Health Plan Quality Metrics Committee (SB 440-2015)

Report to the Legislature

June 7, 2022

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Executive Summary

The Health Plan Quality Metrics Committee (HPQMC) was established by Senate Bill 440 (2015) to be the single body to align health outcome and quality measures for publicly funded health insurance. HPQMC determines which quality measures can be used by the Coordinated Care Organizations (CCO) quality incentive program, the Public Employees' Benefit Board, and the Oregon Educators Benefit Board (OEBB) to incentivize higher quality health care. Committee members are appointed by the Oregon Health Policy Board (OHPB).

This is the second legislative report about progress made by HPQMC, which first convened in April 2017. This report covers the committee's progress from June 2017 through April 2022. During this period, HPQMC established an aligned measure menu, made periodic updates to the menu, and established criteria for adopting and reviewing measures that address important gap areas. The report provides an overview of how the committee selected the current aligned measure menu, including the development of a criteria for review and evaluation of measures.

The report summarizes the measures selected for use each year, and appendices 5 through 8 present more detailed information on measures selection by state-funded health plans from 2019 through 2022 measurement years. These appendices also contain links to each year's report for CCO, PEBB, and OEBB.[1] Caution should be used in comparing the data, however, as the programs operate within very different administrative structures. For example, quality metrics for health plans under the PEBB/OEBB programs are calculated and reported by the health plans, while CCO incentive metrics are calculated by Oregon Health Authority staff. As acknowledged in SB 440, PEBB/OEBB and the Oregon Health Plan serve different populations, which impacts measure selection and implementation.

[1] The Oregon Health Insurance Marketplace (OHIM) quality reporting fell under federal reporting requirements; because the measures are selected by the Centers for Medicare & Medicaid Services (CMS), not from the HPQMC menu, OHIM measures are not listed in the appendices.

Introduction

This is the second of two progress reports submitted for the Health Plan Quality Metrics Committee (HPQMC).[2] The first progress report was submitted in summer 2017, shortly after the committee began meeting, to describe member appointments and launch of committee business.[3] The goal of HPQMC is to ensure measures and requirements are coordinated, evidence-based, and focused on a long-term statewide vision for publicly funded Oregon insurance groups. These groups include:

- Coordinated Care Organizations (CCOs)—networks of health care providers that deliver health care coverage under the Oregon Health Plan (Medicaid),
- Public Employees Benefit Board (PEBB)—benefit plans to employees and dependents at state agencies, universities and local governments (cities, counties, special districts),
- Oregon Educators Benefit Board (OEBB)—benefit plans to subscribers and dependents at school districts, education service districts, community colleges, charter schools and local governments (cities, counties & special districts), and
- Oregon Health Insurance Marketplace (OHIM)—individual health coverage for Oregonians purchased through the exchange with financial assistance available in some circumstances.[4]

Per legislation, the HPQMC has two primary operational functions:

- To identify health outcome and quality measures that may be applied to publicly funded Oregon insurance groups.
- To evaluate on a regular and ongoing basis the health outcome and quality measures adopted by these plans.

Additional characteristics of HPQMC's operations that are set out in statute include that the committee:

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[2] Section 3 of SB 440 (2015) provided: "The Oregon Health Authority shall submit two reports to the Legislative Assembly, in the manner provided in ORS 192.245, on the activities of the Health Plan Quality Metrics Committee and the authority in complying with the provisions of ORS 413.017 (4)(b) to (f). The first report shall be submitted during the 2017 regular session of the Legislative Assembly. A second report shall be submitted during the 2019 regular session of the Legislative Assembly." OHA was granted an extension to submit this second report.

[3] https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/OHA-SB-440-2015-20170609.pdf

[4] Quality measures for OHIM are selected at the federal level and thus do not use the HPQMC measure menu. Additional information can be found in the HPQMC meeting materials from May 2017: https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/HPQMMeetingMaterials20170511.pdf#page=45

- Has 15 members with designated roles and appointed by the Oregon Health Policy Board;
- Uses a public process with opportunities for public input;
- Works collaboratively with the Metrics and Scoring Committee, OEBB, PEBB, and the Department of Consumer and Business Services (DCBS) to adopt health outcome and quality measures in the state;
- Considers the recommendations of the Metrics and Scoring Committee and differences in populations served by CCOs and by commercial insurers; and
- Prioritizes measures using criteria set out in statute, including considerations such as use of measures that have been adopted or endorsed by a national body and can be meaningfully adopted for at least three years.

Users of the HPQMC aligned measures menu are not required to adopt all the menu measures but may not adopt incentive measures that are not on the menu.

The inaugural committee meeting was held in April 2017, and since that time, the committee has continuously adhered to legislative statutes, functions, and roles as described. HPQMC regularly updates an aligned measure menu which is publicly available on the committee's website and included with this report. The committee chair and vice-chair give presentations to the Oregon Health Policy Board (OHPB) to describe progress and key discussions. In addition, a designated liaison of the OHPB regularly attends HPQMC's meetings.

Timeline of activities and accomplishments (2017-2022) are:

- May 2018: Approved initial (2019) aligned measure menu, which was published to HPQMC website.
- Nov 2018: Developed criteria for the review and evaluation of measures (Appendix 2).
- Jan 2019: Developed guidelines for measure governance (Appendix 4).
- Jan 2019: Inaugural implementation of measures selected by state-funded health plans (measure selection lists for 2019 through 2022 are included in Appendices 6-9).
- April 2019: Approved aligned measure menu for 2020, which was published to HPQMC website.
- September 2019: OHPB provided guidance to HPQMC on scope of work (Appendix 10).
- December 2019 and January 2020: Worked with Bailit Health to develop criteria for measurement framework to identify gaps and priority areas.
- February 2020: Adopted selection criteria for priority measures that address state priorities and gaps in existing metrics to further Oregon's health system transformation goals (Appendix 3).
- March 2020: Approved aligned measure menu for 2021, which was published to HPQMC website. Menu included two Oregon-specific transformative measures adopted under the priority measure criteria.

Committee meetings were suspended for April – November 2020 because of the COVID-19 pandemic's impact on the health care system; many members of the committee were directly involved in the pandemic response.

- December 2020: Resumed regular monthly meetings.
- April 2021: Approved updates to the aligned measure menu, which was published to HPQMC website. Menu update included adding a transformative measure adopted under priority measure criteria.
- May 2021: Recommended measures for Cost Growth Target Program to accompany annual reporting.
- March 2022: Approved updates to the aligned measure menu for 2022, adding a transformative measure adopted under priority measure criteria and new dental sealant measures.

Highlights of Progress

Measure review criteria

In developing the initial aligned measure menu, the committee reviewed 117 quality measures, focusing on measures consistent with criteria established in SB 440. Of the 117 measures reviewed, the committee approved 51 quality measures across six domains:

- Prevention/Early Detection
- Chronic Disease and Special Health Needs
- Acute, Episodic and Procedural Care
- System Integration and Transformation
- Patient Access and Experience
- Cost/Efficiency

In selecting the measure menu, HPQMC followed guidelines in SB 440 that direct the committee to prioritize measures that are already in use, rely on existing data, and are not subject to large random variation-based denominator fluctuations.

The committee found, however, that measures meeting these criteria may not drive broader health outcomes or system transformation. To encourage health care transformation and address gaps in existing measure sets, the committee updated the measure review criteria in November 2018. The updated measure criteria set ensures representation across domains, populations, and sectors. These criteria list overarching principles in addition to characteristics for individual measures included in the menu. In this way, the committee developed a framework with which to assess the overall set, in addition to each metric.

These criteria were reviewed again in March 2020 with no significant changes and are reviewed and discussed during significant decisions about measures.

Selection criteria for priority measures

Beginning September 2019, the committee considered how to address the need for transformative measures that address health priorities important to people in Oregon and for which national measures do not exist. The committee wished to develop measure criteria that would be specific to evaluating these types of measures and could be used in tandem with existing criteria for nationally endorsed measures. The committee spent several months working with OHA and contractor Bailit Health to develop these criteria. These criteria for more transformational, high-priority areas were approved in February 2020.

Following the completion of the transformative measure criteria, HPQMC has used the criteria to add new measures each year. In 2020, the committee voted unanimously to include two Oregon-specific, transformative measures in the aligned measures menu – a health equity measure (Meaningful Language Access to Culturally Responsive Health Care) and an obesity evidence-based multisector interventions measure. In 2021, HPQMC added a CCO System-Level Social Emotional Health measure to the menu. In 2022, the committee added a Social Determinants of Health: Social Needs Screening and Referral measure to the menu. Because HPQMC voted to include these measures in the aligned measures menu, the Metrics and Scoring Committee, OEBB or PEBB can select them as incentive measures.

Use of measures from the aligned measures menu

After HPQMC adds measures to the menu, the measures are available for use in programs. Typically, HPQMC approves updates to the measures menu in the year preceding the use of the measure. For example, when HPQMC added measures to the menu in March 2020, those measures were available to be incentivized in calendar year 2021. Each program selects the menu measures to be incentivized.

CCO incentive metrics are selected annually by Metrics and Scoring Committee. For more information on the Metrics and Scoring Committee: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx.

PEBB and OEBB measures are identified annually by staff and consultants in consultation with the boards and incorporated in carrier contracts. For more information on PEBB: https://www.oregon.gov/oha/pebb/Pages/meetings.aspx. For more information on OEBB: https://www.oregon.gov/oha/OEBB/Pages/Public-Meetings.aspx.

Over the years, the number of total measures selected by at least one program and the number of measures selected across all three programs has varied.

Measure Selection

Measure Menu Year	Total measures in aligned measure menu	Measures used by at least *one* program	Measures used by *all three* programs
2019	51	25	12
2020	51	29	6
2021	54	22	7
2022	57	23	3

Tables of selected measures for years 2019, 2020, 2021, and 2022 are included in the appendices.

Impact of aligned measures

Quality measures adopted by the HPQMC and selected by the state-funded health insurance programs impact care delivered to approximately 1.7 million Oregonians. The number of insured lives by health plan are:

- Coordinated Care Organizations – Almost 1.4 million
- Public Employees Benefit Board (PEBB) – 137,000
- Oregon Educators Benefit Board (PEBB) – 150,000

Metric set by measurement framework

The aligned measures menu is meant to cover a variety of domains, healthcare sectors and age groups. The menu includes 57 measures across six major domains:

- Acute, Episodic and Procedural Care (includes Maternity and Hospital)
- Chronic Disease and Special Health Needs
- Cost Efficacy
- Patient Access and Experience
- Prevention/Early Detection
- System Integration and Transformation

The following tables include information on the current aligned measures menu by domain and sector as well as by domain and population age.

2023 Aligned Measures Menu by Domain

Domain	Subdomain	Count of Measures
Acute, Episodic and Procedural Care (Includes Maternity and Hospital)		5
Chronic Disease and Special Health Needs	All Conditions	2
	Behavioral Health Conditions	5
	Physical Health Conditions	7
	Substance Use Disorder (SUD) Conditions	2
Cost/Efficiency		2
Patient Access and Experience		5
Prevention/Early Detection	All Conditions	1
	Behavioral Health Conditions	3
	Oral Health Conditions	4
	Physical Health Conditions	16
	Substance Use Disorder (SUD) Conditions	4
System Integration and Transformation		4
Grand Total		**57**

Please note that some measures fall into more than one domain and subdomain. The grand total in the last row represents the total number of measures, counting each measure once.

2023 Aligned Measure Menu by Sector

Domain	Subdomain	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
Acute, Episodic and Procedural Care (Includes Maternity and Hospital)		0	1	4	0	4	0
Chronic Disease and Special Health Needs	All Conditions	0	0	2	2	0	0
	Behavioral Health Conditions	0	5	3	0	2	0
	Physical Health Conditions	0	0	7	6	0	0
	Substance Use Disorder (SUD) Conditions	0	2	2	0	2	0
Cost/Efficiency		2	2	2	2	2	0
Patient Access and Experience		2	2	2	2	2	0
Prevention/Early Detection	All Conditions	1	1	1	0	0	0
	Behavioral Health Conditions	0	1	2	0	0	0
	Oral Health Conditions	4	0	0	0	0	0
	Physical Health Conditions	0	2	16	0	0	7
	Substance Use Disorder (SUD) Conditions	0	0	3	0	1	2
System Integration and Transformation		0	1	1	0	1	0
Grand Total		**9**	**15**	**45**	**12**	**14**	**9**

Please note that some measures fall into more than one domain, subdomain, and sector. The grand total in the last row represents the total number of measures, counting each measure once.

2023 Aligned Measure Menu by Population

Domain	Subdomain	Older Adults	Adults	Adolescent	Children
Acute, Episodic and Procedural Care (Includes		5	5	3	2

Maternity and Hospital)					
Chronic Disease and Special Health Needs	All Conditions	0	0	2	2
	Behavioral Health Conditions	4	4	3	3
	Physical Health Conditions	7	7	2	2
	Substance Use Disorder (SUD) Conditions	2	2	2	0
Cost/Efficiency		2	2	2	2
Patient Access and Experience		4	4	4	5
Prevention/Early Detection	All Conditions	0	0	1	1
	Behavioral Health Conditions	2	2	2	1
	Oral Health Conditions	2	2	3	3
	Physical Health Conditions	5	9	7	6
	Substance Use Disorder (SUD) Conditions	4	4	2	0
System Integration and Transformation		3	3	2	3
Grand Total		**40**	**44**	**35**	**28**

Please note that some measures fall into more than one domain, subdomain, and age group. The grand total in the last row represents the total number of measures, counting each measure once.

Gaps and priority areas identified

In 2018, the HPQMC identified gaps in the aligned measures menu. The committee identified the following high priority areas which included both gaps and concepts:

- Suicide Prevention for Children, Adolescents and Adults
- Behavioral Health Conditions and Sector
- Substance Use Disorders (SUD) and Sector
- Equity and Addressing Disparities
- Children and Youth with Special Health Care Needs (CYSHCN)
- Access, including Dental, Behavioral Health, SUD, and Telehealth and Virtual Care

For Behavioral health conditions and substance use disorder, committee members concluded that these areas had large, multilevel gaps in the menu.

HPQMC also highlighted other priority measurement areas. Additional identified measure gaps were:

- Multiple Chronic Diseases

- Chronic Dental Disease - including Access and Care Coordination
- Patient-Reported Outcomes
- Pharmaceutical Care
- Social Determinants of Health
- Cost of Care/Efficiency

Other identified concept gaps:

- Topical Fluoride Varnish for Children
- Measures that address screens for pregnant women
- Survey for CYSHCN including questions from Family Experience with Coordination of Care (FECC), Pediatric Intensive Care Survey (PICS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Item Sets
- Depression Remission and Progress Towards Response
- Patient-Reported Outcome Measure of Contraception Care
- Preventable Emergency Department Use

In later years, the HPQMC gap identification informed the creation of upstream quality metrics developed by OHA and others.

The HPQMC legislation specified that the committee create an aligned measure menu for health plans. Given the committee's scope, HPQMC recommended to the Oregon Health Policy Board that an existing or a new committee be charged with measuring hospital performance.

Priority development metric support by OHA and partners

To be successful, measure development requires extended time and effort, including engagement, analysis, testing and revisions. To support priority measure development, OHA convened three workgroups and partnered with the Children's Institute and the Oregon Pediatric Improvement Partnership to support a fourth. These workgroups addressed measure development in priority areas:

- Health Equity Measurement Workgroup: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx
- Health Aspects of Kindergarten Readiness: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx
- Social Determinants of Health Measurement Workgroup: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx
- Multisector Interventions Addressing Obesity: https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/4.%20MSI%20Obesity%20Measure%20Materials%20Packet.pdf
  Note: After initial measure development and pilot testing, this measure was not adopted for implementation in the CCO quality incentive program or PEBB or OEBB contracts.

Events in 2020 and 2021 have affected work on further measure development. First, during the COVID-19 public health emergency, some work on measure development was suspended or delayed. Second, HB 2086 (2021) assigned work on behavioral health metrics to the new Behavioral Health Committee.[5] The committee's purpose is to increase the quality of behavioral health services and transform Oregon's behavioral health system through improved outcomes, metrics, and incentives. The chair of HPQMC is a member of the Behavioral Health Committee, and dialogue between the two committees is anticipated as the Behavioral Health Committee continues its work.

Looking ahead

HPQMC will continue to fulfill its legislative duties to oversee and update the aligned measure menu as well as provide updates to the Oregon Health Policy Board. The committee also plans to create a "lessons learned" report to share thoughts with the new Health Equity Quality Metrics Committee that is currently proposed in the 2022-2027 Medicaid Waiver Application.

[5] https://www.oregon.gov/oha/HSD/BHP/Pages/Behavioral-Health-Committee.aspx

APPENDIX 1: Current Committee Roster

As of April 2022

Member Name	Member Organization	Committee Seat Represented	Years Served
Maggie Bennington-Davis	Health Share of Oregon	CCO Representative	2017-present
Bhavesh Rajani	PacificSource	CCO Representative	2017- present
Ana Quiñones	OSHU-PSU Public Health	Health care consumer	2017- present
Erik Carlstrom	Carlstrom Consulting	Health care consumer	2019- present
Ann Tseng	Neighborhood Health Center	Health care provider	2019- present
Colleen Reuland	Oregon Pediatric Improvement Partnership	Health care quality measurement	2017- present
Jeff Luck	Oregon State University	Health care researcher	2017- present
Melinda Muller	Legacy Health	Hospital representative	2017- present
Lynnea Lindsey	PeaceHealth	Behavioral health and addiction services	2017- present
Tom Syltebo	Oregon Educators Benefit Board	OEBB representative	2017- present
Jon Collins	Oregon Health Authority	OHA representative	2017- present
Shaun Parkman	Public Employees Benefit Board	PEBB representative	2017- present
VACANT		Health care provider	
VACANT		Representing insurers, large employers or multiple employer welfare arrangements;	
VACANT		DCBS Representative	

APPENDIX 2: Criteria for Measure Selection

Adopted November 2018

Each individual measure **MUST PASS** all of the following criteria.

The measure…

1. Is likely to create positive change towards an identified goal.
2. Assesses an activity or type of care that not been demonstrated to be harmful or ineffective for the population to which it is applied.
3. Can be used for minimum of three years. [Statutory requirement of HPQMC]
4. Includes adequate detail for results to be aggregated and reported comparably.
5. Maps to the planned use and timeline over which change will be measured.

Individual measure **NEED TO MEET SOME** of these principles and are not required to meet all.

The measure…

1. Has research evidence or professional consensus that the care or activity measured will successfully achieve an identified goal.
2. Fills a gap in current measures.
3. Is currently in active use.
4. Is understandable to consumers and other audiences.
5. Uses a readily available data source, or the benefit will outweigh the reporting burden on providers, plans, and the state.
6. Has current performance that falls significantly short of goal, indicating meaningful opportunity for improvement.
7. Is one for which improvement is reasonably attainable.
8. Assesses integration of care types within a single setting.
9. Improves integration across sectors by aligning work towards a common goal.
10. Incentivizes transformation to new structures or types of care that are not widely available currently.

Measure Set Criteria:

1. Representative across conditions addressed (physical, behavioral, substance use, and oral conditions)
2. Representative across the sectors whose work is being measured (outpatient specialty, hospital, primary care, specialty behavioral health, dental, etc.)
3. Representative across data source (claims, clinical, patient questionnaire)
4. Representative across population measured, focus on populations of special concern, and representation of the diversity of patients served.

5. Include measures of system capacity, processes, outcomes, waste, and costs, with some measures supporting integration and transformation.
6. Comprehensiveness while eliminating redundancy and minimizing the total number of measures

Appropriate use criteria:

HPQMC may make optional recommendations about the use of a measure.

1. Size of population for which measure will be statistically sound, indicating true change in performance over time or across populations or organizations.
2. Recommended population or entity being measured with consideration to degree of influence over performance improvement.
3. Appropriateness of disaggregating measure based on race, ethnicity, language, disability, or other characteristic.
4. Appropriateness of risk adjustment for populations of patients with differing health or social conditions.
5. Recommended benchmark, if available, or process to determine benchmark if none exists.
6. Recommendations on data collection method to minimize reporting burden
7. Timeline for implementation or over which change would be expected
8. Populations or settings for which measure is known or expected to be reliable and valid.

APPENDIX 3: Selection criteria for priority measures

Adopted February 2020

Performance measures endorsed by national bodies have been assessed as evidence-based, valid and reliable. The following criteria have been developed so that the HPQMC may consider measures that have not been subject to this type of review by national measure bodies.

1. The measure addresses an HPQMC and/or OHPB health priority topic for which there is a gap in the HPQMC Measures Menu.
2. No measures specific to the topic have been endorsed by HPQMC, by national metric endorsing body, or the HPQMC has evaluated the nationally endorsed measures as failing to meet other HPQMC measure selection criteria.
3. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health and/or patient experience. Evidence may include community and consumer experience-informed research.
4. Structured pilot testing or local experience operationalizing the measure has confirmed:
    a. operational feasibility, including how the metric is collected, scored and reported, and
    b. face validity or perceived positive impact of metric use on a care process or outcome.

If a measure meets the above criteria, is adopted by the HPQMC, and is selected and implemented for use by OEBB, OHP or PEBB, it may remain in the Measures Menu only if the following additional criteria are met:

1. OHA or another entity approved by the HPQMC assesses the measure for operational feasibility, reliability, validity and impact no later than 18 months after the initial OEBB, OHP or PEBB contractual effective date for incentive use of the measure*, and the results of the assessment are reviewed by the HPQMC and
    a. confirm measure operational feasibility,
    b. provide no evidence suggesting poor reliability or poor validity, and
    c. provide evidence that benefits to members outweigh the risks.
2. OHA or another entity approved by the HPQMC begin to assess the measure for operational feasibility, reliability, validity and impact no later than 36 months after the initial OEBB, OHP or PEBB contractual effective date for incentive use of the measure and the results of the assessment are reviewed by the HPQMC and
    a. confirm measure operational feasibility,
    b. provide evidence of reliability and validity, and
    c. provide evidence that benefits to members outweigh the risks.

*The first day of the performance period for which the measure was applied for incentive purpose.

APPENDIX 4: Guidelines for Measure Governance

Adopted January 2019

Purpose:

To define how HPQMC will respond when the steward of an adopted measure changes the specifications of a measure or the data source that feeds the measure.

Assumptions:

1. This only applies to measures that are selected by any user, not to all measures on the comprehensive aligned measure list.
2. The timeframe between HPQMC measure adoption and implementation by any user is 9 months. At the longest stretch, measures are adopted in March and implemented the following January.

Background:

HPQMC selects a measure based on its intent, measurement outcome and whether it meets measure criteria at the time of review. HPQMC does not change or make modifications to the technical specifications as they are written by the measure steward. The measure steward is the authoritative body for any changes to measure technical specifications. Users of the measure accept the technical specifications of that measure as written by the measure steward and any subsequent changes to those specifications by the measure steward.

Guidelines:

Measure adoption includes the specifications for the measure as they exist when the measure set is released. If the steward makes changes between this time and the start of the measurement year, *those changes will be reviewed and reconsidered using the following process.*

1. If stakeholders or staff note a change **in measure intent or measure definition**, the measure will be presented for review and discussion at HPQMC to determine the best next step. Feedback from potential users of this measure will be considered in any final decisions.
2. If stakeholders or staff note a change **in process or technical specifications**, and no change in measure intent or measurement definition, the measure will stay on the list with the updated specifications made by the measure steward. Operational impacts and changes will be to the discretion of the user that selected the measure.
3. Measures that use national HEDIS measures or eCQMs must use the most current HEDIS specs that apply to the measurement year without adaptation. These are critical to aligned state and federal reporting.

APPENDIX 5: HPQMC Aligned Measure Menu (including March 2022 updates)

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
1	Childhood Immunization Status (Combo 3, starting in measurement year 2022; replaces Combo 2)	0038	Percentage of children that turned 2 years old during the measurement year and had the Dtap, IPV, MMR, HiB, HepB, VZV, and PCV vaccines by their second birthday.	NCQA	Claims/ Immunization registry	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			Y
2	Immunizations for Adolescents (Combo 2)	1407	Percentage of adolescents that turned 13 years old during the measurement year and had the meningococcal, Tdap, and HPV vaccines by their 13th birthday.	NCQA	Claims/ Immunization registry	Prevention/Early Detection - Physical Health Conditions	Adolescent	All			Y			Y
3	Well-Child Visits in the First 30 Months of Life **^^**	1392	Percentage of children between 15 and 30 months old during the measurement year: Two or more well-child visits.	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			
4	Child and Adolescent Well-Care Visits **^^**	1516	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit during the measurement year	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			
5	Developmental Screening in the First Three Years of Life	1448	Percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life.	OHSU	Claims	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024	Percentage of children ages 3 to 17 that had an outpatient visit with a PCP or OB/GYN practitioner and whose weight is classified based on body mass index percentile for age and gender.	NCQA	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Physical Health Conditions	Children, Adolescent	All			Y			
7	Obesity Evidence-based Multisector Interventions for Obesity Prevention and Treatment **^**	NA	Implementation and documentation of multi-sector, community-based interventions that are evidence-based in the prevention and treatment of obesity.	OHA	Attestation	Prevention/Early Detection - Physical Health Conditions	Children, Adolescent, Adult, Older Adult	All			Y			Y
8	Chlamydia Screening	0033	Percentage of women ages 16 to 24 that were identified as sexually active and had at least one test for Chlamydia during the measurement year.	NCQA	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Physical Health Conditions	Adolescent	Female			Y			Y
9	Colorectal Cancer Screening	0034	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	NCQA	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Physical Health Conditions	Adult, Older Adult	All			Y			
10	Breast Cancer Screening	2372	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Physical Health Conditions	Adult, Older Adult	Female			Y			
11	Cervical Cancer Screening	0032	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	NCQA	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Physical Health Conditions	Adult	Female			Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
12	Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy	NA	Percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.	OHA	Claims	Prevention/Early Detection - Physical Health Conditions	Adolescent, Adult	Female			Y			Y
13	Prenatal & Postpartum Care - Timeliness of Prenatal Care	1517	Percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Adolescent, Adult, Older Adult	Female			Y			Y
14	Prenatal & Postpartum Care - Postpartum Care	1517	Percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Adolescent, Adult, Older Adult	Female			Y			Y
15	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	1927	Percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Adult	All		Y	Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
16	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1932	Percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Adult	All		Y	Y			
17	Screening for Depression and Follow-Up Plan	0418	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.	CMS	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Mental Health Conditions	Adolescent, Adult, Older Adult	All			Y			
18	Depression Screening and Follow-Up for Adolescents and Adults	NA	Percentage of members 12 years of age and older who (1) were screened for clinical depression using a standardized tool and, (2) if screened positive, received follow-up care.	NCQA	Clinical Data	Prevention/Early Detection - Mental Health Conditions	Adolescent, Adult, Older Adult	All			Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
19	Health Aspects of Kindergarten Readiness: CCO System-Level Social-Emotional Health	N/A	The aim of this measure is that children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs. The measure has four components: : 1) Social-Emotional Health Reach Metric Data Review and Assessment 2) Asset Map of Existing Social-Emotional Health Services and Resources 3) CCO-Led Cross-Sector Community Engagement 4) Action Plan to Improve Social-Emotional Health Service Capacity and Access	Oregon Pediatric Improvement Partnership (OPIP) and Children's Institute	Attestation (years 1-3)		Children	All		Y				
20	Tobacco Use: Screening and Cessation Intervention	0028	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	AMA-PCPI	Claims/Clinical Data *(eCQM measure)*	Prevention/Early Detection - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All			Y			Y
21	Cigarette Smoking Prevalence	NA	Percentage of Medicaid members (ages 13 and older) who currently smoke cigarettes or use other tobacco products.	OHA	Clinical Data	Prevention/Early Detection - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All			Y			Y

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
22	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)	NA	Percentage of patients ages 12 years and older who received an age-appropriate screening and, of those with a positive full screen, percentage who received a brief intervention or referral to treatment.	OHA	Clinical Data	Prevention/Early Detection - Substance Use Disorder (SUD) Conditions	Adolescent, Adult, Older Adult	All			Y			
23	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT) in the ED	NA	Percentage of patients ages 12 years and older with a qualifying ED visit during the measurement period, with one or more alcohol or drug use screenings using an age-appropriate, validated screening tool, and if screened positive, received a brief intervention.	OHA	Claims	Prevention/Early Detection - Substance Use Disorder (SUD) Conditions	Adolescent, Adult, Older Adult	All					Y	
24	Sealant Receipt on Permanent 1st Molars	NA	Percentage of enrolled children, who have ever received sealants on permanent **first** molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate	DQA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent	All	Y					
25	Sealant Receipt on Permanent 2nd Molars	NA	Percentage of enrolled children, who have ever received sealants on permanent **second** molar teeth: (1) at least one sealant and (2) all four molars sealed by the 15th birthdate	DQA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent	All	Y					
26	Members Receiving Preventive Dental or Oral Health Services	NA	Percentage of enrolled children (ages 0-18) and adults (ages 19 and older) who received a preventive dental service during the measurement year.	OHA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent, Adult, Older Adult	All	Y					

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
27	Oral Evaluation for Adults with Diabetes	NA	Percentage of adults with diabetes who received at least one oral evaluation within the reporting year.	OHA (modified from DQA/ NCQA)	Claims	Prevention/Early Detection - Oral Health Conditions	Adult, Older Adult	Adults	Y					
28	Mental and Physical Health and Oral Health Assessment Within 60 Days for Children in DHS Custody	NA	Percentage of children ages 0-17 who received a physical health assessment, children ages 1-17 who received a dental health assessment, and children ages 4-17 who received a mental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care).	OHA	Claims/Social Service Data	Prevention/Early Detection - All Conditions	Children, Adolescent	All	Y	Y	Y			
29	Controlling High Blood Pressure	0018	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA	Claims/Clinical Data *(eCQM measure)*	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y	Y		

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
30	Statin Therapy for Patients with Cardiovascular Disease	NA	Percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who (1) were dispensed at least moderate-intensity statin therapy and who (2) remained on a at least moderate-intensity statin medication for at least 80 percent of the treatment period.	NCQA	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y	Y		
31	Statin Therapy for Patients with Diabetes	NA	Percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who (1) were dispensed at least one statin medication of any intensity during the measurement year and who (2) remained on a statin medication of any intensity for at least 80 percent of the treatment period.	NCQA	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y	Y		
32	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	NCQA	Claims/Clinical Data *(eCQM measure)*	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
33	Comprehensive Diabetes Care: Eye Exam	0055	Percentage of patients 18-75 years of age with diabetes 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.	NCQA	Claims/Clinical Data *(eCQM measure)*	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y	Y		
34	Optimal Asthma Control	NA	Percentage of pediatric (5-17 years of age) and adult (18-50 years of age) patients who had a diagnosis of asthma and whose asthma was optimally controlled during the measurement period as defined by achieving BOTH of the following (1) asthma well-controlled as defined by the most recent asthma control tool result available during the measurement period and (2) patient not at elevated risk of exacerbation as defined by less than two ED visits and/or hospitalizations due to asthma in the last 12 months.	MNCM	Clinical Data	Chronic Disease and Special Health Needs - Physical Health Conditions	Children, Adolescent, Adult, Older Adult	All			Y	Y		
35	Asthma Medication Ratio	1800	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA	Claims/ Clinical measure	Chronic Disease and Special Health Needs - Physical Health Conditions	Children, Adolescent, Adult, Older Adult	All			Y	Y		

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
36	Antidepressant Medication Management	0105	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment for (1) 12 weeks and (2) 6 months.	NCQA	Claims/Clinical Data *(eCQM measure)*	Chronic Disease and Special Health Needs - Mental Health Conditions	Adult, Older Adult	All		Y	Y			
37	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NA	Percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who have a PHQ-9 tool administered at least once during a four-month period.	NCQA	Clinical Data	Chronic Disease and Special Health Needs - Mental Health Conditions	Adolescent, Adult, Older Adult	All		Y	Y			
38	Follow-Up After Hospitalization for Mental Illness	0576	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within (1) 30 days and (2) 7 days after discharge.	NCQA	Claims	Chronic Disease and Special Health Needs - Mental Health Conditions	Children, Adolescent, Adult, Older Adult	All		Y			Y	
39	Follow-up After ED Visit for Mental Illness	NA	Percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within (1) 30 days and (2) 7 days of the ED visit.	NCQA	Claims	Chronic Disease and Special Health Needs - Mental Health Conditions	Children, Adolescent, Adult, Older Adult	All		Y	Y		Y	

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
40	Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence	NA	Percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD within (1) 30 days and (2) 7 days of the ED visit.	NCQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adolescent, Adult, Older Adult	All		Y	Y		Y	
41	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0004	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.	NCQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adolescent, Adult, Older Adult	All		Y	Y		Y	
42	Family Experiences with Coordination of Care (FECC)	Multi ple	The FECC Survey is made up of 20 separate and independent quality indicators related to care coordination for children with medical complexity. The survey address care coordination services, messaging, and care/transition plans.	Seattle Children's Hospital	Survey	Chronic Disease and Special Health Needs - All Conditions	Children, Adolescent	All			Y	Y		
43	Pediatric Integrated Care Survey (PICS)	NA	The PICS was developed to measure integrated care from the perspective of the adult patient, capturing the notions of continuity over time and alignment of efforts by professionals, patients, and family members across settings and systems. The 5 constructs underlying the 19-item core instrument are: access, communication, family impact, care goal creation, and team functioning.	Boston Children's Hospital	Survey	Chronic Disease and Special Health Needs - All Conditions	Children, Adolescent	All			Y	Y		

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
44	Cesarean Rate for Nulliparous Singleton Vertex	0471	Percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.	TJC	Claims/Clinical Data	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Adolescent, Adult, Older Adult	Female			Y		Y	
45	Ambulatory Care	NA	Number of ED visits and ED visits per 1,000 member months, regardless of the intensity or duration of the visit, for members of all ages.	NCQA	Claims	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Children, Adolescent, Adult, Older Adult	All			Y		Y	
46	Standardized Healthcare-Associated Infection Ratio	NA	Hospital-reported standard infection ratios (SIR), adjusted for the proportion of members discharged from each acute care hospital, for four different healthcare-associated infections (HAI): • HAI-1: Central line-associated blood stream infections (CLABSI) • HAI-2: Catheter-associated urinary tract infections (CAUTI) • HAI-5: Methicillin-resistant Staphylococcus aureus (MRSA) blood laboratory-identified events (bloodstream infections) • HAI-6: Clostridium difficile laboratory-identified events (intestinal infections)	NCQA	Clinical Data	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Children, Adolescent, Adult, Older Adult	All					Y	
47	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA	Claims/Clinical Data	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Adult, Older Adult	All			Y			

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
48	Disparity Measure: Emergency Department Utilization among Members with Mental Illness	NA	Number of ED visits per 1,000 member months for adult members enrolled within the organization who are identified as having experienced mental illness.	Homegrown CCO	Claims	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Adult, Older Adult	All		Y	Y		Y	
49	Plan All-Cause Readmission	1768	Number of acute inpatient stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA	Claims	System Integration and Transformation	Adult, Older Adult	All					Y	
50	Patient-Centered Primary Care Home (PCPCH) Enrollment	NA	Percentage of CCO members who were enrolled in a recognized patient-centered primary care home (PCPCH).	OHA	Plan Reporting	System Integration and Transformation	Children, Adolescent, Adult, Older Adult	All			Y			
51	Social Determinants of Health: Social Needs Screening & Referral	NA	To build system capacity, this measure requires CCOs to (1) prepare for equitable, trauma-informed, and culturally responsive screening and referrals, (2) work with community-based organizations to build capacity for referrals and meeting social needs, and (3) support data sharing between CCOs, providers, and community-based organizations. Later, CCOs start reporting social needs screening and referral data.	OHA	Attestation and Plan Reporting	System Integration and Transformation	Children, Adolescent, Adult, Older Adult	All						

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
52	Meaningful language access to culturally responsive health care services ^	NA	The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services.	OHA	Plan Reporting	Patient Access and Experience	Children, Adolescent, Adult, Older Adult	All	Y	Y	Y	Y	Y	
53	CAHPS® 5.0H	NA	The CAHPS Health Plan Survey 5.0H provides information on the experiences of commercial and Medicaid members with the health plan and gives a general indication of how well the health plan meets members' expectations. The survey includes the following composites: getting needed care, getting care quickly, how well doctors communicate, health plan customer service, and rating their health plan.	NCQA	Survey	Patient Access and Experience	Children, Adolescent, Adult, Older Adult	All			Y	Y		
54	Dental CAHPS	NA	The CAHPS Dental Plan Survey is a standardized questionnaire with 39 questions that asks adult enrollees in dental plans to report on their experiences with care and services from a dental plan, the dentists, and their staff.	AHRQ	Survey	Patient Access and Experience	Children, Adolescent, Adult, Older Adult	All	Y					

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
55	HCAHPS	0166	The HCAHPS 27-items survey instrument that asks people to report on their recent experiences with inpatient care. The adult and child versions of the survey focus on aspects of hospital care that are important to patients, including: communication with doctors and nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	CMS	Survey	Patient Access and Experience	Children, Adolescent, Adult, Older Adult	All					Y	
56	Total Cost of Care Population-based PMPM Index	1604	The Total Cost Index (TCI) is a measure of a primary care provider's risk-adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	HealthPartners	Claims	Cost/Efficiency	Children, Adolescent, Adult, Older Adult	All	Y	Y	Y	Y	Y	

#	ENDORSED Measures	NQF #	Measure Description	Measure Steward	Data Source*	Domain	Population Characteristics		Sector					
							Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health	Hospital	Public Health
57	Total Resource Use Population-based PMPM Index	1598	The Resource Use Index (RUI) is a risk-adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	HealthPartners	Claims	Cost/Efficiency	Children, Adolescent, Adult, Older Adult	All	Y	Y	Y	Y	Y	

(Data Source) Clinical data includes electronic health records, registry data, and paper medical records. Claims/clinical data includes measures that require claims and clinical data, and measures that require claims or claims and clinical data. Electronic clinical quality measures (eCQMs) are indicated using italic font.

^ Consistent with selection criteria, measure will be assessed for operational feasibility, reliability, validity and impact at 18 and 36 months following implementation by a state-funded health plan (Medicaid CCOs, OEBB, PEBB, Oregon Health Insurance Exchange).

^^ Measure technical specifications and measure name were updated to remain consistent with changes by the measure steward.

Measure Steward Abbreviations

AHRQ: Agency for Healthcare Research and Quality
AMA-PCPI: American Medical Association-convened Physician Consortium for Performance Improvement
CMS: Centers for Medicare & Medicaid Services
DQA: Dental Quality Alliance
MNCM: Minnesota Community Measurement
NCQA: National Committee for Quality Assurance
OHA: Oregon Health Authority
OHSU: Oregon Health & Science University
PQA: Pharmacy Quality Alliance
TJC: The Joint Commission

APPENDIX 6: 2019 Measures Selected by State-Funded Health Plans

The following measures were selected from the initial aligned measure menu, though the programs applied the measures to different measurement years. The following reports are available:

1. CCO Report – https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf
2. PEBB report – https://www.oregon.gov/oha/PEBB/docs/boardattachments/2019-Board-Meeting/PB%20Attachment%207-%20Quality%20Metrics%20Update%20-March%2019,%202019.pdf
3. OEBB report – https://oha.granicus.com/MediaPlayer.php?clip_id=491

CCO quality incentive measures using 2019 data	PEBB and OEBB contract measures, reporting in 2019 based on 2018 data
Alcohol and drug misuse screening, brief intervention and referral for treatment (EHR-based SBIRT)	Antidepressant Medication Management
Assessments within 60 days for children in DHS custody	Breast Cancer Screening
Cigarette smoking prevalence	Members receiving preventive dental services
Disparity measure: Emergency department utilization among members with mental illness	Prenatal and Postpartum Care – Timeliness of Prenatal Care
Effective contraceptive use among women at risk of unintended pregnancy	Statin therapy for patients with diabetes
Oral evaluation for adults with diabetes	Follow-up after hospitalization for mental illness
Weight assessment and counseling for nutrition and physical activity for children and adolescents	
Shared measures but different measurement years for reporting	
Adolescent well-care visit	

Ambulatory Care: Emergency Department utilization per 1000 member months
CAHPS composite: access to care
Childhood immunization status, Combo 2
Colorectal cancer screening
Comprehensive Diabetes Care: HbA1c Poor Control
Controlling high blood pressure
Dental sealants on permanent molars for children
Developmental screening in the first three years of life
Patient-Centered Primary Care Home enrollment
Prenatal and Postpartum Care – Postpartum care
Screening for depression and follow-up plan

APPENDIX 7: 2020 Measures Selected by State-Funded Health Plans

The following measures were selected from the aligned measure menu, though the programs applied the measures to different measurement years. The following report is available for this measurement year:

1. CCO Report – https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-Annual-Report_FINAL.pdf

Carriers reported their quality measures per their contract requirements. but PEBB and OEBB did not publish a final report in 2020 for measurement year 2019.

CCO quality incentive measures using 2020 data	PEBB and OEBB contract measures, reporting in 2020 based on 2019 data
Assessments within 60 days for children in DHS custody	Adolescent well-care visits
Emergency department utilization among members with mental illness	Ambulatory Care: Emergency Department utilization per 1000 member mos.
Immunizations for Adolescents (Combo 2)	Antidepressant Medication Management
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence	Breast Cancer Screening
Oral evaluation for adults with diabetes	Colorectal cancer screening
Screening for depression and follow-up plan	Controlling high blood pressure
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Dental sealants on permanent molars for children
	Developmental screening in the first three years of life
	Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence
	Follow-up After ED Visit for Mental Illness
	Follow-up after hospitalization for mental illness
	Patient-Centered Primary Care Home enrollment

Plan All-Cause Readmission
Prenatal and Postpartum Care – Timeliness of Prenatal Care
Statin therapy for patients with diabetes
Weight assessment and counseling for nutrition and physical activity for children and adolescents

2020 Shared measures but different measurement years for reporting
Alcohol and drug misuse screening, brief intervention and referral for treatment (EHR-based SBIRT)
Childhood immunization status, Combo 2
Cigarette smoking prevalence
Comprehensive Diabetes Care: HbA1c Poor Control
Members receiving preventive dental services
Prenatal and Postpartum Care – Postpartum care

APPENDIX 8: 2021 Measures Selected by State-Funded Health Plans

The following measures were selected from the measure menu. The programs used the same reporting measurement year. Reports for this period will be released later in 2022.

CCO quality incentive measures	PEBB and OEBB contract measures
Assessments within 60 days for children in DHS custody	Breast Cancer Screening
Emergency department utilization among members with mental illness	Colorectal cancer screening
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence	Controlling high blood pressure
Oral evaluation for adults with diabetes	Developmental screening in the first three years of life
Screening for depression and follow-up plan	Follow-up after hospitalization for mental illness
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Patient-Centered Primary Care Home enrollment
Meaningful Language Access to Culturally Responsive Health Care Services	Prenatal and Postpartum Care – Timeliness of Prenatal Care
	Statin therapy for patients with diabetes
	Weight assessment and counseling for nutrition and physical activity for children and adolescents
	Weight assessment and counseling for nutrition and physical activity for children and adolescents

Shared measures
Alcohol and drug misuse screening, brief intervention and referral for treatment (EHR-based SBIRT)

Childhood immunization status (Combo 2)
Immunizations for Adolescents (Combo 2)
Cigarette smoking prevalence
Comprehensive Diabetes Care: HbA1c Poor Control
Prenatal and Postpartum Care – Postpartum care

APPENDIX 9: 2022 Measures Selected by State-Funded Health Plans

The following measures have been selected from the measure menu. The programs are using the same reporting measurement year. Reports for this period are planned for release in 2023.

CCO quality incentive measures	PEBB and OEBB contract measures
Child and adolescent well-care visits	Breast cancer screening
Cigarette smoking prevalence	Colorectal cancer screening
Initiation and Engagement of Alcohol or Other Drug Treatment (IET)	Comprehensive diabetes care: Eye exam
Health aspects of kindergarten readiness: CCO system-level social emotional health	CAHPS - Overall Satisfaction with Health Plan and Getting Needed Care Composite
Meaningful language access to culturally responsive health care services	Follow-up after hospitalization for mental illness
Members receiving preventive dental or oral health services	Plan all-cause readmission
Mental, physical and oral health assessments for children in DHS custody	Statin therapy for patients with cardiovascular disease
Oral evaluation for adults with diabetes	Statin therapy for patients with diabetes
Prenatal & postpartum care – Postpartum care	Weight assessment and counseling for nutrition and physical activity for children and adolescents
Screening, Brief Intervention and Referral to Treatment (EHR-based SBIRT)	
Screening for depression and follow-up plan	
Shared measures	
Childhood immunization status (Combo 3)	
Comprehensive diabetes care: HbA1c poor control	
Immunizations for adolescents (Combo 2)	

APPENDIX 10: Selection criteria for measures that address state priorities and gaps

August 6, 2019

Oregon Health Policy Board

Kate Brown, Governor

Oregon Health Authority

Health Plan Quality Metrics Committee

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Dear Vice-Chair Parkman and Committee Members,

On behalf of the Oregon Health Policy Board (the Board), I am writing to follow-up on Vice-Chair Parkman's presentation to the Board on June 4, 2019. Thanks to your success in ensuring measures in Oregon are coordinated, aligned and evidence-based, Oregon continues to be a national leader in health system transformation. Your efforts to align health outcome and quality measures for the state-funded health plans have created a solid foundation for transformative work.

Vice-Chair Parkman noted in his June presentation to the Board that there is a tension in the Health Plan Quality Metrics Committee (HPQMC)'s work to consider and develop innovative measures that foster and measure greater transformation, while also ensuring measures are as rigorous as possible and minimize burden to providers. While addressing provider burden should continue to be an important priority for the HPQMC, an explicit priority of your work must also be to accelerate health system transformation by selecting measures that foster improved health outcomes for all Oregonians, especially for populations that have been historically marginalized and experience the greatest health disparities.

Governor Brown's recent letter to the Metrics and Scoring Committee emphasizes the importance of innovative performance measures in driving health system transformation and urges the Metrics and Scoring Committee to establish transformational metrics that support the four CCO 2.0 key goals and prioritize children's health.

- Improving the behavioral health system and addressing barriers to access to and integration of care;
- Increasing value and pay for performance;

- Focusing on social determinants of health and health equity; and
- Maintaining sustainable cost growth and ensuring financial transparency.

The Governor's direction is clear that the metrics to be developed and adopted must ensure that we meet the goals of CCO 2.0. The Oregon Health Policy Board and the Oregon Health Authority are equally driven by these priorities and the Board directs HPQMC to share this commitment and help drive the next phase of health system transformation in Oregon.

Specific guidance from the Board regarding HPQMC's scope and charge in the coming years.

1. Balance the need for nationally standardized measures with the need to be transformative by including innovative measures that target Oregon's greatest needs through new concepts and methods that may not have a national standard or model.

The Committee should continue to produce an aligned measure menu that is used by all state-funded health plans and meets rigorous standards for national and best practice measurement. New and innovative measures that are tailored to Oregon's unique needs and priorities, like health equity and value-based-purchasing, but may not be in use nationally, are also critical to this work. We charge the Committee with developing a specific process and criteria to better evaluate new and innovative measures. The Committee shall recommend a process and evaluation criteria for the Board's review and approval. OHA is directed to provide technical assistance to the Committee to develop this process and criteria.

2. Include a health equity measure in the aligned measure menu and report measure demographic information.

In alignment with the Governor's priorities and the values of the Board and OHA, the Board charges HPQMC with considering measure(s) of health equity in the next measure menu. It is the Board's clear expectation that at least one measure of health equity will be adopted by the Committee. OHA is charged with continuing to explore innovative ways to supplement and improve demographic data to enhance reporting on existing measures and support the development of a new health equity measure. OHA's Office of Equity and Inclusion and Health Policy & Analytics Division are charged specifically with supporting HPQMC and with working collaboratively with those communities most likely to be impacted to develop a new measure of health equity.

3. Produce an aligned core measure set that can be used by all health plans across Oregon.

The HPQMC should continue to prioritize measure alignment which will ease administrative and provider reporting burden while increasing transparency and accountability. A core set of measures for all health plans across the state will promote greater alignment across plans, help to ease reporting burden, and is consistent with innovation across the national landscape.

The Oregon Health Policy Board requests the development of a core set of between six and 12 measures, directed toward health plans, that can apply to public and commercial carriers. The core set will be voluntary but should be developed collaboratively with stakeholders and build on measure alignment already in place. The HPQMC is charged with submitting a progress report to the Board regarding core measures annually, including information about adoption of the core set across all plans in the state. The report should be succinct and identify recommended actions that will improve utilization of the core set as well as barriers to adoption and utilization.

As HPQMC considers its work over the coming biennium, we also urge consideration of measures that align with the Governor's direction and priorities for developing measures that address quality for the implementation of SB 889 (2019), the health care cost growth benchmark program.

To remain on the forefront of health system transformation, Oregon must continue to inform the national conversation about what best-practice combined with innovation looks like. We urge the HPQMC to remain steadfast in pushing this frontline in your deliberations and actions. We recognize these are significant charges that will affect the HPQMC's work plan and we look forward to ongoing collaboration with the Committee as we continue to work toward our shared priority of better health for all Oregonians.

Sincerely,

Carla McKelvey, MD, MPH

OHPB Chair