Health Aspects of Kindergarten Readiness Measure: System-Level Social-Emotional Health Metric - FAQ

Updated: February 2024

This document provides frequently asked questions and answers for the new CCO system-level social-emotional health measure, part of the health aspects of kindergarten readiness measurement strategy. This Frequently Asked Questions (FAQ) document adds to the detailed measure specification sheet.[1]

In addition to this FAQ and the measure specification sheet, please see below for additional resources:

- History and development of the metric, including three pilot webinar recordings by the measure steward that provide details about each component of the metric
- Statewide and CCO-specific reach metric data reports: CCOs use reach metric data reports created by OHA to inform their work with partners on system-level social emotional health improvement efforts.

Please send any additional questions to metrics.questions@odhsoha.oregon.gov.

Contents

General questions

1. What is social-emotional health?

Social-emotional health is the developing capacity of the child from birth to 5 years old to:

- Form close and secure relationships with their primary caregivers and other adults and peers;
- Experience, manage and express a full range of emotions; and
- Explore the environment and learn all in the context of family, community and culture

Babies, toddlers and young children can and do suffer from mental health conditions caused by trauma, neglect, biological factors and environmental situations that disrupt their social-emotional development.

[1] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Final-2023-CCO-System-Level-Social-Emotional-Health-Specifications.pdf

2. What are services that address social-emotional health? (Updated 2/8/24)

The types of CCO-covered services that address social-emotional health include: 1) assessments (including Bright Futures recommended screening), evaluation or testing to determine a diagnosis or need for treatment; or 2) issue-focused services that include brief interventions and treatments that address the social-emotional delays or risk factors identified. Below are links to the broad list of current procedural terminology (CPT)/diagnostic codes of services and assessments that can be used in helping a family with young children ages 0–5 and are included in the reach metric component of this measure:

- Social-emotional health HEDIS-style code list (for CCO QI staff)
- Social-emotional health descriptive code list (for clinical staff)

The purpose of the system-level metric is to support efforts that address the system of CCO-covered services that provide this continuum of services and then identify and implement an action plan that includes an aim to increase access to and receipt of issues-focused intervention and treatment services. In alignment with parent and provider-level feedback, the future proposed child-level metric will focus on issue-focused intervention and treatment services.

3. What is the vision of the system-level social-emotional health measure?

The vision 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 drives CCOs to address complex system-level factors that impact the services kids and families receive and how they receive them, and for which there may be payment or policy barriers that need to be addressed. The measure stewards, Children's Institute and the Oregon Pediatric Improvement Partnership (OPIP), designed the measure requirements (Components 1–4) to achieve this vision.

4. What are the four components of this measure?

There are four interdependent components of the measure.

Component 1: CCO reviews and interprets its social-emotional health **reach report**, which is provided by OHA in January each year. The reach report will help each CCO understand the reach of existing social-emotional health screenings, assessments and services; examine the data for populations with historical and contemporary inequitable outcomes; and assess its payment policies and strategies that affect young children.

Component 2: CCO develops an **asset map** of existing social-emotional health services and resources in its community.

Component 3: CCO leads **cross-sector community engagement** activities to review social-emotional health reach data, assets, gaps, and discuss priorities for improvement.

Component 4: CCO works with cross-sector community partners to develop an **action plan** to improve provision of social-emotional health services for children birth to age 5.

5. Does the measure focus on specialty treatment services or a broader spectrum of screening, assessment, brief intervention and social-emotional health treatment services? (Updated 2/8/24)

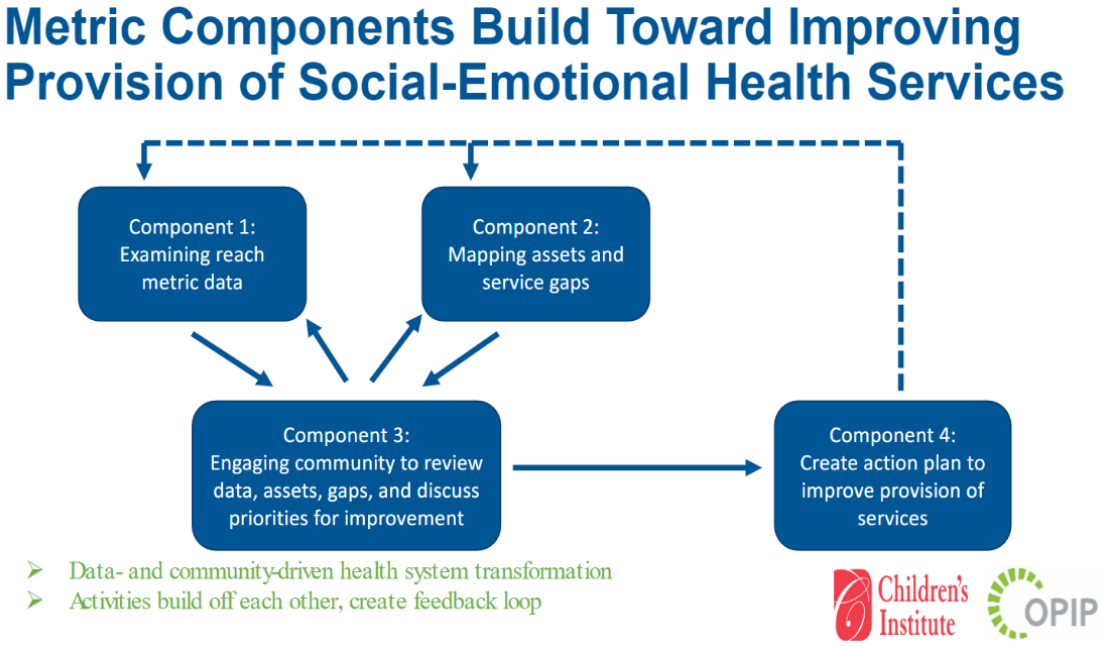
The system-level measure addresses a broad spectrum of social-emotional health services that can be provided by CCO-contracted providers, not only specialty treatment services. The range of services the system-level measure focuses on includes screening and early identification, assessment of social-emotional health and potential delays, and issue-focused interventions that can include brief interventions and treatment services that can be provided in a variety of settings, not just in specialty behavioral health. Starting in 2024, CCOs are required to ensure their action plan includes a focus on access to and provision of issue-focused intervention and treatment services, which can be provided in a variety of settings and is not limited to specialty behavioral health.

The measure vision 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. While this includes specialty treatment services, the purpose of the measure is broader: To improve equitable access to, and build capacity of, *the full spectrum* of social-emotional health services, from prevention to early intervention to treatment for all children that have a need.

The measure vision is aligned with the American Academy of Pediatrics Bright Futures recommendations and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) recommendations that all children should be screened and assessed for social-emotional health in the first five years and then receive issue-focused services to address any delays or risk factors associated with social-emotional delay. The proposed child-level metric will be focused on issue-focused intervention and treatment services.

6. How do Components 1 (reach report), 2 (asset map), and 3 (cross-sector community engagement) relate?

All four of the measure components are interrelated. Activities in components 1–3 should be happening concurrently so they inform each other, rather than completing component 1 before beginning components 2 and 3. Conversations with community partners and families should be informing how CCOs review reach data and create their asset map. Component 3, the cross-sector community engagement that is required of CCOs each year of the measure (2022–2024), not only builds on components 1 and 2, but feeds into these components. By reviewing the social-emotional reach data and the initial asset map with partners, CCOs may find additional resources and assets to add to the asset map or identify new/different priorities. The diagram below shows how the four components are interrelated.



7. What technical assistance is being provided by OHA related to this metric? (Updated 2/8/24)

The OHA Transformation Center worked in partnership with Artemis Consulting to facilitate a virtual learning collaborative for CCOs May 2022–April 2023. The Transformation Center met individually with CCOs in May and June 2023 to better understand CCOs' successes, challenges and needs related to implementation of this quality incentive metric. These meetings informed the current implementation support which is offered by the Transformation Center in collaboration with Oregon Rural Practice Based Research Network. For more information about support for CCOs see the Transformation Center's System-level social-emotional health metric webpage ("Technical assistance" section) or contact Rachel Burdon, Rachel.E.Burdon@oha.oregon.gov.

8. Can CCOs choose to use additional technical assistance by contracting with consultants for tailored implementation support using their own resources?

Yes.

9. How will OHA assess and approve CCO's attestation to the four components of this metric?

CCOs will meet the measure by attesting to the required components in each year and submitting the asset map and action plan (including updated asset maps and action plans) in each of the first three years of the measure. OHA will review to ensure that each CCO has timely submission and completeness of the attestation survey, asset map and action plan and has attested to meeting each must-pass requirement for the measurement year.

10. Where can I find more information about the system-level social-emotional health metric? (Updated 2/8/24)

- Detailed measure specification sheets: 2022, 2023 and 2024.

- Technical assistance to support measure implementation offered by the Transformation Center.
- Measure development background and three measure pilot webinars:
    - Pilot webinar 1 recording: Overview and Description
    - Pilot webinar 2 recording: Components 1 and 2
    - Pilot webinar 3 recording: Components 3 and 4
- Reach metric overview from Oregon Pediatric Improvement Partnership
- Reach metric Q&A from Oregon Pediatric Improvement Partnership

11. Can a CCO include more information in a deliverable (for example, asset map or action plan) than is required? For example, can a CCO provide an asset map in Year 1 that includes contracted behavioral health services, PCPCH integrated behavioral health services, and community-based services? What types of improvements or changes are expected in these deliverables from year one to years two and three?

The specifications set the minimum standard for development in each year. There is no penalty for engaging ahead of schedule. However, CCOs must still review and update deliverables in each year. For example, between Year 1 and Year 2 there may be differences in contracted behavioral health services, identification of additional community-based services, etc.

12. Will OHA be providing substantive feedback on the 2023 attestation documents (asset maps and action plans)? (Updated 2/8/24)

No, OHA will not be providing specific feedback to CCOs related to their 2023 attestation documentation.

13. What are general updates to the 2024 measure specifications? (Updated 2/8/24)

- The measure steward clarified the language focused on treatment services to be "issue-focused intervention/treatment services" (rather than just therapy services). This includes the breadth and depth of services that are addressing identified social-emotional issues/risks through a continuum of intervention and treatment services captured in List 3-5 of the Component 1 Social-Emotional Reach metric rate.

- The measure steward updated Component 1: Social Emotional Reach Metric by adjusting foster care assessment codes, adding diagnosis codes, updating provider taxonomy codes and removing old CPT codes no longer in use.

- The measure steward made clarifications to Component 2 Asset Mapping:
    - Behavioral Health Services (MY1–MY3): Added therapy modality: "Promoting First Relationships"
    - Patient-Centered Primary Care Integrated Behavioral Health (MY2–MY3)
        - Anchored capacity to a historical lookback of two months
        - Added therapy modalities: "Promoting First Relationships" and "Parent Management and Generalized Evidence-Informed Therapies" (aligned with Brief Intervention approaches);

- Community-Based CCO Contract Social-Emotional Services (MY3) – Clarified the scope of the asset map and added a row of "not applicable."

Component 1 – Reach data report

1. Are the Children's Health Complexity Data incorporated into the reach report? How so?

Yes. The reach report includes aggregated data stratified by social complexity risk factors. Examination of the data for children with specific social complexity factors can inform community-level outreach, partner engagement and potential strategies to target efforts for children with historically inequitable outcomes.

2. Can the data from the reach report provided by OHA be shared with community partners?

Yes. The cross-sector community engagement in Component 3 **requires** CCOs to review the *aggregated* level data from the reach report with community partners, in order to collectively identify gaps and opportunities for collaboration and interventions that might be implemented locally. These conversations will be an integral part of Component 4, for which CCOs are required to work with community partners to create an action plan to improve the social-emotional health of children birth to age 5 in their communities.

In fact, as part of Component 3, on cross-sector community engagement, CCOs are required to share a summary of the information from the reach report with community partners. Component 3 requires community engagement to include at least one or more group level meetings, at which CCOs must display or provide copies of the findings from Component 1.1 and 1.2 (both related to the reach report) and Component 2.1 (asset map). In terms of the reach report, this should include:

- The Social-Emotional Health Reach Metric data presented in the CCO aggregate report and CCO reflections about the implications of the findings for the action plan intended to increase access and capacity of CCO covered social-emotional services (1.1).
- The Social-Emotional Reach Metric data findings for at least one population with historical inequitable outcomes (examples: social complexity factors, race, ethnicity, or geographic region) and CCO reflections about the implications of the findings for the action lan intended to increase access and capacity of CCO covered social-emotional services (1.2).

Because the *child-level* reach report includes protected health information (PHI), CCOs must take the appropriate steps to safeguard the privacy and security of those data, as they would with other PHI.

3. Which policies and contracts are included in Component 1 of the measure (the requirement that the CCO assess payment policies and contracts for the claims and services included in the reach report)?

Component 1 includes reviewing the CCO's written payment policies and contracts with entities that currently provide or could provide services to support social-emotional health for the claims and services included in the metric. The goal is to better understand opportunities to clarify, improve and address gaps in payment policies and contracts. This is meant to ensure a continuum of services are available to address social-emotional health from prevention to treatment, including services provided by community-based organizations and providers.

4. What are updates to Component 1 in the 2024 measure specifications? (Updated 2/8/24)

The measure steward made changes to the reach metric by adjusting foster care assessment codes, adding diagnosis codes, updating provider taxonomy codes, and removing old CPT codes no longer in use. Please see Appendix B: Compendium of codes for the child-level social-emotional reach metric in the measure specification.

5. How were the provider taxonomy codes chosen for inclusion? Why are primary care physician provider taxonomies not included? (Updated 2/8/24)

Most of the codes in the Social Emotional Health Reach metric don't require pairing with a provider taxonomy code. Only the codes in lists 2 and 5 of the metric, which are more general and non-specific CPT codes, require pairing with a diagnosis code (ICD-10) and a provider taxonomy code to be captured in the reach metric. These lists were created to capture some broader claims codes that might be used when young children receive social emotional supports, but the required pairing of the service code to specified diagnosis codes and provider taxonomy codes ensures that the reach metric data will count only those services that are specific to social-emotional supports. Therefore, the provider taxonomy codes are narrowed to clinicians with specialized training and expertise in behavioral health.

The social-emotional health metric development team started by outlining the broad categories of behavioral health clinicians that could serve young children and provide a social emotional assessment or intervention — psychologist, psychiatrist, social worker, developmental behavioral pediatrician, for example. Then OHA helped with listing out the provider taxonomy codes used by these clinical providers. Provider taxonomy codes can be imprecise and inconsistently used, but to meet the intent of the metric to specifically measure direct social emotional services, lists 2 and 5 were included to capture potential billing codes behavioral health clinicians might use in their provision of clinical services to young children. In all likelihood, however, behavioral health clinicians will be using claims in lists 1, 3 and 4 where provider taxonomy pairing is not needed.

Including provider taxonomy codes for general medical providers and primary care providers would unfortunately capture many visits that aren't direct social emotional services. Although primary care providers often provide an immense amount of social emotional support for their patients, the intent of the system-level social emotional health metric is to push the system to build up a workforce specifically trained in behavioral health services for young children. Therefore, the reach metric is aiming to provide a measure of what targeted social emotional assessments or supports children are getting in order to fill the gaps in the system where possible (increasing workforce, training up behavioral health clinicians, enhancing workflows to get kids to behavioral health services, etc.).

Based on feedback received in 2023, the provider taxonomy code list for the 2024 system-level social emotional health metric specifications were updated to include a few additional provider codes for clinicians with behavioral health expertise.

6. Are any services from the identified code list that are billed to caregivers included in reach data (for example, family psychotherapy that is billed to a parent)? (Updated 2/8/24)

The reach metric code lists are specific to services at the child level, with claims that are placed on individual children. Services billed for the parent are not linked to the child.

7. Why is the Developmental Screening code 96110 not included in the reach metric? How is screening for social emotional health in primary care captured if 96110 is not in reach metric? (Updated 2/8/24)

96110 is the CPT code for global developmental screening. Although screening tools for global development (such as the Ages and Stages Questionnaire/ASQ) may include questions on social emotional development, they do not directly assess for social emotional health and do not meet the Bright Futures recommendation of screening for social-emotional delay. Therefore, 96110 was not included in the reach metric since it is generally used for children who receive global developmental screening, **not** direct support or assessment of their social emotional health, which is the focus of this metric.

Because there is a CPT code specific to screening and assessment of social emotional health, that is the CPT code included in the reach metric. This CPT code (96127: Brief emotional/behavioral assessment with scoring and documentation, per standardized instrument) can and should be used when a validated tool that directly assesses social emotional health in young children birth to five is administered. CPT code 96127 is captured on list 1 of the social emotional reach metric.

8. How were the diagnosis codes chosen? (Updated 2/8/24)

The diagnosis list was partially based off the Oregon 0–5 Diagnostic Crosswalk, which is a guidance document created by OHA Behavioral Health listing mental health diagnoses deemed appropriate for young children birth to five, while taking into account Oregon's prioritized list of diagnoses. The reach metric diagnosis code list also includes some additional diagnosis codes that were placed on the list after detailed discussions with OHA Behavioral Health and the social-emotional health metric team, in an effort to include diagnoses that might be used in some broader clinical settings where children might receive social emotional supports. For example, some diagnosis codes were included that might be used by integrated behavioral health when assessing or providing brief interventions in primary care and that are on Oregon's prioritized list of diagnoses.

9. If a provider bills multiple service lines within a single claim, is the Reach metric inclusive of all lines of service or just the primary CPT? (Updated 2/8/24)

The reach metric captures any CPT code that is submitted with a claim on any line of service, not just the primary one.

Component 2 – Asset map

1. What is the reason for developing the asset map (Component 2)?

The asset map is intended to document social-emotional health service and provider capacity and characteristics for a breadth of services that support children birth to age 5 and their families. The asset map will (a) inform conversations with community partners as required in Component 3 of the measure; (b) help highlight disparities in access by examining the geographic location of services and provider race, ethnicity, and languages spoken; and (c) be updated as conversations with community partners identify additional social-emotional assets about which the CCO was previously unaware.

2. Do CCOs need to use the fillable asset map on the OHA webpage for Component 2? (Updated 2/8/24)

No, CCOs are not required to use the OHA-provided template; however, CCOs are required to provide all information outlined on pages 5 and 6 of the 2024 (Year 3) measure specifications. CCOs can use or create their own asset map so long as all fields in the measure specifications are included. Each required field in the asset map is important and necessary, as the fields were identified based on community feedback and have been tested in pilots; they are also linked with identified barriers to access and provide an equity-aligned approach to identifying gaps and opportunities.

3. What do CCOs do with the asset map when providers say they can serve children birth to age 5, but they have not seen any children in this age group in the last two months (or longer)?

These providers should be included in the asset map and categorized accordingly. Pilot testing has shown instances in which providers say they see a particular population but have not billed. This creates an opportunity for the CCO to look more deeply at claims as a way of understanding actual service and provider capacity.

4. What happens when providers serve multiple CCOs? Won't this impact the accuracy of the asset map (Component 2) if providers give the same information to all the CCOs they contract with?

The capacity presented in the asset map is the "best case" and not specific to a payor or region. There may be barriers to access for members of the Oregon Health Plan within a CCO region/coverage area. CCOs could consider sharing information at the community level and with other CCOs when there is overlap.

5. How do we capture what screenings are happening in the community/outside clinic (for example, Head Start)?

The purpose of the metric is to focus on Bright Futures and EPSDT recommended CCO-covered services and social-emotional health services provided within health care environments that the CCO contracts. There are other community partners, such as Head Start, home visiting and early intervention, who conduct screenings as part of their work but are not within the scope of this metric. The intent of this metric is to focus on the role of the health care sector in addressing complex system-level factors that impact the services kids and families receive, how they receive them, and ways CCOs and health systems can improve

the social-emotional support young children 0–5 are receiving. Therefore, if screenings happening in the community are not billed as a claim to the CCO, they will not be captured in the reach metric.

A reason these community-based providers, such as Head Start, are included in the Component 3 activities is that they can provide insight on the health care services needed when they identify children in their own screening efforts. They may also have providers in their systems who can provide issue-focused follow-up services and with whom the CCO may consider developing a contract to ensure they are part of the CCO covered network of services. In year 3 of Component 2, CCOs will be performing asset mapping of these early learning community providers to understand current activities and opportunities for how they may support expansions in CCO-covered services.

Therefore, although screenings happening in the community might not be captured in the reach metric, the required engagement of cross-sector community partners who may be doing screenings or otherwise have a role in supporting the 0–5 population is **crucial** to this work, allowing CCOs to get community feedback and collaboratively design improvement strategies. From extensive community work and focus group surveys, it is clear that the pain point for community partners who care for and may be screening young children for social-emotional delays is the lack of services available to address the needs of the children they identify. If these identified children are connected with behavioral health services as a result of screenings in the community, they will be captured in the reach metric. Given the feedback provided during the first few years of the system-level measure, the measure stewards have made it clear that the child-level social-emotional health measure will **not** include screenings and will solely include therapy services by CCO-contracted providers to address this critical need.

6. Are telehealth services (for both behavioral and physical health) among the set of services that CCOs can and should include in the asset map? This is particularly important to know for rural areas where telehealth is the only option because of lack of capacity.

This measure is telehealth eligible as the qualifying numerator services do not require certain in-person place of service codes in claims data. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services. If providers are offering telehealth for assessments or services for children 0–5 years old, then CCOs can include in the asset map and consider standard of care and best practice for service type and populations served.

7. What type of Patient-Centered Primary Care Homes should be included in the CCO's asset mapping process?

In addition to updating their asset maps from Measurement Year 1, for Measurement Year 2 CCOs are required to collect asset map information for contracted Patient-Centered Primary Care Homes (PCPCHs) to which CCO members birth to five are attributed and that have attested to the PCPCH Standard 3.C.3 to indicate they provide integrated behavioral health services (including population-based, same-day consultations by behavioral health providers). For more details, see the PCPCH Program 2020 Recognition Criteria Technical Specifications and Reporting Guide.

PCPCH Standard 3.C.3 is attestation based with a two-year recognition, so to have the most current information, CCOs would need to confirm with practices they are still meeting 3.C.3.

CCOs can download a list of PCPCHs directly from the PCPCH program's "Recognition for Oregon Payers" webpage. This list is updated each month by OHA. It's a password protected document that includes detailed information about each PCPCH (national provider identifier, tax identifier number, etc.). Each CCO should have the information to access the list. To request access, please contact PCPCH@oha.oregon.gov with your name, title and organization.

8. What is the background on the list of therapy modalities included in the optional, fillable asset map? Must a CCO use only this set of therapies when conducting the asset mapping or is it okay to include other therapies that providers are offering to members?

The measure steward for this component (OPIP) developed the list of therapy modalities for asset mapping based on extensive consultations with behavioral health experts, a detailed literature review and previous improvement efforts in multiple communities across the state, gathering input on the most widely used and well-accepted evidence-based behavioral health modalities for children birth to five with social emotional delays. One key criterion for inclusion on this list was the scientific rating of the specific therapy modality, so as the evidence expands and shifts, more therapy modalities will be added. The therapy modalities listed are those that met a scientific rating of 1–3 at the time the specifications were released and are provided in the context of CCO-covered services. Annually the measure steward will examine updated literature on whether any new therapy modalities have been established that meet the scientific rating and will update the technical specifications accordingly.

For now, this list is included in the optional, fillable asset map as a starting point for the types of services that might be offered and that a CCO would capture as part of asset mapping. Based on input received during Year 1 of implementing this metric, the measure stewards have recommended refining the therapy modality list to include "Parent Management Therapies" to capture evidence-based and evidence-informed strategies that are often provided as brief interventions by integrated behavioral health staff in primary care. This refinement should appear in the optional, fillable asset map for year 3 (2024), and the measure stewards will continue to recommend refinements to the list as needed.

In Year 2 (2023), CCO asset maps must include, at a minimum, the required item details noted on page 5 of the 2023 measure specifications, but CCOs may use the optional fillable asset map template and include therapy modalities in the "other" category if it is not currently listed. If a CCO discovers through the asset mapping process that therapies/services other than those listed are offered within their network/region, CCOs can choose to capture them as part of the asset mapping process. That feedback will be important as we continue to learn and refine the metric with the intent of improving services for young children.

9. Is there a list of specific brief intervention services that can be used when collecting information from providers during asset mapping for integrated behavioral health? (Updated 2/8/24)

As described in #8 above, the optional fillable asset map template that OHA provided includes a list of therapy service codes that could be billed for brief interventions. Based on input received during Year 1 of

implementing this metric, the measure stewards have recommended refining the therapy modality list to include "Parent Management Therapies" to capture evidence-based and evidence-informed strategies that are often provided as brief interventions by integrated behavioral health staff in primary care. CCOs can use the "other" category to write in other services that are not currently included in the optional, fillable asset map template if those are being provided. Again, the list in the template is a starting point.

See this list of services and therapies pulled from the fillable asset map template for integrated behavioral health. The measure stewards will continue to recommend refinements to the list as new evidence-based modalities are introduced and input is obtained.

10. What types of providers should CCOs be engaging/surveying to collect information for asset mapping for Year 2 (2023)? Should CCOs focus on qualified mental health professionals, psychiatric mental health nurse practitioners or other provider types?

CCOs should engage contracted providers who provide mental and behavioral health services to publicly insured (Medicaid/CHIP) children birth to age five. As outlined in the specifications, the required providers in Year 2 asset mapping are 1) those contracted to provide specialty behavioral health services and 2) contracted primary care homes that have indicated they have integrated behavioral health. The provider type depends on which type of service/therapy they provide/bill for, and these providers may hold varying credentials. CCOs should collect information for the asset map from a broad set of provider types to capture the information about the services/therapy modalities provided by CCO-contracted providers.

11. Are CCOs required to share asset map information with community partners?

Yes. As part of Component 3 on cross-sector community engagement, CCOs are required to share a summary of the information gathered in the CCO's asset map. Component 3 requires community engagement including at least one or more group level meetings at which CCOs must display or provide copies of the findings from Component 1.1 and 1.2 (both related to the reach report) and Component 2.1 (asset map). In terms of the asset map, this should include the overall number of providers identified, the capacity of the current providers for new referrals, and a summary for each of the descriptive information variables listed in the asset map (for example, rows in the table detailing geographic location, race, ethnicity, language spoken, assessments, therapy services and modalities offered). At the meeting(s) with community partners, the CCO should share their reflections on the findings and implications for the action plan needed to increase access and capacity of CCO-covered social-emotional services.

12. What are updates to Component 2 in the 2024 measure specifications? (Updated 2/8/24)

The measure stewards made the following clarifications to asset mapping:

- Behavioral Health Services (MY 1–MY3): Added "Promoting First Relationships" as a therapy modality;
- Patient-Centered Primary Care Integrated Behavioral Health (MY2–MY3): Capacity now anchored to a historical lookback of two months, added therapy modalities "Parent Management and

Generalized Evidence-Informed Therapies" (aligned with Brief Intervention approaches) and "Promoting First Relationships as a Therapy Modality."
    - Anchoring capacity to a two-month historical look back (rather than asking providers to forecast into the future) was in response to feedback that in many clinics, particularly those in rural areas, behavioral health providers do not manage their own schedules or cannot hold appointments specifically for patients aged birth to five. The look-back allows CCOs and community partners to see how many open appointments in the past were filled with patients birth to five.
- Community-Based CCO Contract Social-Emotional Services (MY3): Clarified the scope of this asset map and added a row to the asset map of "not applicable."

Component 3 – Cross-sector community engagement

1. Is the CCO required to engage with community partners in each year? (Updated 2/8/24)

Yes, CCOs must engage with community partners in each year of the measure (2022–2024). The measure specifications include a specific focus on cross-sector collaboration that will help CCOs better understand and address the social-emotional health needs of children birth to age five and their families. This requirement is detailed, including specific groups the CCO must engage, in the 2024 measure specifications (Component 3.1).

Of note, the measure requires engagement with communities with historical and contemporary inequitable opportunities, to ensure the action plan is grounded in community need and drives toward more equitable access to services and greater cultural and linguistic responsiveness of services. Also, CCOs must reach out to tribal governments and/or the Urban Indian Health Program (UIHP) in their service area. Whether tribal government(s)/UIHP choose to participate is at their sole discretion.

2. Are there requirements for the ways in which CCOs engage with the list of required community partners (Component 3.1)?

Yes. The Year 2 (2023) specifications clarify that to attest to meeting this requirement, CCOs must hold one or more group-level meetings with the required entities. During the meeting, the CCO must provide or display copies of the findings from Component 1.1, 1.2 and 2.1 to ensure the community engagement informs the action plan and that community engagement is anchored to a shared understanding of:

- The current state of child-level CCO covered social-emotional services that are within the scope of the metric; and
- The current network of CCO-covered service providers identified in the asset map (Component 2) and descriptive characteristics about the service providers.

At these group meetings, CCOs must display or provide copies of:

- Reach metric data from aggregate report and CCO reflections about implications of findings for the action plan (from Component 1.1);

- Reach metric data for at least one population with historical inequitable outcomes and CCO reflections about implications of findings for the action plan (from Component 1.2); and
- Summary of information from asset map including overall number of providers, descriptive information and capacity, including CCO reflections on asset map findings and implications for the action plan (Component 2).

3. How can CCOs support their community partners while working with them in partnership on this metric?

CCOs should be respectful of the time and capacity of community partners while valuing the insights and perspectives these organizations bring to improve the social-emotional health of children birth to age 5. OHA has not set aside funds specifically for this engagement work. CCOs are encouraged to compensate the community partners with whom they work.

Child-level metric (section added 2/8/24)

1. What is the process for determining the child-level metric? How can CCOs and providers learn more and give input toward the child-level metric?

In alignment with the glidepath endorsed by the Health Plan Quality Metrics and Metrics and Scoring Committees, the System-Level Social-Emotional Health Metric will be replaced by a child-level metric that will measure and incentivize improvements based on child-level receipt of clinically recommended behavioral health care services provided by CCO-contracted providers. To align with the original intent and vision of the metric, parent and provider feedback, and learnings from implementing the System-Level Social-Emotional Health Metric, the child-level metric will be narrowed to measurement of *issue-focused intervention or treatment services*. These issue-focused intervention services can be provided in an array of settings that the CCO contracts with to fulfill their role of providing recommended behavioral health care.

The measure stewards are offering overview and input sessions about the child level metric for different groups during January and February 2024. See details and registration.

2. The measure steward has indicated that in 2025, the proposed child-level metric will be focused on issue-focused therapy services. Does this includes code lists 3–5 only, or also 1 and 2?

Oregon Pediatric Improvement Partnership (OPIP) is in the process of gathering feedback (described in question 1 above) on the proposed child-level metric planned for 2025. The proposed child-level metric will focus on issue-focused intervention/treatment services that derive from CCO-contracted providers and are captured via administrative claims data.

This subset of the current system-level social emotional reach metric codes will include claims that capture services provided to children for whom an issue has been identified and the services are addressing the issue. Given this design parameter, it could include services such as a focused social emotional assessment for children identified with an issue to determine if therapeutic interventions/treatments are needed and/or claims that clearly indicate issue-focused therapeutic interventions/treatments.

OPIP is not finalizing the set of included claims until input has been obtained about various options, so we cannot clarify yet which of the codes in lists 1–5 will be included. That said, it is known that the metric will not include population-based screenings that occur for all children (which are some of the claims included in list 1), since those claims don't indicate services for children identified with known issues.

3. Will the child-level metric be measured exclusively using claims data? Will there be an opportunity for CCOs to provide supplemental data about other services provided outside of claims data (for example, alternative payment models including per member per month [PMPM] or value-based payment [VBP])?

The metric will focus on issue-focused intervention/treatment services that derive from CCO-contracted providers and are captured via administrative claims data. This addresses administrative burden, allows for child-level tracking of services, and enhances reliability and validity of the metric across CCOs.

4. Component 1.3 of the metric requires the CCO to assess payment policies and contracts for claims and services to ensure there is a "continuum of services that address social-emotional health from prevention to treatment, including community options and arrangements." How should CCOs consider the continuum of service given the child-level metric will primarily focus on issue-focused interventions and therapies?

Within the scope of this metric, there are opportunities to support prevention. One is ensuring access to high-quality well-child care in which anticipatory guidance and promotion and education is provided. This may be tracked by incentivizing access to well-child care for the full age of the population and is aligned with the 3–6-year-old well-child visit metric. Secondly, a number of the issue-focused interventions address issues early when there is an opportunity to prevent future larger mental health and attachment issues. Therefore, supporting early intervention in settings of early promotion and early prevention activities, before development of a diagnosis, would align with the intent.

As an example, modalities such as Triple P and Incredible Years promote attachment, social competence and self-regulation and can be used to support families with children who experience challenging behaviors or are at-risk for behavior problems. When used by behavioral health clinicians to support families, these services can be billed.