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 if it was performed as planned, e.g. for diabetes: % 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 to 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.
Adolescent Well Care (AWC)

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: 65.2% (2018 national Medicaid 75th percentile)

Who:  Adolescents between the age of 12 – 21 as of December 31st 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 from 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 10/1/2018; 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 3 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.
**Adult BMI Assessment (ABA)**

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 Nat’tl Percentile: 93 (75th), 98 (90th)

**Who:** Patients between the ages of 18 (as of Jan 1, 2018) and 74 (as of Dec 31, 2019).

**Why:** BMI provides the most useful population-level measure of overweight and obesity. Careful monitoring of BMI helps providers identify adults at risk of obesity which can lead to serious health problems. Screening for overall healthy weight not only assesses for obesity but can also identify underweight levels and potentially malnourishment.

**What:** Percentage of patients who had an outpatient visit in the measurement year or year prior, who had a BMI assessment.

For patients 20 years of age and older the weight and body mass index value is captured on the date of service and documented.

For patients younger than 20 years of age, height, weight, and BMI percentile is captured on the date of service with BMI percentile documented as a value (e.g., 85th percentile) or plotted on an age-growth chart.

**How:** Any outpatient visits, including seen by a nurse, CMA, nutritionist, or pharmacist. This measure can be satisfied using two methods: 1) by coding BMI and BMI percentiles using ICD-10 codes, or 2) documenting in the medical record:

- Document the weight in pounds or kilograms and BMI in office visit/vitals signs flowsheet
- Less than 20 years of age: document weight and BMI % on growth chart
- BMI can be calculated with height and weight values

**Exclusions:** Pregnant female patients during the measurement year or year prior, or patients in hospice or using hospice services during the measurement year.

**Coding:** ICD-10 BMI: Z68.20 – Z68.39, Z68.41 – Z68.45, BMI Percentile: Z68.51 - Z68.54

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**Adult BMI Assessment FAQs**

**Q:** Does notation in the medical record of weight only count?

**A:** No. For members 20 years and older documentation in the medical record must indicate weight and BMI value on date of service. For members less than 20 years old documentation in the medical record must indicate the height, weight and BMI percentile on the date of service.

**Q:** Does documentation of ranges in the medical record count for the BMI percentile for patients under 20 years of age?

**A:** No. Documentation of a distinct BMI value or percentile, or BMI percentile plotted on an age growth chart in the medical record is required.

**Q:** How do you capture height and weight if a patient has a physical limitation?

**A:** Although not ideal, you can use a stated height and weight. Ask the patient or caregiver, and document that it is “stated”.
**Alcohol and Drug Misuse (SBIRT)**

**New Measure Note:** This measure is now an EHR-based measure and does not require the use of billing codes.

**Who:** All patients age 12 and older

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

**What:** Percent of all patients age 12 years and older that are age-appropriately screened for clinical depression, and had either a brief screen with a negative result or a positive full screen with a brief intervention, a referral to treatment or both.

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

1. percentage of patients who received age-appropriate screening using an approved SBIRT screening tool and had either a brief screen with a negative result or a full screen during the measurement period (Rate 1). Denominator for rate 1 uses denominator criteria for the depression screening and follow-up measure (NQF0418/CMS2).
2. percentage of patients with a positive full screen who received a brief intervention and/or referral to treatment documented within 48 hours of the date of the full screen (Rate 2). Denominator for Rate 2 includes all patients in Rate 1 denominator who had a positive full screen.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Rate 1 Numerator</th>
<th>Rate 1 Denominator</th>
<th>Rate 2 Numerator</th>
<th>Rate 2 Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient refuses screening any point before required screening is complete</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient refuses brief screen</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient completes brief screen that is positive but refuses full screen either before starting or partway through</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient completes brief screen that is negative</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient completes brief screen that is positive and completes full screen, full screen is positive, then check for brief intervention or referral</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, if brief intervention or referral completed</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>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**Exclusions:**
- SBIRT services received in an emergency department or hospital setting do not count towards the numerator
- Patients with an active diagnosis for alcohol or drug dependency, engagement in treatment, dementia or mental degeneration, or who are engaged in alcohol or drug dependence treatment
- limited life expectancy, palliative care or hospice

**Exceptions:**
- 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 a new EHR measure using the denominator criteria for the depression screening and follow-up measure (NQF0418/CMS2). Eligible encounters are identified through the Depression Screening Encounter Codes Grouping Value set. CareOregon must receive data pulled from each clinic’s EHR for this measure; the data is then aggregated across all clinic’s 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 2018; 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 Provider Relations Specialist with any questions about data reporting.
Alcohol and Drug Misuse (SBIRT) FAQ

**Q:** What types of “follow-up” are sufficient?

**A:** Follow-up plans should include one or more of the following:

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

**Q:** What screening tools are approved by the OHA for this measure?

**A:** Approved Evidence-Based Screening Resources/Tool are located here: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx
Check to be sure your screening tool is on this list.

**Q:** How do I submit EHR-based reports to the CCO?

**A:** Reports are generally submitted to the CCO by SFTP or secure email. Reach out to your Provider Relations Specialist 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 approved specifications outlined in the OHA measure technical specifications. Reach out to your Primary Care Innovation Specialist for more information or review the technical specifications on OHAs website: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

**Q:** Does my clinic need to report both rates?

**A:** Yes, both rates must be reported for the data to be accepted. The intent of this measure is not just to screen, but to provide intervention for patients who screen positive.
Ambulatory Care: Emergency Department Utilization (ED Utilization)

Who: All patients enrolled in the CCO

Why: This measure aims to ensure that all patients are effectively engaged in primary care services, and have access to appropriate urgent care services when necessary to reduce costs associated with unnecessary or avoidable emergency department utilization.

What: The total number of all emergency department visits that do not result in an inpatient stay, as a factor of how many patients have been enrolled with the CCO during the year.

How: Some ideas to improve ED Utilization rates:

- Use PreManage to identify when patients visit the ED and follow up with each patient post visit to prevent future avoidable ED use.
- Ensure patients know clinic hours of operation and who to call or where to go when the clinic is closed.

Exclusions: ED visits for mental health and chemical dependency services are not included in the ED visit count. Members with hospice claims within the measurement year are excluded.

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

CPT: 99281-99285, UB Revenue Codes: 0450, 0451, 0452, 0456, 0459, 0981 or

ED Procedure Code Value Set with place of service 23
Ambulatory Care: Emergency Department Utilization (ED Utilization) FAQ

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

A: When an ED 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 or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Q: How can I identify which of my patients had an ED visit?

A: PreManage! If you do not have access, contact your Primary Care Innovation Specialist.

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 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 in the Emergency Department 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. Exclusions for mental health or substance use diagnosis codes are applied at the claim line level; the diagnosis code does not have to be the primary for the visit to be excluded.
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 ages 0 – 17 years placed in DHS custody between November 1, 2018 and October 31, 2019.

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:

<table>
<thead>
<tr>
<th>Age on CCO Notification Date</th>
<th>Physical</th>
<th>Dental</th>
<th>Mental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 12 months old</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>1 to 3 years old</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4 to 17 years old</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

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

Exclusions:
- Children will be excluded from the final measure denominator if there is a breakdown in notification from OHA
- Continuous enrollment is not met
- See OHA technical specifications for a complete list of non-automatic case-by-case basis exclusions

Coding:

<table>
<thead>
<tr>
<th>Physical Health Assessment Codes</th>
<th>Mental Health Assessment Codes</th>
<th>Dental Health Assessment Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 – 99205</td>
<td>90791 – 90792</td>
<td>D0100 – D0199</td>
</tr>
<tr>
<td>99212 – 99215</td>
<td>96101 – 96102</td>
<td></td>
</tr>
<tr>
<td>99381 – 99384</td>
<td>H0031</td>
<td></td>
</tr>
<tr>
<td>99391 – 99394</td>
<td>H1011</td>
<td></td>
</tr>
<tr>
<td>G0438, G0439</td>
<td>H2000 – TG (need modifier)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H0019</td>
<td></td>
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<tr>
<td></td>
<td>H2013</td>
<td></td>
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<tr>
<td></td>
<td>H0037</td>
<td></td>
</tr>
<tr>
<td>Physical Health Diagnosis Codes</td>
<td>Mental Health Diagnosis Codes</td>
<td>Dental Health Diagnosis Codes</td>
</tr>
<tr>
<td>---------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>N/A</td>
<td>F03, F20–F53, F59–F69, F80–F99</td>
<td>N/A</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.

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.
Breast Cancer Screening (BCS)

<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 Data</td>
</tr>
<tr>
<td>Type:</td>
<td>☑ Claims ☐ Chart Documentation ☐ eCQM ☐ Survey ☐ Other</td>
</tr>
<tr>
<td>HEDIS Benchmarks Nat’l Percentile:</td>
<td>76% (75th), 82% (90th)</td>
</tr>
</tbody>
</table>

**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; or members with advanced illness or frailty; or 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 that 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 Metric  ☐ Medicare Star Measure
Quality Measurement Type: ☐ Structure ☐ Process ☐ Outcome ☒ Patient Experience
Data Type: ☐ Claims ☐ Chart Documentation ☐ eCQM ☒ Survey ☐ Other
State Benchmark: Adults = 84.8% and Children = 92.6% (2018 national Medicaid 75th percentile)

**Who:** All members who have been enrolled with the CCO for 6 months or more are eligible to receive a survey.

**Why:** CAHPS surveys ask consumers (patients) to report on and evaluate their experiences with health care; such surveys are a tool that allow for the patient voice to be heard as a critical component of health quality improvement. 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:** Surveys are mailed to a random sample of members (900 adults and 900 children) early in the following year (i.e. surveys to assess 2018 performance are mailed in early 2019). The score for this metric is based on responses to two questions:

1. In the last 6 months, when you (your child) needed care right away for illness, injury, or a condition, how often did you get care as soon as you (your child) needed?
2. In the last 6 months, how often did you (your child) get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you (your child) needed?

The score is based on the percentage of members who answer “usually” or “always” and scores for both the adult and child must meet target to get credit for the measure.

**How:** Some ideas to improve access to care include:
- Save space in schedule template for short-notice appointments
- Ensure that patients know clinic hours of operation and where to go/who to call if they need assistance when the clinic is closed.

**Exclusions:** None

**Coding:** N/A

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 experience or perceived key aspects of care, not how satisfied they were with their care. The survey contains questions relating to 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
Medicare Stars Measures CAHPS

Composite: Consumer Assessment of Health Plan Survey

Medicare Stars Measures – Experience of Care

There are nine Medicare Stars measures which utilize the CAHPS: Annual Flu Vaccine, Care Coordination, Getting Care Quickly, Getting Needed Prescription Drugs, Overall Rating of Health Care Quality, Overall Rating of Plan, Customer Service, and Rating of Drug Plan.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS: Annual Flu Vaccine</td>
<td>Have you had a flu shot since July 1, 2018?</td>
</tr>
<tr>
<td>CAHPS: Care Coordination</td>
<td>- Doctor had medical records and other information about care</td>
</tr>
<tr>
<td></td>
<td>- Got follow-up on test results</td>
</tr>
<tr>
<td></td>
<td>- Got test results quickly</td>
</tr>
<tr>
<td></td>
<td>- Doctor spoke about prescription medicines</td>
</tr>
<tr>
<td></td>
<td>- Got help managing care</td>
</tr>
<tr>
<td></td>
<td>- Doctor is informed and up-to-date about specialist care</td>
</tr>
<tr>
<td>CAHPS: Getting Care Quickly</td>
<td>- Got care as soon as you needed</td>
</tr>
<tr>
<td></td>
<td>- Got an appointment at doctor’s office/clinic as soon as you needed</td>
</tr>
<tr>
<td></td>
<td>- Seen for appointment within 15 minutes of appointment time</td>
</tr>
<tr>
<td>CAHPS: Getting Needed Care</td>
<td>- How often it was easy to get appointments with specialists</td>
</tr>
<tr>
<td></td>
<td>- How often it was easy to get care, tests, or treatment through the health plan</td>
</tr>
<tr>
<td>CAHPS: Getting Needed Prescription Drugs</td>
<td>- Got medicines the doctor prescribed easily</td>
</tr>
<tr>
<td></td>
<td>- Filled prescriptions at a local pharmacy easily</td>
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<tr>
<td></td>
<td>- Filled prescriptions by mail easily</td>
</tr>
<tr>
<td>CAHPS: Customer Service</td>
<td>- Got information or help you needed</td>
</tr>
<tr>
<td></td>
<td>- Were treated with courtesy and respect</td>
</tr>
<tr>
<td></td>
<td>- Forms were easy to fill out</td>
</tr>
<tr>
<td>CAHPS: Overall Rating of Health Care Quality</td>
<td>- Rate your health care in the last 6 months from 0 to 10</td>
</tr>
<tr>
<td>CAHPS: Overall Rating of Plan</td>
<td>- Rate your health plan from 0 to 10</td>
</tr>
<tr>
<td>CAHPS: Rating of Drug Plan</td>
<td>- Rating your prescription drug plan from 0 to 10</td>
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</tbody>
</table>
The CAHPS used for the Medicare Stars measures is run by DSS Research.

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.

The AHRQ CAHPS Improvement Guide is available here:
Care for Older Adults: Functional Status Assessment (COA)

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

Why: A yearly assessment of how well patients are able to perform activities of daily living and/or instrumental activities of daily living provides insight into their ability to care for one’s self, including personal care, mobility, eating, managing finances or medications. This is very important in the aging population because a decline in activities of daily living is often the first sign of a decline in cognition, overall health and/or the ability to continue living independently.

What: The percentage of adults over 66 years with at least one functional status assessment during the measurement year, as documented through either claim or medical record review.

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

Any outpatient visits, including seen by a CMA, nurse, OT/PT, Social Worker, Pharmacist or Provider. The patient, family member, or caregiver can fill out the functional status assessment at the Medicare Wellness visit which is then reviewed by the clinic staff/provider.

Evidence of complete functional status assessment and date the assessment was performed and documented in the medical record or claim with the CPT code listed below.

Complete status assessment tools include: at least five ADLs; or at least four IADLs; or using one of the standardized functional status assessment tools listed in the HEDIS technical specifications.

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: 1170F
Care for Older Adults: Functional Status Assessment (COA) FAQs

Q: Does the functional assessment need to be done in an office visit?

A: No. The assessment can be done telephonically; if the assessment is documented in the medical record. The patient or family member may also fill out the assessment form and send back to the clinic.

Q: How often should a clinic do a functional assessment on a patient?

A: At least once a year and after a significant event for example: a fracture, MI, or CVA.

Q: What is an example of an acceptable non-standard assessment tool?

A: A questionnaire or checklist that incorporates one or more of the standard assessment tools.
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)

<table>
<thead>
<tr>
<th>Performance Measure Set:</th>
<th>☐ CCO Incentive Metric  ☒ Medicare Stars Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measurement Type:</td>
<td>☐ Structure  ☒ Process  ☐ Outcome  ☐ Patient Experience</td>
</tr>
<tr>
<td>Data Type:</td>
<td>☒ Claims  ☒ Chart Documentation  ☐ eCQM  ☐ Survey  ☐ Other</td>
</tr>
<tr>
<td>HEDIS Benchmarks Nat’l Percentile:</td>
<td>89% (75\textsuperscript{th}), 97% (90\textsuperscript{th})</td>
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</tbody>
</table>

**Who:** Adults 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:** 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.
**Childhood Immunization Status (Combo 2)**

**Who:** Children who turn two years of age in 2019

**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 who 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 4 required DTaP vaccines there must be at least four dates of service on which a DTaP was provided). *1 MMR and 1VZV with dates of service on or between the child’s first and second birthdays.

**How:** Some ideas to improve Childhood Immunization 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.).
- 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 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 check the disease histories.

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 is still included in the measure. Please reach out to your Provider Representative for additional resources.
Cigarette Smoking Prevalence

| Performance Measure Set: ☒ CCO Incentive Metric ☐Medicare Star Measure |
|--------------------------|-------------------------|
| Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience |
| Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☒Survey ☐Other |
| Benchmark: 25% Committee consensus |

Who: All members age 13 years and older.

Why: Tobacco dependence is a chronic condition, which is 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: Reduction in tobacco prevalence, specifically cigarette smoking and other tobacco product use. This is a three-rate measure looking at the rate of screening for smoking and/or tobacco use, cigarette smoking rate, and tobacco use rate, however, only cigarette smoking prevalence rate will be used for comparison to the benchmark or improvement target.

How: Three rates are reported for this measure using EHR-based data. OHA prefers reporting for all three rates but will accept cigarette smoking prevalence rate without tobacco use prevalence rate.

Since capturing smoking and tobacco prevalence data from clinic EHRs is difficult due to system variability, only cigarette smoking prevalence is used and determined through three separate rate calculations:

1. Of all patients with a qualifying visit (Rate 1 denominator), 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 & Rate 3)
2. Of all patients with their cigarette smoking or tobacco use status recorded (Rate 2 denominator), how many are cigarette smokers? (This value will be your numerator for Rate 2)
3. Of all patients with their cigarette smoking or tobacco use status recorded (Rate 3 denominator), how many are smokers and/or tobacco users? (This value will be your numerator for Rate 3)
**Exclusions:** This measure is focused on cigarette and tobacco use, therefore members missing smoking or tobacco status are excluded from rate calculations 2 & 3, e-cigarettes, marijuana, or nicotine replacement therapy (NRT) do not qualify as cigarette or tabacco use.

**Data reporting:** Although this measure does not directly align with NQF 0028 (looks for patients age 18 or older), you will need to add visit codes for adolescents. Some EHRs may already have the functionality to report on prevalence based on a custom query from NQF 0028 plus visit codes for adolescents. Please note: clinics must report the three prevalence rates regardless if they are using custom reporting or NQF 0028. Cigarette smoking and/or tobacco use recorded status cannot be older than 24 months. Cigarette smoking and/or tobacco use status is not required at every visit, however, if a patient’s status is recorded at multiple visits in the measurement year or year prior, only the most recent screening will be used to satisfy the measure requirements.

CareOregon must receive data pulled from each clinic’s EHR reporting 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 2019; 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 Provider Relations Specialist with any questions about data reporting.

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.
- For Providers: Follow the 5A’s model for treating tobacco use and dependence.
- For Providers: Refer members using Oregon Tobacco Quit Line Fax Referral Form via fax 1-800-483-3114.
- For Providers: Provide counseling and/or recommend nicotine replacement therapy.
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.

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

A: CareOregon contracts with the same vendor that staffs the State Tobacco Quit Line. The State Tobacco Quit provides free counseling anyone who calls, however, after identification of CareOregon benefits, the individual is transferred to a Quit For Life representative for additional services. The State Quit Line accepts individuals age 13 and older and the age requirement for CareOregon’s Quit For Life contract is 18 and older.

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

A: They will need to come back in so that their status is recorded.
Colorectal Cancer Screening (CRC)

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: 61.1% (2018 national Commercial 50th Percentile)
Medicare HEDIS Benchmark Nat’l Percentile: 72% (75th), 79% (90th)

Who: All members age 51 – 75 years older.

Why: Routine colorectal cancer screening can reduce deaths through the early diagnosis and removal of pre-cancerous polyps. Screening saves lives, but only if people get tested. However, one in three (36%) Oregonians ages 50-75 are not being screened as recommended, and only one in five Latinos were screened (21%) in 2015, the lowest among all racial/ethnic groups in Oregon. (Source: OHA Colorectal Cancer Screening Overview, 2015)

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 2019
- FIT-DNA test in 2017-2019
- Flexible sigmoidoscopy in 2015-2019
- CT Colonography in 2015 - 2019
- Colonoscopy in 2010 – 2019

Please note that 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 age 66 or older who are living long-term in an institutional or enrolled in an I-SNP;
members with colorectal cancer, or 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 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 that is why OHA’s is 61.1% and not 100%. 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 with an essential hypertension diagnosis any time before July 1, 2019 who have had at least one PCP visit in 2019. Medicare note: All members age 18-85 years who had at least two visits on different dates of service during 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 any time before July 1, 2019, 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 2019, their blood pressure is considered out of control and is not numerator compliant. Additional Medicare note: most recent BP reading after second visit date with diagnosis of hypertension.

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 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. Additional Medicare exclusion note:
members age 66 or older who are living long-term in an institutional or enrolled in an I-SNP, patients 81 years of age or older with frailty, and patients 66-80 years of age and older with frailty and advanced illness.

**Medicaid Data reporting:** This measure aligns with NQF 0018/CMS 165v7. CareOregon must receive data pulled from each clinic’s EHR reporting 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 2019; 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 Provider Relations 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 you can use this resource: https://chpl.healthit.gov/#/search, and search for your EHR product, or reach out to your Provider Relations Specialist/Primary Care Innovation Specialist.

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

A: Reports are generally submitted to the CCO by SFTP or secure email. Reach out to your Provider Relations Specialist 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 approved specifications outlined in the OHA measure technical specifications. Reach out to your Primary Care Innovation Specialist if you are concerned about 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 “and will fall into the gap for this measure (i.e. in the measure denominator but not numerator compliant).
Dental Sealants on Permanent Molars for Children

Who: Patients between the age of 6 - 14 years.

Why: Childhood tooth decay causes needless pain and has the potential to lead to infection. Dental sealants are an evidence-based clinical practice and are recommended by federal agencies (Centers for Medicare and Medicaid Services; Centers for Disease Control and Prevention; U.S. Department of Health and Human Services) as well as by professional organizations (American Dental Association; American Academy for Pediatric Dentistry) as an effective preventive method to avoid decay in permanent teeth in children (source: OHA Guidance Document).

What: Percentage of individual members between the ages of 6-14 years who receive a sealant on a permanent molar tooth during the 2019 calendar year. Please note that Sealants can be placed by any dental professional for whom placing a sealant is within his or her scope of practice and counts toward this metric if it is paid for by the CCO in which the child is enrolled.

How: Some ideas to improve initiation and placement of dental sealants include:

- Asking children age 6-14, and their guardians, if they have had a dental visit recently and encourage them to schedule one if not.
- Utilize the CareOregon Dental Portal to request a dental visit for members who have not yet connected with a dental provider. Ask your Provider Relations Specialist for more information on accessing the CareOregon Dental Portal.
- Encourage families to participate in school-based sealant programs if available.

Exclusions: None

Coding: Dental sealants can be captured through dental or medical claims using the following codes:

Dental Claims: D1351 on tooth number 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32

Medical Claims: D1351
Dental Sealants on Permanent Molars for Children FAQ

Q: Do school based sealants count in this metric?

A: Yes! Any sealant placed by a qualified dental provider counts in the metric *if it is paid for by the CCO in which the child is enrolled*. Thus, it is important to relay correct payer information on permission slips for such school-based programs.
Screening for Depression and Follow-Up Plan

| 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. There is no performance benchmark for 2019. CCOs must report data meeting minimum population threshold for this measure to receive 100% of their quality pool payment.

**Who:** All patients age 12 and older

**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:** All patients age 12 years and older should be screened for clinical depression, using an age appropriate standardized tool, on the date of the encounter, and if positive, have a follow-up plan documented on the same day as the positive screening result. **PHQ-9 no longer counts as follow-up to a positive PHQ-2 screening** and additional follow-up options needs to be completed and documented; please see FAQ page below for change.

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

- Standardized, age appropriate, annual screening tools should be used for screening patients at least once per measurement period.
- 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.

**Reporting:** This measure aligns with **NQF 0418/CMS 2v7**. CareOregon must receive data pulled from each clinic’s EHR for this measure; the data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Patient-level detail, for CareOregon members only, is preferred
- Reporting must be for the full calendar year of 2018; 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 Provider Relations Specialist with any questions about data reporting.
Screening for Depression and Follow-up Plan FAQ:

What types of “follow-up” are sufficient?

A: Documented follow-up plans should include one or more of the following:

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

Please note that completing a PHQ-9 as follow-up on the same day as a positive PHQ-2 no longer counts as additional evaluation and does not meet the measure requirements for follow-up.

Q: What screening tools are recommended?

A: Screening tools should be normalized, validated, and age appropriate. 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

Visit OHAs website for more information:
http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx
**Developmental Screening**

<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</td>
</tr>
<tr>
<td>Data Type:</td>
<td>☒ Claims</td>
<td>☐ Chart Documentation</td>
</tr>
<tr>
<td>State Benchmark:</td>
<td>80.0% Metrics and Scoring Committee consensus</td>
<td></td>
</tr>
</tbody>
</table>

**Who:** All patients born between 1-1-2016 and 12-31-2018.

**Why:** Recommendations from “Bright Futures” calls for all children to be screened, using a global developmental screening tool, at three different times in 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 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?


**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. Note: parent/guardian signature is required.

http://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Pages/default.aspx
**Diabetes Care: Eye Exam**

**Who:** All patients age 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 age 66 or older who are living long-term in an institutional or enrolled in an I-SNP, and patients 66 years of age and older with frailty and advanced illness.

**Coding:** HCPC/CPT: 67028, 67030-67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112-67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227-67228, 92002, 92004, 92012, 92014, 92018-92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 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 FAQ

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: HbA1c poor 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

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

Medicaid State Benchmark: 21.7% (2018 CCO 90th Percentile)

HEDIS Benchmarks Nat’l Percentile: 78% (75th), 87% (90th)

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

**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. HbA1c testing helps clinicians identify a need for further intervention.

**What:** Percentage of patients with a diabetes diagnosis, whose most recent HbA1c level is above 9.0%.

**Note:** If a patient does not have a HbA1c during the measurement period, their HbA1c is in poor control.

**How:** Educating patients through motivational interviewing, healthy lifestyle, diabetes educators, registered dietitians, medication management therapy, working with an endocrinologist, or using the diabetes care pathway.

**Exclusions:** Patients in hospice or using hospice services are excluded.

**Additional Medicare Exclusion note:** Patients who did not have a diagnosis of diabetes and 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 age 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.
Medicaid Data reporting: This measure aligns with NQF 0059 122v7. CareOregon must receive data pulled from each clinic’s EHR reporting for this measure; the data is then aggregated across all clinic’s 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 2019; 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 Provider Relations Specialist with any questions about data reporting.

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

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

A: The Medicare Star measure is looking at patients with diabetes who had A1c test during the year and that their blood sugar is under control, therefore a higher number indicates more patients are in control. Although the Star measure is looking at “blood sugar controlled,” the measure data source is HEDIS HbA1c poor control >9% and reports to the public the reverse of poor control. CareOregon dashboards, performance reporting, and targets reflect A1c controlled, the reverse score/target of poor control. 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.

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.
### Diabetes Care: Nephropathy Monitoring

<table>
<thead>
<tr>
<th>Performance Measure Set:</th>
<th>☐ CCO Incentive Metric</th>
<th>☑ Medicare Star Measure</th>
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</tr>
<tr>
<td>Data Type:</td>
<td>☑ Claims</td>
<td>☑ Chart Documentation</td>
</tr>
<tr>
<td>HEDIS Benchmarks Nat’l Percentile:</td>
<td>95% (75th), 97% (90th)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

A: If your office uses OCHIN, check with your site specialist for reports or member lists. If your office uses another EHR system check with your data specialists.
Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SMPI)

Who: All patients 18 years or older enrolled in the CCO who have had at least two mental illness principle diagnoses in the last 36 months are included in this measure. 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: The total number of all emergency department visits that do not result in an inpatient stay, as a factor of how many months patients (age 18 or older at end of measurement year) have been enrolled with the CCO during the year. ED visits for mental health and chemical dependency services are not included in the ED visit count.

How: Some ideas to improve ED Utilization rates:

- Use PreManage to identify when patients visit the ED and 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: Mental health and chemical dependency services are excluded. Members with hospice claims in the measurement year are excluded.

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 ED Procedure Code Value Set with place of service 23
Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness (ED/SMPI) FAQ

Q: What are the specific mental illness codes that identify patients for inclusion in the metric?

A: Patients with at least 2 of any of the following as a principle diagnosis since January 2016 are included in this metric.


Since this is a 36-month rolling look back measure, ICD-9 diagnosis codes in the Members Experiencing Mental Illness Value Set table in the OHA 2019 specifications also apply.

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

A: When an ED 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 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. Exclusions for mental health or substance use diagnosis codes are applied at the claim line level; the diagnosis code does not have to be the primary for the visit to be excluded.
Effective Contraceptive Use

Who: All female patients age 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 percent of pregnancies in Oregon are unintended, and have been for more than three decades. Among women with an unintended pregnancy, 43 percent 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 into 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 into 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.
Surveillance Codes for Effective Contraceptive Use

The Effective Contraceptive Use measure looks at women age 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>N99.3, Z90.710, Z90.711</td>
</tr>
<tr>
<td>Other reproductive system removal</td>
</tr>
<tr>
<td>Z90.722</td>
</tr>
<tr>
<td>Natural Menopause</td>
</tr>
<tr>
<td>N92.4, N95.0, N95.1, N95.2, N95.8, N95.9,</td>
</tr>
<tr>
<td>Z78.0</td>
</tr>
<tr>
<td>Premature Menopause due to survey,</td>
</tr>
<tr>
<td>radiation or other factors</td>
</tr>
<tr>
<td>E28.310, E28.319, E28.39, E28.8, E28.9,</td>
</tr>
<tr>
<td>E89.40, E28.9, E89.40, E89.41, N98.1</td>
</tr>
<tr>
<td>Congenital Anomalies of female genital</td>
</tr>
<tr>
<td>organs</td>
</tr>
<tr>
<td>Q50.02, Q51.0</td>
</tr>
<tr>
<td>Female Infertility</td>
</tr>
<tr>
<td>N97.0, N97.1, N97.2, N97.8, N97.9</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 using the below numerator code table.

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>Female Sterilization</td>
</tr>
<tr>
<td>Z30.2, Z98.51</td>
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<tr>
<td>Intrauterine Device (IUD)</td>
</tr>
<tr>
<td>Z30.014, Z30.430, Z30.431, Z30.433, Z97.5</td>
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<tr>
<td>Hormonal Implant</td>
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<tr>
<td>Z30.016, Z30.017</td>
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<tr>
<td>Injectable</td>
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<tr>
<td>Z30.013</td>
</tr>
<tr>
<td>Oral Contraceptive Pills</td>
</tr>
<tr>
<td>Z30.011</td>
</tr>
<tr>
<td>Patch</td>
</tr>
<tr>
<td>Z79.3</td>
</tr>
<tr>
<td>Vaginal Ring</td>
</tr>
<tr>
<td>Z30.015</td>
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<tr>
<td>Surveillance of a contraceptive method</td>
</tr>
<tr>
<td>Z30.41, Z30.42, Z30.44, Z30.45, Z30.46,</td>
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<tr>
<td>Z30.49</td>
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<tr>
<td>Unspecified Contraception</td>
</tr>
<tr>
<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 pregnancies (and avoiding mistimed) 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 Visit 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](link)

   Telephone and Telemedicine visits are aimed to increase access & 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](table)

   Click the link above for telephone visit toolkit or reach out to Primary Care Innovations Specialist (PCIS), Paula Smith (smithp@careoregon.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 7 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](link) 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...
### Common ECU Surveillance Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Z30.431</td>
<td>Intrauterine Device (IUD/IUS)</td>
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<tr>
<td>Z30.42</td>
<td>Injectable (Depo)</td>
</tr>
<tr>
<td>Z30.46</td>
<td>Hormonal Implant (Nexplanon/Implanon)</td>
</tr>
<tr>
<td>Z30.41</td>
<td>Oral Contraceptive</td>
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<tr>
<td>Z30.45</td>
<td>Hormonal Patch</td>
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<tr>
<td>Z30.44</td>
<td>Hormonal Ring</td>
</tr>
<tr>
<td>Z30.49</td>
<td>Cervical Cap/Diaphragm</td>
</tr>
<tr>
<td>Z90.710</td>
<td>Hysterectomy</td>
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<td>Z30.2</td>
<td>Sterilization</td>
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<tr>
<td>Z98.51</td>
<td>Tubal Ligation</td>
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<tr>
<td>N95.9</td>
<td>Menopause/Post-menopause (40+)</td>
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<td>E28.319</td>
<td>Premature Menopause (&lt;40)</td>
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<tr>
<td>N97.9</td>
<td>Female Infertility</td>
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<td>Z34.90</td>
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Medicare Health Outcomes Survey (HOS) – Monitoring Physical Activity

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

Who: Adults age 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 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?
Medicare Health Outcomes Survey (HOS) – Improving Bladder Control

Who: Adults age 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. 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 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 experience leaking of urine?
2) Have you discussed treatment options with a doctor or other health care provider?

1(NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/management-of-urinary-incontinence-in-older-adults/)
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: 28.0% (2017 CCO 75th Percentile)

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

Who: All patients age 18 years of age or older with a diagnosis of type 1 or type 2 diabetes during the measurement period, or the 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 available¹.

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

How:
- Assess whether diabetic patients are regularly engaged with a dental provider
- Refer patients to dental through CareOregon’s provider portal or other 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.

Coding:
CDT codes: D0120, D0150, or D0180.

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 Nat’l Percentile: 57% (75th), 78% (90th)

Who:  Female patients age 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 lookback 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 institutional setting or enrolled in an I-SNP are excluded. Patients 66-80 years of age and older diagnosed with frailty and advanced illness or patients 81 years of age and older with diagnosed with frailty are excluded.

Coding:

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

Q: Do I need to include women that 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.
Patient Centered Primary Care Home (PCPCH) Enrollment

**Performance Measure Set:** ☒ CCO Incentive  □ Medicare Star Rating  

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

**Data Type:**  □ Claims  □ Chart Documentation  □ eCQM  □ Survey  ☒ Other: PCPCH Membership  

**State Benchmark:** N/A – sliding scale with 68.0% threshold

**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:

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

**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.

To become a Patient Centered Primary Care Home recognized clinic look for core attributes for recognition information at [http://www.oregon.gov/oha/hpa/csi-pcpch/pages/index.aspx](http://www.oregon.gov/oha/hpa/csi-pcpch/pages/index.aspx). You can also reach out to your Primary Care Innovation Specialist for assistance.

**Exclusions:** N/A.

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

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 and April 30, 2020. That is, OHA will include updated information about practices that have applied for 5 STAR designation by December 31, 2019 and receive 5 STAR designation by April 30, 2020 in the measure calculation to ensure CCOs receive credit for members assigned to this clinic.

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.
**Timeliness of Prenatal and Postpartum Care**

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State Benchmark: 69.3%; 2018 national Medicaid 75th percentile

**Who:** Women who had a live delivery between November 6, 2018 and November 5, 2019.

**Measure Change Note:** Although CCOs must submit data for both prenatal and postpartum care, the 2019 CCO incentive measure and quality pool payments are tied to the Postpartum Care rate.

**Why:** The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that a woman with an uncomplicated pregnancy be examined at least once in the first trimester for prenatal care and approximately 4-6 weeks after delivery for postpartum care.\(^1\)

**What:** A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

**How:** A postpartum visit with an OB/GYN practitioner or midwife, family practitioner or other PCP can satisfy this measure. There are 3 ways to meet the requirements:

1. Pelvic exam, or
2. Evaluation of weight, blood pressure, breasts and abdomen, or
3. Notation of postpartum care, including, but not limited to the following:
   - Notation of “postpartum care,” “PP care,” “PP check,” or “6-week check”
   - A preprinted “Postpartum Care” form in which information was documented during the visit

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

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Timeliness of Prenatal Care and Postpartum Care FAQ

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

A: Yes, you can still play a role in encouraging 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 prenatal 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 both a prenatal care or postpartum care visit?

A: No. Although a Pap test alone does not count as a prenatal care visit for the Timeliness of Prenatal Care rate, it will however, count for the Postpartum Care measure.
Weight Assessment and Counseling for Children and Adolescents

| 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: 32.7% (MIPS 2018 benchmark – 70th Percentile) |

**Who:** All patients age 3 - 17 years who have had at least one PCP or OB/GYN visit in 2019.

**Why:** The prevalence of obesity among children has been rapidly increasing over the past two decades, and the number of overweight children at risk of becoming obese is also of great concern. The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. Therefore, children’s weight status is an important thing to monitor and children need guidance on maintaining healthy eating and exercising habits. Oregon’s Health Plan Quality Metrics Committee has visions for this measure as the first step towards an outcome-based approach to reducing childhood obesity.

**What:** Using EHR-based data, this measure reflects the average of three percentages:

- Patients who had their height, weight, and BMI percentile recorded during the year
- Patients who had counseling for nutrition during the year
- Patients who had counseling for physical activity during the year

**How:** An annual wellness visit performed by a PCP or OB/GYN where a patient’s height, weight and BMI percentile is recorded and counseling for nutrition and physical activity is provided during the measurement period.

Some steps to improve your Weight Assessment and Counseling rates are:

- Ensure all patients age 3 to 17 are scheduled for an annual wellness visits
- Identify and implement workflows to ensure BMI is recorded for all children and that any necessary counseling is documented properly

**Exclusions:** Patients who are pregnant or in hospice are excluded.
Data reporting: This measure aligns with **NQF 0024/CMS 155v7**. CareOregon must receive data pulled from each clinic’s EHR reporting for this measure; the data is then aggregated across all clinic’s 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 2019; 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 Provider Relations Specialist with any questions about data reporting.
Weight Assessment and Counseling FAQ

Q: How is performance calculated when there are three rates?

A: The three rates are reported using the same denominator with each numerator calculated independently. Performance will be calculated as a simple average of the three rates.

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 you can use this resource: https://ecqi.healthit.gov or reach out to your Provider Relations Specialists/Primary Care Innovation Specialist.

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

A: Reports are generally submitted to the CCO by SFTP or secure email. Reach out to your Provider Relations Specialist 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 approved specifications outlined in the OHA measure technical specifications. Reach out to your Primary Care Innovation Specialist for more information or review the technical specifications on OHAs website: http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Q: Does my clinic need to report all three rates?

A: Yes, each of the three rates is reported. The intent of this measure is to provide counseling to all patients; therefore, nutrition and physical activity counseling are reported even for patients with a BMI within optimal ranges. The three rates are reported using the same denominator with each numerator calculated independently. Performance will be calculated as a simple average of the three rates.
**Statin Use in Persons with Diabetes (SUPD)**

<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 Data</td>
</tr>
<tr>
<td>Type:</td>
<td>☒ Claims ☐ Chart Documentation ☐ eCQM ☐ Survey ☐ Other</td>
</tr>
<tr>
<td>HEDIS Benchmarks Nat’l Percentile:</td>
<td>80% (75th), 83% (90th)</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.
Medication Adherence for Cholesterol (Statins)

Who: patients 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. Working together, member, doctor, and health plan is important in managing a patient’s high cholesterol.

What: Percent of members with at least two prescription fills on unique dates of service for statin cholesterol 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 statin cholesterol medication(s) during the measurement period.

Exclusions: None.

Statin Medications:
Any Statin medication claim.
Medication Adherence for Hypertension (RAS antagonists)

Performance Measure Set: ☒ CCO Incentive Metric ☑Medicare Star Measure Quality
Measurement Type: ☑Structure ☑Process ☒Outcome ☐Patient Experience Data
Type: ☒Claims ☐Chart Documentation ☐eCQM ☐Survey ☐Other
HEDIS Benchmarks Nat’l Percentile: 86% (75th), 88% (90th)

Who patients 18 years and older

Why: One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. Working together, member, doctor, and health plan is important in managing a 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 with a diagnosis of ESRD or coverage dates, or that received one or more prescriptions for sacubitril/valsartan anytime during the measurement year are excluded.

Blood Pressure Medications:
Renin angiotensin system (RAS) antagonists: Angiotensin converting enzyme inhibitor (ACEI), Angiotensin receptor blocker (ARB), or Direct renin inhibitor medications.
Medication Adherence for Diabetes Medications

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

Who: patients 18 years and older

Why: Taking medication as directed is one of the most important ways people with diabetes can manage their health. Working together, member, doctor, and health plan is important in managing the right diabetes medication.

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.

Diabetes Medications:
Biguanides, Sulfonylureas, Thiazolidinediones, and DiPeptidyl Peptidase (DPP)-IV Inhibitors, Incretin mimetics, Meglitinides, and Sodium glucose cotransporter 2 (SGLT2) inhibitors
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 Nat’l Percentile: 81% (75th), 85% (90th)

Who: Female patients between 40-75 years of age and Males 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 ASCVD.

What: Percent of Female members between 40-75 year of age and Males 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: Percent of patients who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement period.

Exclusions: Patients who have had a claim submitted for In vitro fertilization. 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>
<thead>
<tr>
<th>High-intensity statin therapy</th>
<th>Atorvastatin 40-80 mg</th>
<th>Amlodipine-atorvastatin 40-80 mg</th>
<th>Ezetimibe-atorvastatin 40-80 mg</th>
<th>Rosuvastatin 20-40 mg</th>
<th>Simvastatin 80 mg</th>
<th>Ezetimibe-simvastatin 80 mg</th>
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</thead>
<tbody>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>Atorvastatin 10-20 mg</td>
<td>Amlodipine-atorvastatin 10-20 mg</td>
<td>Ezetimibe-atorvastatin 10-20 mg</td>
<td>Rosuvastatin 5-10 mg</td>
<td>Simvastatin 20-40 mg</td>
<td>Ezetimibe-simvastatin 20-40 mg</td>
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