# CCO Incentive Metrics: Requirements for Reporting on EHR-Based Measures in 2024

*GUIDANCE DOCUMENTATION*

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# Section 1: Executive Summary

This document provides guidance to coordinated care organizations (CCOs) reporting clinical quality measures in Year Twelve (2024) reporting. These measures are:

- Diabetes HbA1c Poor Control (CMS 122/CMIT 148)
- Screening for Depression and Follow-up Plan (CMS 2/CMIT 672)
- Cigarette Smoking Prevalence (state-specific measure)
- SBIRT (Screening, Brief Intervention, and Referral to Treatment) for SUD (state-specific measure).
- Controlling High Blood Pressure (CMS 165/CMIT 167) – no longer incentivized, but still reported ongoing

## 1.1 Background

Clinical quality measures are valued because using clinical data can provide more timely information on outcomes. For example, claims data may demonstrate that a patient with diabetes had an HbA1c test performed, but clinical data can demonstrate the resulting value of the test and whether the patient's diabetes is controlled. OHA expects CCOs to take action to move their networked providers toward adopting and using certified health information technology, which supports the collection and reporting of data for clinical quality metrics.

## 1.2 Changes in Year Twelve (2024)

No EHR-sourced measures were added to or dropped from the measure set for measurement year 2024. The population thresholds for reporting remain the same as 2023.

# Section 2: Reporting Process

For 2024, OHA has combined the Data Proposal and Data Submission template to reduce administrative burden into the CCO EHR-Based Reporting Template. The template will be posted to each CCO's SharePoint site. The process will still require two components: (1) the Data Proposal and (2) the Data Submission. The spreadsheet will contain the following tabs:

1. Instructions – column definitions for the Data Reporting Template
2. Data Reporting Template – combines the previous Data Proposal's Orgs & Practices tab with the Data Submission template
3. Data Proposal Questions – previously the Data Proposal's Additional Info tab
4. Data Submission Questions – new addition
5. Threshold Calculation by Measure – calculates whether thresholds have been met for each measure
6. Measure Calculations – displays results for each measure

Data will continue to be required at an aggregated level in 2024.

## 2.1 Data Proposal Process

The data proposal process is the first step in reporting and a required component. The data proposal provides an overview of the planned metric submissions and how reporting requirements (e.g., minimum population threshold) will be met. OHA will require CCOs to complete the CCO EHR-Based Reporting Template. Starting in the current reporting year 2024,

OHA combined the data proposal template and data submission template into one Excel spreadsheet for ease of use.

In the new template, CCOs will have to fill out the same information collected with past data proposals in the Data Proposal Questions and the Data Reporting Template tabs. Details about report types and other reporting parameters can be found in Section 4. The Data Reporting Template will also contain numerator, denominator, denominator exclusion, and denominator exception columns to be completed during the data submission process.

OHA has integrated real-time feedback for CCOs into the CCO EHR-Based Reporting Template. The Threshold Calculations by Measures tab shows if reporting thresholds have been met for each measure.

The data proposal portion is due **no later than 5:00 p.m. Pacific Time on January 31, 2025** to your CCO's individual CCO Metrics SharePoint site**. Please notify OHA by email at** metrics.questions@odhsoha.oregon.gov when the CCO EHR-Based Reporting Template's data proposal sections are complete so that OHA may begin their review.

After the CCO submits its data proposal sections, OHA will review and notify the CCO of the results no later than February 21, 2025. The review criteria will include the following:

- Was the Data Proposal complete and received by the deadline? If not, is an appropriate rationale provided?
- Are member counts provided current as of December 2024?
- Based on the counts provided, will the required population threshold be met for all measures? If not, has a hardship request been submitted?
- Will all practices submit data for the entire calendar year? If not, is an appropriate exclusion rationale provided?
- Are all practices from the previous year's submission included? If not, is an appropriate exclusion rationale provided? If the practice is still seeing CCO members, has a hardship request been submitted?
- Have any practices or organizations excluded a measure that was reported last year? If so, has a hardship request been submitted?
- Are any non-primary care providers, such as dental or behavioral health practices, included? If so, was that approach discussed with OHA in advance and an appropriate reason provided?
- Are all primary care providers at each organization/practice included? If not, is an appropriate exclusion rationale provided?
- For organizations/ practices using custom query, is custom query being used for the purpose of limiting payer type to CCO Medicaid only? If not, is an appropriate reason provided?
- Are all practices from the previous year's submission who reported CCO Medicaid Only still reporting CCO Medicaid Only for those metrics? If not, has a hardship request been submitted?

The above questions must be answered by CCOs on the Data Proposal Questions tab before CCOs submit the data proposal.

If OHA requests additional information or corrections, the CCO will have 10 business days to respond or revise the CCO EHR-Based Reporting Template fields. OHA will then review the

information and notify the CCO of the results within 10 business days. As necessary, the review process will be iterative as OHA and the CCO work collaboratively to identify and address issues in the required data proposal fields. Although not anticipated, the review process may extend until the deadline for the data submission: 5:00 p.m. Pacific on March 31, 2025. OHA approval of the data proposal fields is required prior to the data submission.

## 2.2 Data Submission Process

The data submission process will be reported in the same excel spreadsheet, the CCO EHR-Based Reporting Template, as the data proposal. In the Data Reporting Template tab, CCOs should add values to the numerator, denominator, denominator exclusion, and denominator exclusion columns for all reported measures. The Data Submission Questions should also be completed. Fields submitted during the data proposal process should **not** change during the data submission process.

The data submission fields are due to OHA **no later than 5:00 p.m. Pacific Time on March 31, 2025** to your CCO's individual CCO Metrics SharePoint site. Please send an email to metrics.questions@odhsoha.oregon.gov when the data submission fields are complete so OHA can review the submission.

Once the data submission is received, OHA will begin initial review and notify the CCO of the results no later than April 14, 2025. If additional information is requested during the initial review, the CCO will have 10 business days to respond or revise the data submission.

Once the initial review is complete, OHA will begin the secondary review to evaluate the content of the data submission. The CCO will be notified of the results within 20 business days of the date the secondary review was initiated. If additional information is requested, the CCO will have 10 business days to respond and/or resubmit the Data Submission as needed.

As necessary, both the initial and secondary review processes will be iterative, as OHA and the CCO work collaboratively to identify and address issues identified in the data submission. Although not anticipated, the review process may extend until the deadline for approval of the data submission, which is **5:00 p.m. Pacific Time on May 21, 2025**.

OHA expects the review criteria to be similar to those noted in Table 1. Please also see the *Appendix B EHR Data Validation Supplement* for more detailed information on how data submissions are assessed for quality.

*Table 1: Expected Data Submission Review Criteria*

| Initial Review | Secondary Review |
|---|---|
| • Was submission received by the deadline?<br>• Was the data submitted using the required process?<br>• Was data received in the appropriate format?<br>• Have any of the data proposal fields changed in the data submission period?<br>• Is the data submission missing data for any required fields for any practice or organization? | • Are requirements for data parameters met?<br>• Are data elements understood for each measure?<br>• If custom queries were used, are they aligned with the CMS specifications?<br>• Are data submission validation flags present? Issues identified include but are not limited to:<br>  ○ Zero denominators<br>  ○ Low denominators<br>  ○ Exclusions higher than expected<br>  ○ Zero numerator<br>  ○ Incorrect rate calculation (greater than 100%)<br>  ○ Denominator greater than count of CCO members at organization/ practice<br>  ○ Mismatches between reported denominators (before exclusions and exceptions) for depression screening and follow-up and SBIRT Rate 1<br>  ○ Incorrect numeric reporting given data parameters |

OHA will email notifications, with a copy to the CCO's Innovator Agent, to the individuals on the data submission distribution list at the conclusion of the initial and the secondary review. CCOs also may submit questions to metrics.questions@odhsoha.oregon.gov. Innovator Agents should be copied on communications regarding the data proposal and data submission.

## Section 3: Measure Specifications

OHA aligns with the 2024 Centers for Medicare & Medicaid Services (CMS) eCQM specifications, which also are used in CMS programs such as the Merit-based Incentive Payment System (MIPS). The CMS eCQM specifications have a corresponding CMS ID, as noted in Table 2.

*Table 2: Measure IDs*

| Measure Name | CMS ID |
|---|---|
| Controlling High Blood Pressure | CMS165v12 |
| Diabetes HbA1c Poor Control | CMS122v12 |
| Depression Screening and Follow-up Plan | CMS2v13 |

Reporting must be aligned to the CMS eCQM specifications. Similar-sounding National Quality Forum (NQF) measure names may not correspond to the CMS eCQM, but instead be based on claims or other data sources. OHA requires use of the current year eCQM specifications. CMS eCQM specifications are updated annually.

The 2024 eCQM specifications can be found in the eCQI Resource Center, which is maintained by CMS and the Office of the National Coordinator for Health IT (ONC). The website also offers annually updated guides to reading eCQMs and eCQM flows. Oregon-specific measures, such as cigarette smoking prevalence and SBIRT, are not available in the eCQI Resource Center. Information on OHA's measure specifications can be found on the CCO metrics webpage. The CCO metrics webpage also has information on all metric benchmarks.

The OHA and CMS eCQM specifications reference value sets to capture clinical concepts and patient data in the EHR and define the codes necessary to calculate the eCQM. The value sets are available from The National Library of Medicine Value Set Authority Center (VSAC). Because of usage restrictions on some code sets, access requires a free license. The free license should be requested through the VSAC website.

For any reporting via custom query, VSAC access will be needed for details necessary to ensure the measure logic used for reporting is aligned with required specifications. OHA reserves the right to request additional detail for any data that is submitted via a custom query.

# Section 4: Parameters

In addition to the specifications outlined above, OHA requires data to be submitted according to specified parameters: a required population threshold, report type, payer type, measurement year, and aggregation level. All parameters must be met for successful reporting. For example, if a CCO does not meet the minimum population threshold, its data submission for that measure would be rejected unless a hardship exception were approved.

## 4.1 Initial Population and Minimum Population Threshold

OHA has adopted an incremental approach to increase the minimum population thresholds for reporting. This approach was intended to account for developing capacities to support EHR-based reporting. OHA encourages CCOs to continue to expand EHR reporting even when thresholds have been met. A summary of the 2024 minimum population thresholds is provided in Table 3:

*Table 3: Required Minimum Population Threshold for 2024*

| Measure | Incentivized? | 2023 Threshold | 2024 Threshold | Threshold increased? |
|---|---|---|---|---|
| Diabetes HbA1c Poor Control | Yes | 70% | 70% | No |
| Depression Screening and Follow-up Plan | Yes | 70% | 70% | No |
| Cigarette Smoking Prevalence | Yes | 35% | 35% | No |
| Drug and Alcohol Screening (SBIRT) | Yes | 20% | 20% | No |
| Controlling High Blood Pressure | No | 70% | 70% | No |

Information about projections for minimum population thresholds in future years is included in Section 5.

### 4.1.1 Definitions

For the EHR-based measures, each CCO must report on a specified minimum percentage of its membership with physical health benefits. This requirement is referred to as the minimum population threshold. In addition, each organization/practice that reported the measure in 2023

should continue to report in 2024 even when the reporting threshold was met, unless the organization no longer sees the CCO's members as patients and/or closed.

The minimum population threshold compares the CCO's initial population for reporting with its total physical health membership as of December of the reporting year (that is, December 2024 for Year Twelve). The initial population is the count of CCO members who are empaneled at or assigned to organizations/ practices that report data included in the CCO's data submission. The count of these members is taken near the end of the measurement period. The initial population is inclusive of adults and children with physical health benefits (i.e., CCO-A and CCO-B). Each CCO is required to identify the initial population by providing membership counts for each organization/practice by the data proposal deadline.

The CCO EHR-Based Reporting Template includes counts of adults and children. In this context, "children" refers to the CCO members who are under age 18 as of the date for which the enrollment report is run. For example, if the CCO ran its report on the count of members assigned to organizations/ practices as of December 29, 2024, then "children" would be members under age 18 as of that date. The CCO EHR-Based Reporting Template contains the Threshhold Calculation by Measure tab which allows CCOs to determine in real time if the CCO has met the minimum population threshold for each measure. OHA will confirm the threshold during the data proposal and data submission review process.

Organizations and practice results for the numerator, denominator, denominator exceptions, and denominator exclusions should be reported by the data submission deadline, even if the report reflects a denominator of zero. However, zeroes should not be reported in the Data Submission for an organization/ practice that did not generate a report. For example, a CCO might include a pediatric clinic and indicate that the clinic is reporting on all measures. When the CCO enters the results hypertension numeric fields, the clinic might not have any patients who meet the denominator criteria. The CCO should indicate zero for the numerator, denominator (before exclusions), and the denominator exclusions. If the CCO has blanks in the data fields for the pediatric clinic, it would appear incorrectly that the clinic did not generate a hypertension report and thus should not be counted toward the minimum population threshold.

The required minimum population threshold applies to each measure. If a CCO with 1,000 members, for example, submitted data from practices assigned a total of 800 members for the diabetes measure (80%) and submitted data from practices assigned a total of 600 members for the depression screening measure (60%), it would meet the 70% threshold for the diabetes measure but not for the depression screening measure.

The threshold is based on the total CCO membership, not a subset of CCO members with a specific condition. For example, a CCO must report on 70% of its total membership for the diabetes measure, but it does not need to report on 70% of its members who have diabetes. Reporting thresholds must be met for the measure to count towards the CCO Quality Incentive Program.

### 4.1.2 Selection

Because EHR-based reporting capacity is typically supported at the organization or practice level, selection of the initial population occurs at the organization/ practice level. For the purposes of this document, "organization" refers to a health system (e.g., Acme Health System) while "practice" refers to a clinic within an organization (e.g., Acme Health – West Town, Acme Health – East Town, etc.).

The CCO's Data Submission is not required to include all practices within an organization, as long as the CCO can provide population counts for each individual practice. That is, a CCO could include Acme Health – West Town and exclude Acme Health – East Town, as long as the CCO could provide in its Data Proposal a count of the membership empaneled at Acme Health – West Town rather than total membership empaneled at Acme Health System. However, a CCO should only move from organizational level reporting to practice level reporting if all practices can be included from the organization.

If a CCO includes an organization/ practice in the data proposal, data for all the MDs, DOs, NPs, and PAs at the selected organization/practice must be included in the data submission. If Acme Health – West Town includes Dr. Smith and Dr. Jones, for example, Acme Health – West Town could not exclude Dr. Jones. This requirement applies whether Acme Health – West Town is aggregating data at the practice level or at the provider level.

Co-located clinics may be treated as separate practices. If Acme Health – West Town Family Medicine is co-located with Acme Health – West Town Cardiology, for example, the Data Submission could include West Town Family Medicine and exclude West Town Cardiology. Practices for CCO incentive reporting should be identified consistently with the way they are identified generally. For example, if the website for Acme Health – Downtown Clinic identifies it as a single practice with 10 providers offering integrated primary care and behavioral health, it would be reasonable to expect all of those providers to be included in reporting for that clinic.[1]

OHA expects that CCOs will build upon prior years' reporting. Each organization/practice that reported the measure in 2023 must continue to report in 2024. CCOs must report these organizations and practices still seeing CCO members even when the reporting threshold is met. The exception to this is if the organization no longer sees the CCO's members as patients and/or the organization has closed. If any practices were included in the previous year but not in the current year for each measure, OHA requires an explanation by the data proposal deadline. If the practice is still seeing CCO members, a hardship exception must be submitted for each measure not reported. If a practice is no longer reporting any measures, they should not be included in the CCO EHR-Based Reporting Template.

OHA strongly encourages CCOs to continue to increase the number of organizations and practices covered in reporting even if the threshold has already been met. Increased reporting allows CCOs to identify quality improvement activities and creates flexibility when a practice or organization closes or accepts CCO members as patients. Organizations/practices that meet one or more of the following criteria should be prioritized for inclusion:

- Primary care practices
- Practices that have implemented certified EHR technology
- Practices that see a high volume of Medicaid beneficiaries
- Practices where a high prevalence of the measure conditions exist
- Practices where any tailored efforts are underway to reach members with the measure conditions

[1] Being included in reporting means that the provider's activities are evaluated, not that the activities meet criteria to count in metric calculations. For example, a clinic might include a provider when running a report on a measure but find the provider had no visits that met denominator criteria; in that case, the practice included the provider in reporting, although no visits to that provider were ultimately counted in the measure denominator or numerator.

OHA reserves the right to require CCOs to reevaluate an approach that omits organizations/ practices that meet one or more of these criteria.

OHA expects that selection will first focus on primary care providers. If a CCO wishes to include other providers, such as dental or behavioral health practices, the CCO must discuss its proposed approach with OHA before the data proposal deadline. Any request must be clearly identified in the data proposal, and OHA reserves the right to reject such requests.

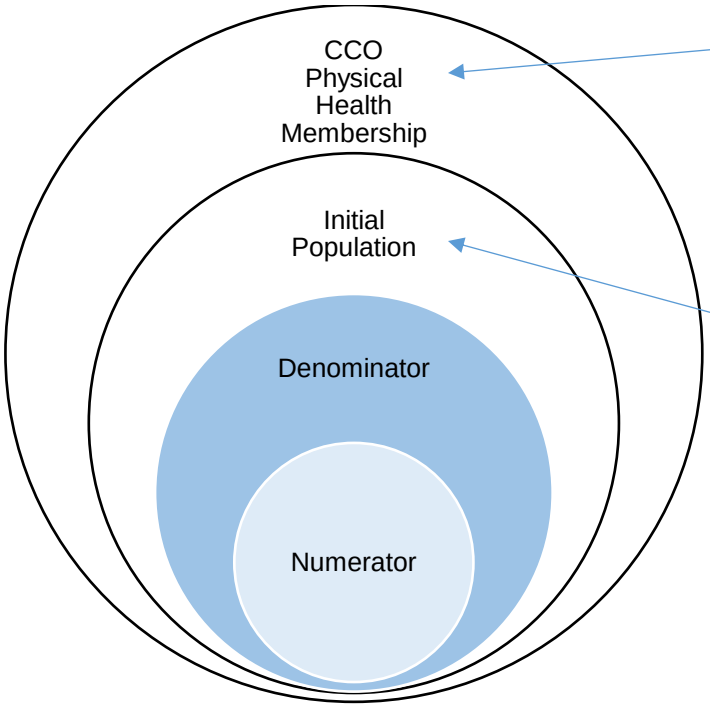
### 4.1.3 Calculation

As noted above, the initial population is the count of CCO members assigned at the organizations/ practices included in the CCO EHR-Based Reporting Template. In the data proposal, the CCO provides the empaneled population count, which should be:

- Representative of patients assigned to the selected organization/practice for primary care purposes
- Inclusive of adults and children
- Inclusive of members with physical health benefits (i.e., CCO-A and CCO-B members)
- Accurate as of the end of the measurement period (i.e., a date sometime within December 2024 and preferably close to the end of the month)

To identify the Total CCO Physical Health Membership, OHA will use the *CCO Enrollment by Plan Type, Medicaid Enrollment Report, December 2024* report. The CCO EHR-Based Reporting Template contains the Threshold Calculations by Measure tab which allows CCOs to determine in real time if the CCO has met the minimum population threshold for each measure. OHA will prepopulate the totals from the *CCO Totals by County* report. The total CCO population counts in this report do change slightly from month to month and OHA will indicate the date the numbers were pulled from the report. The Threshold by Measure tab uses the following calculation by measure:

$$\frac{\text{Initial Population}}{\text{Total CCO Physical Health Membership}} = \text{Must be greater than or equal to applicable minimum population threshold for measure}$$




OHA will use the count provided in the *CCO Totals by County: for Physical Health, OHP, December 2024* report.

OHA will use the count provided by the CCO in the Data Proposal. This count includes adult and child members with physical health benefits at each practice included in the Data Submission.

### 4.1.4 Hardship Exceptions

OHA recognizes that circumstances beyond a CCO's or practice's control could prevent a CCO from being able to report data as planned. In appropriate circumstances, OHA grants hardship exceptions for:

1) a failure to meet the minimum population threshold parameter,
2) no longer reporting on measure(s) by an organization/practice previously included that has empaneled CCO members, and
3) a change in reporting from CCO Member Only in previous year to All Payer in the current year for the same organization or practice.

OHA will only accept a CCO's EHR submission with these attributes if a CCO has been granted a hardship exception. OHA reserves the right to require hardship exceptions in other circumstances.

When a CCO relies on data from a practice that switches EHR vendors, OHA expects that the CCO and practice will plan appropriately and be ready to submit data as outlined in the CCO's data proposal. If unforeseen problems in an EHR implementation occur despite the practice's best efforts, OHA may consider a hardship exception. This is not a blanket exception for all vendor-related delays and would apply only in extreme circumstances.

For an organization or practice that has previously reported a measure, OHA requires the CCO and practice to continue reporting the data if the practice still has empaneled CCO members. OHA also requires that an organization or practice that has reported a measure as CCO Medicaid Only will continue to report the data at this level in all subsequent years. A CCO must submit a hardship exception for an organization or practice not able to meet these requirements.

CCOs are responsible for identifying and addressing quality issues before the data submission period and ensuring consistent reporting by each organization or practice previously reporting. If

a CCO requests a hardship exception, the practice must attest to the issue and how it will be corrected. The practice and CCO must have attempted to address the specific reason for the hardship request. Hardship exceptions are granted for the current year and the organization or practice will be required to submit data the following year.

OHA only grants hardship exceptions in extreme circumstances. OHA will post a link to the hardship request form when OHA releases the CCO EHR-Based Reporting Template. A hardship exception form must be completed and submitted ideally by the data proposal deadline: **January 31, 2025.** Additional hardship requests must be made by the data submission deadline: **March 31, 2025**.

## 4.2 Summary of Required Reporting Parameters

The reporting parameters for submission format, payer type, and aggregation level depend, to some extent, on the report type used by each practice. Table 4 summarizes reporting parameters for each report type, and more detail is provided in the following sections.

*Table 4: Summary of Reporting Parameters*

| Report Type | Submission Format | Payer Type | Measurement Period | Aggregation Level |
|---|---|---|---|---|
| QRDA Category III | • .XML files | • CCO Medicaid Only (preferred)<br>• All Payers | • Full calendar year | • Practice (preferred)<br>• Provider |
| Meaningful Use Attestation Report | • .XLS file (OHA Template) | • CCO Medicaid Only (preferred)<br>• All Payers | • Full calendar year | • Practice (preferred)<br>• Provider |
| Custom Query | • .XLS file (OHA Template) | • CCO Medicaid Only | • Full calendar year | • Practice (preferred)<br>• Organization |

QRDA Category III, Meaningful Use Attestation Report, and Custom Query can be used for eCQM measures Diabetes HbA1c Poor Control (CMS 122/CMIT 148), Depression Screening and Follow-up Plan (CMS 2/CMIT 672), and Controlling High Blood Pressure (CMS 165/CMIT 167). Cigarette Smoking Prevalence (state-specific measure) and Drug and alcohol screening (SBIRT) (state-specific measure) are Oregon homegrown measures and not available through QRDA Category III and Meaningful Use Attestation Report. These two measures can only be reported as Custom Query Report Type and CCO Medicaid Only Payer Type.

## 4.3 Report Type and Submission Format

OHA will accept data from the following report types:

1) QRDA Category III files
2) EHR vendor-provided Meaningful Use attestation reports from EHRs certified to the 2014 Edition, 2015 Edition, or a combination of both
3) Custom Queries

If a practice, organization, or CCO changes an EHR vendor-provided report solely to aggregate from the individual provider to the practice level, OHA does not consider that aggregation to be a form of custom query. Other changes, such as manipulating data from a report to filter by payer rather than using a functionality built into the EHR, are considered a form of custom query.

## 4.4 Payer Type

The payer type is the payer associated with patients included in the measure data. OHA strongly prefers that CCOs submit data for CCO Medicaid beneficiaries only. However, the functionality to parse data by payer (i.e., filter out non-Medicaid beneficiaries) is unavailable in some vendor-provided reports. Therefore, for data submitted **in aggregate** as QRDA Category III or from a Meaningful Use attestation report, OHA will accept data that includes beneficiaries of all payers. Data reported via a custom query must be limited to CCO Medicaid beneficiaries.

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.

When a CCO that has reported on all payer data in previous years switches to reporting on CCO Medicaid only, the CCO may request rebasing of the improvement target if the CCO can submit data to support rebasing. If a CCO requested a rebase to set its 2024 improvement targets, for example, it would have to submit a report of its 2022 data that was limited to CCO Medicaid only. Adding new practices for reporting is not an acceptable rationale for a rebasing request. Questions about this policy may be sent to metrics.questions@odhsoha.oregon.gov.

All practices and organizations from the previous year's submission who reported CCO Medicaid Only must continue to report these practices as CCO Medicaid Only. If a practice is unable to continue reporting CCO Medicaid only, CCOs should submit a hardship request following the process outlined in Section 4.1.4. OHA only grants hardship exceptions in extreme circumstances.

## 4.5 Measurement Period

OHA requires a full calendar year of data: January 1 to December 31, 2024. An exception may be granted if a practice did not have an EHR for the full calendar year, for example, if a practice adopted an EHR for the first time or replaced its EHR during the measurement year. With OHA approval, these practices will be allowed to report a modified measurement period; exceptions must be requested by email to metrics.questions@odhsoha.oregon.gov and should be made by the data proposal deadline: January 31, 2025.

## 4.6 Aggregation Level

The data aggregation level is the level in the network's hierarchical structure (described above in Section 4.1.2) at which data is "sliced" and submitted to OHA. Data might be aggregated and reported at the organization, practice, or provider level. Data are not submitted at the CCO member level.

OHA prefers to receive data at the practice level, when available, but will accept provider level data for practices using QRDA Category III or Meaningful Use attestation reports. Provider level data should not be submitted for data reported via a custom query.

Please see Section 5 of this document for more details about the data aggregation level OHA expects to require in future program years.

# Section 5: Projected Reporting Requirements in Future Years

OHA remains committed to the vision of measurement that uses EHR data to assess outcomes and that is collected in a way that reduces reporting burdens.

At the time of this document's publication, this information represents draft requirements only. OHA reserves the right to modify the requirements as outlined in this section.

## 5.1 Population Threshold

Organizations/practices cannot report EHR-based measures unless they have implemented an EHR. OHA does not expect that 100% of a CCO's primary care network will be able to report. Currently, OHA does not anticipate the minimum population threshold rising above 75%. As new measures are introduced, OHA anticipates using a glide path for the minimum population threshold, which would increase over the reporting years from 25% to 50% and finally to 75% (or whatever the top percentage is in that year).

For 2025, OHA anticipates increasing minimum population thresholds for SBIRT and Cigarette Smoking Prevalence. Over 75% of CCOs report above the 70% threshold for both SBIRT and Cigarette Smoking Prevalence for 2023. Of the two CCOs below 50%, each was within 3 percentage points of the 50% threshold. OHA will consider increasing the threshold in future years as well.

*Table 5: Projected Minimum Population Thresholds for 2025*

| Measure | Incentivized? | *Draft* 2025 Threshold | Increase from 2025? |
|---|---|---|---|
| Diabetes HbA1c Poor Control | Yes | 70% | No |
| Depression Screening and Follow-up Plan | Yes | 70% | No |
| Cigarette Smoking Prevalence | No | 45% | Yes |
| Drug and Alcohol Screening (SBIRT) | No | 45% | Yes |
| Controlling High Blood Pressure | No | 70% | No |

## 5.2 Report Type, Submission Format, and Aggregation Level

OHA anticipates using a similar approach in 2025 as in 2024, with aggregate data submitted using Excel templates.

## 5.3 Payer Type

OHA prefers that data submitted for the CCO Incentive Measures be limited to CCO Medicaid beneficiaries only. However, reporting capacities have required flexibility in allowing aggregated data to be submitted for all payer types, as some EHRs lack capability to parse the data by payer. Many CCOs have chosen to use custom queries for measure reporting, with consideration to this current lack in functionality. OHA will continue to seek ways to address that gap and eliminate the need for custom queries.

## 5.4 Measurement Period

OHA expects that a full calendar year will remain the required measurement period. Exceptions may be approved for practices that did not have an EHR implemented for the full calendar year.

## 5.5 Frequency

OHA expects that an annual submission in an Excel template will continue to be the approach in 2025.

### 5.6 Measure Selection in Future Years

OHA remains committed to efficiently collecting clinical data to enable greater use of outcomes measures. OHA will continue working with interested parties and committees to set a strategy for future years, as new national standards are ready for implementation.

## Section 6: Contacts

For questions related to the content of this document or the CCO Incentive Measure Program, please contact metrics.questions@odhsoha.oregon.gov.

# Appendix A: National Reporting Standards

Previously, EHR certification standards required vendors to support Quality Reporting Data Architecture (QRDA) for reporting health care quality measurement data at the patient level (QRDA I) and aggregated level (QRDA III). More information about QRDA, including CMS Implementation Guides for QRDA I and QRDA III, is available through the eCQI Resource Center.

Because of a change in federal rules in 2020, QRDA I is no longer required to be supported in ambulatory EHRs. In future years, the Fast Healthcare Interoperability Resources (FHIR) standard is expected to support quality reporting. At this time, however, it is still in pilot testing for quality reporting. For the moment, there is not a clear path forward to collecting patient-level data for the eCQMs used in the CCO quality incentive metrics program.

OHA will continue to monitor EHR certification requirements and national standards and will work with the Metrics TAG and other stakeholders on strategies as standards evolve.

# Appendix B: EHR Data Submissions Validations Supplement

*Appendix B EHR Data Validations Supplement* provides additional information on the following data submission validations:

- Zero for the denominator or numerator
- Low denominators
- Exclusions higher than expected
- Denominator greater than count of CCO members at organization/practice
- Incorrect rate calculation (e.g., greater than 100%)
- Measure specific checks (i.e., mismatches between reported denominators before exclusions and exceptions for the Depression Screening and Follow-up Plan measure and Drug and Alcohol Screening (SBIRT) Rate 1)

OHA may adjust the data submission validation thresholds based on patterns across all CCOs submissions after reviewing the MY 2024 Data Submissions. OHA may also add additional data validations if unique issues are identified in the Data Submissions.

Questions about the EHR Data Proposal and Submission process and/or this document can be sent to Metrics Questions at Metrics.Questions@odhsoha.oregon.gov.

## B.1 Denominator Data Validations

Denominator data validations assess if the denominator is realistic. CCOs will be asked to provide explanations or fix the data if submitted data fail denominator data validations. OHA compares the empaneled member data from the Data Proposal to the denominators for each individual measure in the Data Submission. It is important, therefore, that the same level of information (provider, practice, or organization) is submitted in both the Data Proposal and the Data Submission. This allows OHA to fully validate each denominator.

When identifying potential quality issues for review, we flag:

- Lower than expected denominators, including zero denominators
- Higher than expected denominators

OHA checks denominators for both payer types, All Payer and CCO Medicaid Only. OHA also takes into account if the practice or organization is only pediatric when deciding whether to follow up with CCOs on a case by case basis.

### B.1.1 Baseline Population

To perform the denominator data validations, the baseline population must be established. The baseline population is meant to approximate how many individuals would qualify for the metric. The following italicized field names are taken directly from the Data Proposal for each unique combination of the *Organization Name, Practice Name,* and *Provider Name* rows. For the Controlling High Blood Pressure and Diabetes HbA1c Poor Control metrics, the baseline population is *# of CCO Members empaneled at Practice – ADULTS (C)*. For the Depression Screening and Follow-up Plan, Cigarette Smoking and Other Tobacco Use and SBIRT metrics, the baseline population is:

| | | |
|---|---|---|
| *# of CCO Members empaneled at Practice – ADULTS (C)* | + | *20% of # of CCO Members empaneled at Practice – CHILDREN (D)* |

### B.1.2 Low Denominator Data Validation

The low denominator data validation flags cases where percent reporting is potentially low using the following calculation:

(Metric Denominator/Baseline Population) * 100 < Low Denominator Threshold for Metric

The metric denominator is the denominator before exclusions and exceptions have been removed from the denominator. To be included, the metric must have more than 200 individuals in the baseline population for all metrics, except for the Cigarette Smoking and Other Tobacco Use metric. The Cigarette Smoking and Other Tobacco Use metric must have a baseline population greater than 50. The thresholds below are from MY 2022 (Year 10) and may be adjusted once all MY 2024 (Year 12) results have been submitted.

**Table 1 MY2022 Low Denominator Thresholds**

| Measure | CCO Medicaid Only | All Payer |
|---|---|---|
| Depression Screening and Follow-up Plan | < 25% | < 100% |
| Controlling High Blood Pressure | < 7% | < 30% |
| Diabetes HbA1c Poor Control | < 3% | < 12% |
| Smoking and Other Tobacco Status | < 25% | N/A |
| Smoking Only and Broader Tobacco Use Prevalence | < 10% | N/A |
| Drug and Alcohol Screening (SBIRT) Rate 1 | < 25% | N/A |
| Drug and Alcohol Screening (SBIRT) Rate 2 | < 5% | N/A |

The threshold for Diabetes HbA1c Poor Control is based on MY 2022 prevalence, which showed that 8% of continuously enrolled CCO adults age 18 and older qualify for the Oral Evaluation For Adults With Diabetes metric denominator. The threshold for Controlling High Blood Pressure was set based on the national prevalence, which shows nearly half of all adults in the United States have hypertension.[2]

### B 1.3 High Denominator Data Validation

The high denominator data validation uses the same percent reporting calculation as the low denominator data validation:

(Metric Denominator/Baseline Population)*100

When identifying potential issues, rows are flagged for each payer type when:

[2] Hypertension Cascade: Hypertension Prevalence, Treatment and Control Estimates Among US Adults Aged 18 Years and Older Applying the Criteria From the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline —NHANES 2017–2020. Centers for Disease Control and Prevention (CDC). May 12, 2024. Accessed October 3, 2024. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html

- CCO Medicaid Only is greater than 100%
- All Payer is greater than 1000%

## B.2 High Exclusion/Exception Rate Data Validation

To check whether exclusions and exceptions are higher than expected, we flag cases using this formula:

((Exclusions + Exceptions)/Metric Denominator)*100 > Metric Threshold

The metric denominator is the denominator before exclusions and exceptions have been removed. For exclusions to be flagged as high, the denominator before exclusions and exceptions has to be greater than 30. The thresholds below are from MY 2022 (Year 10) and may be adjusted once all MY 2024 (Year 12) results have been submitted.

**Table 2 MY2022 High Exclusion/Exception Thresholds**

| Metrics | % of Cases with Exception or Exclusion |
|---|---|
| Depression Screening and Follow-up Plan | > 55% |
| Controlling High Blood Pressure | > 15% |
| Diabetes HbA1c Poor Control | > 15% |
| Smoking and Other Tobacco Status | N/A |
| Smoking Only and Broader Tobacco Use Prevalence | N/A |
| Drug and Alcohol Screening (SBIRT) Rate 1 | > 40% |
| Drug and Alcohol Screening (SBIRT) Rate 2* | > 40% |

## B.3 Incorrect Performance Calculation

The incorrect performance calculation flags erroneous performance calculations. OHA cannot accept data where the performance calculation is out of range. CCOs will need to fix these errors and resubmit their Data Submission. We use this formula to identify errors in submitted data:

(Numerator)/(Denominator before Exclusions & Exceptions – Exclusions – Exceptions) > 100% or < 0%**Table 3 Incorrect Performance Calculations Examples**

| Depression Numerator | Depression Denominator (before Exclusions and Exceptions) | Depression Denominator Exclusions | Depression Denominator Exceptions | Depression Performance Calculation | Flagged as Incorrect? |
|---|---|---|---|---|---|
| 200 | 175 | 50 | 25 | 200.0% | Yes, higher than 100% |
| 100 | 150 | 40 | 20 | 111.1% | Yes, higher than 100% |

| | | | | | |
|---|---|---|---|---|---|
| 20 | 30 | 25 | 15 | -200.0% | Yes, less than 0% |
| 125 | 200 | 20 | 10 | 73.5% | No, between 0 and 100% |

The Data Submission spreadsheet automatically calculates the performance calculation for each metric. Each metric can only fall between 0 and 100 percent to be correct. Many of the errors for this validation occur with the denominator field. For all measures with exclusions and exceptions, the denominator should be the denominator before exceptions and exclusions are removed. Do not enter the denominator minus exceptions and exclusions in the denominator field.

## B.4 Numerator Data Validations

When the performance calculation appears too low, including 0%, OHA will flag the numerator for further investigation. CCOs will be asked to provide explanations or fix the data. To be included in the numerator data validation, the metric must have more than 200 individuals in the baseline population for all metrics, except for the Cigarette Smoking and Other Tobacco Use metric. The Cigarette Smoking and Other Tobacco Use metric must have a baseline population greater than 50. OHA will flag cases for investigation where:

- Numerator is equal to zero
- Numerator appears low

Low numerators of concern in MY 2022 were Diabetes HbA1c Poor Control numerator and the Cigarette Smoking Only and Broader Tobacco Use numerators. To ensure that following metrics are being assessed accurately, OHA flags when:

- Smoking Only prevalence is under 5% and
- Diabetes HbA1c Poor Control prevalence is under 10%.

## B.5 Measure Specific Data Validation

OHA cannot accept data where measure specific data validations are out of line with measure specifications, as outlined in the following subsections. CCOs will be expected to fix these errors and resubmit their Data Submission.

For the tables in this section, the names of column headers match those in the Data Submission. The tables have been populated with examples of correct data. The data validations listed indicate when the data would need to be corrected and resubmitted by CCOs.

### B.5.1 Depression Screening and Follow-up Plan

When the payer type is CCO Medicaid only for both Depression Screening and Follow-up Plan and SBIRT, the denominators before exclusions and exceptions should be exactly the same. When payer type is CCO Medicaid only for both measures, OHA flags cases where Depression Screening and Follow-up Plan denominator before exclusions and exceptions is not equal to the SBIRT Rate 1 denominator before exclusions and exceptions.

### B.5.2 Drug and Alcohol Screening (SBIRT)

OHA flags rows as incorrect where:

- The Rate 2 denominator before exceptions (G) is higher than the Rate 1 denominator (B minus C minus D).
- The Rate 2 denominator before exceptions (G) is higher than or equal to the Rate 1 numerator (A).

**Table 4 SBIRT Examples of Correct Data**

| A<br>SBIRT Rate 1 screen Numerator | B<br>SBIRT Rate 1 screen Denominator (before exclusions and exceptions) | C<br>SBIRT Rate 1 screen Exceptions | D<br>SBIRT exclusions | E<br>SBIRT Rate 1 screen Perfor-mance | F<br>SBIRT Rate 2 BI or Referral Numerator | G<br>SBIRT Rate 2 BI or Referral Denominator (before exceptions) | H<br>SBIRT Rate 2 BI or Referral Exceptions | I<br>SBIRT Rate 2 BI or Referral Perfor-mance |
|---|---|---|---|---|---|---|---|---|
| 200 | 300 | 40 | 20 | 83.3% | 35 | 50 | 5 | 77.8% |

### B.5.3 Cigarette Smoking and Other Tobacco

The Cigarette Smoking Prevalence rate (G) will be used for comparison to the benchmark improvement target. Although complete reporting is preferred, OHA will accept Data Submissions that include only the Broader Tobacco Use Prevalence rate (H). If a practice can report the Broader Tobacco Use Prevalence rate (H), but not the Cigarette Smoking Prevalence rate (G), the CCO must seek OHA approval to include that practice in the Data Submission.

For this metric, OHA flags rows as incorrect where:

- The Prevalence denominator (F) is higher than the Status (B) denominator.
- The Smoking numerator – Status (A) recorded is not equal to the Prevalence denominator (F).

The Broader Tobacco Use numerator (E) is lower than Cigarette Smoking Only numerator (D).

**Table 5 Cigarette Smoking and Other Tobacco Examples of Correct Data**

| A<br>Smoking Numerator - Status Recorded | B<br>Smoking Denominator - Status Recorded | C<br>Smoking Performance Rate - Status Recorded | D<br>Prevalence Numerator 1 - Cigarette Smoking Only | E<br>Prevalence Numerator 2 - Broader Tobacco Use | F<br>Prevalence Denominator | G<br>Prevalence Performance Rate w/ Numerator 1 | H<br>Prevalence Performance Rate w/ Numerator 2 |
|---|---|---|---|---|---|---|---|
| 500 | 550 | 90.9% | 125 | 150 | 500 | 25.0% | 30.0% |

## B.6 Cross Measure Data Validations

The cross measure data validations compare between the Diabetes HbA1c Poor Control, Controlling High Blood Pressure and Depression Screening and Follow-up Plan measures to ensure that Data Submissions are capturing the correct qualifying population for each denominator. These data validations are meant to identify potential data issues. CCOs will be asked to provide explanations or fix the data when needed.

OHA will flag cases for investigation where:

- The denominators before exclusions are equal for Controlling High Blood Pressure and Diabetes HbA1c Poor Control.
- The Controlling High Blood Pressure denominator before exclusions is less than the Diabetes HbA1c Poor Control denominator before exclusions.
- The Controlling High Blood Pressure and/or Diabetes HbA1c Poor Control denominators before exclusions are higher than the Depression Screening and Follow-up Plan denominator before exclusions and exceptions.

The payer types (i.e., All Payer or CCO Medicaid Only) must be the same between metrics for the comparisons to be made.

# Appendix C: Rebaselining Electronic Health Record (EHR) Measures Policy

When OHA determines that a significant change has been made to a given EHR measure's specifications, OHA will allow CCOs to submit practice and organization data for rebaselining. CCOs may also rebaseline when switching from All Payer to CCO Medicaid Only reporting per the EHR Manual (section 4.4 Payer Type). However, this policy will focus on rebaselining for measure specification changes only.

For measures in the CCO Quality Incentive Program, improvement targets for the incentive measures are based off the previous year's data. Improvement targets allow CCOs to receive credit for the Quality Incentive Measure funds without meeting the benchmark. Rebaselining will ensure that CCOs' improvement targets are calculated with the most comparable information possible when significant changes are made to a measure.

OHA subject matter experts will determine whether rebaselining is appropriate for EHR measures and will notify CCOs of the opportunity to submit data for rebaselining. Because OHA does not have direct access to the clinical data unlike administrative claims data, OHA does not have quantitative guidelines similar to administrative claims rebaselining. OHA will proactively work in partnership with SMEs and interested parties including CCOs to determine if rebaselining is necessary. CCOs can petition for rebaselining by submitting the reason with technical details and, if possible, supporting data to Metrics.Questions@odhsoha.oregon.gov.

OHA will aim to notify CCOs about the opportunity to rebaseline by June 30th of the measurement year although rebaselining notification may occur later due to unforeseen circumstances. When a measure opens for rebaselining, CCOs can then choose to submit their EHR data for rebaselining. To rebaseline, a CCO must resubmit all organizations and practices for rebaselining who submitted during the previous measurement year. If it is not possible to rebaseline due to contractual reasons with the EHR vendor or

other data limitations, CCOs must submit the reason for each group and OHA will review on a case-by-case basis.

All practices and organizations must calculate the previous year's results using the current measurement year's specifications on the prior year data. For example, if 2024 measure's improvement targets are being recalculated, the full 2024 specifications must be used on the 2023 data to calculate the new 2023 results. Organizations and practices must report the metric with the same parameters as previously used for:

- Report Type
- Level of Data Aggregation
- Payer Type
- Measurement Period

After recalculating, the practices and organizations will provide the data to their CCO. The CCO will then submit the data to OHA at the same time as the current year's data submission in a separate rebaselining template.

Rebaselined data will undergo a similar review as the current year's data submission. OHA will accept the CCO submission for rebaselining if:

- Rebaselined data passes the standard required data validations.
- The new submission appears feasible given the original 2023 submission.
- OHA approved the practices or organizations' petitions to forgo rebaselining due to technical or contractual issues.

Once the data have been accepted by OHA, the improvement target will be recalculated for the current measurement year. The calculation will use data from all organizations and practices who submitted in previous measurement year. This means that OHA will use the original data for organizations and practices who could not recalculate the measure along with the groups that were able to recalculate. No new practices can be included in the improvement target calculation, even if they are submitting in current measurement year.