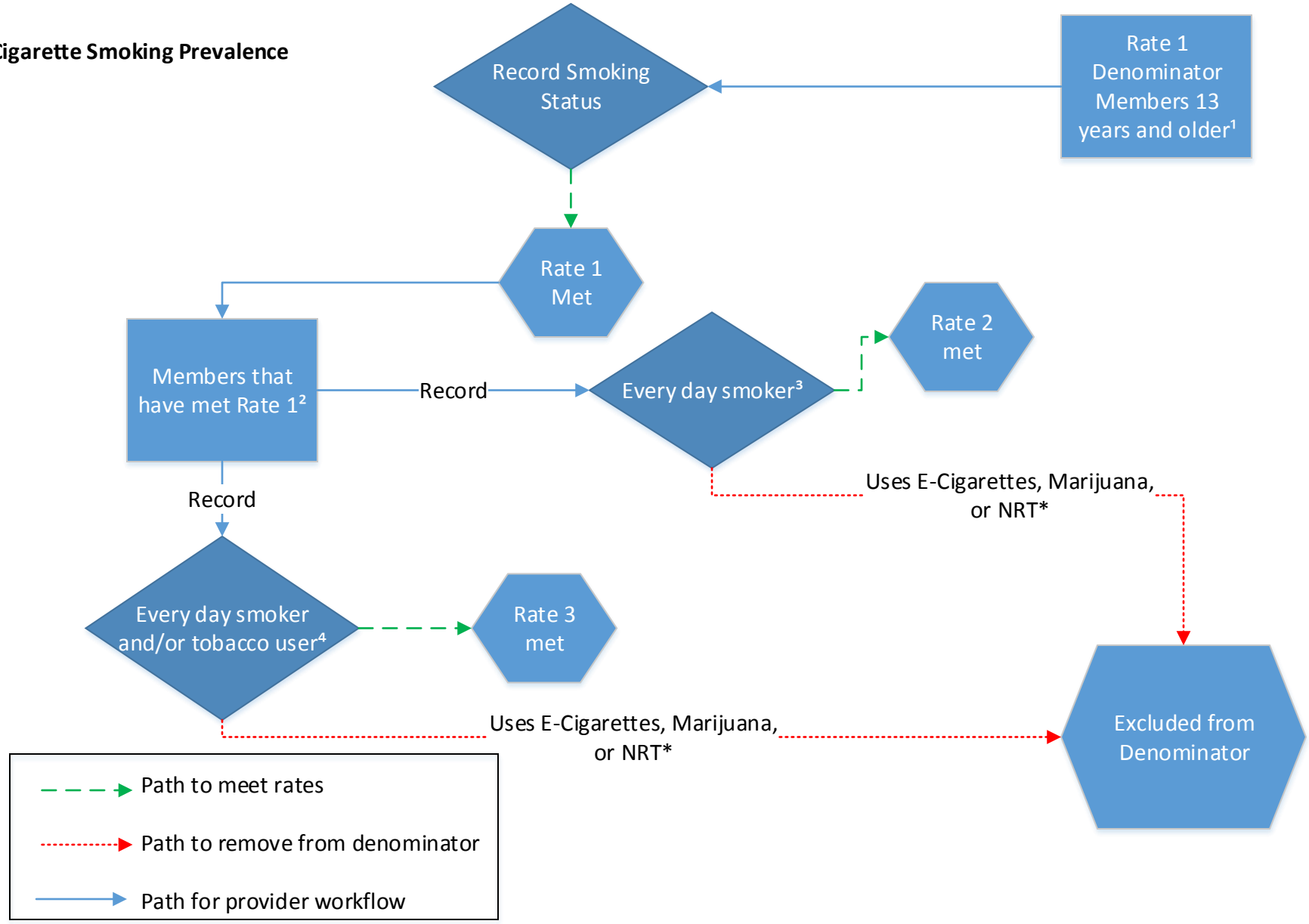
- Record the smoking status of the target population as structured data
- Record the everyday smoking use and/or tobacco use of the members that have met rate 1

Exclusions Rate 2 and 3 [Denominator]: If a patients smoking status is recorded as "unknown if ever smoked"

Exclusions Rate 2 and 3 [Numerator]: Uses E-cigarettes, marijuana, or NRT[1]

[1] If uses NRT but still uses tobacco, do not exclude

Cigarette Smoking Prevalence



[1]Who had a qualifying visit with the provider during the measurement period, who have had their smoking and/or tobacco use recorded as structured data

**See tech specs for example table, notes on recording use, and qualifying visits*

[2]Are rate 2 and 3 denominators

[3]Includes current every day smoker, current some day smoker, smoker current status unknown, heavy tobacco smoker, light tobacco smoker

[4]Includes cigars, snuff, chew, strips, sticks, gum, etc.

**Note: If uses NRT but still uses tobacco, do not exclude*

Cigarette Smoking Prevalence

Measure Basic Information

Name and date of specifications used: OHA developed these specifications based on certification criteria for electronic health records; these specifications also borrow value sets from the tobacco use screening and cessation intervention metric (NQF0028/ CMS138).

URL of Specifications:

- Meaningful Use standards for recording smoking status: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf
- Tobacco use screening and cessation intervention specifications (for those using components of that measure): https://ecqi.healthit.gov/ecqm/measures/cms138v7

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: OHA-developed

Measure Utility:

CCO Incentive ■ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

2016 Benchmark: 25%, goal established in 1115 demonstration waiver for Medicaid tobacco prevalence
2017 Benchmark: 25%, Metrics and Scoring Committee consensus and alignment with 1115 waiver goals
2018 Benchmark: 25%, Metrics and Scoring Committee consensus and alignment with 1115 waiver goals
2019 Benchmark: 25%, Metrics and Scoring Committee consensus

2019 Improvement Targets: Minnesota method with 1 percentage point floor

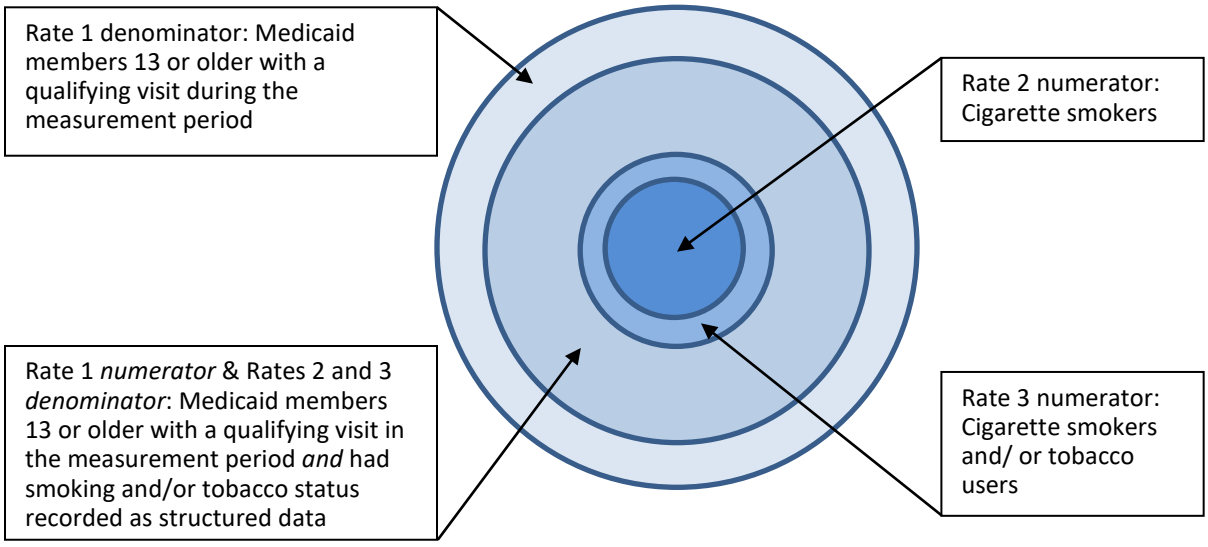
Changes in Specifications from 2018 to 2019

- Per the Metrics & Scoring Committee, the cessation benefit survey component of measure has been removed. Although the cessation benefit survey is no longer a component of this measure, the Tobacco Cessation Coverage Standards are an important resource for understanding how to support tobacco users with cessation interventions. Updated guidance is available here: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/tob_cessation_coverage_standards.pdf
- To improve readability, this specifications sheet was reorganized, and material from separate FAQ documents was added to bring relevant information together in a single place.
- New guidance was added about how to count patients whose smoking or tobacco use status has been recorded during multiple visits. This guidance was revised from its initial draft form based on feedback from the CCO Metrics Technical Advisory Group (TAG).
- Visit codes for adolescent encounter types were added in Appendix 1(2).
- For NQF0028/CMS138, an updated list of value sets is outlined in the Technical Release Notes: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS138v7_TRN.xlsx The "Face-to-Face Interaction" data element was removed and SNOMED codes have been added to other encounter grouping sets to better align between the SNOMED and CPT encounter codes.

Measure Components and Scoring

The intent of the measure is to address tobacco prevalence, including cigarette smoking and use of other tobacco products, such as chew, snuff, and cigars. The measure excludes use of e-cigarettes, marijuana, and nicotine replacement products such as patches.

Three rates are reported for this measure. The measure first looks for (1) the rate of screening for smoking and/or tobacco use and then looks for separate rates for (2) cigarette smoking and (3) tobacco use. The tobacco use rate includes use of cigarettes and other tobacco products, such as snuff and chew.



Only the cigarette smoking prevalence rate (Rate 2) will be used for comparison to the benchmark or improvement target. Although complete reporting is preferred, OHA will accept data submissions that include the cigarette smoking prevalence rate without tobacco use prevalence rate (Rate 3). If a practice is able to report the tobacco use prevalence rate but not the smoking prevalence rate, the CCO must seek OHA approval to include the practice in the CCO's data submission.

The measure requires use of EHR functionality to extract structured data via custom query, rather than a manually conducted chart review of the electronic records to identify tobacco users. The measure can include any cigarette smoking and/or tobacco use status recorded as structured data (i.e., fields in the EHR that can be queried – not chart review or free text chart notes). As long as the status is recorded as structured data and can be queried, it is not required to align with the EHR certification criteria.

Rate 1:

Data elements required denominator: Unique Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period. See Appendix 1 for identifying qualifying visits.

If a patient is seen by the provider more than once during the measurement period, for the purposes of measurement, the patient is only counted once in the denominator.

Only CCO Medicaid members are counted in this measure; open card Medicaid members are not.

Data elements required numerator: Unique members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

> **Note**: Cigarette smoking and/or tobacco use status must be recorded during the measurement year or the year before. It does not need to be recorded on the date of the qualifying visit, but the recorded status cannot be older than 24 months. *For the 2019 measurement year, this means any status recorded prior to January 1, 2018, should not be included.*
>
> **Note**: If smoking or tobacco use status has been recorded multiple times from several providers *within the same practice*, use the most recent status on record from that practice, even if the individual saw multiple providers. If reporting at the practice level, then the individual will be in the denominator and the numerator once.
>
> If smoking or tobacco use status has been recorded multiple times *across multiple practices*, reporting depends on the ability to de-duplicate individuals across multiple practices in the data submission. Because of feasibility concerns, OHA does not require de-duplication across all practices at this time. If reporting this measure at the practice level, the individual will be in the denominator and numerator once per practice, but may be in multiple practices' data.
>
> **Note**: This metric does not require recording smoking or tobacco status at every visit. Nonetheless, sometimes a patient's smoking or tobacco use status may be recorded at multiple visits. In that case, only the most recent screening, which has a documented status of smoking or tobacco use or non-use, will be used to satisfy the measure requirements. This table illustrates some examples, where Visit 1 and Visit 2 occur in the measurement year or year prior:

Patient's Status Recorded at Visit 1	Patient's Status Recorded at Visit 2	How Patient Counts in Rate 2 (smoking)	How Patient Counts in Rate 3 (tobacco)
Current every day smoker	Former smoker; snuff use	*Not* counted in Rate 2 numerator (because most recently recorded status indicates tobacco use but doesn't indicate smoking)	Counted in Rate 3 numerator (because of snuff use)
Current every day smoker	Snuff use	*Not* counted in Rate 2 numerator (because most recently recorded status indicates broader tobacco, but doesn't indicate smoking)	Counted in Rate 3 numerator (because of snuff use)
Current every day smoker	Status not recorded	Counted in Rate 2 numerator (based on status at visit 1)	Counted in Rate 3 numerator (because of smoking as a subset of broader tobacco use)
Current every day smoker	Former smoker	*Not* counted in Rate 2 numerator (because most recent status indicates patient doesn't smoke)	*Not* counted in Rate 3

Rate 2:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 2 denominator, those who are cigarette smokers. The current cigarette smoker rate includes all of the following categories:

- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Heavy tobacco smoker
- Light tobacco smoker

Additionally, any combination of "yes" responses based on the individual EHR's functionality for recording cigarette smoking status as structured data that identifies cigarette smokers also qualifies as a positive numerator event.

Numerator Exclusions: See below

Rate 3:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 3 denominator, those who are cigarette smokers *and/or* tobacco users.

Those Medicaid members ages 13 years and older, who had their tobacco use status recorded as structured data within the EHR who are current tobacco users.

The current tobacco user rate should include all of the above cigarette smoking categories and any other use of tobacco products, as documented in the individual EHR's functionality. For example, any other categories within the EHR that identify patients who use cigars, snuff, chew, strips, sticks, gum, etc.

Numerator Exclusions: See below

Required exclusions for numerator – Rates 2 and 3:

- Members with missing smoking or tobacco use status are excluded from Rates 2 and 3. OHA will monitor Rate 1 (screening) to determine whether this exclusion is potentially incentivizing providers to not record smoking status. For additional information on this exclusion, please see the January 28, 2016, slides and notes from the Metrics Technical Advisory Group (TAG) meeting at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Technical-Advisory-Group.aspx
- This measure does not assess use of e-cigarettes and marijuana (medical or recreational). Use of those products should be excluded. This measure is focused on cigarettes and other tobacco products. Additional clarification may be needed with providers or modifications made to EHRs to ensure that providers and systems are asking about and documenting cigarette smoking and/or tobacco use separately from e-cigarette and marijuana use.
- Likewise, patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).

What are the continuous enrollment criteria: There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS electronic clinical quality measure (eCQM) specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer." The "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: N/A

Define Anchor Date (if applicable): N/A

Appendix 1: Qualifying Visits (Rate 1 denominator)

One of the following options for identifying the tobacco prevalence denominator must be used, and the denominator option must be documented.

(1) If a Meaningful Use Report is available, use the Denominator Encounter Criteria for the MU Smoking Status Objective:

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include:

(1) Concurrent care or transfer of care visits
(2) Consultant visits, or
(3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Notes: Specific E&M codes would need to be defined by those pulling the data. There may be Meaningful Use queries/reports that they could use, but it wouldn't ensure a transparent or standard process (especially for data validation).

(2) Code sets included in NQF0028/ CMS 138, *plus visit codes for adolescents*:

The denominator criteria for NQF0028 may be used to identify visit types. Because that measure looks for patients age 18 or older, however, additional work is needed to pick up the denominator population age 13-17.

Denominator criteria for Tobacco Use: Screening and Cessation Intervention (NQF 0028/ CMS 138) contain the following encounter types:

Type of Visit	Code
Annual Wellness Visit	HCPCS G0438, G0439
Health & Behavioral Assessment - Individual	CPT 96152
Health and Behavioral Assessment - Initial	96150
Health and Behavioral Assessment, Reassessment	96151
Home Healthcare Services	CPT 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Type of Visit	Code
	SNOMED 185460008, 185462000, 185466002, 185467006, 185468001, 185470005, 225929007, 315205008, 439708006, 698704008, 704126008
Occupational Therapy Evaluation	97165, 97166, 97167, 97168
Office Visit	CPT 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 SNOMED 185463005, 185464004, 185465003, 30346009, 3391000175108, 37894004, 439740005
Ophthalmological Services	92002, 92004, 92012, 92014
Preventive Care Services - Established Office Visit, 18 and Up	99395, 99396, 99397
Preventive Care Services - Group Counseling	99411, 99412
Preventive Care Services - Other	99429
Preventive Care Services-Individual Counseling	99401, 99402, 99403, 99404
Preventive Care Services-Initial Office Visit, 18 and Up	99385, 99386, 99387
Psych Visit - Diagnostic Evaluation	90791, 90792
Psych Visit – Psychotherapy	90832, 90834, 90837
Psychoanalysis	90845
Speech and Hearing Evaluation	92521, 92522, 92523, 92524, 92540, 92557, 92625

Additional visit types are appropriate for the adolescent population. Please note that although these visit types may pick up 12-year-olds, the measure looks for CCO members aged 13 and older.

Type of Visit	Code
Preventive Care Visits, ages 12-17	CPT 99384, 99394

Appendix 2: Smoking Status and Tobacco Use Status

For practices using the SNOMED CT codes called out in the EHR certification standards, this table shows how the codes crosswalk to the OHA specifications.

Status	SNOMED	Smoking status recorded (Rate 1)	Smoking prevalence (Rate 2)	Tobacco prevalence (Rate 3)
Current every day smoker	449868002	Y	Y	Y
Current some day smoker	428041000124106	Y	Y	Y
Former smoker	8517006	Y		
Never smoker	266919005	Y		
Smoker, current status unknown	77176002	Y	Y	Y
Unknown if ever smoked[1]	266927001	N		

[1] If a patient's smoking status is recorded as "unknown if ever smoked," that patient should be treated as missing for purposes of this measure. In other words, the patient would be numerator non-compliant for Rate 1 and, therefore, would not be considered for inclusion in Rates 2 and 3.

Heavy tobacco smoker	428071000124103	Y	Y	Y
Light tobacco smoker	428061000124105	Y	Y	Y

Various additional SNOMED CT codes may be used in recording smoking or tobacco use status. Again, these codes are not required for the measure, but this crosswalk to the specifications is provided for reference.

Status	**SNOMED**	**Smoking status recorded** (Rate 1)	**Smoking prevalence** (Rate 2)	**Tobacco prevalence** (Rate 3)
Tobacco use and exposure – finding	365980008	Y		Y
Ex-tobacco user	702975009	Y		
Finding relating to moist tobacco use	228499007	Y		Y
Finding related to tobacco chewing	228509002	Y		Y
Maternal tobacco abuse	16994006	Y		Y
Maternal tobacco use	427189007	Y		Y
Never used tobacco	702979003	Y		
No known exposure to tobacco smoke	711563001	Y		
Passive smoker	43381005	Y		
Snuff use – finding	365983005	Y		Y
Tobacco consumption unknown	160614008	N		
Tobacco smoking behavior – finding	365981007	Y	Y	Y
Tobacco user	110483000	Y		Y

Version Control

Colorectal Cancer Screening

Overview: CCO incentive and state quality measure based off of claims and EHR data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 61.1%

Target population [Denominator]: Medicaid enrollees age 51-75 years of age as of December 31st of the measurement year.

Goal: Give all patients in the target population a Colo-Care card or schedule a colonoscopy[1]

Process:

- Give all patients a Colo-Care card or schedule a colonoscopy[2]
- Record data in EHR

Exclusions [Denominator]: Members in hospice, members 66 years of age and older as of December 31st of the measurement year who are enrolled in a SNP (I-SNP), or living long-term in an institution any time during the measurement year, members 66 years of age and older as of December 31st of the measurement year with frailty and advanced illness during the measurement year.

Exclusions [Numerator]: None

[1] If not done in the last 10 years

[2] If not done in the last 10 years

Colorectal Cancer Screening

Measure Basic Information

Name and date of specifications used:
HEDIS® 2019 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: N/A

Measure Type:
HEDIS ■ PQI☐ Survey☐ Other☐ Specify:

Measure Utility:
CCO Incentive■ State Quality ■ CMS Adult Core Set☐ CMS Child Core Set☐ Other☐
Specify:

Data Source: MMIS/DSSURS, medical records

Measurement Period: January 1, 2019 – December 31, 2019

2013 Benchmark: N/A improvement target only
2014 Benchmark: 47%, Metrics & Scoring Committee consensus.
2015 Benchmark: 47%, Metrics & Scoring Committee consensus.
2016 Benchmark: 47%, Metrics & Scoring Committee consensus.
2017 Benchmark: 50.8%, 2015 CCO 90th percentile.
2018 Benchmark: 54.0%, 2016 CCO 90th percentile.
2019 Benchmark: 61.1%, 2018 national commercial 50th percentile.

2019 Improvement Targets: Minnesota method with 2 percentage point floor.

Incentive Measure changes in specifications from 2018 to 2019:

- HEDIS 2019 revised the age requirements (66 and older as of December 31 of the measurement year) for the exclusions for Medicare members enrolled in an I-SNP or living long-term in an institution, and clarified using LTI flag in Monthly Membership Detail Data File. OHA continues to utilize available data from CMS to identify I-SNP Medicare-Medicaid dual enrollees and remove them from sampling, as well as allowing CCOs' input on additional members identified during the chart review process.
- HEDIS 2019 added exclusions for those with advanced illness and frailty.
- OHA clarified the method used for excluding members utilizing hospice services.

OHA continues to adopt the full HEDIS hybrid specifications for 2019. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMRs), registries, or claims systems.

- If using administrative data to identify numerator compliance, CCOs must follow HEDIS 2019 specifications for allowable codes and measure logic.
- If using medical record data to identify numerator compliance, CCOs must follow HEDIS 2019 specifications to conduct the chart review.

See the guidance document for additional information on allowable data sources. OHA will provide updated guidance to CCOs on the hybrid methodology for 2019 in fall 2019 and samples in early 2020. Guidance will be posted online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

COL	Claim from matching CCO	Denied claims included
Numerator event	N	Y

Measure Details

Data elements required denominator: Medicaid enrollees age 51-75 years as of December 31st of the measurement year. OHA will provide CCOs with the sampling frame for the chart review.

Required exclusions for denominator:

Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

Exclude Medicare members 66 years of age and older as of December 31 of the measurement year who are enrolled in an Institutional SNP (I-SNP), or living long-term in an institution any time during the measurement year. OHA will exclude Institutional SNP (I-SNP) members when drawing the sample list (see footnote[1] for OHA's data source and method). OHA will also update the chart review data

[1] The I-SNP exclusion makes use of the Territorial Benefit Query (TBQ) files from CMS to identify the Contract Number and Plan Number of Oregon Medicaid recipients who are dual eligible in Medicare Advantage plans. Dual eligible Medicaid recipients who were enrolled in Medicare Special Needs Plans

submission template for 2019, to allow CCOs to indicate additional I-SNP members who are identified in the chart review process.

Exclude members 66 years of age and older as of December 31 of the measurement year with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify a member with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years) meet criteria:

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute impatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with and an advanced illness diagnosis (Advanced Illness Value Set).
- A dispensed dementia medication (Dementia Medications List[2]):
    - Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigmine
    - Miscellaneous central nervous system agents: Memantine

(See HEDIS 2019 Value Set Dictionary for detail)

Exclude members with either of the following conditions any time during the member's history through December 31 of the measurement year[3]:

Colorectal Cancer Value Set		
HCPCS	**ICD-9-CM Diagnosis**	**ICD-10-CM Diagnosis**
G0213-G0215, G0231	153, 154.0, 154.1, 197.5, V10.05, V10.06	C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

OR

Total Colectomy Value Set		
CPT	**ICD-9-PCS Procedure**	**ICD-10-PCS Procedure**
44150-44153, 44155-44158, 44210-44212	45.81-45.83	0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

Deviations from cited specifications for denominator: None.

Data elements required numerator: Unique number of individuals receiving at least one of the following screenings for colorectal cancer either during the measurement year or years prior to the measurement year (see table). See **medical record review** section.

Appropriate screenings are defined by:

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and institutionalized at any time during the measurement year are excluded from consideration for the Colorectal Cancer Screening Hybrid Method Medicaid recipient samples.

[2] HEDIS 2019 NDC list is available: https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/

[3] To note, OHA's claims data only goes back to 2002.

FOBT Value Set Fecal occult blood test during the measurement year		
CPT	**HCPCS**	**LOINC**
82270, 82274	G0328	2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6

OR

Flexible Sigmoidoscopy Value Set Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[4]**
45330-45335, 45337-45342, 45345, 45346, 45347, 45349, 45350	G0104	45.24	--

OR

Colonoscopy Value Set Colonoscopy during the measurement year or nine years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[2]**
44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398	G0105, G0121	45.22, 45.23, 45.25, 45.42, 45.43	--

OR

CT Colonography Value Set CT colonography during the measurement year or four years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**ICD-10-CM Procedure[2]**
74261, 74262, 74263	--	--	--

OR

FIT-DNA Value Set FIT-DNA during the measurement year or two years prior to the measurement year			
CPT	**HCPCS**	**ICD-9-CM Procedure**	**LOINC**
81528	G0464	--	77353-1, 77354-9

Note: In office FOBT is not a USPSTF recommended procedure.

[4] HEDIS 2019 does not include ICD-10 procedure codes for this measure, as ICD-10-PCS is intended for coding procedures performed in inpatient settings, whereas colorectal cancer screenings typically occur in outpatient settings.

Required exclusions for numerator: None. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: The measurement year and the year prior to the measurement year.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Define Anchor Date (if applicable): December 31 of the measurement year.

Medical Record Review:

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was 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).

A pathology report that indicates the type of screening (e.g. colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria for inclusion in the measure.

For pathology reports that do not indicate the type of screening and for incomplete procedure:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below:
    - If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
    - If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.

- If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.

Do not count digital rectal exam (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

For more information: The Colorectal Cancer Screening guidance document and other supporting documents can be found at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx and http://www.oregon.gov/OHA/HPA/CSI-TC/Pages/Resources-Metric.aspx

Controlling High Blood Pressure (NQF 0018/CMS 165v7)

Overview: CCO incentive, state quality, and CMS adult core set EHR based measure.

Measurement Period: January 1, 2019 – December 31, 2019

Benchmark: 71.0%

Target population [Denominator]: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

Goal: Have patient's blood pressure controlled at their most recent visit at a level of systolic blood pressure <140 mmHg and diastolic blood pressure of <90 mmHg.

Process:

- Correctly take target populations blood pressure in a clinical setting
- Record in EHR[1]
- Repeat blood pressure if needed

Exclusions [Denominator]: Patients with evidence of ESRD, dialysis or renal transplant before or during the measurement period, patients with a diagnosis of pregnancy, those whose hospice care overlaps the measurement period

Exclusions [Numerator]: None

[1] If no blood pressure is recorded it is assumed "not controlled"

Controlling High Blood Pressure (NQF 0018/CMS 165v7)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2019.

URL of Specifications: https://ecqi.healthit.gov/ecqm/measures/cms165v7

Note: eCQM specifications typically are updated at least annually. The eCQM version number changes with each annual update. Once certified, however, electronic health records (EHRs) are not required to be recertified with updated eCQM specifications, so the Certified HIT Products List may not accurately reflect the version of an eCQM that is actually supported by an EHR vendor. OHA will accept year seven data (2019) submissions from previous releases of the eCQM specifications, but CCOs will need to document the version number of the specifications they are using.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: eCQM

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ■ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

OHA anticipates publishing the Year Seven (2019) Guidance Document in summer 2019.

2013 Benchmark: n/a
2014 Benchmark: n/a
2015 Benchmark: 64%, from the 2014 national Medicaid 75th percentile.
2016 Benchmark: 69.0%, from the 2015 national Medicaid 90th percentile.
2017 Benchmark: 69.0%, from the 2015 national Medicaid 90th percentile.
2018 Benchmark: 70.6%, 2016 national Medicaid 90th percentile
2019 Benchmark: 71.0%, 2018 national Medicaid 90th percentile

2019 Improvement Targets: Minnesota method with 2 percentage point floor

Changes in Specifications from 2018 to 2019: See Technical Release Notes for a complete list of changes: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS165v7_TRN.xlsx. Changes include:

- Updated the Denominator Exclusion statement for patients in hospice care to better align with the logic.
- Made multiple changes in the measure logic, conforming to Quality Data Model (QDM) 5.3 and Clinical Quality Language (CQL).

- Removed the 'Face-To-Face Interaction' data element and added relevant SNOMED codes to the Encounter Grouping value sets to better align between the SNOMED and CPT encounter codes.
- Replaced LOINC and SNOMEDCT single code value sets with direct referenced codes.

Value Set Name and OID	Status
Value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001):	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1264) including 7 codes.
Value set Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016):	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1265) including 11 codes.
Value set Pregnancy (2.16.840.1.113883.3.526.3.378):	Deleted 11 ICD10CM codes (O00.1, O00.10, O00.11, O00.2, O00.20, O00.21, O00.8, O00.9, O33.7, O34.21, Z36).
Value set Payer (2.16.840.1.114222.4.11.3591):	Added 11 SOP codes (299, 32127, 32128, 391, 517, 524, 614, 621, 622, 623, 629) and deleted 3 SOP codes (63, 64, 69).
Value set Kidney Transplant Recipient (2.16.840.1.113883.3.464.1003.109.12.1029):	Added Kidney Transplant Recipient.
Value set Face-to-Face Interaction (2.16.840.1.113883.3.464.1003.101.12.1048):	Removed Face-to-Face Interaction.
Value set Vascular Access for Dialysis (2.16.840.1.113883.3.464.1003.109.12.1011)	Added 2 SNOMEDCT codes (736919006, 736922008) – *2019 Addendum*
Value set Kidney Transplant (2.16.840.1.113883.3.464.1003.109.12.1012)	Added 35 SNOMEDCT codes and deleted 8 SNOMEDCT codes (175899003, 175901007, 175902000, 236138007, 313030004, 52213001, 88930008, 70536003). Added 2 CPT codes (50300, 50320) – *2019 Addendum*
Value set Payer (2.16.840.1.114222.4.11.3591)	Deleted 1 SOP code (24) – *2019 Addendum*

Denied claims: n/a

Measure Details

Data elements required denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension[1] within the first six months of the measurement period or any time prior to the measurement period.

Qualifying Outpatient Service	Grouping Value Set[2]
Office Visit	2.16.840.1.113883.3.464.1003.101.12.1001

[1] Essential hypertension is identified using the Essential Hypertension Grouping Value Set (2.16.840.1.113883.3.464.1003.104.12.1011).

[2] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in

Qualifying Outpatient Service	Grouping Value Set[2]
Preventive Care Services – Established Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.12.1025
Preventive Care Services – Initial Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.12.1023
Home Healthcare Services	2.16.840.1.113883.3.464.1003.101.12.1016
Annual Wellness Visit	2.16.840.1.113883.3.526.3.1240

Required exclusions for denominator:

- Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period.
- Also exclude patients with a diagnosis of pregnancy during the measurement period.
- Exclude patients whose hospice care overlaps the measurement period.

Exclusions	Grouping Value Set
Hospice	Hospice care ambulatory: 2.16.840.1.113762.1.4.1108.15 Discharge to healthcare facility for hospice care (procedure): SNOMEDCT version 2017-09 Code (428371000124100) Discharge to home for hospice care (procedure): SNOMEDCT version 2017-09 Code (428361000124107)
Pregnancy	Pregnancy: 2.16.840.1.113883.3.526.3.378
Renal Diagnosis	End Stage Renal Disease: 2.16.840.1.113883.3.526.3.353 Kidney Transplant Recipient: 2.16.840.1.113883.3.464.1003.109.12.1029 Chronic Kidney Disease, Stage 5: 2.16.840.1.113883.3.526.3.1002
End Stage Renal Disease (ESRD) Procedures	Vascular Access for Dialysis: 2.16.840.1.113883.3.464.1003.109.12.1011 Kidney Transplant: 2.16.840.1.113883.3.464.1003.109.12.1012 Dialysis Services: 2.16.840.1.113883.3.464.1003.109.12.1013
ESRD Encounter	ESRD Monthly Outpatient Services: 2.16.840.1.113883.3.464.1003.109.12.1014

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg) during the measurement period.

Note: Only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Note: The measure specifications for the numerator call for blood pressure results during an adult outpatient visit. Results taken in a hospital setting should not be included.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria:

There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS specifications for this measure, including specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer." The "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/
- How to read eCQMs: https://ecqi.healthit.gov/system/files/Guide-for-Reading-Electronic-Clinical-Quality-Measures-v4-0-2018-0504.pdf
- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Seven (2019) guidance will be available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Dental Sealants on Permanent Molars for Children

Overview: CCO incentive and CMS child core set based off of claims data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 26.8%

Target population [Denominator]: Total unduplicated number of individuals ages 6-9 and 10-14 years of age as of December 31 of the measurement year[1].

Goal: Refer target population needing dental sealants to assigned dental clinic for appointment.

Process:

- Refer target population needing dental sealants to assigned dental clinic for appointment.

Exclusions [Denominator]: N/A

Exclusions [Numerator]: N/A

[1] OHA will be reporting the two age ranges separately but the rates will be combined.

Dental Sealants on Permanent Molars for Children

Measure Basic Information

Name and date of specifications used: Specifications are based on the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Report (Form CMS-416), effective FFY 2014, and on American Dental Association, Dental Quality Alliance measures - Dental Sealants for 6-9 Year Old Children / 10-14 Year Old Children at Elevated Caries Risk. Modifications have been made to enable CCO-level reporting.

URL of Specifications:
CMS EPSDT instructions are online here: https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf

Dental Quality Alliance measure specifications are online here: http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measures-medicaid-and-dental-plan-assessments

Measure Type:
HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: OHA-modified (see links above)

Measure Utility:
CCO Incentive ■ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set ■ Other ☐
Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

2015 Benchmark: 20%, Metrics & Scoring Committee consensus
2016 Benchmark: 20%, Metrics & Scoring Committee consensus
2017 Benchmark: 20%, Metrics & Scoring Committee consensus
2018 Benchmark: 22.9%, 2016 CCO 75th percentile
2019 Benchmark: 26.8%, 2017 CCO 90th percentile

2019 Improvement Targets: Minnesota method with 2 percentage point floor

Measure changes in specifications from 2018 to 2019: none.

Member type: CCO A ■ CCO B ☐ CCO G ☐

Note CCO G members were included in the calculation of the 2014 baseline, but not in subsequent measurement years.

Specify claims used in the calculation:

DS	Claim from matching CCO	Denied claims included
Numerator event	Y	Y

Measure Details

Data elements required denominator:

Total unduplicated number of individuals ages 6-9 and 10-14 years of age as of December 31 of the measurement year. Note the cited measures include two age ranges, 6-9 and 10-14. OHA will measure and report each of these age ranges separately, but the rates will be combined (creating a weighted average by adding numerators and denominators, rather than averaging the rates) for comparison to the benchmark and for calculating the incentive payment.

The CCO incentive measure does not incorporate the Dental Quality Alliance criteria for identifying children at elevated caries risk the denominator. The Dental Quality Alliance is currently the specifications.

For CMS Medicaid Child Core Set measure[1] reporting which adopts the Dental Quality Alliance specifications for age 6-9, OHA is required to only report the members with elevated caries risk in the denominator. Elevated caries risk is determined as follows:

- Any children with a visit with D0602 or D0603 during the measurement year; OR
- Any children with a service code among those in Table 1 in the measurement year; OR
- Any children with a service code among those in Table 1 in any of the three years prior to the measurement year (Note the child does not need to be continuously enrolled for any of these three years, this is simply a look back for any claims history).

Table 1: identifying "elevated risk"

CDT Codes
D2140, D2150, D2160, D2161, D2330-D2332, D2335, D2390-D2394, D2410, D2420, D2430, D2510, D2520, D2530, D2542-D2544, D2610, D2620, D2630, D2642-D2644, D2650-D2652, D2662-D2664, D2710, D2712, D2720-D2722, D2740, D2750-D2752, D2780-D2783, D2790-D2792, D2794, D2799, D2930-D2934, D2940, D2941, D2950, D3110, D3120, D3220-D3222, D3230, D3240, D3310, D3320, D3330, D1354

Required exclusions for denominator: N/A

Deviations from cited specifications for denominator:

[1] Link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

- The EPSDT Form CMS-416 specifications use the Federal Fiscal Year (FFY); OHA's specifications will use the calendar year.
- The EPSDT Form CMS-416 specifications also use September 30th as the date to determine age; OHA's specifications will use December 31st.

Data elements required numerator:

Unduplicated number of children ages 6-9 and 10-14 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (CDT code D1351), during the measurement year. Sealants can be placed by any dental professional for whom placing a sealant is within his or her scope of practice.

As the majority of the dental sealant services are submitted to MMIS in the dental claim format, per EPSDT Form CMS-416 specification, only sealant services on permanent molars (including the third molars, also known as the wisdom teeth), as identified by teeth numbered 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32 will count towards the numerator.

For the dental sealant services submitted through medical professional or facility claims, the tooth number information is not available on the claim form and therefore not required for inclusion in the numerator; any sealant code D1351 submitted through medical professional or facility claims will be included in the numerator. This is a deviation from the EPSDT Form CMS-416 specification.

Table 2: Numerator Dental Sealant Codes

Dental Claims	**CDT Code**	with	**Tooth Number**
	D1351		1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32

OR

Medical Claims	**CDT Code**
	D1351

Sealants must be provided by the CCO the child is enrolled in to count towards the numerator.

Required exclusions for numerator: N/A

Deviations from cited specifications for numerator:
To encourage CCOs integration of medical practice with oral health, OHA accepts dental sealant services submitted through the medical claims format, and the CDT code D1351 alone is valid for the numerator without the tooth number specified (see numerator data requirement above). Note that while dental sealant services can be provided in medical or community-based settings and submitted through medical claims, sealants can only be placed by qualified dental providers. See the Dental Sealant Guidance Document for additional information on which provider types can provide sealants. http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

The Dental Quality Alliance specifications (and the CMS Child Core Set specifications) require determining the numerator claims from dental providers, using provider taxonomy codes (see the cited specifications for more detail). OHA CCO incentive measure specifications align with EPSDT Form CMS-416 and do not use taxonomy codes in the calculation.

What are the continuous enrollment criteria:
Continuously enrolled with a CCO for the entire measurement year.

The EPSDT Form CMS-416 specifications require 90 continuous days enrollment in OHP (FFS and non-specified CCO) Medicaid Title 19. Children enrolled in CHIP Title 21, for at least 90 continuous days (and who are not included in the 416 Report) are included in a separate EPSDT - like report for children covered by CHIP. OHA CCO incentive specifications include both Medicaid and children covered by CHIP, and require the member to be continuously enrolled with a CCO for the entire measurement year.

Note for calculating the 2014 baseline rate: Due to dental integration into CCOs occurring mid-year, OHA used 180-day continuous enrollment criteria rather than the full 12-month measurement year. In addition, while a member could qualify for the denominator in more than one CCO under this method, only the qualifying services provided by the matching enrolled CCO would be counted towards the numerator.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Note OHA did not apply this allowable gap to the 2014 baseline, given the modified measurement period.

Define Anchor Date (if applicable): December 31st of the measurement year.

Note OHA did not apply an anchor date to the 2014 baseline, due to the transition with dental coverage in the year.

Screening for Depression and Follow-Up Plan

(NQF 0418/CMS 2v8)

Overview: CCO Incentive, State Quality and CMS Adult Core Set measure based off of EMR data.

Measurement Period: January 1, 2019- December 31, 2019

Benchmark: N/A. Because of specification changes[1] from 2018 to 2019, there is no performance benchmark for 2019. CCOs must report data meeting minimum population threshold for this measure in order to receive 100% of their quality pool payment.

Target Population [Denominator]: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Goal: Screen patients for depression on the date of the encounter and if positive, document the follow-up plan on the date of the positive screen.

Process:

- Give age appropriate, standardized screening tool
- If positive result, set follow-up plan
- Document follow-up plan on date of positive screen

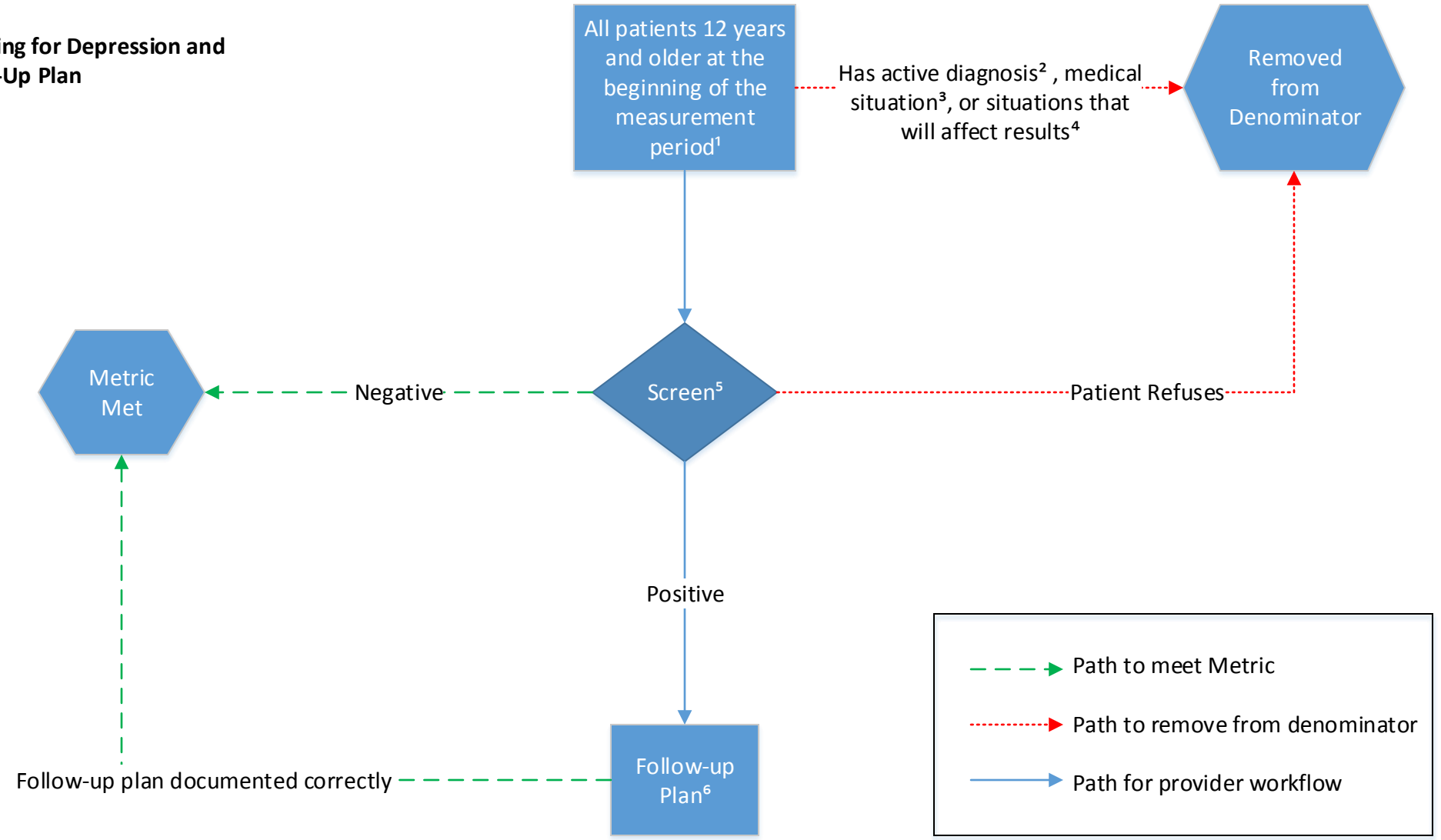
Exclusions [Denominator]: Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.

Exceptions [Denominator]: Patient refuses to participate, patient is in an urgent or emergent situation where time is essence and to delay treatment would jeopardize the patient's health status, situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

Exclusions [Numerator]: None

[1] Please note one key change has been that use of the PHQ9 as a follow-up to a positive PHQ2 no longer counts as additional evaluation and cannot be counted for numerator compliance.

Screening for Depression and Follow-Up Plan



[1] With at least one eligible encounter during the measurement period

[2] Bipolar or depression diagnosis

[3]Patient is in an urgent or emergent situation where time is of he essence and to delay treatment would jeopardize the patient's health stauus

[4] Situations where the patients patient's functional capacity or motivation to improve may impact the accuracy of results of st andardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

[5] A depression screening is once per measurement period, not at all encounters; this is patient based and not an encounter based measure.

***Note*:** Screening tool must be age appropriate. The name of the age appropriate standardized depression screening tool must be documented in the medical record. Please see page 4-6 of the Tech Specs for additional information regarding the screening tools.

[6] The follow-up plan must be related to a positive depression screening. Example: "Patient referred for psychiatric evaluation due to positive depression screening." Please see page 4-6 of the tech specs for additional suggestions of follow-up plans.

Screening for Depression and Follow-Up Plan (NQF 0418/CMS 2v8)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2019.

URL of Specifications: https://ecqi.healthit.gov/ecqm/measures/cms2v8

Note: eCQM specifications typically are updated at least annually. The eCQM version number changes with each annual update. Once certified, however, electronic health records (EHRs) are not required to be recertified with updated eCQM specifications, so the Certified HIT Products List may not accurately reflect the version of an eCQM that is actually supported by an EHR vendor. OHA will accept year seven data (2019) submissions from previous releases of the eCQM specifications, but CCOs will need to document the version number of the specifications they are using.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: eCQM

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ■ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

OHA anticipates publishing the Year Seven (2019) guidance in summer 2019.

2013 Benchmark: n/a
2014 Benchmark: 25%, Metrics & Scoring Committee consensus. For challenge pool only.
2015 Benchmark: 25%, Metrics & Scoring Committee consensus.
2016 Benchmark: 25%; Metrics & Scoring Committee consensus.
2017 Benchmark: 52.9%, 75th percentile of 2015 CCO performance.
2018 Benchmark: 63.0%, 2016 CCO 90th percentile
2019 Benchmark: N/A. Because of specification changes from 2018 to 2019, there is no performance benchmark for 2019. CCOs must report data meeting minimum population threshold for this measure in order to receive 100% of their quality pool payment.

2019 Improvement Targets: N/A (see benchmark note above)

Changes in Specifications from 2018 to 2019: See Technical Release Notes for a complete list of changes: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS2v8_TRN.xlsx. Changes include:

- **Please note the change to the value sets for Additional evaluation for depression – adolescent and Additional evaluation for depression – adult**.
  The deleted SNOMEDCT codes are the codes for completion of a standardized screening tool; this has been removed from the definition of additional evaluation.
    - **This means that use of the PHQ9 as a follow-up to a positive PHQ2 no longer counts as additional evaluation and cannot be counted for numerator compliance.**
      https://oncprojectracking.healthit.gov/support/browse/CQM-3200
- Updated rationale and reference to include information from more current source.
- Added 'or assessment' to the definition of Follow-Up Plan to allow for use of additional assessment tools.
- Updated the definitions section to add two standardized and validated screening tools to the example screening tool list.
- Added the statement 'Depression screening is required once per measurement period, not all encounters; this is patient based and not an encounter based measure' to clarify the assessment frequency.
- Updated guidance related to standardized depression screening tools.
- Added examples of a follow-up plan to the guidance section based on expert recommendations.
- Updated logic expressed using CQL to address an encounter issue resulting in an unexpected exclusion of cases.
- Changed 'Procedure performed' to 'Intervention performed' to harmonize the representation of the data elements within other measures.
- Revised logic for timing of follow-up interventions to better align with the measure intent.
- Made multiple changes in the measure logic, conforming to Quality Data Model (QDM) 5.3 and Clinical Quality Language (CQL).
- Replaced LOINC single code value sets with direct referenced codes.

Value Set Name and OID	Status
Value set Additional evaluation for depression - adolescent (2.16.840.1.113883.3.600.1542)	Deleted 1 SNOMEDCT code (428161000124109) ***NOTE**: Code for standardized adolescent depression screening tool completed (situation)*
Value set Additional evaluation for depression - adult (2.16.840.1.113883.3.600.1545)	Deleted 1 SNOMEDCT code (428151000124107) ***NOTE**: Code for standardized adult depression screening tool completed (situation)*
Value set Depression Screening Encounter Codes (2.16.840.1.113883.3.600.1916)	Added 25 CPT codes and deleted 5 HCPC codes (G0502, G0503, G0504, G0505, G0507)
Value set Follow-up for depression - adolescent (2.16.840.1.113883.3.600.467)	Added 11 SNOMEDCT codes (108313002, 1555005, 15558000, 18512000, 229065009, 75516001, 76168009, 28868002, 304891004, 405780009, 81294000)
Value set Follow-up for depression - adult (2.16.840.1.113883.3.600.468)	Added 11 SNOMEDCT codes (108313002, 1555005, 15558000, 18512000, 229065009, 75516001, 76168009, 28868002, 304891004, 405780009, 81294000)
Value set Suicide Risk Assessment (2.16.840.1.113883.3.600.559)	Added 1 SNOMEDCT code (454331000124109)
Value set Depression medications - adult (2.16.840.1.113883.3.600.470)	Deleted 3 RXNORM codes (730440, 730441, 730442)

Value set Payer (2.16.840.1.114222.4.11.3591)	Added 11 SOP codes (299, 32127, 32128, 391, 517, 524, 614, 621, 622, 623, 629) and deleted 3 SOP codes (63, 64, 69)
Value set Depression diagnosis (2.16.840.1.113883.3.600.145)	Added 2 ICD10CM codes (F53.0, F53.1) and deleted 1 ICD10CM code (F53) – *2019 Addendum*
Value set Payer (2.16.840.1.114222.4.11.3591)	Deleted 1 SOP code (24) – *2019 Addendum*
Value set Depression medications - adult (2.16.840.1.113883.3.600.470)	Deleted 1 RXNORM code (245373) – *2019 Addendum*

Denied claims: n/a

Measure Details

Data elements required denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Eligible encounters are identified through the Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916).[1]

Required exclusions for denominator:

Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Exclusions	Grouping Value Set
Bipolar Diagnosis	2.16.840.1.113883.3.600.450
Depression diagnosis	2.16.840.1.113883.3.600.145

Denominator Exceptions

Any of the following criteria also remove patients from the denominator:

Exception	Grouping Value Set
Patient Reason(s) Patient refuses to participate	Patient Reason refused (2.16.840.1.113883.3.600.791)
Medical Reason(s) 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. OR Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium	Medical or Other reason not done (2.16.840.1.113883.3.600.1.1502)

[1] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients screened for depression on the date of the encounter, using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

The following Grouping Value Sets are used to identify follow-up planning:

- Referral for Depression Adolescent (2.16.840.1.113883.3.600.537)
- Referral for Depression Adult (2.16.840.1.113883.3.600.538)
- Additional evaluation for depression – adolescent (2.16.840.1.113886.3.600.1542)
- Additional evaluation for depression – adult (2.16.840.1.113883.3.600.1545)
- Follow-up for depression – adolescent (2.16.840.1.113883.3.600.467)
- Follow-up for depression – adult (2.16.840.1.113883.3.600.468)
- Depression medications – adolescent (2.16.840.1.113883.3.600.469)
- Depression medications – adult (2.16.840.1.113883.3.600.470)
- Suicide Risk Assessment (2.16.840.1.113883.3.600.559)

Guidance notes: A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the positive screen.

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter
- The screening should occur during a qualified encounter
- Standardized depression screening tools should be normalized and validated for the age appropriate patient population in which they are used

Follow-Up Plan: The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening." Examples of a follow-up plan include but are not limited to:

- Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
- Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
- 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
- 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.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria:

There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS specifications for this measure, including specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer." The "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine . https://vsac.nlm.nih.gov/
- How to read eCQMs: https://ecqi.healthit.gov/system/files/Guide-for-Reading-Electronic-Clinical-Quality-Measures-v4-0-2018-0504.pdf
- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Seven (2019) guidance will be available online at: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Definitions: In addition, the eCQM specifications provide definitions of these terms:

Screening: Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population in which it is being utilized. 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

Follow-Up Plan: Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Development Screening in the First Three Years of Life

Overview: CCO incentive, state quality and CMS child core set measure based off of claims based data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 80.0%

Target population [Denominator]: Children who turn 1, 2, or 3 years of age in the measurement year

Goal: Complete developmental screening

Process:

- Complete development screening for target population during any visit
- Enter correct CPT codes

Exclusions [Denominator]: None

Exclusions [Numerator]: N/A

Developmental Screening in the First Three Years of Life[1]

Measure Basic Information

Name and date of specifications used:
CMS Core set of Children's Health Care Quality Measures for Medicaid and CHIP, Updated February 2018

URL of Specifications: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

Measure Type:
HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: CMS & Oregon Health & Science University

Measure Utility:
CCO Incentive ■ State Quality ■ CMS Adult Core Set ☐ CMS Child Core Set ■ Other ☐
Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

2013 Benchmark: 50%; from Metrics and Scoring Committee consensus
2014 Benchmark: 50%; from Metrics and Scoring Committee consensus
2015 Benchmark: 50%; from Metrics and Scoring Committee consensus
2016 Benchmark: 50%; from Metrics and Scoring Committee consensus
2017 Benchmark: 60.1%; 2015 CCO 75th percentile
2018 Benchmark: 74.0%; 2016 CCO 90th percentile
2019 Benchmark: 80.0%; from Metrics and Scoring Committee consensus

2019 Improvement Targets: Minnesota method with 3 percentage point floor

Incentive Measure changes in specifications from 2018 to 2019:
None.

Note the 'Clarification for coding and billing for developmental screening' is removed from the specifications sheet, as the same information can be found in the guidance document.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

DEV	Claim from matching CCO	Denied claims included
Numerator event	Y	Y

[1] NQF 1448, but NQF is no longer endorsing the measure. Aside from deviations noted overleaf, OHA uses the CMS core measure set specifications.

Measure Details

Data elements required denominator: Children who turn 1, 2, or 3 years of age in the measurement year and had continuous enrollment in a CCO for the 12 months prior to their birthdate in the measurement year, regardless of if they had a medical/clinical visit or not in the measurement year. See Core Set of Children's Health Care Quality Measures for details.

Required exclusions for denominator: None.

Deviations from cited specifications for denominator: None.

Data elements required numerator: Children in the denominator who had a claim with CPT code 96110 in the 12 months preceding the birthday in the measurement year. See new Clarification section below.

Required exclusions for numerator: N/A

Deviations from cited specifications for numerator: If the claim was for CPT 96110, the claim was included regardless of the inclusion of any modifiers. This deviates from published specifications.

What are the continuous enrollment criteria: Enrollment must be continuous for one year prior to the birthday in the measurement year, with maximum of a 45 day gap.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days in the 12 months prior to the birthday in the measurement year.

Define Anchor Date (if applicable): Child's birthdate in the measurement year.

For more information: The Developmental Screening guidance document and supporting documents can be found at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx and http://www.oregon.gov/OHA/HPA/CSI-TC/Pages/Resources-Metric.aspx

Diabetes: HbA1c Poor Control (NQF 0059/122v7)

Overview: CCO incentive, state quality and CMS adult core set measure based off of EHR data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 21.7%

Target population [Denominator]: Patients 18-75 years of age with a diagnosis of Type-1 or Type-2 diabetes with a visit during the measurement year.

Goal: Record target populations most recent HbA1c level[1]

Process:

- Order lab test for HbA1c
- Record test results in EHR once received and reviewed
- Reorder and perform test as often as needed

Exclusions [Denominator]: Patients whose hospice care overlaps the measurement year

Exclusions [Numerator]: None

[1] Patient is numerator compliant if HbA1c level is >9%

Diabetes: HbA1c Poor Control (NQF 0059/122v7)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2019.

URL of Specifications: https://ecqi.healthit.gov/ecqm/measures/cms122v7

Note: eCQM specifications typically are updated at least annually. The eCQM version number changes with each annual update. Once certified, however, electronic health records (EHRs) are not required to be recertified with updated eCQM specifications, so the Certified HIT Products List may not accurately reflect the version of an eCQM that is actually supported by an EHR vendor. OHA will accept year seven data (2019) submissions from previous releases of the eCQM specifications, but CCOs will need to document the version number of the specifications they are using.

As discussed in previous years, the eCQM specifications for CMS122 version 3 contained an error in the measure logic, which makes reported performance look worse than actual performance. Because of that problem, OHA does not intend to accept submissions from CMS122v3 unless there are extenuating circumstances, which should be flagged when the CCO submits its Data Proposal.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: eCQM

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ■ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

OHA anticipates publishing the updated Year Seven (2019) Guidance Document in summer 2019.

2013 Benchmark: n/a
2014 Benchmark: 34%, 2013 National Medicaid 75th percentile. For challenge pool only.
2015 Benchmark: 34%, 2014 national Medicaid 75th percentile.
2016 Benchmark: 19%, 2015 national Commercial 90th percentile.
2017 Benchmark: 19%, 2015 national Commercial 90th percentile.
2018 Benchmark: 22.6%, 2016 CCO 90th percentile.
2019 Benchmark: 21.7% 2018 national Commercial 90th percentile

2019 Improvement Targets: Minnesota method with 2 percentage point floor

Changes in Specifications from 2018 to 2019: See Technical Release Notes for complete list of changes: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS122v7_TRN.xlsx. Changes include:

- Updated clinical recommendation statement to align with current recommendations.
- Updated the Denominator Exclusion statement for patients in hospice care to better align with the logic.
- Made multiple changes in measure logic, conforming to Quality Data Model (QDM) 5.3 and Clinical Quality Language (CQL).
- Removed the 'Face-To-Face Interaction' data element and added relevant SNOMED codes to the Encounter Grouping value sets to better align between the SNOMED and CPT encounter codes.
- Replaced SNOMEDCT single code value sets with direct referenced codes.

Value Set name and OID	Status
Value set Face-to-Face Interaction (2.16.840.1.113883.3.464.1003.101.12.1048)	Removed. Added relevant SNOMED codes to the Encounter Grouping value sets to better align between the SNOMED and CPT encounter codes
Value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1264) including 7 codes.
Value set Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1265) including 11 codes.
Value set Payer (2.16.840.1.114222.4.11.3591)	Added 11 SOP codes (299, 32127, 32128, 391, 517, 524, 614, 621, 622, 623, 629) and deleted 3 SOP codes (63, 64, 69).
Value set Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)	Deleted 17 SNOMEDCT codes.
Value set Payer (2.16.840.1.114222.4.11.3591)	Deleted 1 SOP code (24) – *2019 Addendum*
Value set Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)	Added 36 SNOMEDCT codes – *2019 Addendum*

Denied claims: n/a

Measure Details

Data elements required denominator: Patients 18-75 years of age with diabetes[1] with a visit during the measurement period

Note: Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator; patients with a diagnosis of secondary diabetes due to another condition should not be included.

[1] Diabetes is identified using the Diabetes Grouping Value Set (2.16.840.1.113883.3.464.1003.103.12.1001).

Qualifying Outpatient Service	Grouping Value Set[2]
Office Visit	Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)
Preventive Care Services – Established Office Visit, 18 and Up	Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)
Preventive Care Services – Initial Office Visit, 18 and Up	Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)
Home Healthcare Services	Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)
Annual Wellness Visit	Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)

Required exclusions for denominator: Patients whose hospice care overlaps the measurement period

Exclusions	Grouping Value Set
Hospice	Hospice care ambulatory: 2.16.840.1.113762.1.4.1108.15 Discharge to healthcare facility for hospice care (procedure): SNOMEDCT version 2017-09 Code (428371000124100) Discharge to home for hospice care (procedure): SNOMEDCT version 2017-09 Code (428361000124107)

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%.

Patient is numerator compliant if the most recent HbA1c level >9%, if the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

Note: If there is a test result >9% recorded in the electronic health record, then the numerator criteria is satisfied. A test can be used to determine numerator compliance if the reporting provider has documentation of the test in the patient's record, regardless of who ordered or performed the test. However, this does not mean traditional chart review is required, or allowed, as part of determining numerator compliance. Numerator compliance should still be determined through the EHR-based reporting.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

[2] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g., patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

What are the continuous enrollment criteria:

There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS specifications for this measure, including specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer." The "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine . https://vsac.nlm.nih.gov/
- How to read eCQMs: https://ecqi.healthit.gov/system/files/Guide-for-Reading-Electronic-Clinical-Quality-Measures-v4-0-2018-0504.pdf
- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Seven (2019) guidance will be available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

Overview: CCO incentive measure based off of claims data

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 87.7 / 1,000 member months

Target population [Denominator]: Adult members[1] enrolled with the organization who are identified as having experienced mental illness.

Goal: Treat target population's ED visits as outpatient

Process:

- Treat target population in an outpatient visit if possible

Exclusions [Denominator]: Patients on hospice care

Exclusions [Numerator]: Mental health and chemical dependency services

[1] 18 or older at the end of the measurement year

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

Measure Basic Information

Name and date of specifications used: HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) and Oregon-specific definition for identifying individuals with mental illness.

URL of Specifications: N/A

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: HEDIS, with OHA modifications.

Measure Utility:

CCO Incentive■ State Quality ☐ CMS Adult Core Set☐ CMS Child Core Set☐ Other☐
Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

2018 Benchmark: 92.9 / 1,000 member months; 2016 CCO 90th percentile
2019 Benchmark: 87.7 / 1,000 member months; 2017 CCO 90th percentile

2019 Improvement Targets: Minnesota method with 3 percent floor

Incentive Measure changes in specifications from 2018 to 2019:

- HEDIS 2019 moved instructions for identifying ED/observation visits that result in an inpatient stay to General Guideline 44. The method is modified to exclude any residual ED service dates may previously be identified after an inpatient admission date, but during the duration of the inpatient stay.
- HEDIS 2019 Ambulatory Outpatient Visits Value Set added CPT code 99483.
- HEDIS 2019 Mental and Behavioral Disorders Value Set added 15 ICD10CM diagnosis codes: F10.11, F11.11, F12.11, F12.23, F12.93, F13.11, F14.11, F15.11, F16.11, F18.11, F19.11, F50.82, F53.0, F53.1, F68.A. Deleted all ICD9CM diagnosis codes
- HEDIS 2019 ED Procedure Code Value Set added 42 and deleted 29 CPT codes.
- OHA clarified how members are identified in the denominator using all claims history in the 36-month lookback period, but only their enrollment and ED visits within the measurement year are attributed to the organizations for the same year. These are clarifications and do not change how OHA produces the measure.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS

codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

Disparity	Claim from matching CCO	Denied claims included
Mental illness claims for denominator member list	N	N
Numerator AMB ED event	Y	N

Measure Details

Data elements required denominator: 1,000 member months of the adult members enrolled with the organization, who are identified as having experienced mental illness. The adult members are identified as age 18 or older at the end of the measurement year. OHA uses claims from the measurement year, and the two years preceding the measurement year (a rolling look back period for total of 36 months), and the members who had two or more visits[1] with any of the diagnoses in the Members Experiencing Mental Illness Value Set[2] below are identified for inclusion in the denominator:

Members Experiencing Mental Illness Value Set	
ICD-9 Diagnosis	**ICD-10 CM Diagnosis**
2967, 2973, 2988, 2989, 3003, 29500, 29501, 29502, 29503, 29504, 29505, 29510, 29511, 29512, 29513, 29514, 29515, 29520, 29521, 29522, 29523, 29524, 29525, 29530, 29531, 29532, 29533, 29534, 29535, 29540, 29541, 29542, 29543, 29544, 29545, 29550, 29551, 29552, 29553, 29554, 29555, 29560, 29561, 29562, 29563, 29564, 29565, 29570, 29571, 29572, 29573, 29574, 29575, 29580, 29581, 29582, 29583, 29584, 29585, 29590, 29591, 29592, 29593, 29594, 29595, 29600, 29601, 29602, 29603, 29604, 29605, 29606, 29610, 29611, 29612, 29613, 29614, 29615, 29616, 29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636, 29640, 29641, 29642, 29643, 29644, 29645, 29646,	F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F23, F24, F250, F251, F258, F259, F28, F29, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F320, F321, F322, F323, F324, F325, F328,

[1] A 'visit' is defined as a unique member and date of service.
[2] The 'Members Experiencing Mental Illness Value Set' is defined by OHA specifically for the Disparity measure, which should not be confused with the HEDIS Mental Illness Value Set.

29650, 29651, 29652, 29653, 29654, 29655, 29656, 29660, 29661, 29662, 29663, 29664, 29665, 29666, 29680, 29681, 29682, 29689, 29690, 29699, 30122, 30183, 30981	F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F348, F349, F39, F42, F4310, F4311, F4312, F603

To note, the denominator members are identified on an individual-basis. A member could be included in the measure due to a history of qualifying mental illness claims in the 36-month look back period from any of the organizations in OHP with which they have coverage at the time. Once the members are identified, their length of enrollment (member months) within the measurement year is attributed according to the organizations they have enrolled with for the same year for the denominator. The mental illness claims in the 36-month look back period do not need to match the organization(s) to which the member has enrolled with during the measurement year.

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

Hospice Value Set		
CPT/HCPCS	**UBREV**	**UBTOB**
99377, 99378, G0182, G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046	0115, 0125, 0135, 0145, 0155, 0235, 0650-0652, 0655-0659	0810-0815, 0817-0825, 0827-0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082O, 082X, 082Y, 082Z

Deviations from cited specifications for denominator: None.

Data elements required numerator: Number of emergency department visits from the denominator members (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit. Emergency Department visits are specified by the following codes:

ED Value Set	
CPT	**UB Revenue**
99281-99285	0450, 0451, 0452, 0456, 0459, 0981

OR

ED Procedure Code Value Set		**ED POS Value Set**
CPT		**POS**
Total of 5,790 CPT codes are included. See HEDIS 2019 Value Set Dictionary for detail	With	23

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

HEDIS 2019 General Guideline 44: When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on

the day prior to the admission date, or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Inpatient Stay Visits Value Set	
UBREV	0100, 0101, 0110 – 0114, 0116 – 0124, 0126 – 0134, 0136 – 0144, 0146 – 0154, 0156 – 0160, 0164, 0167, 0169 – 0174, 0179, 0190 – 0194, 0199 – 0204, 0206 – 0214, 0219, 1000 – 1002

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the following codes. Note OHA began applying the exclusions at the claim line level in measurement year 2016. OHA keeps all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Mental and Behavioral Disorders Value Set
Principal ICD-10 CM Diagnosis
Total of 724 diagnosis codes are included. See HEDIS 2019 Value Set Dictionary for detail

OR

Psychiatry Value Set
CPT
90785, 90791, 90792, 90832 - 90834, 90836 - 90840, 90845 - 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

OR

Electroconvulsive Therapy Value Set
ICD-10 PCS Procedure
GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: None.

What are allowable gaps in enrollment: None.

Define Anchor Date (if applicable): None.

Effective Contraceptive Use

Overview: CCO incentive measure based off of claims data.

Measurement Period: January 1, 2019 – December 31, 2019

Benchmark: 53.9%

Target population [Denominator]: All women ages 15-50 as of December 31 of the measurement year.

Goal: Record effective contraception use in target population in the EHR

Process:

- Use correct codes to record effective contraception use[1]

Exclusions [Denominator]: Any women with a history of hysterectomy, bilateral oophorectomy, other female reproductive system removal, destruction, resection related to hysterectomy, natural menopause, premature menopause due to survey, radiation or other factors, congenital anomalies of female genital organs, and/or female infertility

Exceptions [Denominator]: Women who were *not numerator compliant* with a pregnancy claim

Exclusions [Numerator]: None

[1] If target population has a hormonal implant or IUD/IUS, a yearly surveillance code must be added

Effective Contraceptive Use

Measure Basic Information

Name and date of specifications used: OHA developed these specifications in 2014 based on national specifications that were under development with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), and in collaboration with the Oregon Preventive Reproductive Health Advisory Council and the CCO Metrics Technical Advisory Workgroup.

As CMS has formally adopted the Contraceptive Care - All Women ages 15-44 (CCW) measure for FFY2018 Medicaid Core Set of Health Care Quality Measures (for both Adult and Child/CHIP sets), OHA has decided to continue using its own algorithm for the Effective Contraceptive Use (ECU) measure. OHA continues to monitor the algorithm and codes being used between the measures for adequate alignment.

The main differences between CCW and ECU are:

Population:

- CMS CCW reports on women age 15-44; OHA ECU includes women age 15-50.

Denominator exclusion:

- OHA ECU includes more denominator exclusion codes based on the Oregon Medicaid Hysterectomy and Sterilization Consent Audit Criteria, and CCO feedback on the draft 2017 specifications released in November 2016.
- CMS CCW uses denominator exclusion criteria to address postpartum contraceptive use, and the remaining women in the denominator are not pregnant in the measurement year, or had a pregnancy that ended in the first 10 months of the measurement year, or had an ectopic pregnancy, stillbirth, miscarriage, or induced abortion. OHA ECU specifications address postpartum contraceptive use by providing denominator exceptions for members with pregnancy history in the year.

Numerator:

- While both measures only include the top two tiers of most and moderately effective contraceptive methods (defined by CDC[1]), CMS CCW measure reports separate rates for the two tiers, and the OHA ECU measure reports a combined rate.
- CMS CCW specifications adjust for LARC removals and re-insertions in the numerator logic, whereas OHA ECU specifications look for evidence of LARC installation and surveillance.
- OHA ECU includes more numerator codes for indirect evidence and surveillance of effective contraceptive methods.

URL of Specifications: n/a. For more information on CMS' Maternal and Infant Health Initiative and the CCW measure: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf#page=46

[1] https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf

Measure Type:

HEDIS ☐ PQI☐ Survey☐ Other■ Specify: OHA-developed

Measure Utility:

CCO Incentive■ State Quality ☐ CMS Adult Core Set☐ CMS Child Core Set☐ Other☐
Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 - December 31, 2019

2015 Benchmark: 50%. Metrics & Scoring Committee consensus
2016 Benchmark: 50%. Metrics & Scoring Committee consensus
2017 Benchmark: 50%. Metrics & Scoring Committee consensus
2018 Benchmark: 50%. Metrics & Scoring Committee consensus
2019 Benchmark: 53.9%. 2017 CCO 90th percentile

2019 Improvement Targets: Minnesota method with 3 percentage point floor

Incentive Measure changes in specifications from 2018 to 2019:

- Moved ICD procedure codes related to destruction and occlusion of fallopian tubes from denominator exclusion section, to female sterilization section as permanent numerator hits. These codes include: ICD9-PCS: 6631, 6632, 6639, 6651, 6652, and ICD10-PCS: 0U570ZZ, 0U573ZZ, 0U577ZZ, 0UB70ZZ, 0UB73ZZ, 0UB74ZZ, 0UB77ZZ, 0UB78ZZ, 0UL70CZ, 0UL70DZ, 0UL70ZZ, 0UL73CZ, 0UL73DZ, 0UL73ZZ, 0UL77DZ, 0UL77ZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ.
- Removed CPT codes 58340 and 74740 from the permanent numerator female sterilization section, as these are supporting imaging methods which can also be used on other fertility-related diagnostic visits.
- Moved the 'pregnancy non-compliant exclusion' from the 'denominator exclusion' section to 'denominator exception' section for better clarity.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

ECU	Claim from matching CCO	Denied claims included
Denominator exclusion	N	Y
Numerator event	N	Y

Measure Details

Data elements required denominator: All women ages 15-50 as of December 31 of the measurement year who were continuously enrolled in a CCO for the 12-month measurement period.

Note: *OHA will also be measuring and reporting on adolescent and adult women separately, by ages 15-17 and ages 18-50. The all-age rate (age 15-50) will be tied to the CCO's incentive payment.*

Required exclusions for denominator: Remove from the denominator any women with history through December 31 of the measurement year for the following:

Denominator Exclusion	ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	ICD-10 Diagnosis Codes	ICD-10 Procedure Codes	CPT/HCPCS
Hysterectomy	V45.77, V88.01, V88.02	68.31, 68.39, 68.41, 68.49, 68.51, 68.59, 68.61, 68.69, 68.71, 68.79, 68.9	N99.3, Z90.710, Z90.711	(conversions of the ICD-9 procedure codes are included in the two categories below)	51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291-58294, 58541-58544, 58548, 58550, 58552-58554, 58570-58573, 58943, 58950- 58954, 58956-58958, 58960, 59135, 59525
Bilateral oophorectomy		65.51, 65.52, 65.53, 65.54		0UT00ZZ, 0UT04ZZ, 0UT08ZZ, 0UT0FZZ, 0UT10ZZ, 0UT14ZZ, 0UT17ZZ, 0UT18ZZ, 0UT1FZZ, 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ	58700, 58720, 58940
Other female reproductive system removal, destruction, resection related to hysterectomy			Z90.722	0U520ZZ, 0U523ZZ, 0U524ZZ, 0UB20ZZ, 0UB23ZZ, 0UB24ZZ, 0UB27ZZ, 0UB28ZZ, 0UT07ZZ, 0UT40ZZ, 0UT44ZZ, 0UT47ZZ, 0UT48ZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ	

Denominator Exclusion	ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	ICD-10 Diagnosis Codes	ICD-10 Procedure Codes	CPT/HCPCS
Natural menopause	627.0-627.9, V49.81		N92.4, N95.0, N95.1, N95.2, N95.8, N95.9, Z78.0		
Premature menopause due to survey, radiation, or other factors	256.1, 256.2, 256.31, 256.39, 256.8		E28.310, E28.319, E28.39, E28.8, E28.9, E89.40, E89.41, N98.1		
Congenital anomalies of female genital organs	752.0, 752.31, 752.49		Q50.02, Q51.0		
Female infertility	628.0, 628.2, 628.3, 628.4, 628.8, 628.9		N97.0, N97.1, N97.2, N97.8, N97.9		

Note: existence of any of these codes "count" independently; they do not need to be used in combination for exclusion. The denominator exclusion criteria utilize all historical claims in OHA's system (which dates back to 2002). That is, providers do not need to document evidence of exclusions every measurement year, as long as there is existing Medicaid claims history with evidence of the exclusion. OHA compiles an 'ECU permanent exclusion table' using all OHP claims, and applies exclusions to CCOs in rolling reports. If CCOs identify additional members who qualify for the permanent exclusion, from non-OHP claims, EHR, or other sources, OHA accepts submission of supplemental information to exclude members from the measure. The template, evidence requirement and submission timeline will be available on http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Required exceptions for denominator: Among women in the denominator who were *not numerator compliant*, exclude those with a pregnancy claim from the measurement year.

ICD-10 Diagnosis	CPT
See HEDIS 2019 Pregnancy Value Set (total of 2,318 ICD-10 diagnosis codes)	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 59425, 59426

Data elements required numerator:
Women in the denominator with evidence of female sterilization anytime throughout the claims history in OHA's system, or one of the following methods of contraception during the measurement year: IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm using the following Numerator Code Table, and the National Drug Codes (NDC) table (posted online separately):

Numerator	ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	ICD-10 Diagnosis Codes	ICD-10 Procedure Codes	CPT/HCPCS
Female Sterilization (permanent numerator hits)	V25.2, V26.51	66.2x, 66.31, 66.32, 66.39, 66.51, 66.52	Z30.2, Z98.51	0U570ZZ, 0U573ZZ, 0U574ZZ, 0U577ZZ, 0U578ZZ, 0UB70ZZ, 0UB73ZZ, 0UB74ZZ, 0UB77ZZ, 0UB78ZZ, 0UL70CZ, 0UL70DZ, 0UL70ZZ, 0UL73CZ, 0UL73DZ, 0UL73ZZ, 0UL74CZ, 0UL74DZ, 0UL74ZZ, 0UL77DZ, 0UL77ZZ, 0UL78DZ, 0UL78ZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ	58565, 58600, 58605, 58611, 58615, 58670, 58671, A4264
Intrauterine Device (IUD/IUS)	996.32, 996.65, V25.11, V25.13, V25.42, V45.51	69.7	T83.31xA, T83.32xA, T83.39xA, T83.59xA, T83.69xA, Z30.014, Z30.430, Z30.431, Z30.433, Z97.5	0UH97HZ, 0UH98HZ, 0UHC7HZ, 0UHC8HZ	58300, J7300, J7301, J7297, J7298, Q0090, S4981, S4989
Hormonal Implant	996.30, V25.43, V25.5, V45.52		Z30.016, Z30.017		11981, 11983, J7306, J7307
Injectable (1-month/ 3-month)			Z30.013		J1050, J1051, J1055, J1056
Oral Contraceptive Pills	V25.01, V25.41		Z30.011		S4993
Patch			Z79.3		J7304
Vaginal Ring			Z30.015		J7303
Diaphragm					57170, A4266

Numerator	ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	ICD-10 Diagnosis Codes	ICD-10 Procedure Codes	CPT/HCPCS
Surveillance of a contraceptive method			Z30.41, Z30.42, Z30.44, Z30.45, Z30.46, Z30.49		
Unspecified Contraception	V25.02, V25.40, V25.49, V25.9, V45.59		Z30.018, Z30.019, Z30.40, Z30.8, Z30.9		

Notes:

- Women who had claims indicating female sterilization would count as a numerator hit in the measurement year, as well as the subsequent years. OHA will compile a 'female sterilization permanent numerator table' using all the OHP claims history (which dates back to 2002) and give numerator credit to the CCO that the member is continuously enrolled with during the measurement year.

- The rest of the numerator categories are identified using claims only during the measurement year; no look back periods are applied. However, several surveillance codes are included in the specifications to account for women utilizing long-acting reversible contraception or permanent contraceptive options who would not otherwise have a pharmacy claim or procedure code during the 12-month measurement period.

- The surveillance and diagnosis codes listed in the Numerator Code Table do not need to be primary diagnoses; they can be in any position on the claim for credit toward this measure.

- The use of any of the codes "count" independently; codes to not have to be used in combination (e.g., CPT and NDC) for inclusion in the numerator.

- The Numerator Code Table includes some expired codes (e.g., J1051, code expired 2013). These codes are included in case they are still in use anywhere in Oregon; however, they may be removed from the measure specifications in future years and providers should only utilize current codes. This also applies for ICD-9 codes listed in the specifications.

- National Drug Codes (NDC) included in the measure are based on Therapeutic Classes 36 and 63. See ECU NDC Code Table posted separately online for additional details. NDCs are reviewed annually for potential updates and may be refreshed prior to final calculation for a measurement year to ensure most accurate results.

Required exclusions for numerator: None. Please see 'denominator exception' for women who are not numerator compliant, but had a pregnancy claim in the measurement year.

What are the continuous enrollment criteria: the 12-month measurement period.

What are allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the measurement period.

Define Anchor Date (if applicable): December 31st of the measurement year.

Oral Evaluations for Adults with Diabetes

Overview: CCO incentive measure based off of claims data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 28%

Target population [Denominator]: Unduplicated members age 18 and above as of December 31 of the measurement year with diabetes identified from claim/encounter data or pharmacy data during the measurement year or the year prior to the measurement year[1]

Goal: Give target population a comprehensive, periodic, or periodontal oral evaluation in the measurement year[2]

Process:

- Refer qualifying patients to assigned dental clinic

Exclusions [Denominator]: Members identified with gestational diabetes or steroid induced diabetes, but who not have a diagnosis of diabetes in any care setting.

Exclusions [Numerator]: None

[1] See full tech specs for qualifying criteria

[2] Identified by CPT codes: D0120, D0150 or D0180

Oral Evaluation for Adults with Diabetes

Measure Basic Information

Name and date of specifications used: TBD (DQA has not yet officially published the specifications; this specification sheet will be updated once the official version is available)

URL of Specifications: n/a

Measure Type: HEDIS ☐ PQI☐ Survey☐ Other■ Specify: DQA

Measure Utility: CCO Incentive■ State Quality Measure☐ CMS Adult Core Set☐ CMS Child Core Set☐ Other☐ Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2019 – December 31, 2019

2019 Benchmark: 28.0%, *2017 CCO 75th percentile*

2019 Improvement Targets: Minnesota method with 3 percentage point floor

Member type: CCO A ■ CCO B ☐ CCO G ☐

Specify claims used in the calculation:

CDC-HbA1c	Only use claims from matching CCO that a member is enrolled with	Denied claims included
Numerator event	Y	Y

Measure Details

Data elements required denominator:
Unduplicated members age 18 and above as of December 31 of the measurement year with diabetes identified from claim/encounter data or pharmacy data, during the measurement year or the year prior to the measurement year: (qualify for any one of the following criteria occurring over both years)

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

- Dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis (Diabetes Medications List).

(See HEDIS 2019 Value Set Dictionary for detail codes)

Diabetes Medications[1]

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin • Empagliflozin-metformin • Glimepiride-pioglitazone	• Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Required exclusions for denominator:

DQA requires exclusion for members identified with gestational diabetes or steroid-induced diabetes (HEDIS 2019 Diabetes Exclusions Value Set), but who do not have a diagnosis of diabetes (HEDIS 2019 Diabetes Value Set) in any care settings. This is originally an optional exclusion for the HEDIS Comprehensive Diabetes Care measure, and DQA adopts the logic as a required denominator exclusion.

Deviations from cited specifications for denominator: TBD (though see note on continuous enrollment criteria below)

[1] HEDIS 2019 NDC lists are available at:
http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018/hedis-2018-ndc-license

Data elements required numerator:

Number of unduplicated member in the denominator who received a comprehensive, periodic or periodontal oral evaluation in the measurement year, identified by any of the following CDT codes: D0120, D0150, or D0180.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: The measurement year.

Note this is a deviation from DQA specifications which will require only 180 days of continuous enrollment.

What are allowable gaps in enrollment:
No more than one gap in enrollment of up to 45 days during the measurement year.

Define Anchor Date (if applicable):
December 31 of the measurement year.

For More Information: n/a

Patient Centered Primary Care Home (PCPCH) Enrollment

Overview: CCO incentive measure based on self-reporting.

Measurement period: This measure is looking for total PCPCH enrollment by the end of the calendar year 2019 (December 2019)

Benchmark: N/A. CCO's receive credit for this measure according to a tiered formula.

Target population [Denominator]: CCOs

Goal: To attest to the highest tier possible

Process:

- Self-report tier status to OHA

Exclusions [Denominator]: None

Exclusions [Numerator]: None

Patient Centered Primary Care Home (PCPCH) Enrollment

Measure Basic Information

Name and date of specifications used: OHA originally developed these specifications based on recommendations from OHA's Metrics and Scoring Committee, December 2012, and has updated them to reflect changes in the Patient Centered Primary Care Home Program structure, November 2016, and changes to the exclusions for 2017 and 2018 made by the Metrics & Scoring Committee in October 2017.

URL of Specifications: N/A

Measure Type:

HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: OHA-developed

Measure Utility:

CCO Incentive ■ State Quality ■ CMS Adult Core Set ☐ CMS Child Core Set ☐ Other ☐ Specify:

Data Source: Patient Centered Primary Care Home (PCPCH) enrollment by tier via self-report from CCOs; total CCO enrollment via MMIS/DSSURS

Measurement Period:
This measure is looking for total PCPCH enrollment by the end of calendar year 2019 (December 2019). OHA will collect updated PCPCH enrollment rates from CCOs quarterly throughout 2019, but the final calculation will be based on PCPCH enrollment as of December 31, 2019. See due dates in Reporting section below.

2019 Benchmark: The PCPCH Enrollment measure does not have a benchmark. CCOs receive credit for this measure according to a tiered formula which provides greater weight for members enrolled in clinics that are recognized at higher tiers of the PCPCH program. In previous years, this score was set at 60.0. The Metrics & Scoring Committee selected a threshold score of 68.0 for differentiating between quality pool payment levels for 2019 (the "sliding scale").[1]

2019 Improvement Targets: n/a

Incentive Measure Changes in specifications from 2018 to 2019:

- In October 2017 Metrics & Scoring Committee decided to exclude members attributed or assigned to tribal clinics from this measure for both the 2017 and 2018 measurement periods. However, beginning in 2019 (with these measure specifications), members enrolled in tribal clinics will again be counted in the measure.

Denied claims: N/A

[1] See annual Quality Pool Methodology ("Reference Instructions") posted online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Member type: CCO A ■ CCO B ■ CCO G ☐

Measure Details

Data elements required denominator: Total CCO enrollment for the same month as the PCPCH enrollment snapshot multiplied by 5.

OHA produces total CCO enrollment from MMIS/DSSURS as of the 15th of the month. For example, the December 2019 snapshot of PCPCH enrollment will use December 15th, 2019 total CCO enrollment (times 5) for the denominator. Monthly enrollment reports can be found online at http://www.oregon.gov/oha/HSD/OHP/Pages/Reports.aspx

Required exclusions for denominator: None.

Deviations from cited specifications for denominator: N/A

Data elements required numerator: Number of CCO members enrolled in PCPCHs by tier, using the following formula:

(# of members in Tier 1 clinics *1) + (# of members in Tier 2 clinics*2) + (number of members in Tier 3 clinics*3) + (# members in Tier 4 clinics*4) + (# members in 5 STAR clinics*5) = numerator

Given the length of time it might take for site visits for 5 STAR designation to be completed, OHA is including a 'grace period' for the final CY 2019 reporting. Specifically, if CCOs have practices that have applied for 5 STAR designation by December 31, 2019 that have not yet received a site visit, OHA will ask CCOs to provide this information as part of the Q4 reporting.

OHA will then work with the PCPCH program to include any updated information for recognition occurring between January 1 and April 30, 2020. That is, OHA will include updated information about practices that have applied for 5 STAR designation by December 31, 2019 and receive 5 STAR designation by April 30, 2020, in the measure calculation to ensure CCOs receive credit for members assigned to this clinic.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: N/A

Full Measure Formula

[(# of members in Tier 1 clinics *1) + (# of members in Tier 2 clinics*2) + (number of members in Tier 3 clinics*3) + (# members in Tier 4 clinics*4) + (# members in 5 STAR clinics*5)] / (Total CCO enrollment *5)

What are the continuous enrollment criteria: None.

What are allowable gaps in enrollment: None.

Define Anchor Date (if applicable): None.

Reporting

CCOs are contractually obligated to report on the number of members assigned to providers in PCPCH practices on a quarterly basis. CCOs can also provide additional information on the number of health care teams or clinics meeting PCPCH standards, and the number of primary care practitioners accepting members in a PCPCH by tier.

CCOs report on the number of members assigned to providers in PCPCH practices quarterly, via online survey: https://www.surveymonkey.com/s/PCPCHReport. Due dates for each quarter are:

Q1 2019 – Due May 1, 2019
Q2 2019 – Due August 1, 2019
Q3 2019 – Due November 1, 2019
Q4 2019 – Due February 1, 2020

OHA may request a member-level attribution file, showing which members are assigned to which certified PCPCHs, at some point during the 2019 measurement year. This file will support more detailed analysis and cross-tabulation with other measures as well as measure validation. If requested, OHA will provide details on this reporting via the CCO Metrics Technical Advisory Group (TAG).

Prenatal and Postpartum Care

(NQF 1517)

Overview: CCO incentive (postpartum), state quality, CMS adult core set (postpartum), and CMS child core set (prenatal) based off of claims and EHR data.

Measurement period: November 6, 2018 and November 5, 2019

Benchmark [Prenatal]: 90.8%

Benchmark [Postpartum]: 69.3%

Target population [Denominator]: All live birth deliveries with estimated delivery dates in the "intake period": between November 6 of the prior measurement year and November 5 of the measurement year

Goal [Prenatal]: Provide prenatal care with evidence in the first trimester of pregnancy: 176-280 days before delivery

Goal [Postpartum]: Provide a pelvic exam or postpartum care on or between 21 and 56 days after delivery

Process:

- Refer target population to OB/GYN practitioner, midwife, family practitioner or PCP[1]

Exclusions [Denominator]: Members in hospice care. CCO's can also report "no confirmed live birth"[2]

Exclusions [Numerator]: N/A

[1] If seen my PCP, a diagnosis of pregnancy must be present, a note regarding when prenatal or postpartum visit occurred must be in the documentation, and a note indicating the date the visit occurred must be present as well as evidence found on page 4 and 5 of the full technical specifications

[2] OHA will exclude the cases accordingly

Prenatal and Postpartum Care (NQF 1517)

Measure Basic Information

This specification sheet contains information for both Timeliness of Prenatal Care and Postpartum Care, the two rates associated with the NQF measure Prenatal and Postpartum Care. Prior to 2019, the CCO incentive measure and quality pool payments were only tied to performance on Timeliness of Prenatal Care against benchmarks and improvement targets. Starting in 2019, the Metrics and Scoring Committee decided to change and use the Postpartum Care rate performance against the benchmark for incentive measure purposes. However, CCOs are still required to report on both parts of the measure for the Quality Incentive Program.

Name and date of specifications used:
HEDIS® 2019 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: N/A

Measure Type:
HEDIS ■ PQI ☐ Survey☐ Other☐ Specify:

Measure Utility:
CCO Incentive■ (Postpartum) State Quality ■ CMS Adult Core Set■ (Postpartum)
CMS Child Core Set■ (Prenatal) Other☐ Specify:

Data Source: MMIS/DSSURS, medical records

Measurement Period: OHA is using the HEDIS® measurement intake period without modification. The measure looks for live births with estimated delivery date (EDD) on or between November 6, 2018 and November 5, 2019.

2013 Prenatal Care Benchmark: 69.4%; 2012 National Medicaid 75th percentile, administrative data only
2014 Prenatal Care Benchmark: 90.0%; 2013 National Medicaid 75th percentile (hybrid)
2015 Prenatal Care Benchmark: 90.0%; 2014 National Medicaid 75th percentile (hybrid)
2016 Prenatal Care Benchmark: 93.0%; 2015 national Medicaid 90th percentile (hybrid)
2017 Prenatal Care Benchmark: 91.0%; 2016 national Medicaid 90th percentile (hybrid)
2018 Prenatal Care Benchmark: 91.7%; 2017 national Medicaid 90th percentile (hybrid)
2019 Prenatal Care Benchmark: 90.8%; 2018 national Medicaid 90th percentile (hybrid)

2013 Postpartum Care Benchmark: 43.1%; 2012 National Medicaid 75th percentile, administrative only
2014 Postpartum Care Benchmark: 71.0%; 2013 National Medicaid 75th percentile (hybrid)
2015 Postpartum Care Benchmark: 71.0%; 2014 National Medicaid 75th percentile (hybrid)
2016 Postpartum Care Benchmark: 71.0%; 2015 national Medicaid 75th percentile (hybrid)
2017 Postpartum Care Benchmark: 67.5%; 2016 national Medicaid 75th percentile (hybrid)
2018 Postpartum Care Benchmark: 69.4%; 2017 national Medicaid 75th percentile (hybrid)
2019 Postpartum Care Benchmark: 69.3%; 2018 national Medicaid 75th percentile (hybrid)

2019 Postpartum Improvement Targets: Minnesota method with 3 percentage point floor

Note: The CCO incentive measure and quality pool payments are tied to the Postpartum Care rate; however, CCOs must submit data for both prenatal and postpartum care to be eligible to earn any quality pool funds associated with the measure.

Incentive Measure changes in specifications from 2018 to 2019:

- In administrative specifications, HEDIS 2019 deleted prenatal visits with internal organization codes for LMP/EDD and obstetrical history/risk assessment counseling from Decision Rule 3. Internal organization codes are supplemental data and are in the scope of the hybrid specifications.
- HEDIS 2019 clarified that documentation in the medical record of gestational age with either prenatal risk assessment and counseling/education or complete obstetrical history meets criteria for the Timeliness of Prenatal Care numerator.
- HEDIS clarified in the Notes that nonancillary services must be delivered by the required provider type.
- OHA reorganized the specification sheet for the denominator and separate numerator sections for prenatal and postpartum measures. OHA also added more detail on how the estimated delivery dates (EDD) are determined from delivery claims, how CCOs' self-reported EDD and delivery dates are used. These updates are clarifications, which are not changes to how OHA produces the measure.

OHA continues to adopt the full HEDIS hybrid specifications for 2019. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMR/EHR), registries or claims systems.

1) If using administrative data to identify numerator compliance, CCOs must follow HEDIS 2019 specifications for allowable codes and measure logic.
2) If using medical record data to identify numerator compliance, CCOs must follow HEDIS 2019 specifications to conduct the chart review.

See the annual chart review guidance document for additional information on allowable data sources. OHA will provide sampling frames and updated guidance to CCOs on the hybrid methodology for 2019 in fall 2019. Guidance will be posted online at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Denied claims: Included ■ Not included ☐

Member type: CCO A ■ CCO B ■ CCO G ☐

Measure Details

Data elements required denominator: All live birth deliveries with estimated delivery date (EDD) in the 'intake period': between November 6 of the year prior to the measurement year, and November 5 of the measurement year, and the members of the organization who meet the continuous enrollment criteria.

For adopting the HEDIS hybrid method, OHA identifies the live birth deliveries from administrative data and provide CCOs with a random sample delivery list for the chart review. CCOs should perform hybrid record review for all cases in the sample, for both prenatal and postpartum measures.

OHA follows the HEDIS method to identify deliveries:

Step1: Identify all deliveries in the measurement intake period using Deliveries Value Set.

Step2: Exclude non-live births using Non-live Births Value Set.

Step3: Identify continuous enrollment (from 43 days prior to estimated delivery date through 56 days after EDD, with no gaps).

HEDIS gives specific directions on counts of multiple births in a year, and counting one delivery per pregnancy (of twins, triplets, etc). However, HEDIS is not prescriptive on how to address the issue when a 'single pregnancy and delivery' results in multiple service dates on the delivery claims that are close together, especially with twins and triplets. To address this, OHA uses a '180-day rule' which determines separate deliveries if the delivery service dates are more than 180 days apart; each separate delivery is eligible for being randomly sampled. When the delivery service dates are within 180 days apart, OHA considers them as a cluster, and uses the latest delivery service date as a single EDD.

In the chart review data submission, OHA also allows CCOs to report the original EDD from the prenatal care providers' perspective, which would help address early or late delivery issues. When a different EDD is reported by the CCO, the eligible window for timely prenatal care is recalculated. If the CCO self-reported EDD is outside of the intake period, the case is excluded.

Required exclusions for denominator:
Members in hospice are excluded from this measure. These members are identified using HEDIS 2019 Hospice Value Set, with claims within the measurement year. (See HEDIS 2019 General Guideline 17 for detail.)

OHA also allows CCOs to report 'no confirmed live birth' in the data submission, and excludes the cases accordingly.

Deviations from cited specifications for denominator:
See OHA's implementation of the 180-day delivery service date rule, and CCO self-reported EDD sections above.

What are the continuous enrollment criteria:
43 days prior to the Estimated Date of Delivery (EDD) through 56 days after EDD.

What are allowable gaps in enrollment: None.

Define Anchor Date (if applicable):
Estimated Date of Delivery (EDD).

Timeliness of Prenatal Care Numerator:

Administrative method – A first prenatal visit within the eligible timely window and required service components. See HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) for details.

Medical Record Review – Prenatal care services:
Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
    - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing) **or**
    - TORCH antibody panel alone, **or**
    - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
    - Ultrasound of a pregnant uterus.
- Documentation of LMP or EDD in conjunction with *either* of the following.
    - Prenatal risk assessment and counseling/education.
    - Complete obstetrical history

Eligible window for timely first prenatal visit:

For women continuously enrolled during the first trimester (176-280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.

For women who were not continuously enrolled in the first trimester:

- If the last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
- If the last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.

Postpartum Care Numerator:

Administrative method – A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. See HEDIS® 2019 Technical Specifications for Health Plans (Volume 2) for details.

Medical Record Review – Postpartum Care:
A postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP. Documentation in the medical record must include a note indicating the date on which a postpartum visit occurred and *one* of the following:

- Pelvic exam, or
- Evaluation of weight, blood pressure, breasts and abdomen, or
- Notation of postpartum care, including, but not limited to the following:
    - 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.
- A Pap test alone does not count as a prenatal care visit, but is acceptable for the Postpartum Care measure.

Eligible window for postpartum care visit:

Between 21 and 56 days after delivery.

Notes:

- *For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner, or other PCP with a principal diagnosis of pregnancy.*
- *Services that occur over multiple visits count toward this measure as long as all services are within the measurement timeframe. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.*
- *HEDIS allows using EDD for identifying the first trimester for timeliness of prenatal care, and the delivery date for the postpartum care. OHA allows CCOs to confirm live births and submit different dates for EDD and the date of delivery. When different EDD or delivery date is report by the CCO, the original claims-based EDD is not used.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a visit is with a PCP, OB/GYN, or other prenatal practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g. fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to HEDIS 2019 Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.*

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (NQF 0024/CMS 155v7)

Overview: CCO incentive and CMS child core set measure based off of EHR data.

Measurement period: January 1, 2019 – December 31, 2019

Benchmark: 32.7%, using a simple average across all 3 reported rates

Target population [Denominator]: Patients 3-17 years of age with at least one outpatient visit with a PCP or OB/GYN during the measurement period

Goal: To record a BMI, give nutritional counseling and give physical activity counseling for the target population

Process:

- Take target populations height, weight and BMI
- Discuss target populations nutrition and counsel however needed
- Discuss target populations physical activity and counsel however needed
- Document all information in the EHR accurately

Exclusions [Denominator]: Patients who has a diagnosis of pregnancy during the measurement period and patients whose hospice care overlaps the measurement period

Exclusions [Numerator]: None

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (NQF 0024/ CMS 155v7)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2019.

URL of Specifications: https://ecqi.healthit.gov/ecqm/measures/cms155v7

Note: eCQM specifications typically are updated at least annually. The eCQM version number changes with each annual update. Once certified, however, electronic health records (EHRs) are not required to be recertified with updated eCQM specifications, so the Certified HIT Products List may not accurately reflect the version of an eCQM that is actually supported by an EHR vendor. OHA will accept year seven data (2019) submissions from previous releases of the eCQM specifications, but CCOs will need to document the version number of the specifications they are using.

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: eCQM

Measure Utility:

CCO Incentive ■ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set ■
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2019 – December 31, 2019

OHA anticipates publishing the updated Year Seven (2019) Guidance Document in summer 2019.

2018 Benchmark: 30.4%, using a simple average across all 3 reported rates (MIPS 2017 benchmark – 50th percentile)
2019 Benchmark: 32.7%, using a simple average across all 3 reported rates (MIPS 2018 benchmark—Decile 8, 70th percentile)

2019 Improvement Targets: Minnesota method with 3 percentage point floor

Changes in Specifications from 2018 to 2019: See Technical Release Notes for a complete list of changes. https://ecqi.healthit.gov/system/files/ecqm/measures/CMS155v7_TRN.xlsx Changes include:

- Updated clinical recommendation statement to align with current recommendations.
- Updated the Denominator Exclusion statement for patients in hospice care to better align with the logic.
- Updated the numerator to indicate that counseling should be during the measurement year to align with the HEDIS parent measure.

- Made multiple changes in the measure logic, conforming to Quality Data Model (QDM) 5.3 and Clinical Quality Language (CQL).
- Replaced SNOMEDCT single code value sets with direct referenced codes.

Value Set name and OID	Status
Value set Face-to-Face Interaction (2.16.840.1.113883.3.464.1003.101.12.1048)	Removed. Added relevant SNOMED codes to the Encounter Grouping value sets to better align between the SNOMED and CPT encounter codes.
Value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1264) including 7 codes.
Value set Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)	Added SNOMEDCT extensional value set (2.16.840.1.113883.3.464.1003.101.11.1265) including 11 codes.
Value set Counseling for Physical Activity (2.16.840.1.113883.3.464.1003.118.12.1035)	Added 6 SNOMEDCT codes (171356009, 171357000, 171358005, 171359002, 171360007, 171361006).
Value set Counseling for Physical Activity (2.16.840.1.113883.3.464.1003.118.12.1035)	Added 4 SNOMEDCT codes (183073003, 429778002, 435551000124105, 710849009) and deleted 12 SNOMEDCT codes. – 2019 Addendum
Value set Pregnancy (2.16.840.1.113883.3.526.3.378)	Deleted 11 ICD10CM codes (O00.1, O00.10, O00.11, O00.2, O00.20, O00.21, O00.8, O00.9, O33.7, O34.21, Z36).
Value set Payer (2.16.840.1.114222.4.11.3591)	Added 11 SOP codes (299, 32127, 32128, 391, 517, 524, 614, 621, 622, 623, 629) and deleted 3 SOP codes (63, 64, 69).
Value set Payer (2.16.840.1.114222.4.11.3591)	Deleted 1 SOP code (24). – *2019 Addendum*.
Value set Counseling for Nutrition (2.16.840.1.113883.3.464.1003.195.12.1003)	Added 46 SNOMEDCT codes and deleted 23 SNOMEDCT codes. – *2019 Addendum*

Denied claims: n/a

Measure Details

Data elements required denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period

Outpatient visit	Grouping Value Sets
Office Visit	Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)
Preventive Care Services-Individual Counseling	Preventive Care Services-Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)
Preventive Care- Initial Office Visit, 0 to 17	Preventive Care- Initial Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1022)
Preventive Care - Established Office Visit, 0 to 17	Preventive Care - Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)
Preventive Care Services - Group Counseling	Preventive Care Services - Group Counseling (2.16.840.1.113883.3.464.1003.101.12.1027)

Outpatient visit	Grouping Value Sets
Home Healthcare Services	Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)

Note: The visit must be performed by a PCP or OB/GYN.

Required exclusions for denominator:

- Patients who have a diagnosis of pregnancy during the measurement period.
- Patients whose hospice care overlaps the measurement period.

Deviations from cited specifications for denominator: None.

Data elements required numerator:

- Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period
- Numerator 2: Patients who had counseling for nutrition during the measurement period
- Numerator 3: Patients who had counseling for physical activity during the measurement period

Note: Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria:

There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS specifications for this measure, including specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer." The "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine . https://vsac.nlm.nih.gov/
- How to read eCQMs: https://ecqi.healthit.gov/system/files/Guide-for-Reading-Electronic-Clinical-Quality-Measures-v4-0-2018-0504.pdf
- CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Seven (2019) guidance will be available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx