CareOregon Quality Metrics Toolkit

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

Performance Measure Set:

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

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

Quality Measurement Type:

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

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

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

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

Data Source/Type:

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

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

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

eCQMs: Clinical Quality Measures (CQM) are a mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. Electronic CQMs are reported using electronic specifications from an electronic health record (EHR) in the form of a report.
Survey: survey instruments capture self-reported information from patients about their health care experience and outcome. Surveys are typically administered to a sample of patients by mail, by telephone, or via the intranet.

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

CCO Incentive Metrics
Alcohol and Drug Misuse (SBIRT)

| Performance Measure Set: ☒ CCO Incentive  ☐ Medicare Star Rating |
|-----------------------------|-----------------------------|
| Quality Measurement Type: ☐ Structure  ☒ Process  ☐ Outcome  ☐ Patient Experience |
| Data Type: ☐ Claims  ☐ Chart Documentation  ☒ eCQM  ☐ Survey  ☐ Other |
| State Benchmark: N/A. CCOs must report data for a minimum population threshold (estimated 20%). |

**Who:** All patients aged 12 and older.

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

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

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

1. Of the patients aged 12 years and older who had a visit with your clinic during the year, what percentage received age-appropriate screening for alcohol and drug misuse and had either a brief screen with a negative result or a full screen.
   a. The denominator for rate 1 uses the same denominator criteria as the depression screening and follow-up measure (NQF0418e/CMS2v9).

2. Of those patients who had a positive full screen during the year, what percentage of patients received a brief intervention, referral to treatment, or both that is documented within 48 hours of the date of the full screen.
   a. The denominator for rate 2 includes those patients in the rate 1 numerator who had a positive full screen (i.e. subset of rate 1 numerator).

**Example:**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Rate 1</th>
<th>Rate 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient refuses screening any point before required screening is completed.</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient completes brief screen that is positive but refuses to complete full screen.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patient completes brief screen that is negative.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient completes brief screen that is positive and completes full screen that is also positive. Results are discussed, and brief intervention or referral is completed.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient completes full screen that is positive but refuses brief intervention or referral to treatment.</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Performance Measure Set:**

- ☒ CCO Incentive
- ☐ Medicare Star Rating

**Quality Measurement Type:**

- ☐ Structure
- ☒ Process
- ☐ Outcome
- ☐ Patient Experience

**Data Type:**

- ☐ Claims
- ☐ Chart Documentation
- ☒ eCQM
- ☐ Survey
- ☐ Other

**State Benchmark:** N/A. CCOs must report data for a minimum population threshold (estimated 20%).
**Exclusions:** Any of the following criteria remove people from the denominator:

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

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

- Patient-level detail, for CareOregon members only;
- Final reporting must be for the full calendar year; mid-year reports preferred in a rolling 12-month timeframe;
- Data can be formatted in QRDA category 1 or Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.
**Alcohol and Drug Misuse (SBIRT) FAQ**

**Q:** Does a brief screen count toward the measure?

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

**Q:** What score counts as a “positive” screening result?

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

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

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

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

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

**Q:** What screening tools are recommended?

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

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

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

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

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

Who: Children and adolescents aged 0–17 years newly placed in DHS custody between November 1, 2019, and October 31, 2020.

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

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

<table>
<thead>
<tr>
<th>Age on CCO Notification Date</th>
<th>Required assessments for children entering DHS custody</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical</td>
</tr>
<tr>
<td>Less than 12 months old</td>
<td>YES</td>
</tr>
<tr>
<td>1 to 3 years old</td>
<td>YES</td>
</tr>
<tr>
<td>4 to 17 years old</td>
<td>YES</td>
</tr>
</tbody>
</table>

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

Exclusions: Children will be excluded from the final measure denominator if:
- The CCO does not receive timely notification from OHA;
- The child does not remain in DHS custody and enrolled with the CCO for 60 days after notification. See OHA technical specifications for a complete list of other exclusions handled on a case-by-case basis.

Coding:

<table>
<thead>
<tr>
<th>Physical Health Assessment</th>
<th>Mental Health Assessment</th>
<th>Dental Health Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212 – 99215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99381 – 99384</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99391 – 99394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0438, G0439</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Assessments for Children in DHS Custody FAQs

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

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

Q: How does the CCO coordinate this measure?

A: CCO staff maintain a list of children in foster care and points of contact with local DHS offices. They work with physical, mental, and dental health plan staff to outreach to foster parents and facilitate the scheduling of needed services.
**Childhood Immunization Status (Combo 2)**

<table>
<thead>
<tr>
<th>Performance Measure Set:</th>
<th>☒ CCO Incentive Metric</th>
<th>☐ Medicare Star Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measurement Type:</td>
<td>☐ Structure</td>
<td>☒ Process</td>
</tr>
<tr>
<td>Data Type:</td>
<td>☐ Claims</td>
<td>☒ Chart Documentation</td>
</tr>
<tr>
<td>State Benchmark: 81.9% for 2019, 2020 Benchmark is TBD (Prior year National Medicaid 90th percentile)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Who:** Children who turn two years of age in 2020.

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

**What:** This measure reports the percentage of children who turn two-years-old in 2019 and receive all the following immunizations before their second birth date:

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

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

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

**How:** Some ideas to improve Childhood Immunization Status rate:

- Ensure that immunization records in ALERT are up to date and that all patient information is correct (e.g., name spelled correctly, correct date of birth, etc.).
- Schedule immunizations visits months before their second birthday.
- Ensure that patient decision-aid tools and catch-up schedules are available for all parents when deciding to vaccinate their children (see resources for more information).
- Schedule subsequent vaccine visits before parents leave the office.
- Implement patient recall workflows.

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

**Coding:** N/A
Childhood Immunization Status (Combo 2) FAQ

Q: What immunization combination does this metric follow?

A: HEDIS® 2019 Combination 2.

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

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

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

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

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

A: Members whose second birthday is within 2020 and have had physical health coverage with the CCO continuously for the 12 months prior to their second birthday are included in the denominator. Please note that OHA is considering a temporary revision to the continuous enrollment criteria for the 2020 measurement year to account for changes in service areas and new CCOs with the implementation of the CCO 2.0 contracts. Please check with your Primary Care Innovation Specialist or Quality Improvement Analyst with any questions.

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

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

Resources

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

Who: All members aged 13 years and older.

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

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

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

Rate 2: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current cigarette smokers?

Rate 3: Of all patients with their cigarette smoking or tobacco use status recorded, how many are current smokers and/or tobacco users?

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

How: To reduce the prevalence rate, clinics should:

- Ask their CareOregon Primary Care Innovation Specialist or Provider Relations Specialist about CareOregon smoking cessation benefits.
- Encourage members to call the State Quit Line, 800-QUIT-NOW or 1-800-784-8669 English, or 855-DEJELO-YA (1-855-335356-92) for Spanish and identify that they have CareOregon coverage for expanded services.
- Refer members using Oregon Tobacco Quit Line Fax Referral Form via fax 1-800-483-3114.
- Follow the 5A’s model for treating tobacco use and dependence.
- Ask about cigarette smoking and/or tobacco use status at every visit and provide counseling and/or
recommend nicotine replacement therapy.

**Data reporting:** This measure is similar to, but does not directly align with NQF 0028e/CMS 138v8 (which looks for patients aged 18 or older). If your reporting is based on NQF 0028e/CMS 138v8, you will need to incorporate adolescents aged 13-17 through custom query. Please note that clinics must report the three prevalence rates regardless whether they are using custom query reporting or NQF 0028e/CMS 138v8.

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

- Member-level detail, for CareOregon members only, is preferred
- Reporting must be for the full calendar year of 2020; monthly reports in a rolling 12-month timeframe are preferred
- Data can be formatted in QRDA category 1 or Excel

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

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

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

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

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

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

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

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

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

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

A: No. Cigarette smoking and/or tobacco use recorded status must be recorded within the previous 24 months.
Preventive Dental Services for Children aged 1-5 and 6-14

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

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

What: All patients who will be age 1–14 by the end of the 2020 calendar year who are continuously enrolled with the CCO for at least 6 months and have at least one preventive dental service with a dental provider, or at a Federally Qualified Health Center or Rural Health Center.

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

How: to increase preventive dental visits, clinics should:
- Discuss the importance of dental health during all physical health wellness visits
- Include dental visits in your existing referral coordination workflow
- Use CareOregon’s dental referral process, in the OneHealth Portal, to easily connect CareOregon members to a dental care coordinator who can help them schedule with a dental provider

Exclusions: N/A

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

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

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

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

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

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

A: CPT code 99188 (topical fluoride varnish) billed with a First Tooth visit on a medical claim does NOT count towards the metric numerator. This service does count toward the measure, but only if billed on a dental claim by a dental provider, FQHC or RHC (CDT code D1206 for a topical fluoride varnish).
Screening for Depression and Follow-Up Plan

Performance Measure Set: ☒ CCO Incentive Metric  ☐ Medicare Star Rating
Quality Measurement Type: ☐ Structure  ☒ Process  ☐ Outcome  ☐ Patient Experience
Data Type: ☐ Claims  ☐ Chart Documentation  ☒ eCQM  ☐ Survey  ☐ Other
State Benchmark: N/A. 2020 is considered a reporting-only year for this measure.

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

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

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

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

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

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

- Standardized, age appropriate, annual screening tools should be used for screening patients at least once per measurement period; ideally integrated in EHR workflows.
- Workflows that include front desk staff, MAs, and providers are necessary to ensure each patient receives the appropriate screening, correct scoring, review, and documentation during at least one encounter per year.
- Staff should be prepared to discuss your clinic’s confidentiality practices and the importance of screening with each patient.

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

Reporting: This measure aligns with NQF 0418e/CMS 2v9. CareOregon must collect data from each clinic’s EHR for this measure. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:
• Patient-level detail for CareOregon members only is preferred
• Reporting must be for the full calendar year of 2020; mid-year reports preferred in a rolling 12-month timeframe
• Data can be formatted in QRDA category 1 or Excel.

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

Recommend Workflow and Reporting Logic:

* follow-up as defined by OHA specifications: referral, medication, suicide risk assessment.
Screening for Depression and Follow-up Plan FAQ:

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

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

Q: What counts as a “positive” score?

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

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

A: Documented of at least one of the following:

• **Additional evaluation or assessment** for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder. Follow-up can be provided by clinic BHC (psychologist, social worker, psychiatrist, or PMHNP).

• **Suicide Risk Assessment** such as Columbia Suicide Severity Rating Scale or SAFE-T, discussed during the visit with the provider and captured for reporting purposes.

• **Referral to a practitioner or program** for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. This can be an internal or external referral, and either type should be documented in a way that is captured in reporting.

• **Other interventions designed to treat depression** such as psychotherapy, pharmacological interventions, or additional treatment options.
  • Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient’s prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Q: What screening tools are recommended?

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

Adolescent Screening Tools (12-17 years)

• Patient Health Questionnaire for Adolescents (PHQ-A)
• Beck Depression Inventory-Primary Care Version (BDI-PC)
• Mood Feeling Questionnaire (MFQ)
• Center for Epidemiologic Studies Depression Scale (CES-D)
• Patient Health Questionnaire (PHQ-9)
• Pediatric Symptom Checklist (PSC-17)
• PRIME MD-PHQ2

Adult Screening Tools (18 years and older)
• Patient Health Questionnaire (PHQ9)
• Beck Depression Inventory (BDI or BDI-II)
• Center for Epidemiologic Studies Depression Scale (CES-D)
• Depression Scale (DEPS)
• Duke Anxiety-Depression Scale (DADS)
• Geriatric Depression Scale (GDS)
• Cornell Scale for Depression in Dementia (CSDD)
• PRIME MD-PHQ2
• Hamilton Rating Scale for Depression (HAM-D)
• Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
• Computerized Adaptive Testing Depression Inventory (CAT-DI)
• Computerized Adaptive Diagnostic Screener (CAD-MDD)

Perinatal Screening Tools
• Edinburgh Postnatal Depression Scale
• Postpartum Depression Screening Scale
• Patient Health Questionnaire 9 (PHQ-9)
• Beck Depression Inventory
• Beck Depression Inventory-II
• Center for Epidemiologic Studies Depression Scale
• Zung Self-Rating Depression Scale
Diabetes Care: HbA1c Poor Control

Performance Measure Set: ☒ CCO Incentive  ☒ Medicare Star Rating

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

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

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

Medicaid State Benchmark: 23.4% or lower (2018 CCO statewide average)

HEDIS Benchmarks National Percentile: 78% (75th), 87% (90th)

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

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

What: Percentage of patients with a diabetes diagnosis, whose most recent HbA1c level is above 9.0%. If a patient does not have a HbA1c documented during the measurement period, their HbA1c is considered in poor control.

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

How: Best practices to improve Diabetes Poor Control include

- Educating patients about healthy lifestyle choices through motivational interviewing
- Employing diabetes educators, clinical pharmacists, or registered dietitians in the care management team
- Using an evidence-based diabetes care pathway for medication management and other care options.

Exclusions:

- Patients in hospice or using hospice services during the calendar year
- Patients 66 and older who are living in long term institutional setting or I-SNP
- Patients 66 and older with advanced illness and frailty
- Patients 80 or older who use frailty devices, dementia medications, or have a diagnosis of advance illness during the measurement period.

Medicaid Data Reporting: This measure aligns with CMS122v8. CareOregon must collect data from each clinic’s EHR reporting for this measure. Data is then aggregated across all clinic’s in the CCO region and submit to OHA. Please note the following reporting requirements:
• Patient-level detail for CareOregon members only is preferred
• Reporting must be for the full calendar year of 2020; mid-year reports preferred in a rolling 12-month timeframe
• Data can be formatted in QRDA Category 1 or Excel

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

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

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

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

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

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

Q: Is prior authorization required for GLP1 diabetes pharmaceuticals?

A: CareOregon covers exenatide (BYETTA/BYDUREON) and liraglutide (VICTOZA), however, a prior authorization is required for Medicaid patients.
Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SMPI)

Performance Measure Set: ☒ CCO Incentive Metric  ☐ Medicare Star Measure
Quality Measurement Type: ☐ Structure  ☐ Process  ☒ Outcome  ☐ Patient Experience
Data Type: ☒ Claims  ☐ Chart Documentation  ☐ eCQM  ☐ Survey  ☐ Other
Medicaid State Benchmark: 86.5/1000-member months or lower (CCO 90th Percentile two years prior)

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

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

What: This measure reports the total number of all emergency department visits that do not result in an inpatient stay as a factor of how many months patients (aged 18 or older) have had active coverage with the CCO during the year.

How: Some ideas to improve ED Utilization rates:

- Use PreManage to identify when patients visit the ED and quickly follow up with each patient after their ED visit to prevent future avoidable ED use.
- Ensure patients are connected to behavioral health provider and that there is an effective communication loop between mental health and primary care.

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

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

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

See septate Mental Illness Value Set handout for codes that identify members for inclusion in this measure.
Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SMPI) FAQ

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

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

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

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

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

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

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

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

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

EVENT 1
Outpatient
Dx1 of laceration
Dx2 of pain
Dx3 of depression

24 months before measure year

EVENT 2
ED visit & admission

EVENT 3
Outpatient
Dx1-15 = Depression

EVENT 4
ED visit Treat and release
Dx1 = fracture (physical health)
Dx2 = Depression

EVENT 5
ED treat and release
Dx1 = schizophrenia
CPT = psych eval

Measure Year Jan to Dec (if enrolled full year then 12 MM)

4 >= 2 MI Dx events so Chad qualifies as a member for denominator
**Diagnosis Definitions for Members Experiencing Mental Illness Value Set**

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

<table>
<thead>
<tr>
<th>Schizophrenia</th>
<th>F200 – Paranoid Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F201 - Disorganized schizophrenia</td>
</tr>
<tr>
<td></td>
<td>F202 - Catatonic schizophrenia</td>
</tr>
<tr>
<td></td>
<td>F203 - Undifferentiated schizophrenia</td>
</tr>
<tr>
<td></td>
<td>F205 - Residual schizophrenia</td>
</tr>
<tr>
<td></td>
<td>F2081 - Schizophreniform disorder</td>
</tr>
<tr>
<td></td>
<td>F2089 - Other schizophrenia</td>
</tr>
<tr>
<td></td>
<td>F209 - Schizophrenia, unspecified</td>
</tr>
<tr>
<td>Schizotypal disorder</td>
<td>F21 - Schizotypal disorder</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>F23 - Brief psychotic disorder</td>
</tr>
<tr>
<td></td>
<td>F24 - Shared psychotic disorder</td>
</tr>
<tr>
<td>Schizoaffective disorders</td>
<td>F250 - Schizoaffective disorders</td>
</tr>
<tr>
<td></td>
<td>F251 - Schizoaffective disorder, depressive type</td>
</tr>
<tr>
<td></td>
<td>F258 - Other schizoaffective disorders</td>
</tr>
<tr>
<td></td>
<td>F259 - Schizoaffective disorder, unspecified</td>
</tr>
<tr>
<td>Manic Episode</td>
<td>F3010 - Manic episode without psychotic symptoms, unspecified</td>
</tr>
<tr>
<td></td>
<td>F3011 - Manic episode without psychotic symptoms, mild</td>
</tr>
<tr>
<td></td>
<td>F3012 - Manic episode without psychotic symptoms, moderate</td>
</tr>
<tr>
<td></td>
<td>F3013 - Manic episode, severe, without psychotic symptoms</td>
</tr>
<tr>
<td></td>
<td>F302 – Manic episode, severe with psychotic symptoms</td>
</tr>
<tr>
<td></td>
<td>F303 – Manic episode in partial remission</td>
</tr>
<tr>
<td></td>
<td>F304 – Manic episode in full remission</td>
</tr>
<tr>
<td></td>
<td>F308 – Other manic episodes</td>
</tr>
<tr>
<td></td>
<td>F309 - Manic episode, unspecified</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>F310 - Bipolar disorder, current episode hypomanic</td>
</tr>
<tr>
<td></td>
<td>F3110 - Bipolar disorder, current episode manic without psychotic features, unspecified</td>
</tr>
<tr>
<td></td>
<td>F3111 - Bipolar disorder, current episode manic without psychotic features, mild</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>F3112</td>
<td>Bipolar disorder, current episode manic without psychotic features, moderate</td>
</tr>
<tr>
<td>F3113</td>
<td>Bipolar disorder, current episode manic without psychotic features, severe</td>
</tr>
<tr>
<td>F312</td>
<td>Bipolar disorder, current episode manic severe with psychotic features</td>
</tr>
<tr>
<td>F3130</td>
<td>Bipolar disorder, current episode depressed, mild or moderate severity, unspecified</td>
</tr>
<tr>
<td>F3131</td>
<td>Bipolar disorder, current episode depressed, mild</td>
</tr>
<tr>
<td>F3132</td>
<td>Bipolar disorder, current episode depressed, moderate</td>
</tr>
<tr>
<td>F314</td>
<td>Bipolar disorder, current episode depressed, severe, without psychotic features</td>
</tr>
<tr>
<td>F315</td>
<td>Bipolar disorder, current episode depressed, severe, with psychotic features</td>
</tr>
<tr>
<td>F3160</td>
<td>Bipolar disorder, current episode mixed, unspecified</td>
</tr>
<tr>
<td>F3161</td>
<td>Bipolar disorder, current episode mixed, mild</td>
</tr>
<tr>
<td>F3162</td>
<td>Bipolar disorder, current episode mixed, moderate</td>
</tr>
<tr>
<td>F3163</td>
<td>Bipolar disorder, current episode mixed, severe, without psychotic features</td>
</tr>
<tr>
<td>F3164</td>
<td>Bipolar disorder, current episode mixed, severe, with psychotic features</td>
</tr>
<tr>
<td>F3170</td>
<td>Bipolar disorder, currently in remission</td>
</tr>
<tr>
<td>F3171</td>
<td>Bipolar disorder, in partial remission, most recent episode hypomanic</td>
</tr>
<tr>
<td>F3172</td>
<td>Bipolar disorder, in full remission, most recent episode hypomanic</td>
</tr>
<tr>
<td>F3173</td>
<td>Bipolar disorder, in partial remission, most recent episode manic</td>
</tr>
<tr>
<td>F3174</td>
<td>Bipolar disorder, in full remission, most recent episode manic</td>
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<tr>
<td>F3175</td>
<td>Bipolar disorder, in partial remission, most recent episode depressed</td>
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<tr>
<td>F3176</td>
<td>Bipolar disorder, in full remission, most recent episode depressed</td>
</tr>
<tr>
<td>F3177</td>
<td>Bipolar disorder, in partial remission, most recent episode mixed</td>
</tr>
<tr>
<td>F3178</td>
<td>Bipolar disorder, in full remission, most recent episode mixed</td>
</tr>
<tr>
<td>F3181</td>
<td>Bipolar II disorder</td>
</tr>
<tr>
<td>F3189</td>
<td>Other bipolar disorder</td>
</tr>
<tr>
<td>F319</td>
<td>Bipolar disorder, unspecified</td>
</tr>
<tr>
<td></td>
<td><strong>Depressive Disorder</strong></td>
</tr>
<tr>
<td>F320</td>
<td>Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td>F321</td>
<td>Major depressive disorder, single episode, moderate</td>
</tr>
<tr>
<td>F322</td>
<td>Major depressive disorder, single episode, severe without psychotic features</td>
</tr>
<tr>
<td>F323</td>
<td>Major depressive disorder, single episode, severe with psychotic features</td>
</tr>
<tr>
<td>F324</td>
<td>Major depressive disorder, single episode, in partial remission</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F325</td>
<td>Major depressive disorder, single episode, in full remission</td>
</tr>
<tr>
<td>F328</td>
<td>Other depressive episodes</td>
</tr>
<tr>
<td>F329</td>
<td>Major depressive disorder, single episode, unspecified</td>
</tr>
<tr>
<td>F330</td>
<td>Major depressive disorder, recurrent, mild</td>
</tr>
<tr>
<td>F331</td>
<td>Major depressive disorder, recurrent, moderate</td>
</tr>
<tr>
<td>F332</td>
<td>Major depressive disorder, recurrent severe without psychotic features</td>
</tr>
<tr>
<td>F333</td>
<td>Major depressive disorder, recurrent, severe with psychotic symptoms</td>
</tr>
<tr>
<td>F3340</td>
<td>Major depressive disorder, recurrent, in remission, unspecified</td>
</tr>
<tr>
<td>F3341</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
</tr>
<tr>
<td>F3342</td>
<td>Major depressive disorder, recurrent, in full remission</td>
</tr>
<tr>
<td>F338</td>
<td>Other recurrent depressive disorders</td>
</tr>
<tr>
<td>F339</td>
<td>Major depressive disorder, recurrent, unspecified</td>
</tr>
<tr>
<td></td>
<td><strong>Affective disorder</strong></td>
</tr>
<tr>
<td>F348</td>
<td>Other persistent mood [affective] disorders</td>
</tr>
<tr>
<td>F3481</td>
<td>Disruptive mood dysregulation disorder</td>
</tr>
<tr>
<td>F3489</td>
<td>Other specified persistent mood disorders</td>
</tr>
<tr>
<td>F349</td>
<td>Persistent mood [affective] disorder, unspecified</td>
</tr>
<tr>
<td>F39</td>
<td>Unspecified mood [affective] disorder</td>
</tr>
<tr>
<td></td>
<td><strong>OCD</strong></td>
</tr>
<tr>
<td>F42</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>F422</td>
<td>Mixed obsessional thoughts and acts</td>
</tr>
<tr>
<td>F423</td>
<td>Hoarding disorder</td>
</tr>
<tr>
<td>F428</td>
<td>Other obsessive-compulsive disorder</td>
</tr>
<tr>
<td>F429</td>
<td>Obsessive-compulsive disorder, unspecified</td>
</tr>
<tr>
<td></td>
<td><strong>PTSD</strong></td>
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<td>F4310</td>
<td>Post-traumatic stress disorder, unspecified</td>
</tr>
<tr>
<td>F4311</td>
<td>Post-traumatic stress disorder, acute</td>
</tr>
<tr>
<td>F4312</td>
<td>Post-traumatic stress disorder, chronic</td>
</tr>
<tr>
<td></td>
<td><strong>Schizoid personality disorder</strong></td>
</tr>
<tr>
<td>F603</td>
<td>Schizoid personality disorder</td>
</tr>
</tbody>
</table>
Immunizations for Adolescents (Combo 2)

Who: Children who turn 13 years of age in 2020.

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

What: This measure reports the percentage of adolescents who turn 13-years-old in 2020 who receive all the following immunizations before their 13th birth date:

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

  OR

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

How: Some ideas to improve Immunizations for Adolescents performance:

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

Coding: N/A

Resources

CDC recommended schedule of immunizations for adolescents:
https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
Childhood Immunization Status (Combo 2) FAQs

Q: What immunization combination does this metric follow?

A: HEDIS® 2020 Combination 2.

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

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

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

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

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

A: Members whose 13th birthday is within 2020 and have physical health coverage with the CCO continuously for the 12 months prior to their 13th birthday are included in the denominator. Please note that OHA is considering a temporary revision to the continuous enrollment criteria for the 2020 measurement year to account for changes in service areas and new CCOs with the implementation of the CCO 2.0 contracts. Please check with your Primary Care Innovation Specialist or Quality Improvement Analyst with any questions. birthday.

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

A: No. If the child does not receive immunizations, they will remain in the denominator but not the numerator.
Initiation and Engagement of Alcohol and Other Drug Use Treatment (IET)

**Who:** Members aged 18 years and older with a new diagnosis of alcohol or other drug use between January 1, 2020–November 13, 2020. A diagnosis is considered “new” if the member has not had a diagnosis of alcohol or other drug use in the previous 60 days.

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

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

1. **Initiation** – For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 60 days), this metric measures the percentage of those who initiated treatment within 14 days through either medication dispensing or a visit with a provider.

2. **Engagement** - For members with a new episode of alcohol or other drug use (diagnosis on a claim with no other diagnosis in the previous 60 days), this metric measures the percentage of those who had two treatment events, either medication dispensing or a visit with a provider, within 34 days from their initial treatment event.
   a. If treatment was initiated through a medication dispensing event, only one of the two required engagement events can be through medication and the other must be through a visit with a provider.

**How:** There are over 230 codes that count toward numerator criteria for treatment through a visit with a provider; please see OHA specifications for full details. The following medications are counted as numerator compliant treatment events.

### Medication Treatment for Alcohol Use Disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldehyde dehydrogenase inhibitor</td>
<td>Disulfiram (oral)</td>
</tr>
<tr>
<td>Antagonist</td>
<td>Naltrexone (oral and injectable)</td>
</tr>
<tr>
<td>Other</td>
<td>Acamprosate (oral; delayed-release tablet)</td>
</tr>
</tbody>
</table>

State Benchmark: Initiation for Age 18+ – 46.8% (2019 National Medicaid 75th percentile)

Engagement for Age 18+ – 18.5% (2019 National Medicaid 75th percentile)

Must meet both components to achieve measure.
### Medication Treatment for Opioid Use Disorder

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antagonist</strong></td>
<td>Naltrexone (oral and injectable)</td>
</tr>
<tr>
<td><strong>Partial Agonist</strong></td>
<td>Buprenorphine (sublingual tablet, injection, implant)</td>
</tr>
<tr>
<td></td>
<td>Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)</td>
</tr>
</tbody>
</table>

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

**Exclusions:** Hospice during any point in the year.

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

**Q:** Is tobacco use included in this metric?

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

**Q:** What is considered as “other drugs” in this metric?

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

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

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

- Outpatient visits
- Telehealth
- Intensive outpatient visits
- Partial hospitalization
- Detoxification visits
- ED visits or Observation
- Acute or non-acute inpatient admits
- Online assessment
**Oral Evaluation for Adults with Diabetes**

Performance Measure Set: ☑ CCO Incentive  ☐ Medicare Star Rating

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

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

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

**New Measure Note:** Specification sheet may change once the official specification is available.

**Who:** All patients aged 18 years or older with type 1 or type 2 diabetes during the measurement year.

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

**What:** A comprehensive, periodic or periodontal oral evaluation in the measurement year.

**How:**

- Assess whether diabetic patients are regularly engaged with a dental provider.
- Request dental outreach for patients through CareOregon’s provider portal or other internal referral processes.
- Discuss the need for routine oral health care with all diabetic patients.

**Exclusions:** Patients identified with gestational diabetes or steroid-induced diabetes but who do not have a diagnosis of diabetes in any care settings. Patients in hospice or 66 and older as of the end of the measurement year who meet the criteria for frailty or advanced illness.

**Coding:**

CDT codes: D0120, D0150, or D0180

Timeliness of Postpartum Care

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

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

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

State Benchmark: Postpartum Care – 61.3% (2018 CCO statewide average)

**Note:** Although CCOs must submit data for timeliness of both prenatal and postpartum care, the 2020 CCO incentive measure and quality pool payments are tied to the Postpartum Care rate.

**Who:** Women who had a live delivery between October 8, 2019—October 7, 2020.

**Why:** Early preventive care during pregnancy is associated with better outcomes for both the parent and baby. It can help reduce poor birth outcomes including spontaneous abortion, low birth weight and neonatal infection. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend at least one exam during the first trimester for prenatal care in an uncomplicated pregnancy and one exam approximately 4–6 weeks after delivery for postpartum care.¹

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

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

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

**Exclusions:** Non-live birth and patients in hospice.

Timeliness of Postpartum Care FAQ

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

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

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

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

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

A: Yes. Although a Pap test alone does not count as a prenatal care visit for the Timeliness of Prenatal Care rate, it will count for the Postpartum Care measure.
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Who: Children who are 3–6-years-old as of December 31 of the measurement year.

Why: Regular check-ups during the preschool and early school-age children are important for detection of vision, speech and language problems. Early intervention can help a child improve communication skills and avoid or reduce language and learning problems. Annual well-child visits are recommended for 2-6 year-olds.

What: The percentage of members 3–6 years of age who had one or more well child visits during the measurement year.

How: At least one well-child visit by any provider type during the measurement year.

Exclusions: Members in hospice are excluded from this measure. Telehealth visits do not count in 2020.

Coding: Diagnosis codes do not have to be primary. Do not count visits billed with a telehealth modifier or billed with a telehealth POS code.

CPT: 99381-99385, 99391-99395, 99461
ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

Note: The ICD-10 codes below (Z02.xx ICD-10 codes) are not covered under OHP administrative rules or on the prioritized list as of 10/1/2019; however, this measure does include denied claims.
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life FAQs

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

A:

• A health history. Health history is an assessment of the member’s history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.

• A physical developmental history. Physical developmental histories assess specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.

• A mental developmental history. Mental developmental histories assess specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.

• A physical exam.

• Health education/anticipatory guidance. Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

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

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

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

A: No, the provider does not have to be the assigned PCP.
Part Two

Medicare Stars Metrics
Breast Cancer Screening (BCS)

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**Who:** Female patients between the ages of 52 and 74.

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

**What:** One or more mammograms any time between October 1 of the two years prior to the measurement year through December 31 of the measurement year. For example, for the 2019 measurement year, the qualifying period is October 1, 2017–December 31, 2019.

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

**Exclusions:** Women 60–80 years of age as identified by the LTI flag; members with advanced illness or frailty; women who have had a bilateral mastectomy or history of a bilateral mastectomy; evidence of a right and a left unilateral mastectomy; or patients in hospice or using hospice services.

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

**Coding:**
CPT: 77055-77057, 77061–77063, 77065-77067, HCPCS: G0202, G0204, G0206
Breast Cancer Screening (BCS) FAQs

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

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

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

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

Q: How do I close the referral loop?

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

Performance Measure Set: ☑ CCO Incentive ☑ Medicare Star Rating

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

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

**Who:** All members who have been enrolled with the Medicare Advantage Plan for 6 months or longer are eligible to receive a survey.

**Why:** Patient experience surveys focus on how patients experienced or perceived key aspects of care, not how satisfied they were with their care. The survey contains questions relating to patients’ communication with their doctors, understanding their medication instructions, and the overall coordination of their healthcare needs. The CAHPS program is funded and overseen by the U.S. Agency for Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private research organizations to ensure survey standards and rigor.

**What:** The Survey is administered annually to a large sample of members through two survey mailings and follow-up calls made to non-respondents from February through June. Questions included fall into these categories: Annual Flu Vaccine, Care Coordination, Getting Care Quickly, Getting Needed Prescription Drugs, Overall Rating of Health Care Quality, Overall Rating of Plan, and Rating of Drug Plan.

**How:** The CAHPS Ambulatory Care Improvement Guide is a comprehensive resource for health plans, medical groups, and other providers seeking to improve their performance in the domains of patient experience measured by CAHPS surveys of ambulatory care. Use this guide to help your organization:

- Cultivate an environment that encourages and sustains improvements in patient-centered care.
- Analyze the results of CAHPS surveys and other forms of patient feedback to identify strengths and weaknesses.
- Develop strategies for improving performance.

The AHRQ CAHPS Improvement Guide is available here: https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html

**Exclusions:** None Coding: N/A
Care for Older Adults: Medication Review (COA)

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

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

What: A review of all a patient’s medications during the measurement year.

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

At least one medication review in the measurement year conducted by a prescribing practitioner or clinical pharmacist, with the reviewed medication list signed and dated in the medical record during a visit or transitional care-management services.

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

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

Coding: CPT/HCPCS: 90863, 99605, 99606, 99495, 99496, G8427 CPT-CAT-II: 1160F, 1159F
Care for Older Adults: Medication Review (COA) FAQs

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

A: Yes.

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

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

Q: Is an outpatient visit required to meet criteria?

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

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

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

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

A: Yes, if the medication list is in the encounter and the provider or clinical pharmacist states that the medications were reviewed.
Care for Older Adults: Pain Assessment (COA)

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

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

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

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

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

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

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

Coding: CPT-CAT-II: 1125F, 1126F
Care for Older Adults: Pain Assessments (COA) FAQs

Q: Will notation of a pain management plan or pain treatment plan alone in the record meet criteria?
   A: No. Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Q: Does screening for chest pain or documentation in the medical record of chest pain alone meet criteria?
   A: No. Patients coming in for chest pain or who have chest pain as a chief complaint typically get elevated to a more specific level of systems assessment that could potentially lead to something more serious.

Q: Do I need to document negative findings when screening for pain?
   A: Yes. To meet criteria, documentation must include that the patient was assessed for pain and the results, positive or negative.

Q: Who can document the pain assessment?
   A: CMA, RN, PT/OT, Pharmacist, and Provider.

Q: Does whole body pain need to be assessed?
   A: No. Pain assessment can originate from a chief complaint, reason for visit, or question of overall how well the patient is feeling.

Q: Is an outpatient visit required to meet criteria?
   A: No. A CMA, nurse clinical pharmacist, or provider can assess pain with a patient via a phone conversation. For example: asking how the patient is feeling or asking follow-up questions from a previous visit for leg pain, etc.
Colorectal Cancer Screening (CRC)

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

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

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

- Fecal occult blood test (FOBT) in 2020
- FIT-DNA test in 2018–2020
- Flexible sigmoidoscopy in 2016–2020
- CT Colonography in 2016–2020
- Colonoscopy in 2011–2020

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

How: Some ideas to improve Colorectal Cancer Screening rates:

1. Participate in CareOregon’s BeneFIT Program (CareOregon Members Only). CareOregon will mail FIT kits directly to members on behalf of your primary care clinic. Clinic staff will work directly with the CareOregon program administrator to determine program initiation and planning. Activities include determination of timing of the mailing, creation of member mailing list, and development of materials. For more information, please email Kelly Coates, Program Administrator (coatesk@careoregon.org).

2. Implement the STOP CRC Program (Entire Clinic Population) in your clinic. Refer to the STOP CRC Implementation Guide to determine your capacity and required technical resources. STOP CRC Guideline.

3. Other Clinic Activities.
   - Distribute FIT kits to patients during their annual wellness exam.
   - Have culturally appropriate decision guides readily available for your patients.
   - Offer FOBT when patients refuse other screening procedures.
   - Use health maintenance alerts or chart scrubbing prior to scheduled visits to identify members that are due for a screen and address during visit.
**Exclusions:** Patients aged 66 or older who are living long-term in an institution or are enrolled in an I-SNP; members with colorectal cancer, or who have had a total colectomy; patients 66 or older with frailty and advanced illness, and patients in hospice or using hospice services during the measurement year.

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

**Coding Continued:**

**CPT:** 82270, 82274, 44388-44394, 44397, 44401-44408, 45330-45335, 45337-45342, 45345, 45346, 45347, 45349, 45350, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398, 74261, 74262, 74263, 81528

**HCPCS:** G0328, G0104, G0105, G0121, G0464
**Colorectal Cancer Screening (CRC) FAQs**

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

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

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

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

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

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

**A:** Documentation in the medical record must include a note indicating the date and type of screening performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered). (Source: OHA specification 2019)

**Q:** Why are FIT tests an acceptable screening?

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

A: A list of members assigned to your clinic, and which metric related screenings they are due for, can be found on the CareOregon Business Intelligence (COBI) portal. If you do not have COBI access, please email your Provider Relations Specialist to set it up.

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

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

Q: What if a patient declines colorectal cancer screening?

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

Who: All members age 18–85 years who had an essential hypertension diagnosis and at least one PCP visit in 2020. Medicare Note: All members age 18–85 years who had at least two visits on different dates of service during the measurement year or year prior with a diagnosis of hypertension

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

What: Percentage of members with an essential hypertension diagnosis whose most recent blood pressure reading is below 140/90 mmHg. Please note that only blood pressure readings from the clinical office setting are accepted (home readings not accepted). Medicare Note: The blood pressure reading is below 140/90 mmHg and must occur on or after the date of the second diagnosis visit. (Only one of the two visits can be a telephone visit, an online assessment or a telehealth visit.) If a member does not have a blood pressure reading recorded during 2020, their blood pressure is considered out of control and not numerator compliant.

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

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

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

Medicaid Data reporting: This measure aligns with NQF 0018/CMS 165v8. Even though the measure is not incentivized for 2020, CareOregon must still collect data from each clinic’s EHR to submit to OHA
as required in the state’s Medicaid Demonstration Waiver from CMS. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred
- Reporting must be for the full calendar year of 2020; mid-year reports preferred in a rolling 12-month timeframe
- Data can be formatted in QRDA category 1 or Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.
Controlling High Blood Pressure FAQ

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

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

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

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

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

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

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

A: Use the lower of the two readings.

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

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

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

A: The patient’s blood pressure is assumed “not controlled” if there are no blood pressure reading during the measurement year and will fall into the gap for this measure (i.e. remain in the measure denominator but not numerator compliant).
# Diabetes Care: Eye Exam

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

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

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

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

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

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

**Coding:** HCPC/CPT: 67028, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67111-67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227-67228, 92002, 92004, 92012, 92014, 92018-92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245, S0620-S0621, S3000, 2022F, 2024F, 2026F, 3072F, 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
Diabetes Care: Eye Exam FAQs

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

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

Q: How do I close the referral loop?

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

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

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

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

HEDIS Benchmarks National Percentile: 95% (75th), 97% (90th)

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

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

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

**How:** A urine test for albumin or protein, or evidence of ACE inhibitor/ARB therapy, visit with a nephrologist, ESRD, dialysis, renal failure, or renal transplant

Some ideas to improve nephropathy screenings include:

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

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

**Coding:** HCPC/CPT: 81000 – 81003, 81005, 82042, 82043, 82044, 84156, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 36147, 36800, 36810, 36815, 36818-36821, 36831—36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512, 52065, 59339, G0257

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

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

A: If your office uses OCHIN, check with your site specialist for reports or member lists. If your office uses another EHR system check with your data specialists.
Medicare Health Outcomes Survey (HOS) – Improving Bladder Control

Performance Measure Set: ☐ CCO Incentive ☒ Medicare Star Rating

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

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

Who: Adults aged 65 or older who had a problem with urine leakage in the past six months, who discussed it with their doctor and got treatment during the year.

Why: 51% of women and 14% of men in the U.S. experience urinary incontinence\(^1\). Adults who experience urinary incontinence report worse physical health, mental health and quality of life. For older adults, it can potentially reduce independence and the ability to socialize. Discussing urinary incontinence with patients can help address and reduce symptoms with evidence-based treatment.

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

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

Improving Bladder Control is based on two questions:

1) In the past six months, have you experienced leaking of urine?
2) Have you discussed treatment options with a doctor or other health care provider?
Medicare Health Outcomes Survey (HOS) – Monitoring Physical Activity

Performance Measure Set: ☐ CCO Incentive  ☒ Medicare Star Rating

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

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

Who: Adults aged 65 or older.

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

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

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

Monitoring Physical Activity is based on two survey questions:

1) In the past 12 months, did you talk with a doctor or provider about your level of exercise or physical activity?

2) In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?
Medicare Health Outcomes Survey (HOS) – Reducing the Risk of Falling

Performance Measure Set: ☐ CCO Incentive  ☒ Medicare Star Rating

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

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

Who: Adults aged 65 or older who had a problem with a fall, walking or balancing, who discussed it with their doctor and got treatment during the year.

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

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

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

Reducing risk of falling is based on four questions:

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

Who: Patients aged 18 years and older.

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

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

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

Exclusions: Hospice or ESRD

Statin Medications:
Lovastatin, simvastatin, pravastatin, atorvastatin, or rosuvastatin.
**Medication Adherence for Diabetes Medications**

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

**Who:** Patients 18 years of age and older.

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

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

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

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

**Diabetes Medications:**
Biguanides, sulfonylureas, thiazolidinediones, dipeptidyl peptidase (DPP)-IV inhibitors, incretin mimetics, meglitinides, and sodium glucose cotransporter 2 (SGLT2) inhibitors.
Medication Adherence for Hypertension (RAS Antagonists)

Who: Patients 18 years of age and older.

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

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

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

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

Blood Pressure Medications:
Renin angiotensin system (RAS) antagonists: angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or direct renin inhibitor medications.
Osteoporosis Management in Women Who had a Fracture (OMW)

Performance Measure Set: ☑ CCO Incentive Metric ☑ Medicare Star Measure Quality
Measurement Type: ☑ Structure ☑ Process ☑ Outcome ☑ Patient Experience
Data Type: ☑ Claims ☑ Chart Documentation ☑ eCQM ☑ Survey ☑ Other
HEDIS Benchmarks National Percentile: 57% (75th), 78% (90th)

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

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

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

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

Important look-back timelines that will satisfy appropriate testing or treatment for a woman with a qualifying fracture:

- On osteoporosis medications 12-months prior to fracture.
- Check imaging reports to see if BMD testing occurred 2 years or less prior to fracture.

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

Coding:

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

CareOregon Quality Metrics Toolkit
Osteoporosis Management FAQs

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

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

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

A: If you find a patient that is in the osteoporosis measure but they did not have a fracture, bring it to the provider’s attention for correction of charting and claims.
**Rheumatoid Arthritis Management (ART)**

<table>
<thead>
<tr>
<th>Performance Measure Set:</th>
<th>☑ CCO Incentive  ☒ Medicare Star Rating</th>
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<tbody>
<tr>
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<td>Data Type:</td>
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<tr>
<td>HEDIS Benchmarks National Percentile:</td>
<td>82% (75th), 87% (90th)</td>
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</tbody>
</table>

**Who:** Members aged 18-years-old and older in the measurement period.

**Why:** Rheumatoid arthritis is one of the most common autoimmune inflammatory arthritis in adults. It has significant negative impact on a person’s ability to perform daily household tasks and work. This measure helps in accessing and monitoring disease activity for improved treatment and better outpatient outcomes.

**What:** Percentage of members with rheumatoid arthritis who were dispensed one or more ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

**How:** Members who were diagnosed with rheumatoid arthritis having two visits (outpatient and/or nonacute inpatient stay) with different dates of service in the measurement year.

**Exclusions:** Members with a diagnosis of HIV or female members with a diagnosis of pregnancy any time during the measurement year. Members in hospice or using hospice services are excluded.

**Coding:**
- HCPCS: J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J2960, J9310
Statin Therapy for Patients with Cardiovascular Disease (SPC)

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

Who: Female patients between 40–75 years of age and male patients between 21–75 years of age.

Why: Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease (Benjamin et al., 2017). People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing ASCVD⁴.

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

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

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

High-intensity and Moderate-intensity Statin Medications:

<table>
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<tr>
<th>High-intensity statin therapy</th>
<th>Atorvastatin 40-80 mg</th>
<th>Simvastatin 80 mg</th>
<th>Rosuvastatin 20-40 mg</th>
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<tr>
<td></td>
<td>Amlodipine-atorvastatin 40-80 mg</td>
<td>Ezetimibe-simvastatin 80 mg</td>
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<tr>
<td>Moderate-intensity statin therapy</td>
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<td>Pravastatin 40-80 mg</td>
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<td></td>
<td>Amlodipine-atorvastatin 10-20 mg</td>
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<tr>
<td>Drug</td>
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<td>--------------------</td>
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<tr>
<td>Rosuvastatin</td>
<td>5-10 mg</td>
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</tr>
<tr>
<td>Simvastatin</td>
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<td></td>
</tr>
<tr>
<td>Ezetimibe-simvastatin</td>
<td>20-40 mg</td>
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Statin Use in Persons with Diabetes (SUPD)

<table>
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<tr>
<th>Performance Measure Set:</th>
<th>☐ CCO Incentive Metric  ☒ Medicare Star Measure</th>
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<td>Data Type:</td>
<td>☒ Claims  ☐ Chart Documentation  ☐ eCQM  ☐ Survey  ☐ Other</td>
</tr>
<tr>
<td>HEDIS Benchmarks National Percentile: 80% (75th), 83% (90th)</td>
<td></td>
</tr>
</tbody>
</table>

**Who:** Patients between 40–75 years of age.

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

**What:** Percent of members with at least two diabetes medication fills who received a statin medication fill during the measurement period.

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

**Exclusions:** Patients with a ESRD diagnosis or coverage dates, or enrolled in hospice are excluded.

**Statin Medications:**
Any statin medication claim.
Part Three

Retired CCO Metrics
Adolescent Well Care (AWC)

Who: Adolescents between the age of 12–21 as of December 31 of the measurement year, who complete an annual well-care exam during the calendar year.

Why: “Bright Futures” recommends annual well-care visits for adolescents ages 11–21 years, as they are a strong vehicle to deliver screening, anticipatory guidance, and health education to support healthy development now and in the future (source: OHA Guidance Document).

What: An annual well-care exam completed during the 2019 calendar year that includes at least a physical exam, health and developmental history, health education, and anticipatory guidance.

How: Some ideas to improve Adolescent Well Care visits include:

- Flip sick visits into well-care visits (modifier 25).
- Encourage adolescents to get a well-care exam instead of a sports physical.
- SWAG events.

Exclusions: None.

Coding: The following codes do not need to be used in combination; one CPT or diagnosis code will be sufficient, and codes do not need to be primary to count toward the metric.

CPT: 99383-99385, 99393-99395

ICD-10: 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

Note: The ICD-10 codes below (Z02.xx ICD-10 codes) are not covered under OHP administrative rules or on the prioritized list as of October 1, 2018; however, this measure does include denied claims.
Adolescent Well Care (AWC) FAQs

**Q:** What documentation do I need to have in the chart to support an Adolescent Well Care visit?

**A:** There are three areas that need to be addressed to have appropriate documentation for an Adolescent Well Care visit:

1. Health & Development History (Physical & Mental)
2. Physical Exam
3. Health Education or Anticipatory Guidance

**Q:** If the member comes in for a different type of visit (e.g. sick visit), can I also complete a well care visit and get credit for it?

**A:** Yes! When providing two separate services, modifier 25 can be used to bill for both if there is documentation to support it (see Adolescent Well Care documentation above). Modifier 25 is used to denote “Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure."

**Q:** How do I know which members are due for an Adolescent Well Care visit?

**A:** Each CareOregon member should have an Adolescent Well Care at least once per calendar year. If you haven’t seen a member this year, we suggest outreaching to schedule an appointment. Additionally, you can find a list of members assigned to your clinic who are due for an Adolescent Well Care visit per CareOregon claims data on the CareOregon Business Intelligence (COBI) portal. If you do not have COBI access, please email your Provider Services Representative.

**Q:** How many well visits can an adolescent have?

**A:** CareOregon will cover as many Adolescent Well Care visits as appropriate per provider discretion within a 12-month period. We believe well visits are important and do not want to create barriers to members receiving them.

**Q:** What if the member only has secondary CCO coverage, and their primary insurer is commercial, Medicare, or some other payer?

**A:** Members with secondary CCO coverage are included in the measure per the OHA specifications. The CCO is required to assign a PCP to all members (even those with secondary coverage). This means sometimes members might be assigned to you by the CCO even if their primary insurance assigns them somewhere else. This can seem unfair to clinics, but it is how the CCO is measured by the OHA. The good news is, this is a small group of members compared to the whole measure denominator!
Q: What is the difference between a Well Child Check and an Adolescent Well Care visit?

A: Some providers, clinics and parents may still refer to the visits as Well Child Checks. It is technically an adolescent well-care visit when the patient is between the ages of 12 and 21. The difference is the type of exam and discussion in the visit. Young children might need more immunizations or developmental screenings, but adolescents begin to receive counseling about drug/violence avoidance, sexual health, and taking responsibility for their own health from providers.

Q: Does an Adolescent Well Care visit done at a School Based Health Center count toward the metric?

A: Yes! Visits to school-based health centers (SBHC) in a CCO’s provider network are included in the measure if the billing/coding is submitted as a claim through the CCO.

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

A: No. The provider does not have to be the assigned PCP.
Colorectal Cancer Screening (CRC)

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

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

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

- Fecal occult blood test (FOBT) in 2020
- FIT-DNA test in 2018–2020
- Flexible sigmoidoscopy in 2016–2020
- CT Colonography in 2016–2020
- Colonoscopy in 2011–2020

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

**How:** Some ideas to improve Colorectal Cancer Screening rates:

1. Participate in CareOregon’s BeneFIT Program (CareOregon Members Only). CareOregon will mail FIT kits directly to members on behalf of your primary care clinic. Clinic staff will work directly with the CareOregon program administrator to determine program initiation and planning. Activities include determination of timing of the mailing, creation of member mailing list, and development of materials. For more information, please email Kelly Coates, Program Administrator (coatesk@careoregon.org).

2. Implement the STOP CRC Program (Entire Clinic Population) in your clinic. Refer to the STOP CRC Implementation Guide to determine your capacity and required technical resources. STOP CRC Guideline.

3. Other Clinic Activities.
   - Distribute FIT kits to patients during their annual wellness exam.
   - Have culturally appropriate decision guides readily available for your patients.
   - Offer FOBT when patients refuse other screening procedures.
   - Use health maintenance alerts or chart scrubbing prior to scheduled visits to identify members that are due for a screen and address during visit.
**Exclusions:** Patients aged 66 or older who are living long-term in an institution or are enrolled in an I-SNP; members with colorectal cancer, or who have had a total colectomy; patients 66 or older with frailty and advanced illness, and patients in hospice or using hospice services during the measurement year.

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

**Coding Continued:**

**CPT:** 82270, 82274, 44388-44394, 44397, 44401-44408, 45330-45335, 45337-45342, 45345, 45346, 45347, 45349, 45350, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398, 74261, 74262, 74263, 81528

**HCPCS:** G0328, G0104, G0105, G0121, G0464
Colorectal Cancer Screening (CRC) FAQs

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

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

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

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

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

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

A: Documentation in the medical record must include a note indicating the date and type of screening performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered). (Source: OHA specification 2019)

Q: Why are FIT tests an acceptable screening?

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

A: A list of members assigned to your clinic, and which metric related screenings they are due for, can be found on the CareOregon Business Intelligence (COBI) portal. If you do not have COBI access, please email your Provider Relations Specialist to set it up.

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

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

Q: What if a patient declines colorectal cancer screening?

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

Who: All members age 18–85 years who had an essential hypertension diagnosis and at least one PCP visit in 2020. Medicare Note: All members age 18–85 years who had at least two visits on different dates of service during the measurement year or year prior with a diagnosis of hypertension.

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

What: Percentage of members with an essential hypertension diagnosis whose most recent blood pressure reading is below 140/90 mmHg. Please note that only blood pressure readings from the clinical office setting are accepted (home readings not accepted). Medicare Note: The blood pressure reading is below 140/90 mmHg and must occur on or after the date of the second diagnosis visit. (Only one of the two visits can be a telephone visit, an online assessment or a telehealth visit.)

If a member does not have a blood pressure reading recorded during 2020, their blood pressure is considered out of control and not numerator compliant.

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

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

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

Medicaid Data reporting: This measure aligns with NQF 0018/CMS 165v8. Even though the measure is not incentivized for 2020, CareOregon must still collect data from each clinic’s EHR to submit to OHA.
as required in the state’s Medicaid Demonstration Waiver from CMS. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred
- Reporting must be for the full calendar year of 2020; mid-year reports preferred in a rolling 12-month timeframe
- Data can be formatted in QRDA category 1 or Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.
Controlling High Blood Pressure FAQ

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

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

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

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

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

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

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

A: Use the lower of the two readings.

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

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

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

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

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<td>☒ Claims</td>
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<tr>
<td>State Benchmark:</td>
<td>80.0% Metrics and Scoring Committee consensus</td>
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**Who:** All patients born between January 1, 2017–December 31, 2019.

**Why:** Recommendations from “Bright Futures” call for all children to be screened, using a global developmental screening tool, at three different times during the first three years of life in the context of routine well-child visits or when a concern is raised through standardized developmental surveillance. The CCO incentive metric is intended to operationalize whether “Bright Futures” recommended care is provided for young children.

**What:** Percentage of children who were screened for risk of developmental, behavioral or social delays in the 12 months prior to eligible birthday.

**How:** The American Academy of Pediatrics recommends developmental surveillance be incorporated at every well-child preventative care visit. Screening tests are recommended at 9 months, 18 months, and 24 months, or 30 months depending upon frequency of pediatric visits.

OHA Recommended tools:
- Ages and Stages Questionnaire, Third Edition (ASQ-3)4, or
- Parents’ Evaluation of Developmental Status (PEDS)5, with or without the Developmental Milestones (DM).

For complete list of qualifying screening tools refer to OHA Guidance Document.

**Exclusions:** None.

**Coding:** CPT: 96110

The Oregon Health Authority reimburses for developmental screening under the CPT code 96110 for physicians, nurse practitioners (NPs) or physician assistants (PAs). The reimbursement for the code is based on the provider’s time reviewing the results and interpreting the findings with the family.
Developmental Screening FAQs

Q: What documentation do I need to have in the chart to support a developmental screening?

A: Results of screen, documented review with parent/guardian, and provider records of what action was taken (including “no action taken” for normal results).

Q: Can my medical assistant add developmental screening answers to the medical record after the visit?

A: It can be added in an addendum once the encounter has been closed; however, it MUST be added on the day of service.

Best practice: Have the MA enter results into the medical record after the parent fills it out but before the provider enters the room. The provider can auto-populate results into the chart note, review with parent, and document action taken.

Q: Does my organization have to use the Ages & Stages Questionnaire?

A: No, OHA also accepts the Parents Evaluation of Developmental Status (PEDS)5, with or without the Developmental Milestones (DM).

Q: Where can my organization purchase these screening tools?

A: Ages & Stages Questionnaire:

Parents Evaluation of Developmental Status:
http://www.pedstest.com/default.aspx

Q: Can I screen a child during a sick visit, or only during a Well Child Check?

A: Yes, you can administer the screening at any time you see that the patient is due, even if they are not there for a well-child check.

Q: Who gives the screening tool to the parent/guardian?

A: It depends on what works best for your clinic. A lot of clinics have found it helpful to give the screening to the parent/guardian at check-in, giving them time to fill it out before being called back. The MA can then score the tool in the room and enter it into the EHR. The provider must review the results with the parent/guardian.

Q: Is the PCP required to complete the screen?

A: No, anyone can assist parents in completing the screen; the PCP is only required to interpret the results and discuss them with the family.
Q: Will the patient/parent/guardian be billed for the screening? What if it’s done more than once in a year?

A: The screening is covered by insurance regardless of the frequency of screening.

Q: What happens if we get an abnormal result?

A: The provider should review the results first. If they determine the child is not developing typically a referral should be made. The uniform Oregon referral form for early intervention can be located online:

http://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Pages/default.aspx

Note: Parent/guardian signature is required.
**Effective Contraceptive Use**

<table>
<thead>
<tr>
<th>Performance Measure Set:</th>
<th>☒ CCO Incentive</th>
<th>☐ Medicare Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measurement Type:</td>
<td>☐ Structure</td>
<td>☒ Process ☐ Outcome ☐ Patient Experience</td>
</tr>
<tr>
<td>Data Type:</td>
<td>☒ Claims</td>
<td>☐ Chart Documentation ☐ eCQM ☐ Survey ☐ Other</td>
</tr>
<tr>
<td>State Benchmark:</td>
<td>53.9% (2017 CCO 90th percentile)</td>
<td></td>
</tr>
</tbody>
</table>

**Who:** All female patients aged 15–50-years-old

**Why:** For women and adolescents between the ages of 15 and 50, reproductive health care is an essential part of their overall health care. For many women, reproductive health concerns are the only reason they seek routine medical care. Almost 50% of pregnancies in Oregon are unintended, and have been so for more than three decades. Among women with an unintended pregnancy, 43% reported using contraception, but they were using it incorrectly or inconsistently. Fifty-two percent reported using no contraception method at all.

**What:** Evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implants, contraception injection, contraceptive pills, patch, ring, or diaphragm.

**How:**
- Discuss contraception or family planning at every visit (consider One Key Question®).
- Create EHR templates that help providers code correctly every time.
- Improve the availability of long acting reversible contraceptives.
- Use telephone visits to surveille contraception for women who may not need an in-person visit every year.

**Exclusions:** History of a hysterectomy or bilateral oophorectomy, menopause, female infertility, and pregnancy during the measurement year.

Permanent numerator hits: female sterilization anytime throughout the claims history in OHA’s system.

**Coding:** Except for tubal ligations, there must be claims evidence of the contraceptive method every year. A procedure for administering or implanting contraception or a pharmacy fill will satisfy this requirement. Some birth control methods (long acting reversible contraception) last for several years after insertion. These methods need to be surveilled annually to be captured in the measure. See the accompanying coding cheat sheet for most common surveillance codes (not an exhaustive list).
Effective Contraceptive Use FAQ

Q: What are workflows we can implement to improve our process?

A: One Key Question® is the recommended approach for pregnancy intention screening in Oregon.

Q: Why are adolescents included in the measure?

A: Ensuring that adolescents have access to contraception is an effective strategy for reducing teen pregnancy. However, OHA acknowledges that not all adolescent females are sexually active, in fact only approximately 40% of female teens have a contraceptive need. This was taken in to account by the OHA when selecting the measure benchmark. The goal is not to prescribe contraceptives to all teens, but rather to ensure that the 40% who have a contraceptive need, have that need met.

Q: What if the woman does not have sex with men, is not sexually active/abstinent, is trying to become pregnant, or has a monogamous partner who had a vasectomy?

A: Unfortunately, these are all limitations of the measure. Because the Effective Contraceptive Use measure is a claims-based measure there is no way to capture these scenarios. In addition, there could be ethical reasons why these circumstances should not be coded on claims. This was taken in to account by the OHA when selecting the measure benchmark.

Q: My patient had a tubal ligation, do I need to code that every year?

A: It depends, if surveilled on a claim prior to 2019, the OHA will count ANY claims history of a tubal ligation or sterilization as a permanent numerator hit unless there is evidence the tubal ligation was reversed. If your patient had a tubal ligation and this is not reflected in your CareOregon member list you have two options:

1) Conduct surveillance and coding of the tubal ligation status during a 2019 visit and drop the appropriate ICD 10 code: Z98.51;

2) Contact your CareOregon QI analyst for instructions on how you can submit chart documentation.

Q: How does a member’s pregnancy impact the measure?

A: If member is pregnant during the measurement year, the member is excluded from the denominator. However, if the member has an effective contraceptive method documented after the pregnancy in the measurement year, the member is still excluded from the denominator and is counted in the numerator.
Surveillance Codes for Effective Contraceptive Use

The Effective Contraceptive Use measure looks at women aged 15–50 to determine if they have evidence of an effective contraceptive type during the measurement year. This measure is based on claims during the calendar year; codes must be submitted on a billable visit to exclude women or count her as having met the measure. Below are exclusion and numerator diagnosis codes for Effective Contraceptive Use.

**Exclusions:** Women can be excluded from the denominator if they have evidence of the following diagnoses:

<table>
<thead>
<tr>
<th>Denominator Exclusion Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Other reproductive system removal</td>
</tr>
<tr>
<td>Natural Menopause</td>
</tr>
<tr>
<td>Premature Menopause due to survey, radiation or other factors</td>
</tr>
<tr>
<td>Congenital Anomalies of female genital organs</td>
</tr>
<tr>
<td>Female Infertility</td>
</tr>
</tbody>
</table>

**NOTE:** Clinics do not need to document exclusions every measurement year if there is existing Medicaid claims history with evidence of exclusion.

**Numerator:** Women in the denominator with evidence of one of the following methods of contraception during the measurement period: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm, per the numerator code table below.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>DX Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sterilization</td>
<td>Z30.2, Z98.51</td>
</tr>
<tr>
<td>Intraterine Device (IUD)</td>
<td>Z30.014, Z30.430, Z30.431, Z30.433, Z97.5</td>
</tr>
<tr>
<td>Hormonal Implant</td>
<td>Z30.016, Z30.017</td>
</tr>
<tr>
<td>Injectable</td>
<td>Z30.013</td>
</tr>
<tr>
<td>Oral Contraceptive Pills</td>
<td>Z30.011</td>
</tr>
<tr>
<td>Patch</td>
<td>Z79.3</td>
</tr>
<tr>
<td>Vaginal Ring</td>
<td>Z30.015</td>
</tr>
<tr>
<td>Unspecified Contraception</td>
<td>Z30.018, Z30.019, Z30.40, Z30.8, Z30.9</td>
</tr>
</tbody>
</table>
Strategies to Improve Rates

The OHA ECU Guidance Document provides a few strategies to improve rates, summarized below:

1. Screen women for their pregnancy intention on a routine basis.
   a. Several pregnancy intention screening tools are available for use in clinical and non-clinical settings, with Oregon served as a national leader in this area with the One Key Question® initiative, developed by the Oregon Foundation for Reproductive Health. [Click here for more information]

2. Improve Availability and Uptake of long acting reversible contraception (LARCs).
   a. For clinics that can provide IUDs and implants, it is important to get the care team on board. Effective contraceptive use is not solely the responsibility of the clinician. Administrative and other support staff, health educators, and clinicians all have roles to play in supporting LARC adoption.
      i. Recommended strategies include:
         1. Create a dedicated family planning team or lead staff within the clinic to affect change.
         2. Integrate family planning into staff development initiatives, including new hire orientation.

3. Create QI process for contraceptive care.
   a. Quality improvement processes for contraceptive care can be developed at the clinic level. Helping women plan healthy (and avoid mistimed) pregnancies is a core component of primary care.
      i. Clinics can use administrative (claims and encounter) and/or electronic health record (EHR) data to track pregnancy intentions and contraceptive use as a core preventive service in primary care settings, similar to cancer screenings.
      ii. Clinics can ensure providers and clinic staff receive standardized training and develop skills in contraceptive counseling and the provision of contraception services.

4. Use Telephone Visits to drop surveillance code.
   a. For organizations who do not implement ECU for the entire calendar or measurement year, a telephone visit is a way to capture information for patients and ensure they have a contraceptive method that works for them.
Telephone Visit Billing

[Click here for telephone visit toolkit](#)

Telephone and Telemedicine visits are aimed to increase access and efficiency by utilizing another means for management of chronic diseases. These visits expand the physical reach a care team has with members and reduce or eliminate barriers such as transportation, work time and child care. Below are codes that are reimbursed.

Below are codes that are eligible for payment as telephone calls.

<table>
<thead>
<tr>
<th>Service by Qualified Healthcare Professional (Link)</th>
<th>Service by Qualified Non-Physician (Link)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441 Telephone assessment and mgmt 5-10 min</td>
<td>98966 Telephone assessment and mgmt 5-10 min</td>
</tr>
<tr>
<td>99442 Telephone assessment and mgmt 11-20 min</td>
<td>98967 Telephone assessment and mgmt 11-20 min</td>
</tr>
<tr>
<td>99443 Telephone assessment and mgmt 21-30 min</td>
<td>98968 Telephone assessment and mgmt 21-30 min</td>
</tr>
<tr>
<td>99444 On-line assessment and mgmt</td>
<td>98969 On-line assessment and mgmt</td>
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</tbody>
</table>

Click the link above for telephone visit toolkit or reach out to Primary Care Innovations Specialist (PCIS), Paula Smith ([smithp@careoreon.org](mailto:smithp@careoreon.org)) for additional information.

Things to remember when billing:

- Codes are time based and the exact amount of time spent with patient should be documented.
- Phone visit should not originate from a previous visit within the previous seven days nor should it lead to assessment in the next 24 hours.
- Phone call must be patient-initiated or pre-scheduled.
- Visit should involve some medical decision making or care coordination.

**What about Private Pay and billing?**

[Senate Bill 144](#) requires that health insurance companies cover and pay for a service if a doctor or nurse practitioner offers their care remotely through a secure video conference technology.
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<tr>
<td>Intrauterine Device (IUD/IUS)</td>
<td>Z30.431</td>
</tr>
<tr>
<td>Injectable (Depo)</td>
<td>Z30.42</td>
</tr>
<tr>
<td>Hormonal Implant (Nexplanon/Implanon)</td>
<td>Z30.46</td>
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<td>Oral Contraceptives</td>
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</tr>
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<td>Z30.2</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>Z98.51</td>
</tr>
<tr>
<td>Menopause/Post-menopause(40+)</td>
<td>N95.9</td>
</tr>
<tr>
<td>Premature Menopause(&lt;40)</td>
<td>E28.319</td>
</tr>
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**Patient Centered Primary Care Home (PCPCH) Enrollment**

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<th>☐ Medicare Star Rating</th>
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<td>☐ Process  ☐ Outcome  ☐ Patient Experience</td>
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<tr>
<td>Data Type:</td>
<td>☐ Claims</td>
<td>☐ Chart Documentation</td>
</tr>
<tr>
<td>State Benchmark:</td>
<td>N/A – sliding scale with 68.0% threshold</td>
<td></td>
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**Who:** CCO Members enrolled in a State Certified Patient Centered Primary Care Home.

**Why:** The Patient-Centered Primary Care Home Program (PCPCH) is part of Oregon's efforts to fulfill a vision of better health, better care and lower costs for all Oregonians.

**What:** CCO membership enrollment is determined using assignment and clinic tier recognition. The following formula is used to calculate the number of CCO members enrolled in a Patient Centered Primary Care Home by tier:

\[
\text{Tier 1 members} \times 1 + \text{Tier 2 members} \times 2 + \text{Tier 3 members} \times 3 + \text{Tier 4 members} \times 4 + \text{5 STAR members} \times 5) / (\text{Total CCO enrollment} \times 5)
\]

**How:** CareOregon submits a quarterly survey to OHA, however the survey information is based on CareOregon’s membership and the Patient Centered Primary Care Home program data. Each clinic is responsible for the Patient Centered Primary Care Home recognition process and tier maintenance/advancement. CareOregon reconciles clinic tier recognition monthly to monitor enrollment for measure requirements.


You can also reach out to your Primary Care Innovation Specialist for assistance.

**Exclusions:** N/A.

**Coding:** None.
Patient Centered Primary Care Home Enrollment FAQs

Q: What if a clinic has applied for 5 STAR recognition, but a site visit hasn’t been completed by the end of the year?

A: Given concerns about 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 Patient Centered Primary Care Home program to include any updated information for recognition occurring between January 1–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.

Q: Do members enrolled (assigned/attributed) in a Tribal Clinic count for this measure?

A: Yes. Previously members assigned/attributed to tribal clinics were excluded from this measure, however, with the 2019 specifications, members enrolled in tribal clinics will be counted.