Cigarette Smoking Prevalence

Measure Basic Information

Name and date of specifications used: OHA developed these specifications based on certification criteria for electronic health records; these specifications also borrow value sets from the tobacco use screening and cessation intervention metric (CMS138v12).

URL of Specifications:

- Meaningful Use standards for recording smoking status: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf
- Tobacco use screening and cessation intervention specifications (for those using components of that measure): https://ecqi.healthit.gov/ecqm/ec/2024/cms0138v12

  Note: Although the cessation benefit survey is no longer a component of this measure, the Tobacco Cessation Coverage Standards are an important resource for understanding how to support tobacco users with cessation interventions. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/tob_cessation_coverage_standards.pdf

Measure Type:

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

Measure Utility:

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

☐ Other. Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2024 – December 31, 2024

Benchmark: Lower is better for this measure.

	2022	2023	2024
Benchmark for OHA measurement year	25.0%	22.9%	17.8%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 1 percentage point floor
Source	Committee Consensus	MY2021 CCO median	MY2022 CCO 75th percentile

For standard, national measures, the Metrics & Scoring Committee has used CCO percentiles and national-level data/percentiles from the National Committee for Quality Assurance (NCQA). For all types of measures, Metrics and Scoring has also used CCO statewide data/percentiles. For ease of reference, the measurement year (MY) is noted for national-level and CCO statewide data/percentiles rather than the publication year. NCQA publishes annual data with national Medicaid, Commercial, and Medicare percentiles.

Note on telehealth: This measure is telehealth eligible. The qualifying visits for the rate 1 (screening) denominator may be derived from the tobacco screening and cessation intervention measure (CMS138),

which according to CMS 2024 telehealth guidance is telehealth eligible. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in Specifications from 2023 to 2024

- Value set Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089): Added 4 CPT codes (98980, 98981, 99444, 99457) based on review by technical experts, SMEs, and/or public feedback. Added 3 HCPCS codes (G2250, G2251, G2252) based on review by technical experts, SMEs, and/or public feedback.
- Added new direct reference codes and value sets for exclusions for patients who are in hospice or palliative care for any part of the measurement period. These are listed in the table of value set changes below and in the exclusions section.
- Direct code reference CPT code (99429) value set name changed to Unlisted Preventative Medicine Services.

The following changes have been made in value sets for encounter types:

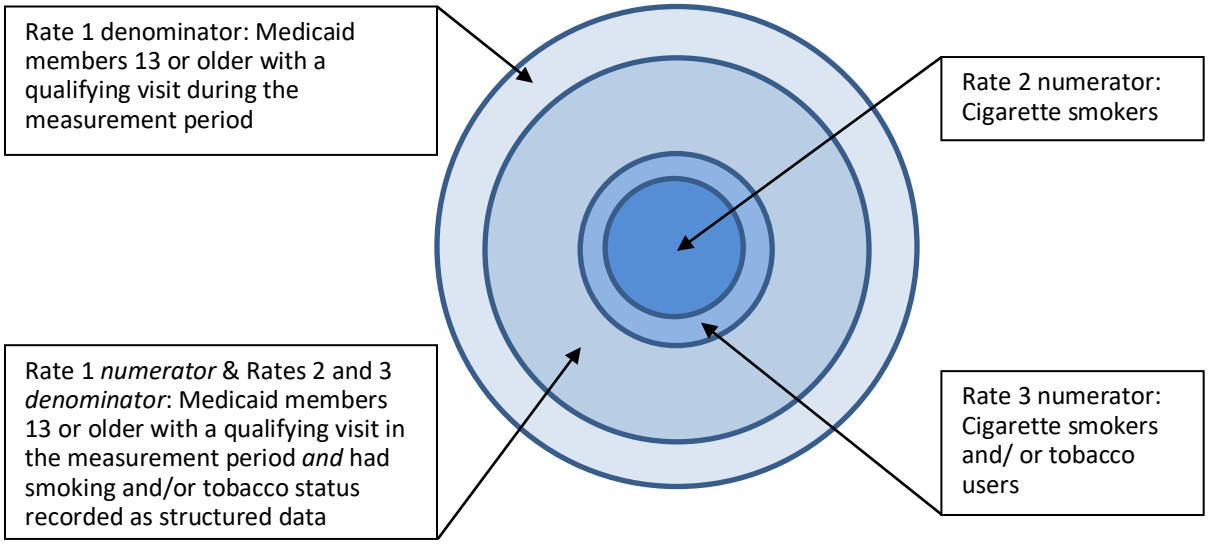
Value Set Name and OID	Status
Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)	Added 4 CPT codes (98980, 98981, 99444, 99457) based on review by technical experts, SMEs, and/or public feedback. Added 3 HCPCS codes (G2250, G2251, G2252) based on review by technical experts, SMEs, and/or public feedback.
Direct reference code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")	Added as part of hospice exclusion
Direct reference code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")	Added as part of hospice exclusion
Value set "Hospice Encounter" (2.16.840.1.113883.3.464.1003.1003)	Added as part of hospice exclusion
Value set "Hospice care [Minimum Data Set]" ("LOINC Code (45755-6)"), where HospiceAssessment.result ~ "Yes (qualifier value)" ("SNOMEDCT Code 373066001)")	Added as part of hospice exclusion
Value set "Hospice Care Ambulatory" (2.16.840.1.113883.3.526.3.1584)	Added as part of hospice exclusion
Value set "Hospice Diagnosis" (2.16.840.1.113883.3.464.1003.1165)	Added as part of hospice exclusion

Measure Details

Measure Components and Scoring

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

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



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

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

Rate 1:

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

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

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

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

> **Note**: Cigarette smoking and/or tobacco use status must be recorded during the measurement year or the year before. It does not need to be recorded on the date of the qualifying visit, but the recorded status cannot be older than 24 months. *For the 2024 measurement year, this means any status recorded prior to January 1, 2023, should not be included.*
>
> **Note:** OHA is aware that starting in 2021, the measure steward for CMS138 reduced the timeframe for screening from 24 months to 12 months. OHA has **not** changed the specifications for cigarette smoking prevalence. This smoking prevalence measure retains the same 24-month timeframe as in previous years.
>
> **Note**: If smoking or tobacco use status has been recorded multiple times from several providers *within the same practice*, use the most recent status on record from that practice, even if the individual saw multiple providers. If reporting at the practice level, then the individual will be in the denominator and the numerator once.

If smoking or tobacco use status has been recorded multiple times *across multiple practices*, reporting depends on the ability to de-duplicate individuals across multiple practices in the data submission. Because of feasibility concerns, OHA does not require de-duplication across all practices at this time. If reporting this measure at the practice level, the individual will be in the denominator and numerator once per practice, but may be in multiple practices' data.

Rate 2:

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

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

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

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

Numerator Exclusions: See below.

Rate 3:

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

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

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

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

Numerator Exclusions: See below.

Required exclusions for numerator – Rates 2 and 3:

- Members with missing smoking or tobacco use status are excluded from Rates 2 and 3. OHA will monitor Rate 1 (screening) to determine whether this exclusion is potentially incentivizing providers to not record smoking status. For additional information on this exclusion, please see the January 28, 2016, slides and notes from the Metrics Technical Advisory Group (TAG) meeting at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Technical-Advisory-Group-Archives.aspx
- This measure does not assess use of e-cigarettes and marijuana (medical or recreational). Use of those products should be excluded. This measure is focused on cigarettes and other tobacco products. Additional clarification may be needed with providers or modifications made to EHRs to ensure that providers and systems are asking about and documenting cigarette smoking and/or tobacco use separately from e-cigarette and marijuana use.
- Likewise, patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).
- **Note**: This metric does not require recording smoking or tobacco status at every visit. Nonetheless, sometimes a patient's smoking or tobacco use status may be recorded at multiple visits. In that case, only the most recent screening, which has a documented status of smoking or tobacco use or non-use, will be used to satisfy the measure requirements. This table illustrates some examples, where Visit 1 and Visit 2 occur in the measurement year or year prior:

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

			smoking as a subset of broader tobacco use)
Current every day smoker	Former smoker	*Not* counted in Rate 2 numerator (because most recent status indicates patient doesn't smoke)	*Not* counted in Rate 3 numerator

Denominator Exclusions and Exceptions – Rate 1, 2, and 3

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Hospice care	Discharge to home for hospice care (procedure)	SNOMEDCT Code 428361000124107
Hospice care	Discharge to healthcare facility for hospice care (procedure)	SNOMEDCT Code 428371000124100
Hospice care	Hospice Encounter	2.16.840.1.113883.3.464.1003.1003
Hospice care	Hospice care [Minimum Data Set]	LOINC Code 45755-6, where HospiceAssessment.result ~ "Yes (qualifier value) SNOMEDCT Code 373066001
Hospice care	Hospice Care Ambulatory	2.16.840.1.113883.3.526.3.1584
Hospice care	Hospice Diagnosis	2.16.840.1.113883.3.464.1003.1165

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the "eligible as of the last date of the reporting period" rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: N/A

Define Anchor Date (if applicable): N/A

Appendix 1: Qualifying Visits (Rate 1 denominator)

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

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

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

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

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

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

(2) Code sets included in NQF0028e/ CMS138, *plus visit codes for adolescents*:

The denominator criteria for CMS138 may be used to identify visit types. Because that measure looks for patients age 18 or older, however, additional work is needed to pick up the denominator population age 13-17. Any one of these visits counts a qualifying visit.

Denominator criteria for Tobacco Use: Screening and Cessation Intervention (CMS138v12) contain these value sets for qualifying visits.

Value Set Name	Value Set OID
Annual Wellness Visit	2.16.840.1.113883.3.526.3.1240
Preventive Care Services Established Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.12.1025
Preventive Care Services Group Counseling	2.16.840.1.113883.3.464.1003.101.12.1027
Unlisted Preventive Medicine Service	CPT code (99429)
Preventive Care Services Individual Counseling	2.16.840.1.113883.3.464.1003.101.12.1026
Preventive Care Services Initial Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.12.1023
Health behavior intervention, individual, face-to-face; initial 30 minutes (Direct Reference Code)	CPT Code (96158)
Health behavior assessment, or re-assessment (Direct Reference Code)	CPT Code (96156)
Home Healthcare Services	2.16.840.1.113883.3.464.1003.101.12.1016
Nutrition Services	2.16.840.1.113883.3.464.1003.1006
Occupational Therapy Evaluation	2.16.840.1.113883.3.526.3.1011
Office Visit	2.16.840.1.113883.3.464.1003.101.12.1001
Ophthalmological Services	2.16.840.1.113883.3.526.3.1285
Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure	CPT Code (99024)
Physical Therapy Evaluation	2.16.840.1.113883.3.526.3.1022
Psych Visit - Diagnostic Evaluation	2.16.840.1.113883.3.526.3.1492
Psych Visit Psychotherapy	2.16.840.1.113883.3.526.3.1496
Psychoanalysis	2.16.840.1.113883.3.526.3.1141
Speech and Hearing Evaluation	2.16.840.1.113883.3.526.3.1530
Telephone Visits	2.16.840.1.113883.3.464.1003.101.12.1080
Online Assessments	2.16.840.1.113883.3.464.1003.101.12.1089

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

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

Appendix 2: Smoking Status and Tobacco Use Status

For practices using the SNOMED CT codes called out in the EHR certification standards, this table shows how the codes crosswalk to the OHA numerator specifications for individuals who smoke cigarettes.

Status	**SNOMED**	**Smoking status recorded** (Rate 1)	**Smoking prevalence** (Rate 2)	**Tobacco prevalence** (Rate 3)
Current every day smoker	449868002	Y	Y	Y
Current some day smoker	428041000124106	Y	Y	Y
Former smoker	8517006	Y		
Never smoker	266919005	Y		
Smoker, current status unknown	77176002	Y	Y	Y
Unknown if ever smoked[1]	266927001	N		
Heavy tobacco smoker	428071000124103	Y	Y	Y
Light tobacco smoker	428061000124105	Y	Y	Y

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

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

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

For more information:

- Value set content can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine: https://vsac.nlm.nih.gov/
    - For more information about value sets and the code systems used, a guide can be found in the CMS Measure Management Blueprint: https://www.cms.gov/files/document/blueprint-codes-code-systems-value-sets.pdf
- Additional information on OHA reporting requirements will be available in the Year Twelve (2024) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx