2025 Incentive Measure Selection Packet

This packet contains information for the Metrics & Scoring Committee to use in selecting the 2025 incentive measure set. To aid in your decisions, this packet contains the following:

- **Measure specifications.**
    - Mental, physical, and oral health assessments for children in ODHS custody (p. 76)
    - Child-level social emotional health (kindergarten readiness) (DRAFT) (p. 85)
    - Equity: Meaningful language access to culturally responsive health care services (p. 87)
    - Social determinants of health: Social needs screening and referral (p. 131)
    - Cigarette smoking prevalence (p. 156)
    - Timeliness of postpartum care (p. 165)
    - Depression screening and follow-up plan (p. 171)
    - Comprehensive diabetes care: HbA1c poor control (p. 175)
    - Initiation and engagement of substance use disorder treatment (IET) (p. 179)
    - Childhood immunization status (p. 190)
    - Immunizations for adolescents (p. 196)
    - Child and adolescent well-care visits (ages 3-6) (p. 200)
    - Oral evaluation for adults with diabetes (p. 204)

Health Plan Quality Metrics Committee
Aligned Measure Menu Set
Reflecting HPQMC decisions through March 29, 2022
and all 2024 CMS Adult and Child Core Set measures

The aligned measure menu set includes 80 health care quality measures that span six domains of health care services:

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

Domain	Sub-Domain	Number of Measures
Prevention/ Early Detection	Physical Health Conditions	20
	Mental Health Conditions	3
	SUD Conditions	4
	Oral Health Conditions	6
	All Conditions	1
Chronic Disease and Special Health Needs	Physical Health Conditions	12
	Mental Health Conditions	8
	SUD Conditions	7
	All Conditions	4
Acute, Episodic and Procedural Care (includes maternity and hospital)		6
System Integration and Transformation		3
Patient Access and Experience		4
Cost/Efficiency		2
Total		80

As established in ORS 413.017(4) , these measures provide the collection of quality and outcome measures that may be applied to:

- Services provided by coordinated care organizations (CCOs), or
- Health benefit plans sold through the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees' Benefit Board.

For measure technical specifications, please refer to the specifications as written by the measure steward listed for each measure.
Please direct any questions to Metrics.Questions@odhsoha.oregon.gov

Annual Updates Tracker

- May 10, 2018: HPQMC adopts the initial 2019 Aligned Measure Menu set with 51 measures and 3 on-deck measures.
- March 14, 2019: HPQMC adopts the 2020 Aligned Measure Menu set with no measure changes from the previous year
- March 12, 2020: HPQMC adopts the 2021 Aligned Measure Menu set with changes listed below:
    - ADDED: Depression Screening and Follow-up for Adolescents and Adults – (previous on-deck measure, committee decision on 1/9/2020)
    - REMOVED: 2020 on-deck Postpartum Follow-up and Care Coordination measure (committee decision on 1/9/2020)
    - ADDED: Optimal Asthma Control - (previous on-deck measure, committee decision on 2/13/2020)
    - ADDED: Asthma Medication Ratio - (committee decision on 2/13/2020)
    - REMOVED: Absence of Controller Therapy (committee decision on 2/13/2020)
    - ADDED: Obesity Evidence-based Multisector Interventions for Obesity Prevention and Treatment* – (committee decision on 3/12/2020)
    - ADDED: Meaningful Language Access to Culturally Responsive Health Care Services* – (committee decision on 3/12/2020)
- February 23 through May 25, 2021: HPQMC updates the Aligned Measure Menu set with changes listed below:
    - UPDATED: Well-Child Visits in the First 30 Months of Life and Child and Adolescent Well-Care Visits with changes from the measure steward (committee decision 2/23/2021)
    - ADDED: Sealant Receipt on Permanent 1st Molars and Sealant Receipt on Permanent 2nd Molars as on-deck measures (committee decision 4/26/2021)
    - ADDED: CCO System-Level Social-Emotional Health (committee decision 4/26/2021)
    - UPDATED: Childhood Immunization Status – Combo 2 replaced with Combo 3 for use starting in measurement year 2022 (committee decision 5/25/2021)
- March 29, 2022: HPQMC updates the Aligned Measure Menu set with changes listed below:
    - ADDED: Social Determinants of Health: Social Needs Screening and Referral (committee decision 3/29/2022)
    - REMOVED: Dental Sealants on Permanent Molars for Children (committee decision 3/29/2022)
    - ADDED: Sealant Receipt on Permanent 1st Molars and Sealant Receipt on 2nd Molars (previous on-deck measures, committee decision 3/29/2022)
- April 17, 2024: OHA updates Aligned Measure Menu to add all 2024 CMS Adult and Child Core Set measures that were not already on the menu.

*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).

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Prevention/Early Detection - Physical Health Conditions	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
	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
	Well-Child Visits in the First 30 Months of Life (W30)^^	1392	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 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			
	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 from a PCP or OB-GYN during the measurement year	NCQA	Claims/Clinical Data	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			
	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			
	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			
	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
	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
	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			
	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			
	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			
	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

Health Plan Quality Metrics
2021 Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Prevention/Early Detection and Treatment of Health Conditions	Contraceptive Care - Postpartum Women Ages 15 to 44	NA	Percentage of women ages 15 to 44 who had a live birth and were provided a most effective or moderately effective method of contraception within 3 days of delivery and within 90 days of delivery.	OPA	Claims	Prevention/Early Detection - Physical Health Conditions	Adolescent, Adult	Female			Y			Y
	Contraceptive Care - All Women Ages 15 to 44	NA	Percentage of women ages 15 to 44 who were provided a most effective or moderately effective method of contraception.	OPA	Claims	Prevention/Early Detection - Physical Health Conditions	Adolescent, Adult	Female			Y			Y
	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
	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
	Live Births Weighing Less Than 2,500 Grams	NA	Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.	CDC/NCHS	State vital records	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			
	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			
	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			
	Lead Screening in Children	NA	Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	NCQA	Claims or hybrid	Prevention/Early Detection - Physical Health Conditions	Children	All			Y			
	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			
	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			

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
action - Mental	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				
Prevention/Early Detection - Substance Use Disorder (SUD) Conditions	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 during the measurement period AND who received tobacco cessation 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
	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
	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			
	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	
Prevention/Early Detection - Oral Health Conditions	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					
	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					
	Topical Fluoride for Children	NA	Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.	DQA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent	All	Y					
	Oral Evaluation, Dental Services	NA	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.	DQA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent	All	Y					
	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 or oral health service during the measurement year.	OHA	Claims	Prevention/Early Detection - Oral Health Conditions	Children, Adolescent, Adult, Older Adult	All	Y					
	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					

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Prevention/Early Detection - All Conditions	Assessments 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 Oregon Department of Human Services (foster care).	OHA	Claims/Social Service Data	Prevention/Early Detection - All Conditions	Children, Adolescent	All	Y	Y	Y			
Chronic Disease and Special Health Needs - Physical Health Conditions	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		
	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		
	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		
	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			
	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		
	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		

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Chronic Disease and Special Health Needs - Mental Health	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		
	PQI 01: Diabetes Short-Term Complications Admission Rate	NA	Hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.	AHRQ	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All				Y	Y	
	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	NA	Hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	AHRQ	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All				Y	Y	
	PQI 08: Heart Failure Admission Rate	NA	Hospitalizations with a principal diagnosis of heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.	AHRQ	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All				Y	Y	
	PQI 15: Asthma in Younger Adults Admission Rate	NA	Hospitalizations with a principal diagnosis of asthma per 100,000 beneficiary months for beneficiaries ages 18 to 39.	AHRQ	Claims	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult	All				Y	Y	
	HIV Viral Load Suppression	NA	Percentage of beneficiaries age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	HRSA	Claims or EHR	Chronic Disease and Special Health Needs - Physical Health Conditions	Adult, Older Adult	All			Y	Y		
	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			
	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			
	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	
	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	
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NA	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (>9.0%).	NCQA	Claims or hybrid	Chronic Disease and Special Health Needs - Mental Health Conditions	Adult, Older Adult	All		Y				
	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	NA	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	NCQA	Claims or EHR	Chronic Disease and Special Health Needs - Mental Health Conditions	Children	All		Y		Y		

Health Plan Quality Metrics
Aligned Measures Menu

Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions

ENDORSED Measures	NQF Number	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
Metabolic Monitoring for Children Adolescents on Antipsychotics	NA	Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing.	NCQA	Claims	Chronic Disease and Special Health Needs - Mental Health Conditions	Children, Adolescent	All		Y		Y		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NA	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	NCQA	Claims	Chronic Disease and Special Health Needs - Mental Health Conditions	Children, Adolescent	All		Y		Y		
Follow-up After ED Visit for Substance Use	NA	Percentage of ED visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any other diagnosis of drug overdose, who had a follow-up visit 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	
Initiation and Engagement of Substance Use Disorder Treatment	0004	Initiation and Engagement of Substance Use Disorder Treatment.	NCQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adolescent, Adult, Older Adult	All		Y	Y		Y	
Use of Opioids at High Dosage in Persons Without Cancer	NA	The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.	PQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All		Y	Y			
Concurrent Use of Opioids and Benzodiazepines	NA	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	PQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All		Y	Y			
Use of Pharmacotherapy for Opioid Use Disorder	NA	Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year.	CMS	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All		Y	Y			
Medical Assistance with Smoking and Tobacco Use Cessation	NA	Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	NCQA	Survey	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All		Y	Y			

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Chronic Disease and Special Health Needs - All Conditions	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NA	Percentage of beneficiaries ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	NCQA	Claims	Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions	Adult, Older Adult	All		Y	Y			
	Family Experiences with Coordination of Care (FECC)	Multiple	•	Seattle Children's Hospital	Survey	Chronic Disease and Special Health Needs - All Conditions	Children, Adolescent	All			Y	Y		
	Pediatric Integrated Care Survey (PICS)	NA	Discussing Cessation Medications. A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement	Boston Children's Hospital	Survey	Chronic Disease and Special Health Needs - All Conditions	Children, Adolescent	All			Y	Y		
	Long-Term Services and Supports Comprehensive Care Plan and Update		Percentage of beneficiaries receiving long-term services and supports (LTSS) services ages 18 and older who have documentation of a comprehensive long-term services and supports (LTSS) care plan in a specified time frame that includes core elements.	NCQA	Case management record review	Chronic Disease and Special Health Needs - All Conditions	Adult, Older Adult	All				Y		
	National Core Indicators Survey	NA	The National Core Indicators® – Intellectual and Developmental Disabilities (NCI-IDD®)1 provide information on beneficiaries' experience and self-reported outcomes of long-term services and supports for individuals with intellectual and/or developmental disabilities (I/DD) and their families.	NASDDDS/HSRI	Survey	Chronic Disease and Special Health Needs - All Conditions	Adult, Older Adult	All				Y		
Acute, Episodic and Procedural Care (Includes Maternity an	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	
	Low-Risk Cesarean Delivery	NA	Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births delivered by cesarean during the measurement year.	CDC/NCHS	State vital records	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Adolescent, Adult, Older Adult	Female			Y			
	Ambulatory Care	NA	Discussing Cessation Strategies. A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	NCQA	Claims	Acute, Episodic and Procedural Care (Includes Maternity and Hospital)	Children, Adolescent, Adult, Older Adult	All			Y		Y	
	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	

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
ıd Hospital)	Avoidance of Antibiotic Treatment with Acute Bronchitis	0058	Percentage of members 3 months – 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)	Children, Adolescent, Adult, Older Adult	All			Y			
	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	
System Integration and Transformation	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	
	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			
	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						
Patient Access and Experience	Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency	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	
	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		
	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					
	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	

Health Plan Quality Metrics
Aligned Measures Menu

	ENDORSED Measures	NQF Number	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
Cost/Efficiency	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	
	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.

1. For the purposes of this matrix, we have classified OB/GYNs as primary care providers. Marc Overbeck (Healthcare Workforce) shared that OHA counts OB/GYNs as primary care providers when running workforce calculations. Sara Kleinschmit (Metrics and Scoring) shared that OHA classifies OB/GYNs as a primary care provider if the endorsed measure does as well.

2. The HPQMC also endorsed the Children with Complex Conditions Supplemental Item Set, found within the CAHPS 5.0H survey under the "Patient Access and Experience" domain.

NCQA: National Committee for Quality Assurance
OHA: Oregon Health Authority
OHSU: Oregon Health & Science University
PQA: Pharmacy Quality Alliance
TJC: The Joint Commission

Buying Value
Measure Selection Criteria Worksheet
February 13, 2014

The priority performance goals of the program being measured are:

1. _____
2. _____
3. _____
4. _____
5. _____

I. Technical Measure Criterion (tests that <u>each</u> measure should meet)				
Potential criterion	**Description**	**Include**	**Consider**	**Exclude**
1. Evidence-based and scientifically acceptable	The measure will produce consistent (reliable) and credible (valid) results. The measure has been endorsed by the NQF or by another national body with a rigorous method for review and endorsement of measures (e.g., NCQA).			
2. Has a relevant benchmark	State, regional or national level performance data are available for the same measure.			
3. Not greatly influenced by patient case mix	Providers serving more complex or ill patients will not be disadvantaged by comparative measurement.			
II. Program-Specific Measure Criterion (tests that <u>each</u> measure should meet)				
Potential criterion	**Description**	**Include**	**Consider**	**Exclude**
4. Consistent with the goals of the program	The measure corresponds to a program performance priority.			
5. Useable and relevant	The intended users (consumers, purchasers, providers, and/or policy makers) can understand the results of the measure and are likely to find them useful for quality improvement and decision-making.			

Potential criterion	Description	Include	Consider	Exclude
6. Feasible to collect	The measure can be implemented and data can be collected without undue burden.			
7. Aligned with other measure sets	The measure aligns with a measure that providers in the program are otherwise required to report and/or for which they are held accountable.			
8. Promotes increased value	Improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.			
9. Present an opportunity for quality improvement	There is a gap between baseline performance and best-practice performance.			
10. Transformative potential	Improving this measure will fundamentally change care delivery in a desired manner.			
11. Sufficient denominator size	In order to ensure that the measure is not prone to the effects of random variation, the measure should have a sufficient denominator in the context of the program.			
III. Potential Measure Set Criteria (tests that <u>the overall measure set</u> should meet)				
Potential criterion	**Description**	**Include**	**Consider**	**Exclude**
12. Representative of the array of services provided by the program				
13. Representative of the diversity of patients served by the program				
14. Not unreasonably burdensome to payers or providers				

METRICS & SCORING COMMITTEE: MEASURE RETIREMENT CHECKLIST

The Metrics & Scoring Committee's measure retirement checklist was adopted in June 2015 for the Committee's use when retiring CCO incentive measures. Not all of these criteria must be met before a measure could be retired. Note retired CCO incentive measures may continue as monitoring measures.

☐ NO ADDITIONAL OPPORTUNITY FOR MEANINGFUL PERFORMANCE IMPROVEMENT ("TOPPED OUT")

For example, the statewide rate and all (or most) CCO rates exceed the highest possible benchmark; there is not a higher benchmark that could be adopted; or performance has not yet met the benchmark, but there is clear rationale (e.g., underlying differences in data sources) and no reasonable expectations for further meaningful improvement.

☐ MEASURE NO LONGER ADDS MEANINGFUL VALUE

For example, the measure set already contains measures that focus on the population or domain of interest (e.g., relative importance); a more appropriate or relevant measure exists to address the population or domain that the original measure was intended to address; the measure is redundant or duplicative; the measure is less transformational than other measures in the set, given the need for parsimonious measure selection; there is evidence of unanticipated or unintended consequences of implementing the measure; there is evidence that the measure undermines quality improvement activities or underlying manipulation to 'meet' a measure.

☐ SUPPORTING CLINICAL GUIDELINES OR EVIDENCE-BASE HAVE CHANGED

For example, the measure was based on a clinical guideline which has since changed (e.g., the process of care has been shown to be irrelevant or harmful); review of literature suggests that the measure no longer predicts anything important to the patient (e.g., no longer scientifically acceptable); the measure may be slated for retirement or modification due to change in clinical guidelines, but there is a lag between the measurement year and the retirement or modification date.

☐ MEASURE HAS BEEN RETIRED NATIONALLY / PENDING RETIREMENT BY MEASURE STEWARD

For example, the measure steward (e.g., NCQA, CMS) has recently retired or announced plans to retire the measure from its active set(s); the measure has lost endorsement; or does not have an active measure steward.

☐ MEASURE CANNOT BE MEASURED

For example, the state, CCOs, or providers no longer have the capacity to maintain or report on the measures; the available data cannot be used for the intended purpose of the measure; data for the measure is no longer available or will cease to be available for the measurement year; or low prevalence of a condition or small denominators lead to low reliability and high variation for the measure.

Standing Reminder / Center for Work: Definition Adopted by Oregon Health Policy Board and OHA

Health Equity Definition

- Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
- Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
  - The equitable distribution or redistribution of resources and power; and
  - Recognizing, reconciling and rectifying historical and contemporary injustices.

Oregon Health Authority

Committee Working Definition of Transformation

May 2021

Given the definition of health equity adopted by the Oregon Health Policy Board, Metrics & Scoring Committee survey done to align the committee's views/definition on transformation, discussions at the April and May 2021 Committee meetings, and the strategic goal to eradicatehealth inequities by 2030, the Committee's working definition of transformation is:

- Measures, a measure set, and an incentive program which advances health equity byrecognizing, reconciling, and rectifying historical and contemporary injustices.

- This includes, but is not limited to, focusing on priority populations as identified in the health equity definition; addressing inequities in health care delivery, directly at the patient-provider level, as well as structural and systemic bias in the healthcare system itself; addressing the full spectrum of the healthcare delivery system, including physical,behavioral, social, and oral health; and, addressing inequities outside the healthcare system that impact health outcomes, including the social determinants of health and equity.

- Furthermore, this means understanding the measure selection process is not singularlyfocused and acknowledges the dynamic, orchestrated effort needed to achieve transformation, both for individual measures, as well as the intersectionality of measures across the measure set.

BACKGROUND

In May 2021 the Metrics and Scoring Committee collectively created this working, shared definition of transformation. As transformation can mean different things to different people the Committee wanted to have a shared definition to consider in selecting CCO Quality Incentive Program measures; it is based off the health equity definition adopted by the Oregon Health Policy Board and OHA in 2019. As it is a working definition, the Committee may choose to revise it in the future.

Metrics & Scoring Committee Draft Position Statement and Health Equity Measure Selection Criteria

Using the NCQA White Paper and Office of Health Policy Report previously reviewed by the Committee, a subset of Committee members drafted a position statement and health equity measure selection criteria for the Committee to use in measure selection. These are drafts and may be revisited by the Committee at a later time.

Draft Position Statement: We shall recognize and keep in mind the role of historical and contemporary oppression and structural barriers that different people and communities in Oregon face.

Draft Health Equity Measure Selection Criteria: A measure that advances health equity should,

1. Be a measure in which disparities in care are known the exist for certain populations or that address health care disparities and culturally appropriate care.

2. Reflect available evidence on the relationship between adverse social determinants of health (policies and structures that facilitate inequities) or social risk factors (individual-level specific adverse social conditions that are associated with poor health) and health or health care outcomes.

3. Incentivize achievement or improvement for at-risk beneficiaries.

4. Include design features or specifications that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement.

CCO Incentive Measures since 2013[3]

CCO Incentive Measures	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Adolescent well-care visits												
Alcohol or other substance misuse screening (SBIRT)					[1]							
Ambulatory care: Emergency department (ED) utilization												
CAHPS composite: Access to care												
CAHPS composite: Satisfaction with care												
CCO system-level social-emotional health (kindergarten readiness)												
Child & adolescent well-care visits (age 3-6, kindergarten readiness)[2]	adolescents (age 13)							ages 3-6				
Childhood immunization status												
Cigarette smoking prevalence												
Colorectal cancer screening												
Controlling high blood pressure												
Dental sealants on permanent molars for children												
Depression screening and follow-up plan												
Developmental screening in the first 36 months of life												
Diabetes: HbA1c poor control												
Disparity measure: ED visits among members with mental illness												
Early elective delivery												
Effective contraceptive use												
Electronic health record adoption												
Follow-up after hospitalization for mental illness												
Follow-up for children prescribed ADHD medication												
Health assessments for children in DHS custody												
Immunizations for adolescents												
Initiation and engagement in drug and alcohol treatment												
Meaningful language access to culturally responsive health care services												
Oral evaluation for adults with diabetes												
Patient centered primary care home enrollment												
Preventive dental or oral health services, ages 1-5 (kindergarten) & 6-14												
Social determinants of health: Social needs screening and referral												
Timeliness of prenatal care												
Timeliness of postpartum care												
Weight assessment and counseling for children and adolescents												
	Legend:	Incentive Measure		Challenge Pool Measure								

[1] The claims-based SBIRT measure was removed as a CCO incentive measure for CY 2017 and 2018. An EHR-based SBIRT measure was developed and reinstated for CY 2019.

[2] Beginning 2022 the national measure steward combined Adolescent well-care visits and Well-child visits in the 3rd, 4th, 5th, & 6th years of life to create the Child and adolescent well-care visits measure.

[3] This document summarizes the changes in the CCO incentive measure set since the first year of the program, 2013, including the challenge pool measures and major specification changes.

Summary of Changes to CCO Incentive Measures

2014

Significant Changes

- Colorectal cancer screening - measurement methodology changed from claims-based and a rate (number of screenings per 1,000 member months) to a hybrid method which reports the percentage of members up to date on colorectal screening.
- Timeliness of prenatal care: data source expanded to hybrid approach, resulting in higher rates.

2015

Retired Measures

- Follow-up for children prescribed ADHD medication
- Early elective delivery

New Measures

- Dental sealants
- Effective contraceptive use

Significant Changes

- DHS custody - dental assessment requirement added
- SBIRT - age reduced from 18 to 12
- FUH MI - same day follow-up services added to the numerator

Challenge Pool Changes

- Patient centered primary care home enrollment removed as challenge pool measure
- Developmental screenings added as challenge pool measure

2016

Retired Measures

- Electronic health record adoption

New Measures

- Tobacco prevalence

- Childhood immunization status

Challenge Pool Changes

- None.

2017

Retired Measures

- The claims-based SBIRT measure has been removed from the measure set due to coding challenges. An EHR-based measure is in development and will be reinstated as an incentive measure in CY 2019.

New Measures

- None

Challenge Pool Changes

- Replaced Diabetes: HbA1c Poor Control with Effective Contraceptive Use
- Removed SBIRT

Significant Changes

- See 2017 specification changes summary, and 2017 specification Q&A documents online at http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

2018

Retired Measures

- Follow-up after hospitalization for mental illness
- Satisfaction with care (CAHPS)

New Measures

- Weight assessment, nutrition, and activity counseling for children and adolescents
- Disparity measure: ED utilization among members with mental illness

Challenge Pool Changes

- Removed Depression screening and follow-up plan; and Effective contraceptive use
- Added: Assessments for children in DHS custody; Childhood immunization status; and Timeliness of prenatal care
    - (Committee selected challenge pool measures to focus on early childhood health as a step toward connecting with kindergarten readiness)

Significant Changes

- Access to care (CAHPS) will have separate benchmarks for adults and children; CCOs must meet the target on both populations to achieve this measure.
- Effective contraceptive use: Adolescents ages 15-17 added to the incentive measure; Provide permanent numerator credit for tubal ligations.
- 2018 specification changes summary, and 2018 specification Q&A documents will be available in December 2017 at: http://www.oregon.gov/oha/hpa/analytics/Pages/CCO-Baseline-Data.aspx

2019

Retired Measures

- Timeliness of Prenatal Care

New Measures

- Drug and alcohol screening (EHR–based SBIRT)
- Timeliness of Postpartum Care
- Oral evaluation for adults with diabetes

Challenge Pool Changes

- Replaced Timeliness of prenatal care with Timeliness of postpartum care
- Continued to focus challenge pool on early childhood health in anticipation of measure development work around the health sector's role in kindergarten readiness

Significant Changes

- Dropped cessation benefit component from Cigarette smoking prevalence measure, as this is now a coverage requirement per the Prioritized List.
- Made decision that in 2020 specifications for the Health assessments for children in DHS custody measure will be changed to align with DHS Child Welfare Policy / AAP guidelines, requiring physical and dental assessments within 30 days, and mental health assessments for children ages 3+ within 60 days.
- Made decision that in 2020 specifications for the Dental sealants on permanent molars for children measure will be changed to align with those of the Dental Quality Alliance (which limits denominator to those with elevated risk codes / restorative services).

2020

Retired Measures

- Weight assessment and counseling
- Patient Centered Primary Care Home enrollment
- Effective contraceptive use
- Developmental screening in the first 36 months of life
- Dental sealants on permanent molars for children

- CAHPS composite: access to care
- Ambulatory care: ED utilization
- Adolescent well-care visits
- Colorectal cancer screening
- Controlling high blood pressure

New Measures

- Well-child visits for 3-6-year-olds (kindergarten readiness)
- Preventive dental visits, ages 1-5 (kindergarten readiness) and 6-14
- Immunizations for adolescents
- Initiation and engagement in drug and alcohol treatment

Challenge Pool Changes

- Chose new challenge pool set (no theme for 2020) - Disparity Measure: ED visits among members with mental illness; Oral evaluation for adult members with diabetes; and Well-child visits for 3-6-year-olds (kindergarten readiness).

Significant Changes

- Because of disruptions caused by the COVID-19 pandemic, the Metrics & Scoring Committee decided at its July 17, 2020 meeting to make all 2020 CCO incentive measures reporting only.
- Decided that alignment of Health assessments for children in DHS custody measure with DHS Child Welfare Policy / AAP guidelines (requiring physical and dental assessments within 30 days, and mental health assessment for children 3+ within 60 days) will wait until a future year. OHA, DHS, and CCOs will work to improve reporting over 2020, such that this change can be made in future.

2021

Retired Measures

- None; the Committee decided to roll over all 2020 incentive measures to 2021.

New Measures

- Meaningful language access to culturally responsive health care services

Challenge Pool Changes

- Removed Disparity measure: ED utilization among members with mental illness and Oral evaluation for adults with diabetes.
- Added Initiation and engagement of alcohol and other drug abuse or dependence treatment; Health assessments for children in DHS custody; and Immunizations for adolescents.

Significant Changes

- Made decision to use 2019 as a baseline to assess 2021 performance (2019 will be the reference year for 2021 measures with improvement targets). Improvement targets will be calculated using the Minnesota method only, with no floors applied.
- Made decision to roll forward the original 2020 benchmarks into 2021 for the following measures:
    - Timeliness of postpartum care
    - Assessments for children in DHS custody
    - Cigarette smoking prevalence
    - Depression screening and follow-up plan
    - Screening, Brief Intervention, and Engagement to Treatment (SBIRT)
    - Equity measure: Meaningful language access to culturally responsive health care services
    - Timeliness of postpartum care
- Benchmarks for the remaining measures were reduced in September 2021 after meeting criteria related to pandemic-related external factors:
    - Childhood immunization status
    - Immunizations for adolescents
    - Child and adolescent well-care visits (incentivized ages 3-6)
    - Diabetes: HbA1c poor control
    - Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET), both components
    - Preventive dental or oral health services, ages 1-5 and 6-14, at least one component
    - Oral evaluation for adults with diabetes

2022

Retired Measures

- Disparity: ED utilization among members with mental illness

New Measures

- CCO system-level social-emotional health (kindergarten readiness)

Challenge Pool Changes

- Chose new challenge pool set: CCO system-level social emotional health (kindergarten readiness); Child and adolescent well-care visits, ages 3-6 (kindergarten readiness), Meaningful language access to culturally responsive health care services, and Preventive dental or oral health services ages 1-5 (kindergarten readiness) and 6-14.

Significant Changes

- Adolescent well-care visits and Well-child visits in the 3rd, 4th, 5th, and 6th years of life were combined to create the Child and adolescent well-care visits measure, with ages 3-6 incentivized (this is per national measure steward). Through 2019 only age 13 was incentivized; only ages 3-6 have been incentivized since 2020 (as part of kindergarten readiness measurement strategy).
- Childhood immunization status was changed from Combo 2 to Combo 3.

2023

Retired Measures

- None; the Committee decided to roll over all 2022 incentive measures to 2023.

New Measures

- Social determinants of health: Social needs screening and referral

Challenge Pool Changes

- Removed CCO system-level social emotional health (kindergarten readiness) and Meaningful language access to culturally responsive health care services.
- Added immunizations for adolescents (Combo 2) and postpartum care.

Significant Changes

- None.

2024

Retired Measures

- None; the Committee decided to roll over all 2023 incentive measures to 2024.

New Measures

- None.

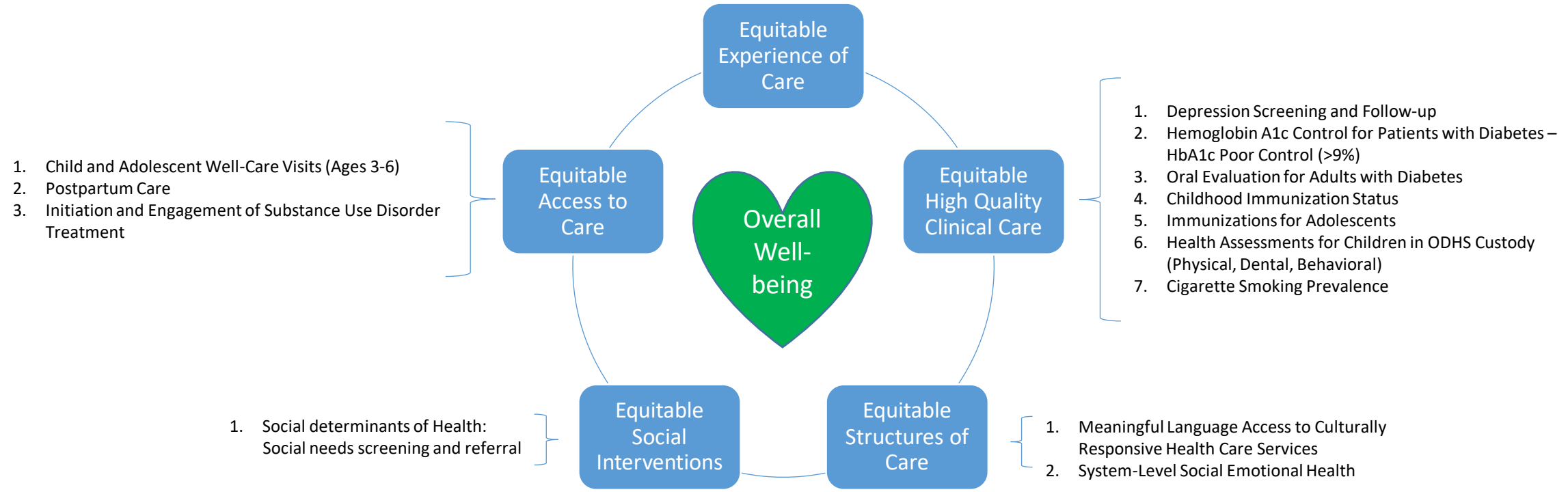
Challenge Pool Changes

- Removed immunizations for adolescents (Combo 2).
- Added CCO system-level social emotional health (kindergarten readiness).

Significant Changes

- None.

Equitable data, Equitable systems, Equitable outcomes



Position Statement: We shall recognize and keep in mind the role of historical and contemporary oppression and structural barriers that different people and communities in Oregon face.

A measure that advances health equity shall aim to:

- Be a measure in which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care.
- Reflect available evidence on the relationship between adverse social determinants of health (policies and structures that facilitate inequities) or social risk factors (individual-level specific adverse social conditions that are associated with poor health) and health or health care outcomes.
- Incentivize achievement or improvement for at-risk beneficiaries.
- Include design features/specs that guard against unintended consequences of worsening quality or access or disincentive resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement.

NCQA Framework: Where do the 2024 Incentive Measures Fit?*

NCQA Domain	Measure
Equitable High-Quality Clinical Care	Depression Screening and Follow-up for Adolescents and Adults Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) Oral Evaluation for Adults with Diabetes Childhood Immunization Status Immunizations for Adolescents Health Assessments for Children in ODHS Custody Cigarette Smoking Prevalence
Equitable Experience of Care (e.g., measures of health care experiences)	N/A
Equitable Structures of Care • Race/Ethnicity Diversity of Membership • Language Diversity of Membership	CCO System-Level Social-Emotional Health (Kindergarten Readiness) Meaningful Language Access to Culturally Responsive Health Care Services
Overall Well-Being (e.g., physical and mental health rating questions from BRFSS)	N/A
Equitable Access to Care	Child and Adolescent Well-Care Visits (Ages 3-6) Postpartum Care Initiation and Engagement of Substance Use Disorder Treatment
Equitable Social Interventions	Social Determinants of Health: Social Needs Screening and Referral

*This table does not include 2024 incentive measures that are ineligible to continue onto the 2025 incentive measure set.

Equity measure crosswalk

Purpose: To see which downstream measures align with national health equity measures

Pros and cons of national equity measures

	Pros	Cons
NCQA Equity Framework	• Measures selected for relevance, validity, reliability, scientific soundness and relationship to outcomes • Wide range of stakeholders engaged in development • Considered with racial equity framing	• Intended to be implemented as a set, **not** "cherry-picked" measures • Not all measures are currently feasible for collecting data • All six domains should be represented
NCQA stratifies by race and ethnicity	• More likely to align with other states' race and ethnicity reporting	• Based on data feasibility, **not** racial equity framing

Pros and cons of national equity measures

	Pros	Cons
National Quality Forum (NQF) disparity-sensitive measures	• Used a tiered scoring approach • Measures mapped to NQF-endorsed communication sensitive practices	• Not updated since 2012 • NQF committee expressed concerns about data quality, which impacted first scoring tier • Only included NQF-endorsed measures • As of 2023, NQF is no longer contracted by CMS to endorse measures

Adult Core Set

Measure	NCQA Health Equity Framework	NCQA stratifies race/ethnicity	NQF disparity-sensitive	2024 incentive measure
Breast cancer screening (not currently reported)	X	X		
CAHPS: Doctors communication	X			
Cervical cancer screening		X	X	
Colorectal cancer screening	X	X		
Follow-up after ED visit for mental illness		X		
Follow-up after ED visit for substance use (new)		X		
Follow-up after hospitalization for mental illness	X	X		
Initiation and engagement of SUD treatment		X		X
Pharmacotherapy for opioid use disorder (new)		X		
Postpartum care*	X	X		X
Timeliness of prenatal care*	X	X		

*Hybrid sample, race and ethnicity reporting is limited

Adult Core Set: EHR measures (no REALD data)*

Measure	NCQA Health Equity Framework	NCQA stratifies race/ethnicity	NQF disparity-sensitive	2024 incentive measure
Controlling high blood pressure	X	X	X	
Depression screening and follow-up	X			X
Diabetes care: HbA1c poor control	X		X	X

*CCOs report EHR measures at a population level only

Child Core Set

Measure	NCQA Health Equity Framework	NCQA stratifies race/ethnicity	NQF disparity-sensitive	2024 incentive measure
CAHPS: Doctors communication	X			
Child and adolescent well-care visits	X	X		X
Childhood immunization status		X		X
Depression screening and follow-up	X			X
Follow-up after ED for mental illness		X		
Follow-up after ED visit for substance use (new)		X		
Follow-up after hospitalization for mental illness	X	X		
Immunizations for adolescents		X		X
Postpartum care*	X	X		X
Timeliness of prenatal care*	X	X		
Well-child visits in first 30 months		X		

*Hybrid sample, race and ethnicity reporting is limited

Crosswalk with NCQA Framework

Purpose: To see which downstream measures align with NCQA Framework domains

Adult and Child Core Set

Social interventions	Access to care	High-quality clinical care
• N/A*	• Child and adolescent well-care visits • Follow-up after hospitalization for mental illness • Postpartum care • Timeliness of prenatal care	• Breast cancer screening (not currently reported) • Colorectal cancer screening • Controlling high blood pressure • Depression screening and follow-up** • Diabetes care: HbA1c poor control**

Experience of care	Structures of care	Overall well-being
• CAHPS: Doctors communication	• N/A***	• N/A

*National measures closely align with homegrown SDOH measure

**CCOs report EHR measures at a population level only, no REALD data available

***Upstream Health equity: Meaningful language access measure may be considered for this domain

Measures not in equity frameworks

Adult Core Set

Measure	Reported annually?	Notes
Adherence to antipsychotic medications for individuals with schizophrenia	X	New reporting metric in MY2023
Anti-depressant medication management	X	New reporting metric in MY2023
Asthma medication ratio	X	New reporting metric in MY2023
Avoidance of antibiotic treatment for acute bronchitis/ bronchiolitis	X	New reporting metric in MY2023
CAHPS: Medical assistance with tobacco use cessation	X	
Chlamydia screening	X	
Concurrent use of opioids and benzodiazepines		
Contraceptive care		Excluded due to equity concerns
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	X	New reporting metric in MY2023
Diabetes care for people with serious mental illness: HbA1c poor control	X	New reporting metric in MY2023

Adult Core Set (cont.)

Measure	Reported annually?	Notes
HIV viral load suppression		Requires data linking, not currently reported
Long-term services and supports comprehensive care plan and update		Cannot report; uses case management records
National Core Indicators Survey		Cannot report
Plan all-cause readmissions	X	
PQI 01: Diabetes short-term complications admission rate		PQI measures excluded due to methodology concerns; rates volatile at CCO-level
PQI 05: Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate		
PQI 08: Heart failure admission rate		
PQI 15: Asthma in younger adults admission rate		
Use of opioids at high dosage in persons without cancer		
Use of pharmacotherapy for opioid use disorder	X	New reporting metric in MY2023

Adult Core Set (cont.)

Measure	Reported annually?	Notes
HIV viral load suppression		Requires data linking, not currently reported
Long-term services and supports comprehensive care plan and update		Cannot report; uses case management records
National Core Indicators Survey		Cannot report
Plan all-cause readmissions	X	
PQI 01: Diabetes short-term complications admission rate		PQI measures excluded due to methodology concerns; rates volatile at CCO-level
PQI 05: Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate		
PQI 08: Heart failure admission rate		
PQI 15: Asthma in younger adults admission rate		
Use of opioids at high dosage in persons without cancer		
Use of pharmacotherapy for opioid use disorder	X	New reporting metric in MY2023

Child Core Set

Measure	Reported annually?	Notes
Ambulatory care: Emergency department (ED) visits	X	
Asthma medication ratio	X	New reporting metric in MY2023
Avoidance of antibiotic treatment for acute bronchitis/ bronchiolitis	X	New reporting metric in MY2023
Chlamydia screening	X	
Contraceptive care		Excluded due to equity concerns
Developmental screening in first three years of life	X	
Lead screening in children	X	New reporting metric in MY2023
Live births weighing less than 2,500 grams		CMS reports; requires data linking
Low-risk cesarean delivery		CMS reports; requires data linking
Metabolic monitoring for children/adolescents on antipsychotics	X	New reporting metric in MY2023

Child Core Set (cont.)

Measure	Reported annually?	Notes
Oral evaluation, dental services	X	
Sealant receipt on permanent first molars	X	
Topical fluoride for children	X	
Use of first-line psychosocial care for children/adolescents on antipsychotics	X	New reporting metric in MY2023
Weight assessment and counseling for nutrition and physical activity for children/adolescents		Excluded due to equity concerns

2024 CCO Quality Incentive Program: Measure Summaries

Measure overview

Each year, coordinated care organizations (CCOs) can earn bonus funds by showing that they have improved care for members of the Oregon Health Plan (OHP). The program through which CCOs can earn these funds is called the CCO Quality Incentive Program (sometimes referred to as the Quality Pool). The program is one of our most effective tools for improving quality for members of the Oregon Health Plan.[1]

Since the program began in 2013, over a billion dollars has been distributed to CCOs through the program. To earn these funds, CCOs must improve on a set of health care quality measures selected by the Metrics & Scoring Committee each year. The Metrics & Scoring Committee reviews the measure set each year and may drop or add measures to continue to improve care for members of the Oregon Health Plan.

This document provides information about each of the 2024 CCO incentive measures. Each entry answers three questions:

1. What is being measured?
2. Why is it being measured?
3. How is it being measured?

Technical specifications with details on how each measure is calculated are available here.

Important considerations about data sources

Claims or equivalent encounter information. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service. Learn more at CMS >

Electronic health record (EHR): An electronic health record is a digital version of a patient's medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don't have data about people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important to consider because many people who aren't represented in these data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition,

[1] https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf

Oregon Health Authority

because data we get from EHRs shows only overall totals from clinics, we can’t dig deeper into questions about communities included in those totals.

CCO Incentive Measures for 2024

in alphabetical order

Assessments for Children in DHS Custody

This measure helps us make sure kids who are entering foster care get the age-appropriate physical, mental, and dental health care they need. The Oregon Department of Human Services notifies CCOs when one of their members enters foster care. The CCO then has 60 days to make sure that child gets care.

It's important for us to measure this because timely health assessments are vital to the health and well-being of kids in foster care, according to the American Academy of Pediatrics and the Oregon Department of Human Services.[2]

We measure this by comparing a list of children in foster care who are enrolled in CCOs with CCO claims or equivalent encounter data to see if the children received a timely health assessment. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Child and Adolescent Well-Care Visits - Age 3-6

We measure the percentage of kids age 3-6 who have at least one well-care visit during the year. Well-care visits are important because they help providers find concerns early, when it's easier to address any possible problems.

This measure is part of a broader effort to make sure children are prepared for kindergarten, which is critical to meeting OHA's health equity goals. To measure this, we look at medical claims or equivalent encounter data for kids ages 3-6 who are enrolled in a CCO. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Childhood Immunization Status (Combo 3)

We measure the percentage of kids who are up to date on vaccines by their second birthday. We look at kids from birth to their second birthday because approximately 300 children die from vaccine-preventable illnesses in the United States each year,[3] and vaccines are one of the safest, easiest, and most effective ways to protect kids from disease.[4] Vaccines we look for include:

---

[2] See Child Welfare Policy: OAR 413-015-0465 and American Academy of Pediatrics - see page 22: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Ch2_PP_Primary.pdf#Page=12

[3] https://www.ncqa.org/hedis/measures/childhood-immunization-status/

[4] https://www.hhs.gov/immunization/get-vaccinated/for-parents/five-reasons/index.html

- diphtheria, tetanus and acellular pertussis (DTaP);
- polio (IPV);
- measles, mumps and rubella (MMR);
- haemophilus influenza type B (HiB);
- hepatitis B (HepB);
- chicken pox (VZV); and
- pneumococcal conjugate (PCV).

To measure this, we:

- check the state's immunization registry (ALERT Immunization Information System) and see whether children who are two years old and enrolled in a CCO have all their vaccines, and
- look at medical claims submitted by healthcare providers. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Cigarette Smoking Prevalence

We measure the percentage of people ages 13+ who smoke cigarettes. We measure this for many reasons, including but not limited to:

- Cigarettes continue to be the most widely used tobacco product in the U.S. and Oregon.
- On average, smokers die 10 years earlier than nonsmokers.[5]
- Additionally, tobacco companies have focused their marketing to communities subject to historical and contemporary injustices, which makes cigarette smoking prevalence an important indicator of inequity.[6,7]

We see how CCOs do on this measure using information from electronic health records (EHR). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don't have data about people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in these data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because data we get from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

[5] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm
[6] https://www.cdc.gov/tobacco/data_statistics/sgr/1998/complete_report/pdfs/complete_report.pdf
[7] https://www.trinketsandtrash.org/.

Though the data for this measure come from clinic EHRs, effective smoking cessation and prevention strategies is not limited to clinical intervention but includes CCO advocacy for and implementation of community interventions, although these strategies are not measured by this metric. See more about Evidence-Based Strategies for Reducing Tobacco Use: A Guide for CCOs.

Depression Screening and Follow Up Plan

This measure looks at the percentage of people age 12+ who received a depression screening and, if needed, a plan to address their needs. This measure encourages providers to ask their patients about depression, which is important because depression can have serious and lasting impacts on a person's health.

We see how CCOs do on this measure using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don't have data about people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in these data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because data we get from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

Diabetes: HbA1c Poor Control

This measure looks at the percentage of people ages 18-75 who have diabetes and who also have high blood sugar. Diabetes is a leading cause of death and disability in the United States, so it's important to make sure we help people manage their blood sugar.

We measure whether someone's blood sugar is over healthy levels through a test called the HbA1c. If someone's HbA1c result is higher than 9%, they're at higher risk for complications like nerve damage. The fewer people who have a high result, the better. Because it's so important to make sure providers are monitoring the blood sugar of patients with diabetes, if there is not an HbA1c test record for a patient, that person will be counted in the metric as having high blood sugar.

We measure this using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. Because we use data from EHRs, this means we don't have data about some people, including people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in this data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because the data we get from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency

This measure was created specifically to incentivize health equity by ensuring people who communicate in languages other than English or are hard of hearing are provided with certified and qualified health care interpretation services.

People who communicate in languages other than English or are hard of hearing:

- Face barriers accessing health services,[8]
- Receive lower quality care relative to patients whose preferred language is English,[9] and
- Are at higher risk for medical errors.[10]

Qualified and certified health care interpreters are vital to combating the disparate impact of COVID-19 on communities subjected to historical and contemporary injustices.

We measure this in two ways:

1. CCOs must complete a self-assessment of the language services they provide. CCOs verify whether they meet minimum requirements and provide higher quality and more robust language services over time.
2. CCOs report whether people who've said they want interpreter services get them from a qualified or certified interpreter for each visit to health care.

Immunization for Adolescents (Combo 2)

We measure the percentage of children who are up to date on their vaccines by their 13th birthday. These vaccines include meningococcal, tetanus, diphtheria toxoids and acellular pertussis (Tdap), and human papillomavirus (HPV).

We measure this because immunizations are one of the safest, easiest, and most effective ways to protect youth from potentially serious and sometimes fatal diseases, including cancer, breathing and heart problems, seizures, and nerve damage.[11] For example, HPV causes more than 45,000 cases of cancer each year,[12] and more than 90% of these

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690153/
[9] https://pubmed.ncbi.nlm.nih.gov/19179539/
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5111827/
[11] https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/
[12] https://www.cdc.gov/cancer/hpv/statistics/index.htm

cancers are easily preventable with vaccination,[13] but a person needs to get vaccinated *before* they get the virus.

To measure this, we look at the number of thirteen-year-olds who are enrolled in a CCO and see whether they are fully vaccinated using information from the state's immunization registry, ALERT Immunization Information System and medical claims or equivalent encounter data submitted by healthcare providers. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Initiation and Engagement of Substance Use Disorder Treatment – Initiation & Engagement - Total - Adult age 18+

We measure the percentage of adults who are newly diagnosed with substance use disorder and look at whether they enter and continue in treatment. We measure this because less than 20% of people who have substance use disorder get treatment.[14] Treatment is important because it can improve health and well-being, as well as reduce healthcare spending in the long run.

We measure this by looking at medical claims or equivalent encounter data for adult CCO members who are newly diagnosed with substance use disorder to see whether they:

1. began treatment within 14 days and
2. continued treatment for at least another 34 days.

A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service. We look at "new episodes" rather than individual OHP members, which means a person could experience more than one substance use disorder episode in a year and be counted in the metric more than once.

Oral Evaluation for Adults with Diabetes

This measure looks at the percentage of adults with diabetes who received a comprehensive oral health evaluation during the measurement year. People with diabetes have higher rates of periodontal disease,[15] and annual check-ups can help providers catch and treat disease early, resulting in better health outcomes.[16] In addition, poor oral health can make a person's diabetes more difficult to manage.[17]

Measuring oral health care in adults with diabetes is important to our equity goals because we know that that people subjected to historical and contemporary injustices are more likely

[13] https://www.cdc.gov/hpv/hcp/protecting-patients.html
[14] https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3228943/
[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3645457/
[17] https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/diabetes/art-20043848

to be affected by diabetes. For example, non-Hispanic Black people are twice as likely as non-Hispanic white people to die from diabetes.[18]

To measure this, we look at CCO members who have diabetes and use dental claims or equivalent encounter data to see if they have had an oral health assessment during the measurement year. A claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Preventive Dental or Oral Service Utilization - Ages 1 to 5 and Ages 6-14

This measure looks at the percentage of kids who received preventive dental or oral health care during the measurement year. We focus on oral health because untreated oral health problems can lead to problems eating, speaking, playing, and learning.[19]

The measure is broken into two parts:

1. Ages 1-5 because this is a crucial age in kindergarten readiness, which is important to meeting our health equity goals.
2. Ages 6-14 because we know that poor oral health is one of the leading causes of absences from school.[20]

We measure this by looking at medical and dental claims or equivalent encounter data to see if kids received preventive dental or oral health care. A claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Screening & Brief Intervention

We measure the percentage of people ages 12+ who are screened for unhealthy drug and alcohol use and the percentage who receive a brief intervention if they report unhealthy drug or alcohol use. This measure is important because early intervention helps address unhealthy substance use before it becomes a substance use disorder.

We measure this using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. Because we use data from EHRs, this means we can't capture data about some people, including people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in this data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because the data we get

[18] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18
[19] https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=Untreated%20cavities%20can%20cause%20pain,least%20one%20untreated%20decayed%20tooth
[20] https://www.attendanceworks.org/bringing-dental-care-to-schools/

from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

Social Determinants of Health (SDOH)

Ensuring people have access to stable housing, good food, and reliable transportation are key components health and mental well-being. This measure promotes housing, transportation and food need screenings for all CCO members. If a member has one or more needs, the measure encourages CCOs and their providers to give the member a referral to have those needs met.

The measure requires CCOs to create policies with CCO members in a collaborative, trauma informed way. Screenings should not cause harm to members. Screenings can cause harm if needs are never identified and never addressed. Screenings also can cause harm if needs are identified one or more times and never addressed.

We measure progress in two ways:

1. CCOs must complete a self-assessment of the screenings and referrals they provide in partnership with community-based organizations for each need: housing, food, and transportation. CCOs verify whether the CCO meets the measure's minimum requirements in creating a system that supports the screening and referral process.
2. In future years, CCOs will begin reporting on the percent of members screened, percent who have a housing, food and/or transportation need, and percent with a need who receive a referral.

Child-Level Social-Emotional Health Metric (kindergarten readiness measure)

This measure holds CCOs accountable for providing clinically-recommended, EPSDT-aligned issue-focused intervention and treatment services for young children (birth to five) with social-emotional health issues. The measure development included significant community input and engagement, including parents of young children enrolled in CCOs, and addresses needs for improvements that were identified through the System-Level Social Emotional Health Metric.

This measure will help ensure that young children have equitable access to services that support their social-emotional health and are the best match for their needs, and the metric data will allow for stratification by REAL-D and other factors to guide targeted improvement efforts. The child-level social emotional metric is part of a broader effort to make sure children are prepared for kindergarten, which is critical to meeting our health equity goals. In focus groups of Oregon families, parents reported that the social-emotional health of their children is critical to preparing them for kindergarten.

Timeliness of Prenatal and Postpartum Care: Postpartum Care Rate

We measure the percentage of people who have given birth who receive post-partum care between one and 12 weeks following the birth. The weeks following birth are critical for long-term health and well-being for the birthing parent and child alike.[22] Post-partum care helps birthing parents address complications, like pain and incontinence, as well social-emotional health needs.

This measure supports OHA's health equity goals because high-quality postpartum care is also important for addressing the inequitable maternal health outcomes for people of color. For example, American Indian and Alaska Native (AI/AN) and Black women are 2-3 times more likely to die from pregnancy-related causes than white women.[23]

To measure this, we look at CCO members who've given birth in the last year and use medical claims and chart review to see if they had at least one postpartum visit in the one to 12 weeks following the birth. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

[22] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care
[23] https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html

Measure: Use of Pharmacotherapy for Opioid Use Disorder

2024 CMS Core Set Measure

Measure overview: The percentage of members ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

Rate 1: A total overall rate capturing any medications used in medication assisted treatment of opioid dependence and addiction.

Four separate rates representing the following types of FDA-approved drug products:

- **Rate 2:** Buprenorphine
- **Rate 3:** Oral naltrexone
- **Rate 4:** Long-acting, injectable naltrexone
- **Rate 5:** Methadone

Denominator: Members ages 18 to 64 who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.

Numerator:

- **Rate 1:** Members ages 18 to 64 with an opioid use disorder who filled at least one prescription or who were administered or dispensed an FDA-approved medication for opioid use disorder.
- **Rate 2:** Members ages 18 to 64 with an opioid use disorder who filled at least one prescription for buprenorphine.
- **Rate 3:** Members ages 18 to 64 with an opioid use disorder who filled at least one prescription for oral naltrexone.
- **Rate 4:** Members ages 18 to 64 with an opioid use disorder who filled at least one prescription for long-acting, injectable naltrexone.
- **Rate 5:** Members ages 18 to 64 with an opioid use disorder who had at least one dose of methadone.

Continuous enrollment criteria: Continuously enrolled for the measurement year.

Data source: Administrative/claims

2022 CCO statewide averages:

- **Rate 1: 70.2%** (CCO range 56.9% - 74.9%)
- **Rate 2: 45.5%** (CCO range 36.6% - 57.1%)
- **Rate 3: 2.7%** (CCO range 1.8% - 6.0%)
- **Rate 4: 0.8%** (CCO range 0.3% - 3.0%)
- **Rate 5: 26.7%** (CCO range 8.4% - 41.7%)

Rate 1 (Total), 2022 CCO rates

PacificSource Marion Polk	74.9%
Columbia Pacific	74.5%
Yamhill Community Care	74.3%
Health Share of Oregon	72.9%
PacificSource Central	71.8%
Umpqua Health Alliance	71.4%
InterCommunity Health Network	70.7%
Jackson Care Connect	70.3%
PacificSource Lane	66.9%
PacificSource Gorge	65.9%
Advanced Health	65.7%
Trillium North	65.0%
Trillium South	64.2%
AllCare CCO	62.3%
Eastern Oregon CCO	59.1%
Cascade Health Alliance	56.9%

Rate 2 (Buprenorphine), 2022 CCO rates

PacificSource Gorge	57.1%
InterCommunity Health Network	53.9%
Columbia Pacific	52.6%
PacificSource Central	52.5%
Yamhill Community Care	50.7%
Advanced Health	50.1%
Eastern Oregon CCO	49.5%
Umpqua Health Alliance	49.2%
Trillium North	47.9%
Jackson Care Connect	46.4%
PacificSource Lane	46.3%
Trillium South	45.1%
Cascade Health Alliance	44.0%
Health Share of Oregon	43.4%
AllCare CCO	39.5%
PacificSource Marion Polk	36.6%

Rate 3 (Oral naltrexone), 2022 CCO rates

Cascade Health Alliance	6.0%
PacificSource Central	5.2%
InterCommunity Health Network	3.9%
Umpqua Health Alliance	3.9%
Advanced Health	3.7%
Trillium North	3.6%
Trillium South	3.6%
Eastern Oregon CCO	3.3%
PacificSource Lane	3.3%
Yamhill Community Care	3.0%
AllCare CCO	2.7%
PacificSource Marion Polk	2.4%
PacificSource Gorge	2.2%
Columbia Pacific	2.1%
Jackson Care Connect	2.1%
Health Share of Oregon	1.8%

Rate 4 (Long-acting, injectable naltrexone), 2022 CCO rates

PacificSource Central	3.0%
Trillium North	1.7%
Trillium South	1.6%
Cascade Health Alliance	1.4%
Yamhill Community Care	1.4%
PacificSource Gorge	1.3%
PacificSource Lane	1.0%
InterCommunity Health Network	0.9%
Umpqua Health Alliance	0.6%
Advanced Health	0.6%
PacificSource Marion Polk	0.6%
Health Share of Oregon	0.6%
Jackson Care Connect	0.5%
AllCare CCO	0.4%
Eastern Oregon CCO	0.3%
Columbia Pacific	0.3%

Rate 5 (Methadone), 2022 CCO rates

PacificSource Marion Polk	41.7%
Health Share of Oregon	32.3%
AllCare CCO	27.7%
Yamhill Community Care	26.0%
Jackson Care Connect	25.8%
Columbia Pacific	23.8%
Umpqua Health Alliance	23.5%
PacificSource Lane	21.7%
Trillium North	19.8%
PacificSource Central	18.3%
Trillium South	17.7%
InterCommunity Health Network	16.8%
Advanced Health	16.4%
Cascade Health Alliance	9.6%
PacificSource Gorge	8.8%
Eastern Oregon CCO	8.4%

Measure: Follow-Up After Emergency Department Visit for Substance Use

2024 CMS Core Set Measure

Measure overview: Percentage of emergency department (ED) visits for members ages 13-17 and 18+ with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates for each age group are reported:

Rate 1: Percentage of ED visits for which the member received follow-up within **30 days** of the ED visit (31 total days).

Rate 2: Percentage of ED visits for which the member received follow-up within **7 days** of the ED visit (8 total days).

Denominator: ED visits for members 13-17 or 18+ with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose.

Numerator:

- **Rate 1:** Follow-up visits or pharmacotherapy dispensing events within **30 days** after the ED visit (31 total days). Includes visits and pharmacotherapy events that occur on the date of the ED visit.
- **Rate 2:** Follow-up visits or pharmacotherapy dispensing events within **7 days** after the ED visit (8 total days). Includes visits and pharmacotherapy events that occur on the date of the ED visit.

Continuous enrollment criteria: The date of the ED visit through 30 days after the ED visit (31 total days).

Data source: Administrative/claims

2022 CCO statewide average:

- **Rate 1 (30 days), ages 13-17:** 39.3% (CCO range 0.0% - 66.7%)
- **Rate 1 (30 days), ages 18+:** 34.3% (CCO range 26.8% - 40.9%)
- **Rate 2 (7 days), ages 13-17:** 27.1% (CCO range 0.0% - 52.9%)
- **Rate 2 (7 days), ages 18+:** 23.5% (CCO range 18.1% - 29.1%)

Rate 1 (30 days), ages 13-17 2022 CCO rates

PacificSource Gorge	66.7%
AllCare CCO	64.7%
PacificSource Central	63.6%
Columbia Pacific	50.0%
PacificSource Lane	46.5%
Trillium South	45.5%
Yamhill Community Care	40.0%
Health Share of Oregon	39.3%
Jackson Care Connect	36.4%
InterCommunity Health Network	36.1%
PacificSource Marion Polk	30.6%
Trillium North	30.0%
Eastern Oregon CCO	29.4%
Umpqua Health Alliance	25.0%
Cascade Health Alliance	25.0%
Advanced Health	-

Rate 1 (30 days), ages 18+ 2022 CCO rates

PacificSource Central	40.9%
AllCare CCO	38.9%
Cascade Health Alliance	38.6%
Jackson Care Connect	38.0%
PacificSource Gorge	36.8%
Yamhill Community Care	36.6%
Health Share of Oregon	35.1%
PacificSource Marion Polk	33.5%
Columbia Pacific	33.5%
PacificSource Lane	33.4%
Eastern Oregon CCO	32.2%
InterCommunity Health Network	31.0%
Umpqua Health Alliance	30.4%
Advanced Health	30.3%
Trillium South	28.9%
Trillium North	26.8%

Rate 2 (7 days), ages 13-17 2022 CCO rates

AllCare CCO	52.9%
Trillium South	45.5%
PacificSource Lane	32.6%
PacificSource Central	31.8%
InterCommunity Health Network	30.6%
Columbia Pacific	30.0%
Jackson Care Connect	27.3%
Health Share of Oregon	27.0%
Umpqua Health Alliance	25.0%
Yamhill Community Care	25.0%
PacificSource Marion Polk	21.0%
Trillium North	20.0%
Eastern Oregon CCO	17.6%
Cascade Health Alliance	12.5%
Advanced Health	-
PacificSource Gorge	-

Rate 2 (7 days), ages 18+ 2022 CCO rates

PacificSource Central	29.1%
Yamhill Community Care	27.7%
AllCare CCO	26.0%
Cascade Health Alliance	24.7%
Health Share of Oregon	24.6%
Jackson Care Connect	24.5%
Eastern Oregon CCO	23.1%
PacificSource Gorge	23.0%
PacificSource Marion Polk	22.6%
PacificSource Lane	22.1%
Advanced Health	21.2%
Columbia Pacific	21.0%
InterCommunity Health Network	20.8%
Umpqua Health Alliance	20.3%
Trillium North	20.0%
Trillium South	18.1%

Measure: Oral Evaluation, Dental Services

2024 CMS Core Set Measure

Measure overview: The percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Denominator: Unduplicated number of children under age 21 on the last day of the measurement year.

Numerator: Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service, identified by CDT code D0120, D0150, or D0145, by a provider with the following NUCC-maintained taxonomy codes: 122300000X, 1223P0106X, 1223X0008X, 125Q00000X, 126800000X, 1223D0001X, 1223P0221X, 1223X0400X, 261QF0400X, 261QD0000X, 1223D0004X, 1223P0300X, 124Q00000X, 261QR1300X, 204E00000X, 1223E0200X, 1223P0700X, 125J00000X, 1223X2210X, 261QS0112X, 1223G0001X, 1223S0112X, 125K00000X, 122400000X

Continuous enrollment criteria: Continuously enrolled for at least 180 days in the measurement year.

Data source: Administrative/claims

More details about this measure can be found on the CCO Performance Metrics Dashboard and in the measure specifications.

2022 CCO statewide average:

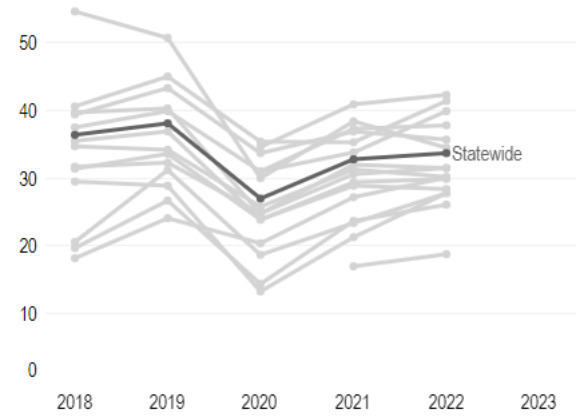
- Ages 0-5: 33.6% (CCO range 18.7% - 42.2%)
- Ages 6-14: 48.2% (CCO range 27.5% - 56.6%)
- Ages 15-20: 28.7% (CCO range 16.5% - 32.4%)

Additional information: OHA publishes this measure with two age breakouts, 0-5 and 6-14. We've included data for the 15-20 age group, statewide and by CCO, here as well. The committee may choose to incentivize one/any of these age groups, or to incentivize the measure with the age group reported to CMS (0-20).

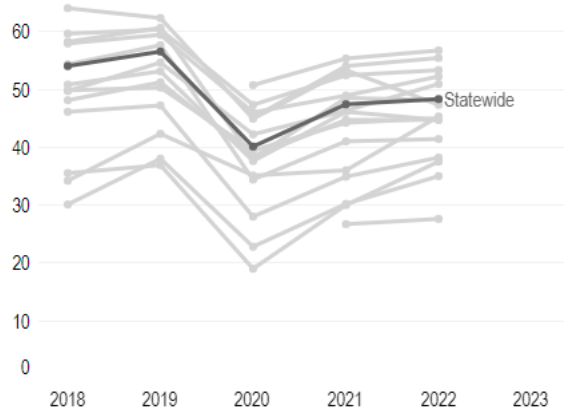
Dental Services Provider Table by Taxonomy Code

122300000X	Dentist	**124Q00000X**	Dental Hygienist
1223P0106X	Dentist, Oral and Maxillofacial Pathology	**261QR1300X**	Clinic/Center, Rural Health
1223X0008X	Dentist, Oral and Maxillofacial Radiology	**204E00000X**	Allopathic & Osteopathic Physicians, Oral & Maxillofacial Surgery
125Q00000X	Oral Medicinist	**1223E0200X**	Dentist, Endodontics
126800000X	Dental Assistant	**1223P0700X**	Dentist, Prosthodontics
1223D0001X	Dentist, Dental Public Health	**125J00000X**	Dental Therapist
1223P0221X	Dentist, Pediatric Dentistry	**1223X2210X**	Dentist, Orofacial Pain
1223X0400X	Dentist, Orthodontics and Dentofacial Orthopedics	**261QS0112X**	Clinic/Center, Oral & Maxillofacial Surgery
261QF0400X	Federally Qualified Health Center	**1223G0001X**	Dentist, General Practice
261QD0000X	Clinic/Center, Dental	**1223S0112X**	Dentist, Oral and Maxillofacial Pathology
1223D0004X	Dentist, Dentist Anesthesiologist	**125K00000X**	Advanced Practice Dental Therapist
1223P0300X	Dentist, Periodontics	**122400000X**	Denturist

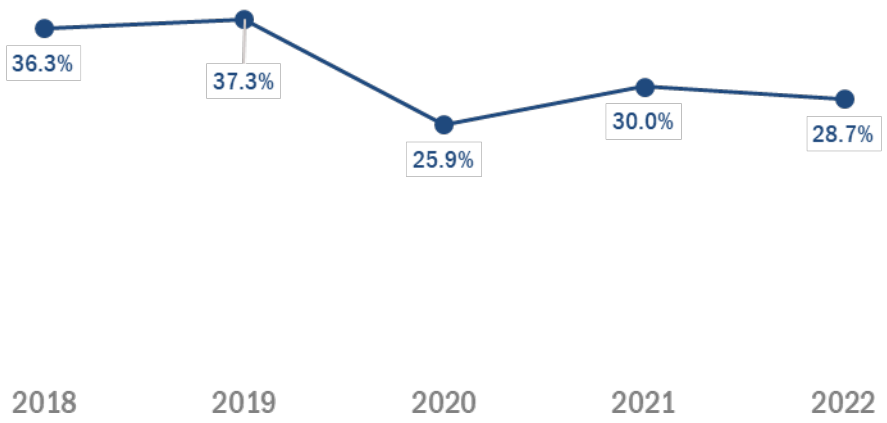
Ages 0-5, 2022 Statewide rate 33.6%



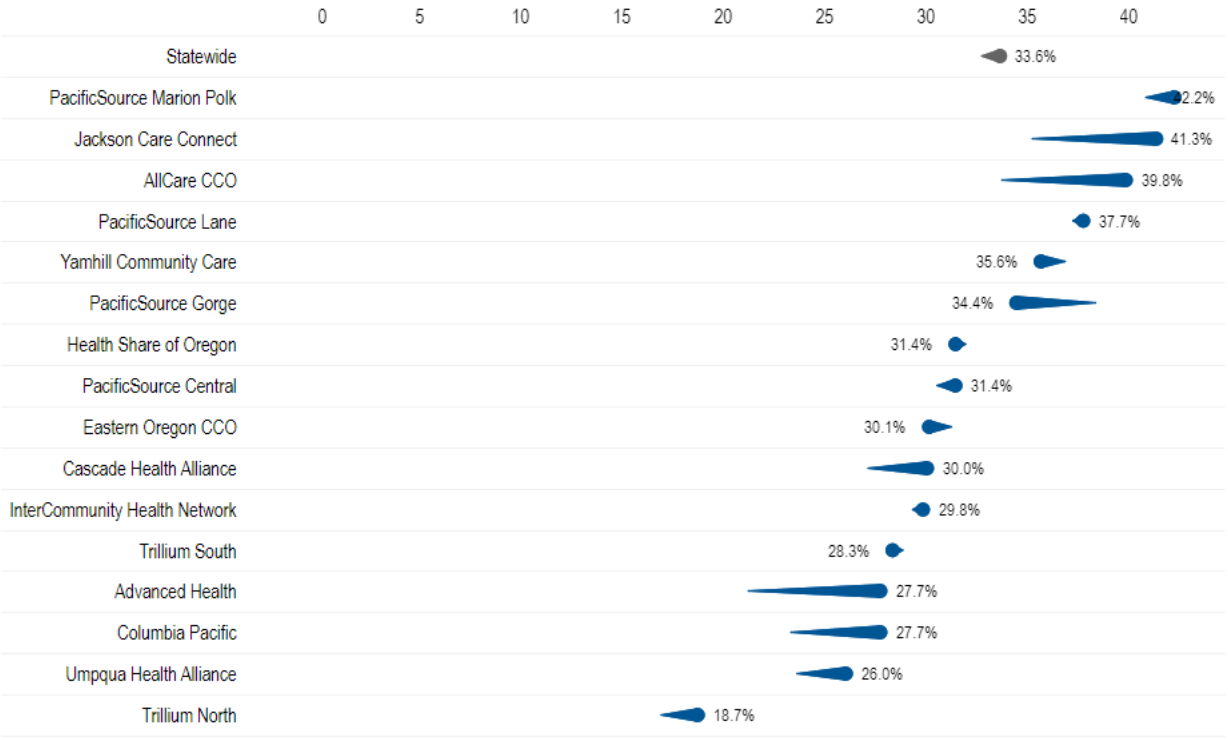
Ages 6-14, 2022 Statewide rate 48.2%



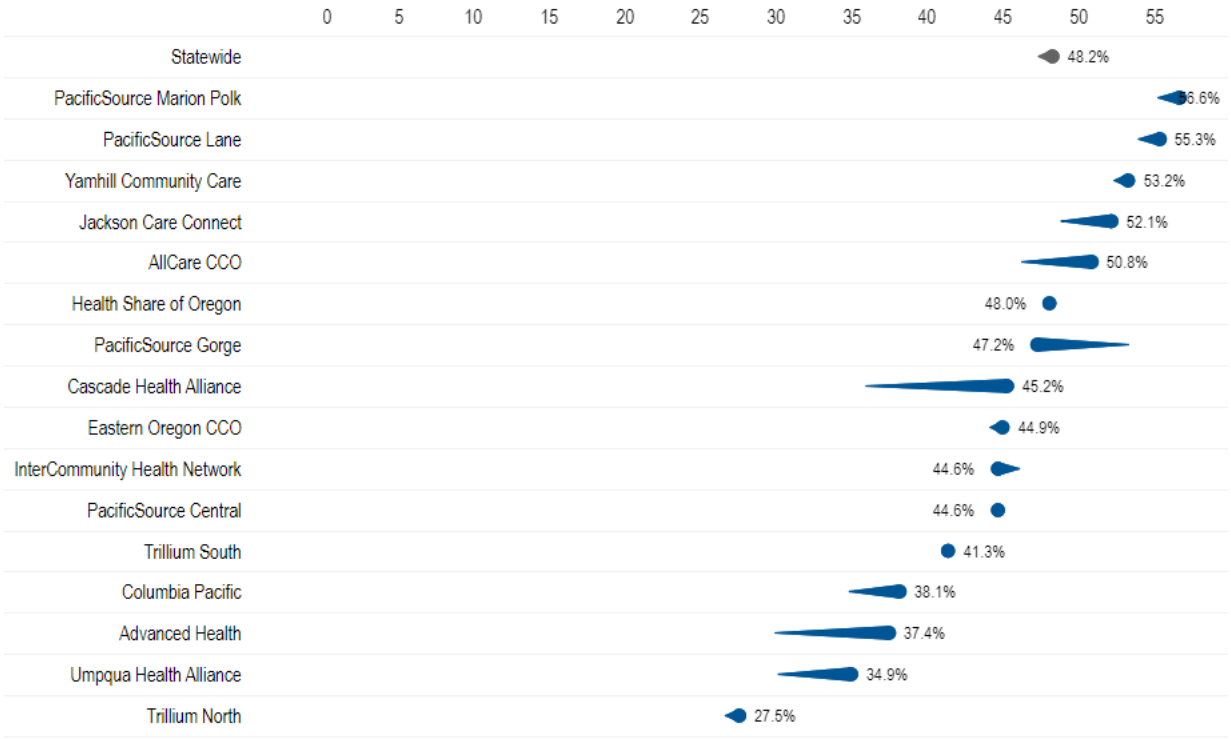
Ages 15-20, 2022 Statewide rate 28.7%



Ages 0-5, 2022 CCO rates



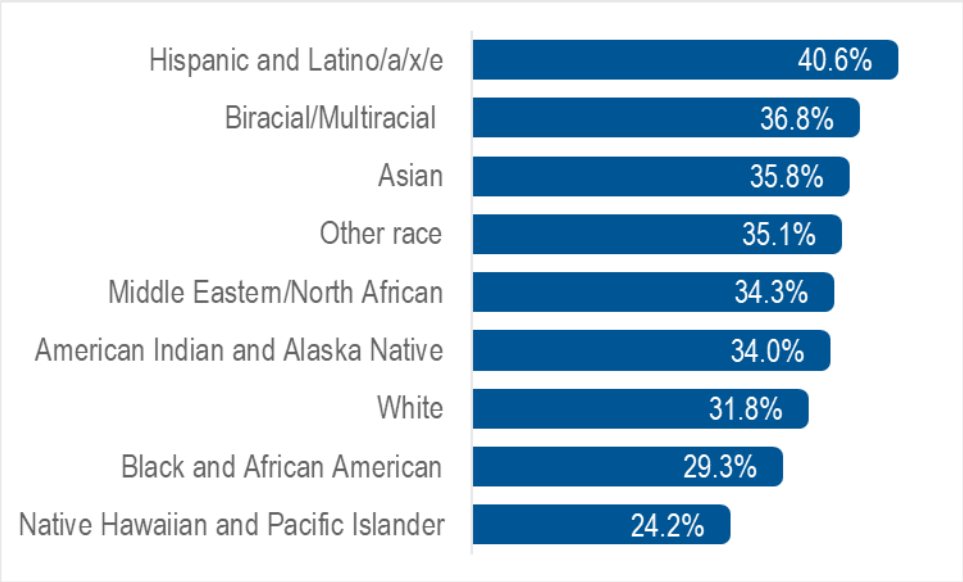
Ages 6-14, 2022 CCO rates



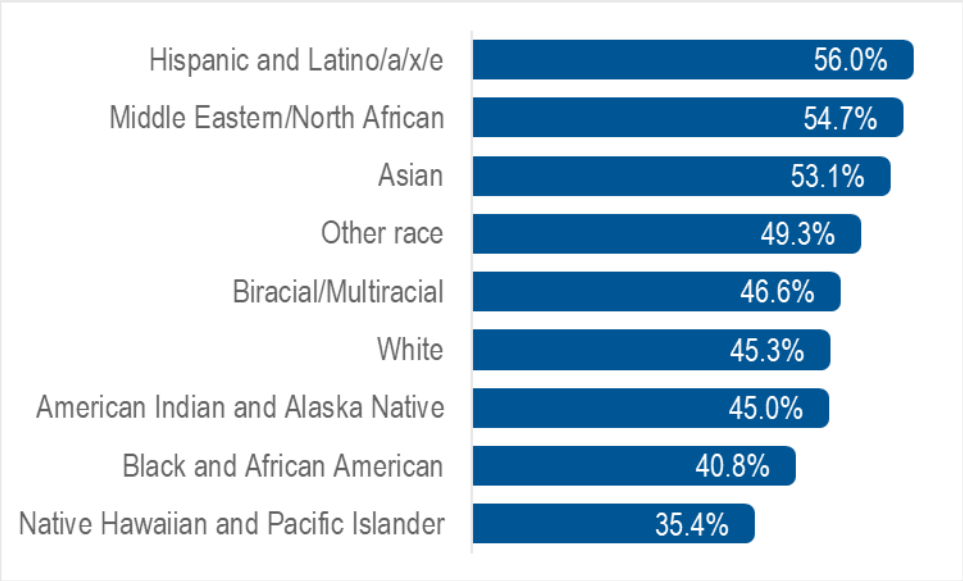
Ages 15-20, 2022 CCO rates

Yamhill Community Care	32.4%
PacificSource Marion Polk	31.1%
Health Share of Oregon	30.8%
Eastern Oregon CCO	30.7%
PacificSource Gorge	29.8%
Jackson Care Connect	28.7%
PacificSource Lane	28.4%
AllCare CCO	26.2%
Advanced Health	25.9%
Cascade Health Alliance	25.8%
InterCommunity Health Network	25.4%
Umpqua Health Alliance	25.2%
Columbia Pacific	23.8%
PacificSource Central	22.9%
Trillium South	22.2%
Trillium North	16.5%

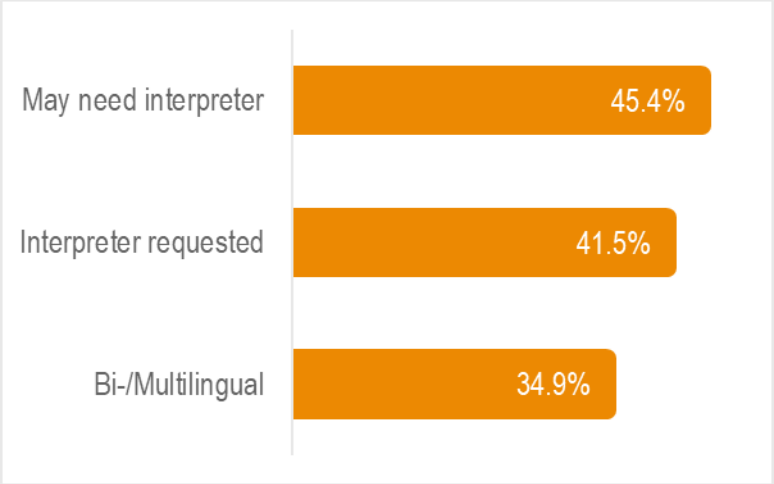
Ages 0-5, 2022 Race/Ethnicity breakouts



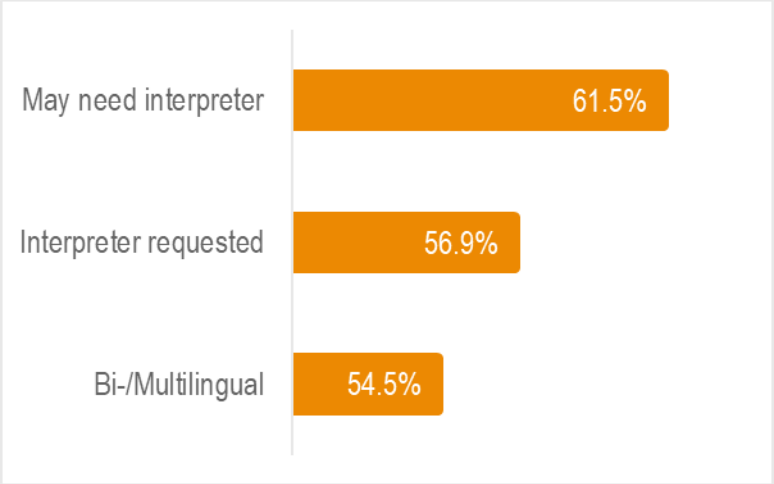
Ages 6-14, 2022 Race/Ethnicity breakouts



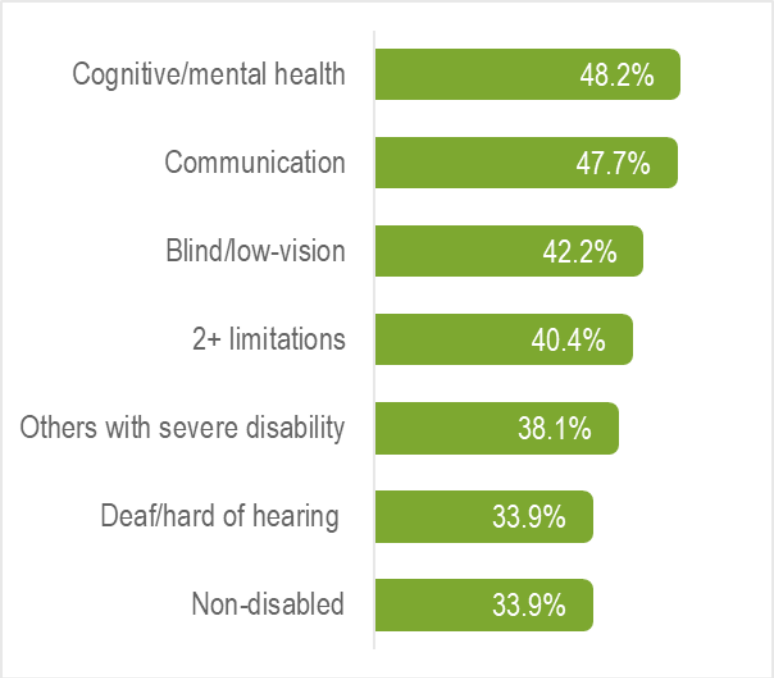
Ages 0-5, 2022 Language breakouts



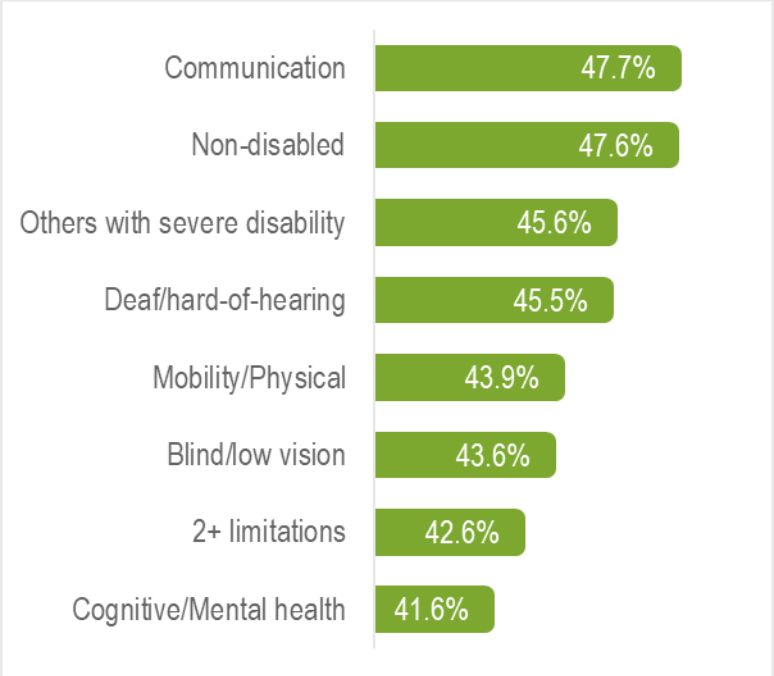
Ages 6-14, 2022 Language breakouts



Ages 0-5, Disability breakouts



Ages 6-14, 2022 Disability breakouts



Measure: Sealant Receipt on Permanent First Molars

2024 CMS Core Set Measure

Measure overview: The percentage of children who have ever received sealants on permanent first molar teeth by the 10th birthdate: (Rate 1) at least one sealant and (Rate 2) sealants on all four molars.

Denominator: Unduplicated number of children with their 10th birthdate in the reporting year.

Numerator:

- Rate 1: Unduplicated number of children who have ever received sealants on at least one permanent molar tooth prior to the 10th birthdate. CDT code D1351 for tooth number 3, 14, 19, **or** 30.
- Rate 2: Unduplicated number of children who have received sealants on all four permanent molar teeth prior to their 10th birthdate. CDT code D1351 for tooth number 3, 14, 19, **and** 30.

Continuous enrollment criteria: Continuously enrolled for 12 months prior to the child's 10th birthdate with an allowable single gap of no more than 45 days.

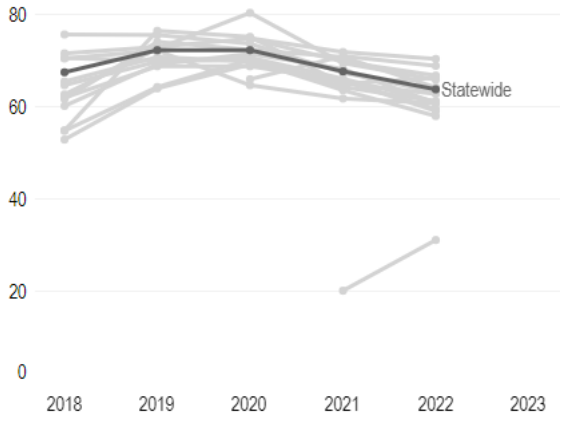
Data source: Administrative/claims

More details about this measure can be found on the CCO Performance Metrics Dashboard and in the measure specifications.

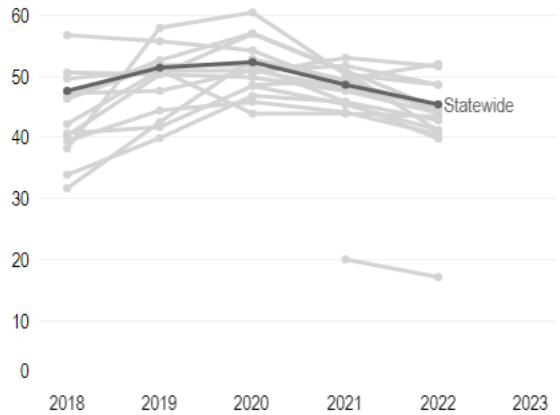
2022 CCO statewide average:

- At least one molar: 63.7% (CCO range 31.0% - 70.3%)
- All four molars: 45.3% (CCO range 17.1% - 51.9%)

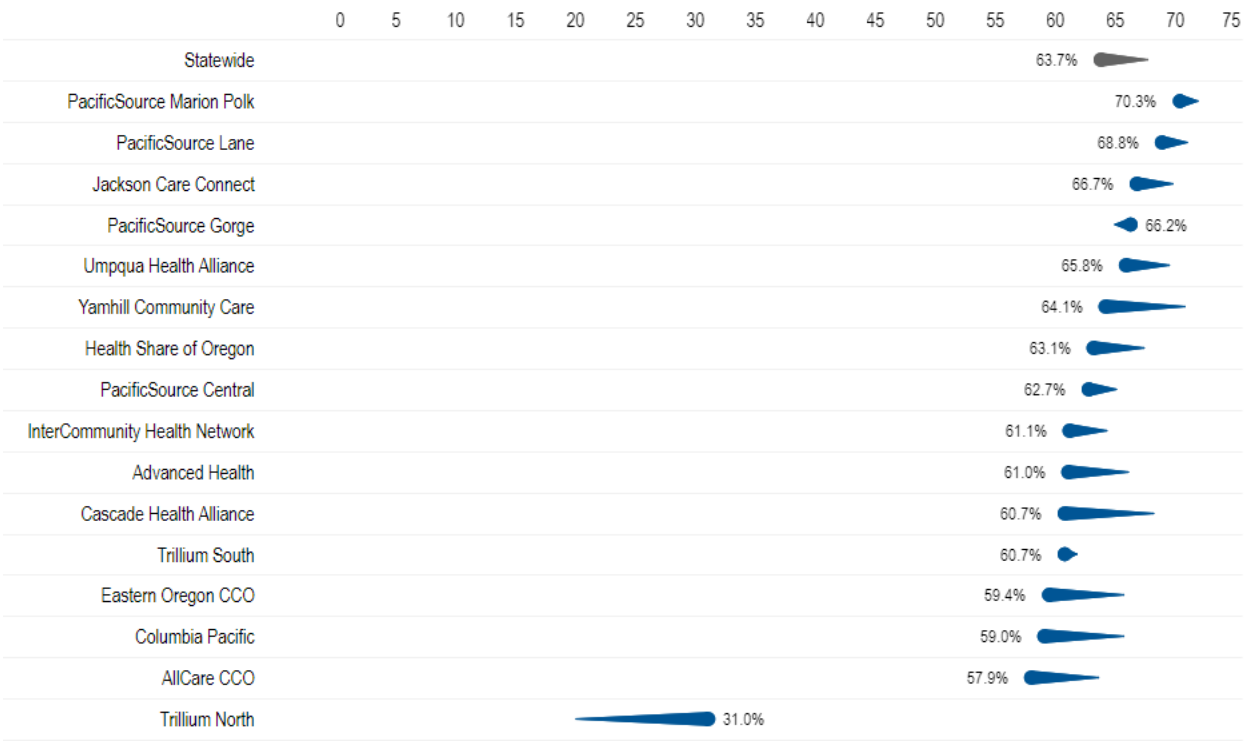
At Least One Molar 2022 statewide rate



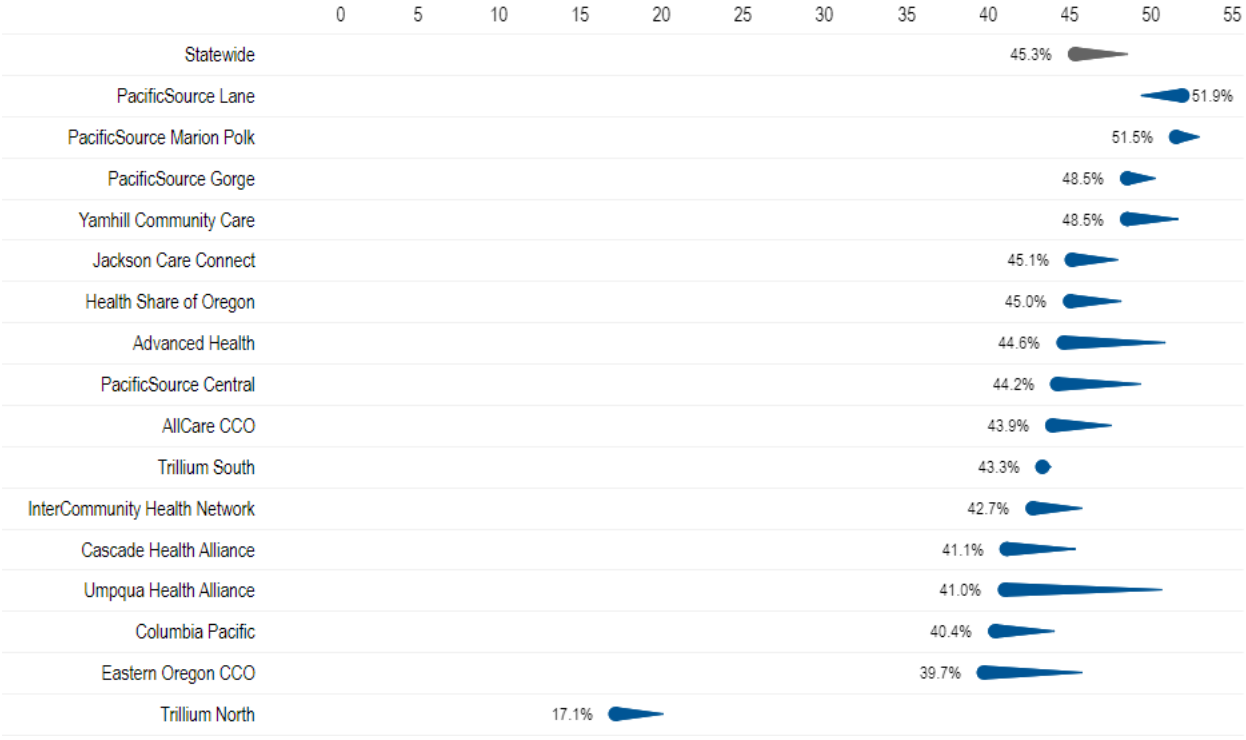
All Four Molars 2022 statewide rate



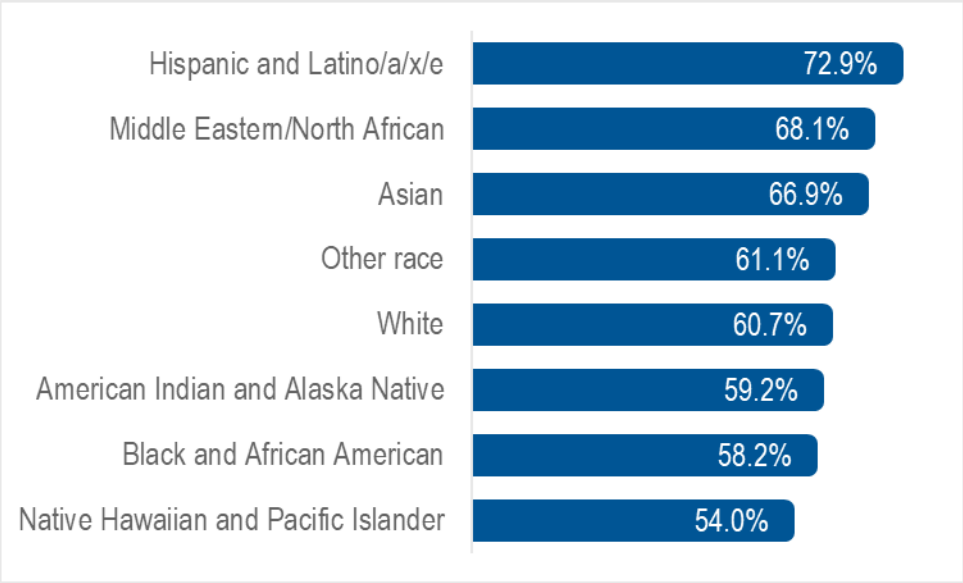
At Least One Molar 2022 CCO rates



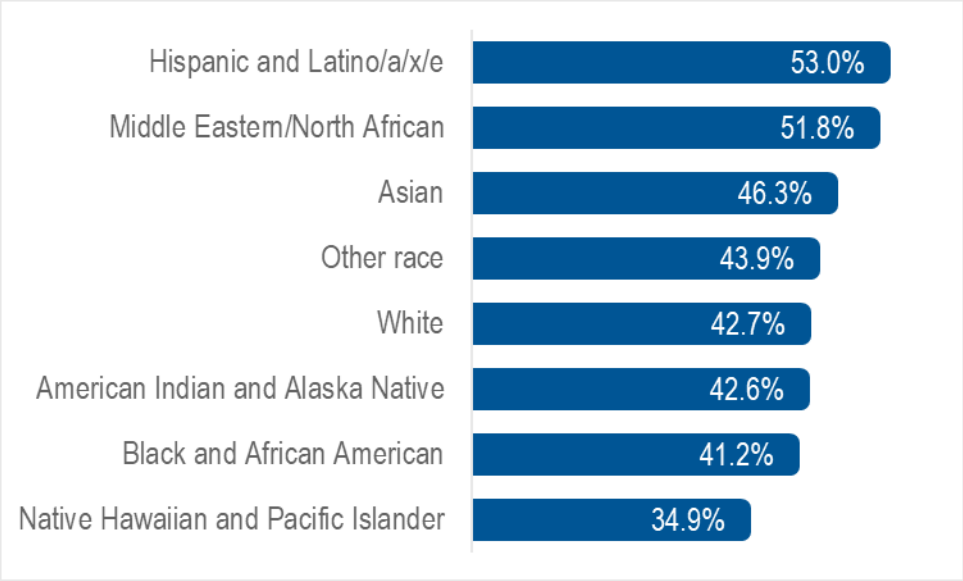
All Four Molars 2022 CCO rates



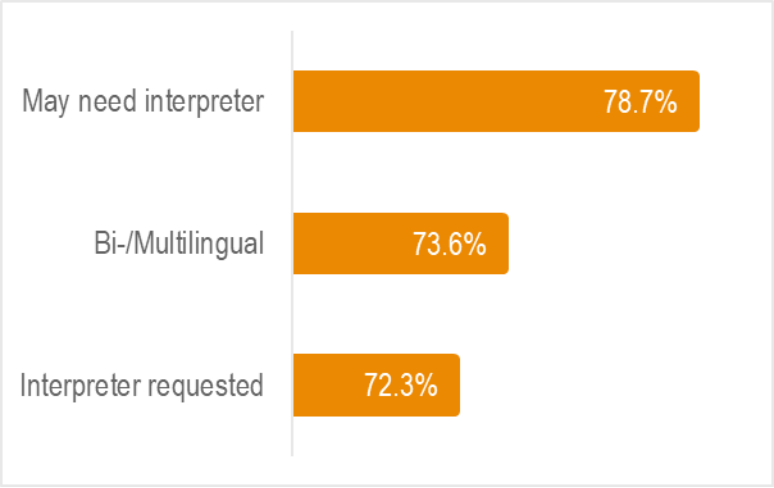
At Least One Molar 2022 Race/Ethnicity breakouts



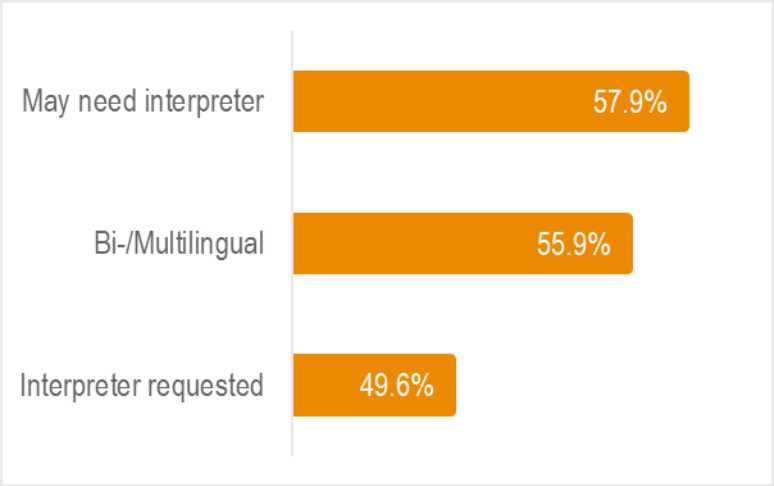
All Four Molars 2022 Race/Ethnicity breakouts



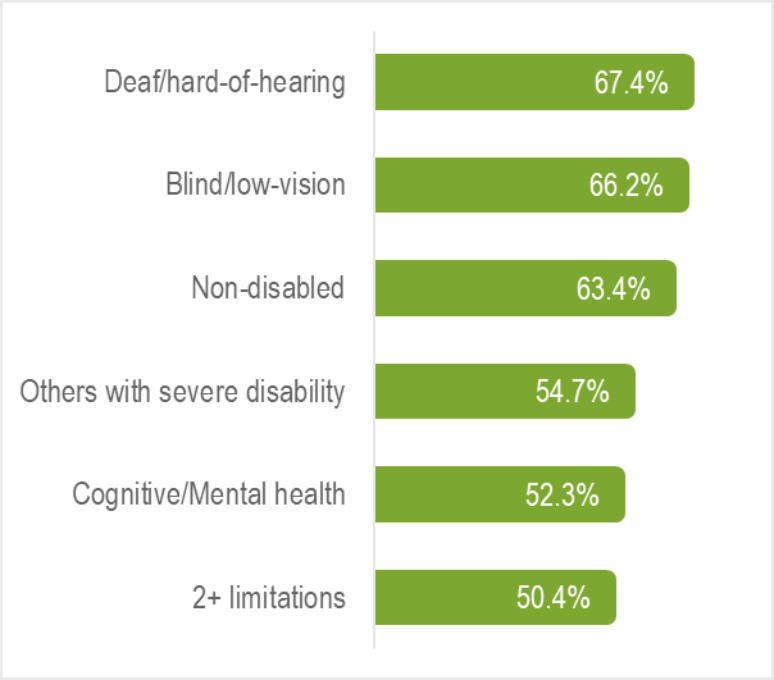
At Least One Molar 2022 Language breakouts



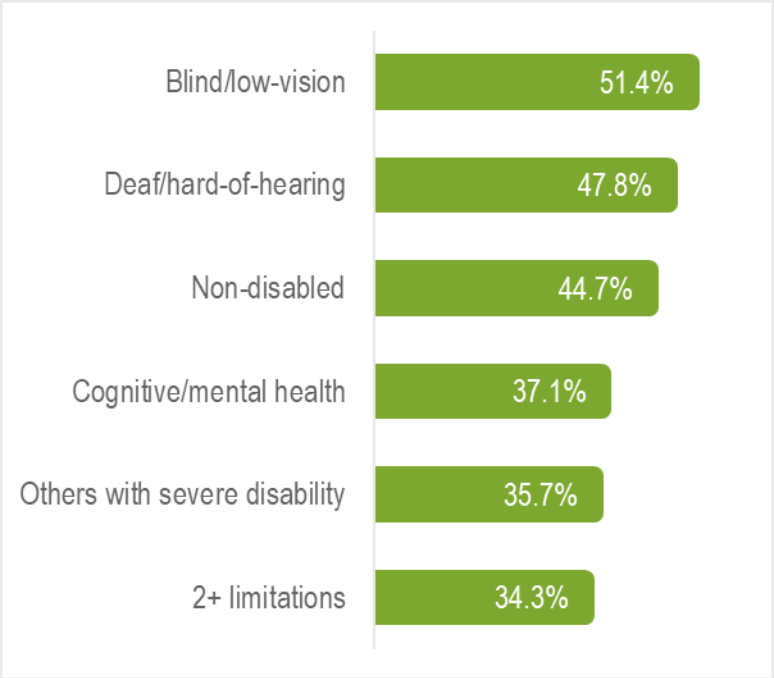
All Four Molars 2022 Language breakouts



At Least One Molar 2022 Disability breakouts



All Four Molars 2022 Disability breakouts



Measure: Topical Fluoride for Children

2024 CMS Core Set Measure

Measure overview: The percentage of children age 1 – 20 years who received at least 2 topical fluoride applications as (1) dental OR oral health services, (2) dental services, and (3) oral health services within the measurement year. **OHA currently publishes Rate 1 only.**

Denominator: Unduplicated number of children age 1 – 20 years on the last day of the measurement year.

Numerator: Unduplicated number of children who received at least 2 topical fluoride applications as (1) dental OR oral health services, (2) dental services, and (3) oral health services within the measurement year.

- Rate 1 (dental or oral health services) codes: CDT code D1206 or D1208, or CPT code 99188
- Rate 2 (dental services) codes: CDT code D1206 or D1208, by a provider with the following NUCC-maintained taxonomy codes: 122300000X, 1223P0106X, 1223X0008X, 125Q00000X, 126800000X, 1223D0001X, 1223P0221X, 1223X0400X, 261QF0400X, 261QD0000X, 1223D0004X, 1223P0300X, 124Q00000X, 261QR1300X, 204E00000X, 1223E0200X, 1223P0700X, 125J00000X, 1223X2210X, 261QS0112X, 1223G0001X, 1223S0112X, 125K00000X, 122400000X
- Rate 3 (oral health services) codes: CDT code D1206 or D1208, or CPT code 99188, by a provider with a valid NUCC-maintained provider taxonomy code that is **NOT** listed in Rate 2.

Continuous enrollment criteria: Continuously enrolled for the measurement year (12 months) with a gap of no more than 31 days.

Data source: Administrative/claims

More details about this measure can be found on the CCO Performance Metrics Dashboard and in the measure specifications.

2022 CCO statewide average:

- Ages 1-5: 21.1% (CCO range 10.4% - 28.4%)
- Ages 6-14: 23.1% (CCO range 10.9% - 32.8%)

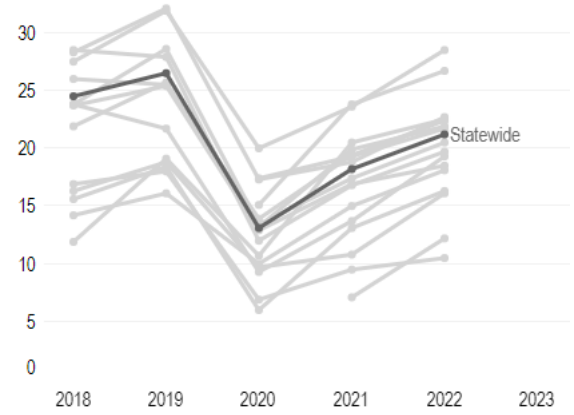
Additional information: OHA publishes Rate 1 of this measure with two age breakouts, 1-5 and 6-14. The committee may choose to incentivize a different rate, one/both of these age groups, or the age group reported to CMS (1-20).

Dental Services Provider Table by Taxonomy Code

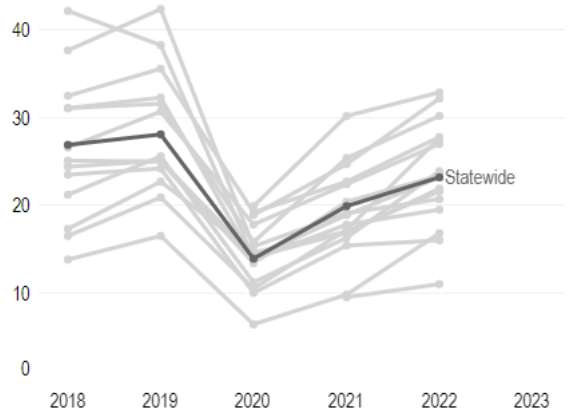
122300000X	Dentist	**124Q00000X**	Dental Hygienist
1223P0106X	Dentist, Oral and Maxillofacial Pathology	**261QR1300X**	Clinic/Center, Rural Health
1223X0008X	Dentist, Oral and Maxillofacial Radiology	**204E00000X**	Allopathic & Osteopathic Physicians, Oral & Maxillofacial Surgery
125Q00000X	Oral Medicinist	**1223E0200X**	Dentist, Endodontics
126800000X	Dental Assistant	**1223P0700X**	Dentist, Prosthodontics
1223D0001X	Dentist, Dental Public Health	**125J00000X**	Dental Therapist
1223P0221X	Dentist, Pediatric Dentistry	**1223X2210X**	Dentist, Orofacial Pain
1223X0400X	Dentist, Orthodontics and Dentofacial Orthopedics	**261QS0112X**	Clinic/Center, Oral & Maxillofacial Surgery

261QF0400X	Federally Qualified Health Center	**1223G0001X**	Dentist, General Practice
261QD0000X	Clinic/Center, Dental	**1223S0112X**	Dentist, Oral and Maxillofacial Pathology
1223D0004X	Dentist, Dentist Anesthesiologist	**125K00000X**	Advanced Practice Dental Therapist
1223P0300X	Dentist, Periodontics	**122400000X**	Denturist

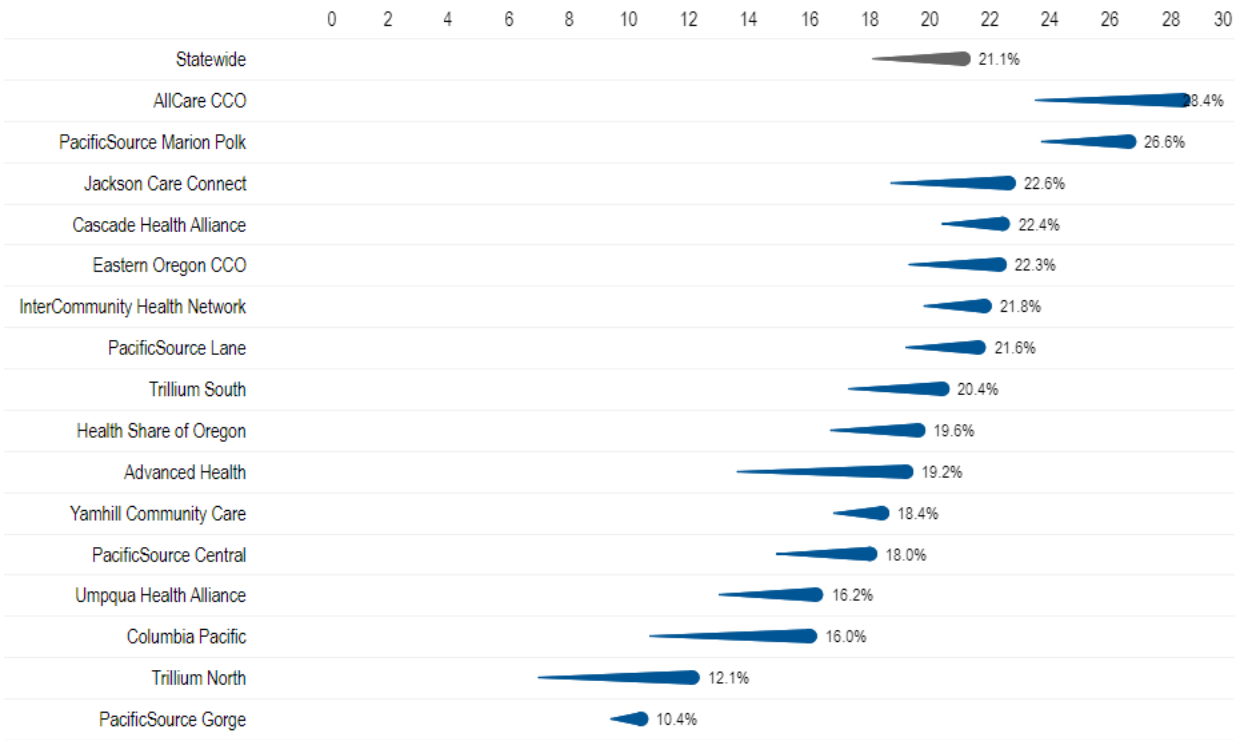
Ages 1-5 2022 Statewide rate 21.1%



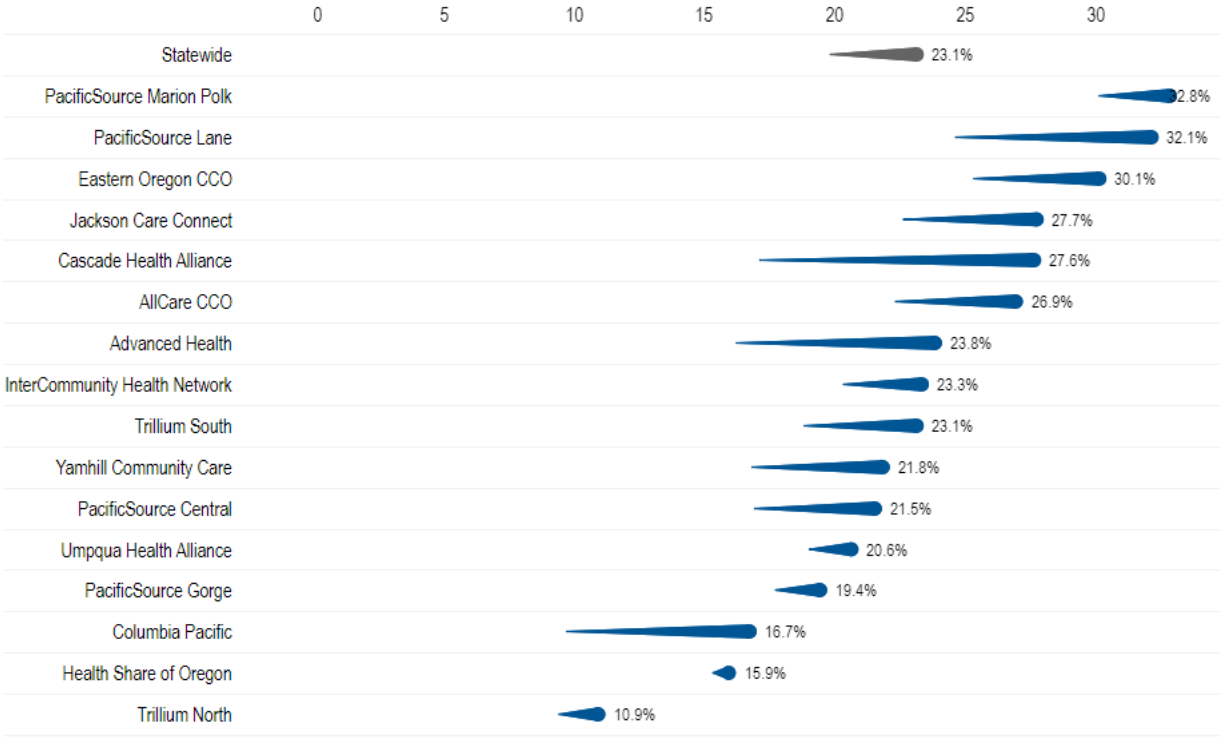
Ages 6-14 2022 Statewide rate 23.1%



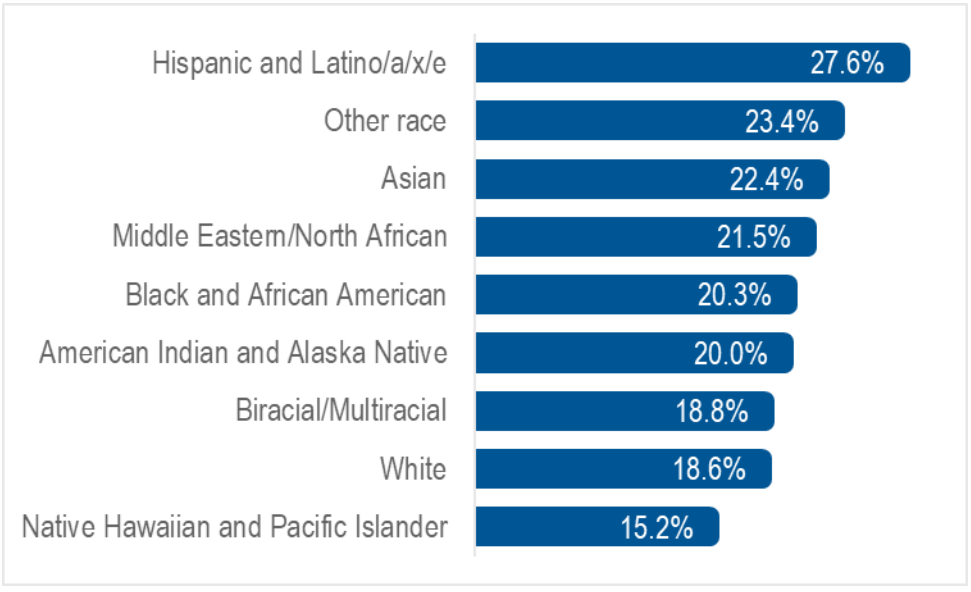
Ages 1-5 2022 CCO rates



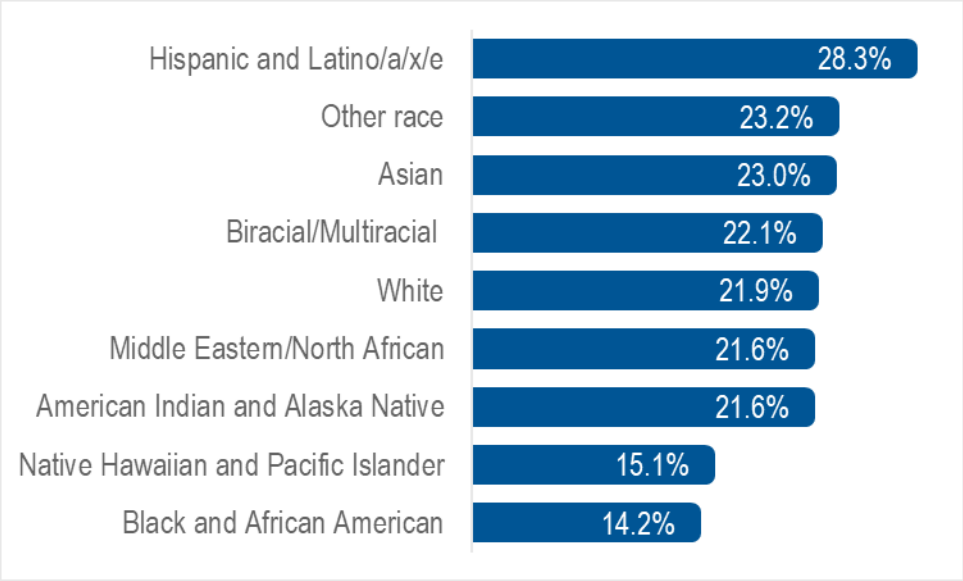
Ages 6-14 2022 CCO rates



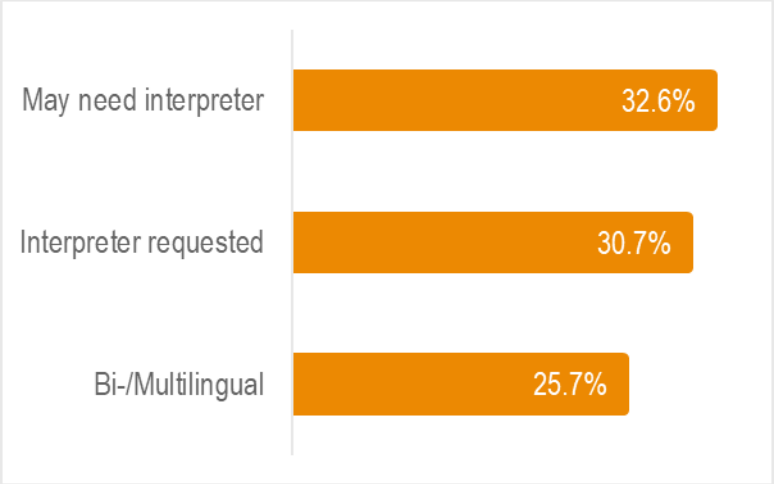
Ages 1-5 2022 Race/Ethnicity breakouts



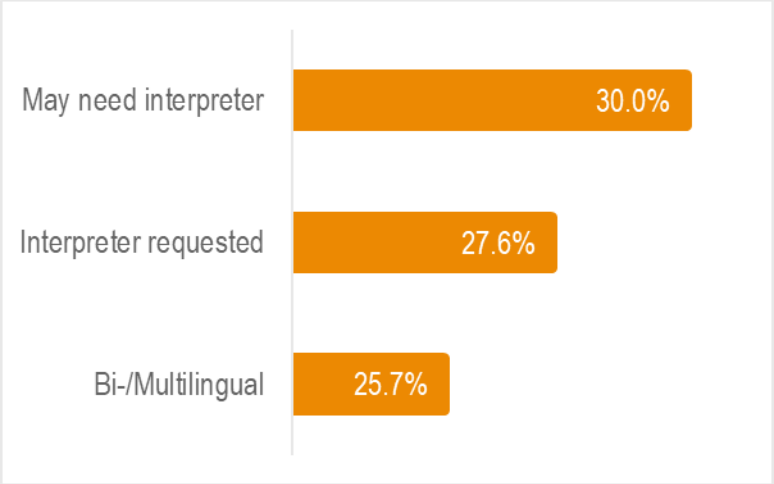
Ages 6-14 2022 Race/Ethnicity breakouts



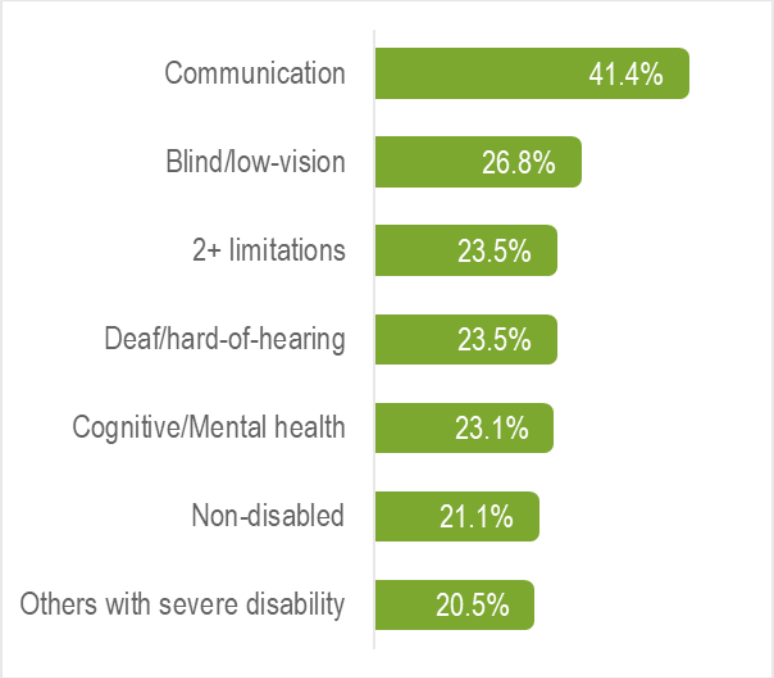
Ages 1-5 2022 Language breakouts



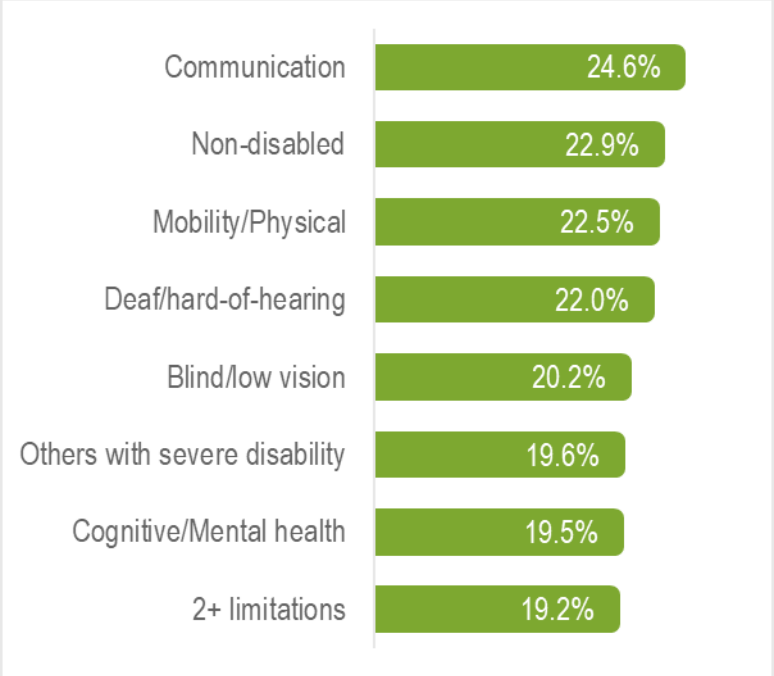
Ages 6-14 Language breakouts



Ages 1-5 2022 Disability breakouts



Ages 6-14 2022 Disability breakouts



Assessments for Children in DHS Custody

Measure Basic Information

Name and date of specifications used: OHA developed these specifications based on requirements for physical, mental, and dental health assessments for children who enter DHS custody.

URL of Specifications: N/A

Measure Type:

☐HEDIS ☐Survey ■Other Specify: OHA-developed

Measure Utility:

■CCO Incentive ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS and OR-KIDS

Measurement Period: Cases with First Notification Date November 1, 2023 – October 31, 2024

Note the cut-off date of notification is on October 31st so the health assessment period can occur by the end of the year.

DHS	2022	2023	2024
Benchmark for OHA measurement year	90%	90%	93.2%
Improvement target for OHA measurement year	MN method with no floor	MN method with 2 percentage point floor	MN method with 3 percentage point floor
Source:	Metrics & Scoring Committee consensus	Metrics & Scoring Committee consensus	MY 2022 CCO 75th percentile

Note on telehealth: This measure is telehealth eligible as the qualifying numerator services do not require 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.

Changes in specifications from MY2023 to MY2024:

- Expanded the mental health assessment required age range from 4-17 years old to 3-17 years old, to align with the ODHS policy.
- Added clarification that only the very first 'First Notification Date' is used for calculating the measure. Added notes in the Appendix for rare scenarios when the First Notification Date in the weekly notification file may be restarted.

Member type: ■CCOA ☐CCOB ☐CCOE ☐CCOF ☐CCOG

- Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

DHS	Only use claims from matching CCO	Denied claims included
Numerator in 60-day assessment period	Y	Y
Numerator in 30-day lookback period, or when the enrollment with the notified CCO has not started	N (all MMIS/DSSURS claims for the member are used, regardless of Open Card claims, or from other CCOs)	Y

Measure Details

Data elements required denominator: Identified children/adolescents 0 – 17 years of age as of the first date of DHS/OHA notification and remained in custody for at least 60 days. Only children/adolescents that DHS/OHA notified CCOs about will be included in the denominator. Include cases notified from November 1 of the year prior to the measurement year, to October 31 of the measurement year.

Whether a child 'remained in custody' is determined by Child Welfare discharge date or transfer of custody (such as OYA) in the OR-Kids data. If a CCO received information from DHS for change of custody, the CCO should preserve communication records; OHA will review these records and determine exclusions from the metric on a case-by-case basis.

Note: OHA and DHS launched a new weekly notification data layout on January 13, 2021 which included the key improvements:

- An 'Episode Start Date' (also known as the Foster Care Entry date, or DHS Custody Entry Date) is provided in the notification file for the CCO to determine whether a new round of assessments is needed.
- Notified cases stay in the weekly files for 90 days so the CCO can receive updates on placement status changes through the assessment period.
- A 'First Notification Date' remains constant with the unique episode throughout the time the case stays in the report and there is a 'count of days with CCO' which helps the CCO to keep track of the assessment completion timeline. There are rare scenarios that could cause child to be dropped from the weekly notification file, then the First Notification Date would be restarted if they returned to the notifications; in this case, only the very first 'First Notification Date' of each unique episode is used to for the calculation to anchor the continuous enrollment and assessment period.

See Appendix for full detail of data fields in the new weekly notification file, including scenarios that could cause the First Notification Date to be restarted.

OHA continues to use the CCO notification files as the main source for identifying denominator cases for the measure. The 834 enrollment files can provide supplemental information on changes in eligibility and

enrollment for all children in DHS custody within a CCO, but they are not the main source for identifying new cases that require assessments.

Required exclusions for denominator:

Children will be automatically excluded from the final measure denominator for the following reasons:

- The CCO did not receive notification from OHA on the child, even if the CCO was informed by DHS or another source when the child entered DHS custody/ substitute care.
- The child did not enroll with the CCO or did not meet the continuous enrollment criteria. See detail in the continuous enrollment and allowable gap sections.
- The child entered DHS custody/substitute care more than 30 days prior to OHA notification, i.e., a case is excluded if the 'First Notification Date' to the CCO is more than 30 days after the Episode Start Date in the new weekly notification file.
- If a CCO is notified more than once for the same case of a child entering DHS custody (same Episode Start Date for a child on more than one weekly notification file), only the very first 'First Notification Date' documented in the weekly file is used, and the continuous enrollment and numerator assessment periods are calculated based on this date. Any other CCO notification dates for the same child and DHS custody entry are excluded.
- The child's custody with DHS is ended or transferred to Oregon Youth Authority (OYA) during the 60 days following CCO notification.
- The child is in Run-Away status during the 60 days following CCO notification are identified from OR-Kids and excluded. The child is still in DHS custody, but they are usually dis-enrolled from the CCO and entered into Fee for Service / Open Card until their next placement (and thus can also be excluded based on continuous enrollment criteria).

Children may be excluded from the final measure denominator for the following reasons, with OHA review of supporting evidence:

- A child placed in a rehabilitation, residential treatment facility or in OYA detention is not an automatic exclusion, unless the placement is out of the service area for the CCO, or the local DHS instructed the CCO to not follow up with the case. The CCO needs to preserve communication records for OHA review and determination.

Required exceptions for denominator: Among children in the denominator who did not complete all required assessments in the appropriate window, exclude those in the following scenarios:

- Children with a delayed start of enrollment, i.e., the child's enrollment with the CCO (for CCOA coverage) does not start when the CCO is notified for up to 7 days (see Continuous Enrollment and Allowable Gap sections for more detail).
- Children who were already in 'Trial Reunification' when the case was notified to the CCO, or changed their status to 'Trial Reunification' anytime within the 60-day assessment period as indicated in OR-Kids data.

Continuous enrollment criteria:

- All cases must remain in DHS custody for at least 60 days from the OHA notification date.
- All cases continuously enrolled with the notified CCO (for CCOA coverage) from the date of notification through 60 days after with no gaps in coverage, are included in the measure.
- Cases with delayed start of enrollment to the notified CCO for up to 7 days are included only if they are also numerator compliant (the CCO would receive credit on the metric). This means cases with delayed start of enrollment which did not complete all the required assessments are excluded.

Allowable gaps in enrollment: None. Note, there is an allowable delayed start of enrollment for up to 7 days if the case is also numerator compliant (see continuous enrollment section above), but there are no allowable gaps once the enrollment to the notified CCO has started.

Anchor Date (if applicable): None

Data elements required numerator: Depending on age at CCO notification date, members in the denominator are required to receive a physical health assessment (all ages 0-17), a dental health assessment (age 1-17), and a mental health assessment (age 3-17), within 60 days of the notification date, or within 30 days prior to the notification date.

	Required assessments for children entering DHS custody		
Age on CCO Notification Date	**Physical**	**Dental**	**Mental**
Less than 1 year old	YES	NO	NO
1 to 2 years old	YES	YES	NO
3 to 17 years old	YES	YES	YES

Qualifying health assessments are identified by one of the following procedure codes:

Physical health assessment codes:

- Outpatient and office evaluation and management codes: 99201 - 99205, 99212 – 99215
- Preventative visits: 99381 – 99384, 99391 – 99394
- Annual wellness visits: G0438, G0439
- If physical health assessments as indicated in these new patient E&M codes CPT 99201-99205 include qualifying mental health or child abuse/neglect diagnosis on the same claim (see code table below), they will count as both mental and physical health assessments. This is to reflect assessments provided by a psychiatric (nurse or physician) provider, but OHA does not apply a check of provider specialty in the calculation. Qualifying diagnosis codes include[1]:

[1] Qualifying diagnosis codes are based on the OHA Health Analytics Behavioral Health team review with Oregon's Prioritized List and additional codes that may be picked up in deferred diagnosis situations.

Visits with CPT 99201 – 99205 can count as both physical and mental health assessments if paired with following diagnosis codes:	
Source	ICD-10CM Diagnosis (All diagnosis fields apply)
Mental Health Diagnosis Value Set	F03, F20 – F53, F59 – F69, F80 – F99 (total of 291 codes)
Diagnosis related to child abuse or neglect	T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.32xA, T74.32xD, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, T76.32xA, T76.32xD, T76.92xA, T76.92xD

Mental health assessment codes:

- Psychological assessment and intervention codes: 90791, 90792, 96130, 96131, 96136, 96137, 96138, 96139, H0031, H1011
- Mental health assessment, by non-physician with CANS assessment: H2000-TG (modifier must be included)
- Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days): H0019[2]
- Psychiatric health facility service, per diem: H2013
- Community psychiatric supportive treatment program, per diem: H0037

Dental health assessment codes:

- Dental diagnostic codes (clinical oral evaluations): D0100-D0199

Required exclusions for numerator: N/A

For more information: The guidance document for this measure is available online at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

[2] Use of this code counts as both mental and physical health assessment for children in PRTS.

Appendix: Data Fields in Revised CCO Weekly Notification Report for Children in DHS Custody

	Column Name	Description	Notes
A	firstnotificationdate	The date that the child first appears on the report. To identify the first notification date used in the OHA metric calculation	A child can have a new "first" notification date if the child goes to Out of State (No Service Area Exception), Runaway or Detention and returns to a placement within the first 90 days of the foster care episode.
B	CountOfDaysWithCCO	Report run date minus first notification date	
C	newtoccoflag	Values can be Y, N, or N/A Y = Child is new to this CCO but not new to this report. Count of days with CCO is 0 days N = Child is not new to this CCO, has been on report previously for this CCO, Count of days with CCO is greater > 0 N/A = Child is new to this report. Count of days with CCO is 0 days.	The count of days with CCO can start over if child is missing from the report for a week or more. This might be because they are returning after a status of Detention or Runaway or because their eligibility is being updated etc.
D	managedcareregion	The region the CCO is governed by	Codes can be found here
E	mmisproviderid	The CCO Provider ID	
F	mmisprovidername	CCO the child is enrolled in	
G	eligibilityeffectivedate	The date the child's medical eligibility began	Not always the same date as foster care episode start date
H	primeid	The child's prime ID from OR-Kids	
I	lastcaseid	The child's OR-Kids case ID	
J	childid	The child's OR-Kids person ID	
K	lastname	The child's last name	
L	firstname	The child's first name	
M	dob	The child's date of birth	
N	gender	The child's gender (m/f)	
O	primaryracelabel	The child's primary race	
P	episodestartdate	The first day of the foster care episode	
Q	daysfcepisodeopen	Run date minus Episode Start Date	
R	lastsvcstartdate	Current service the child is placed in	See tab called "List of Services"
S	lastservicedesc	The type of foster care placement the child is in	See tab called "List of Services"
T	cwcaretakerid	ID of current caretaker	If ID shows as 9999, it means child is on trial reunification

U	cwcaretakeridchangeflag	Values can be Y, N, or N/A Y = Child has new caretaker from previous report N = Child does not have new caretaker from previous report N/A = Child is new to this report so does not have new caretaker from previous report	
V	cwcaretakername	Name of current caretaker	Field will be blank for kids on trial reunification at home with their parents
W	street	Street address of child's current location	
X	city	City of child's current location	
Y	state	State of child's current location	
Z	zip	Zip of child's current location	
AA	phone	Phone number at child's current location	
AB	email	Email at child's current location	
AC	addressstartdate	Start date of current address	
AD	addresschangeflag	Values can be Y, N, or N/A Y = Child has new address from previous report N = Child does not have new address from previous report N/A = Child is new to this report so does not have new address from previous report	
AE	districtdesc	District of primary worker	District map can be found here
AF	branchid	MMIS Branch code	
AG	rundate	Date that this report was run out of OR-Kids	

Overview

The weekly CCO Notification report will provide timely notification to the child's enrolled Coordinated Care Organization (CCO) that the child has entered foster care and is enrolled in the named CCO. The child will appear on the report if both criteria are met: an open foster care placement and open eligibility/enrollment to a CCO. The child will remain on the report until the foster care placement has been open for ninety days or until disenrollment occurs (for reasons such as Out of State, Detention or Runaway Placement).

Change Flags

If the child moves but remains with the same CCO, the report will update to the current address for the child. If the child moves and the CCO changes, the child's info will update to reflect the new CCO name and child's new address and create a new First Notification Date. A child's address can change because the provider moved while the child remains with that provider, or the child moves to a new provider/placement. Many CCO's upload their list into their own data systems, therefore change flags will be included to specify what changed from the prior day:

- Provider/Placement Change Flag (new provider/placement from prior day)
- Address Change Flag (new address from prior day)
- CCO Enrollment Change Flag (new CCO Provider ID from prior day)

Non-Subcare Placement Rules

If a child goes on **Runaway** and a notification to DHS Central Office staff occurs, a manual disenrollment will take place. Because this doesn't always happen, the report will drop the child when the runaway placement is opened in ORKids, before MMIS disenrollment occurs. There are three runaway placements: Missing/Runaway (Cd 131), Missing/Abducted (Cd 1080), and Missing/Other (not known why child is missing) (Cd 1081). If the child returns to a foster care placement and enrollment to a CCO occurs prior to the foster care episode being open for ninety days, the child will re-appear with a new First Notification Date, whether the CCO has changed or not.

If a child goes to **Detention** (Cd 134) and a notification to DHS Central Office staff occurs, a manual disenrollment will take place. Because this doesn't always happen, the report will drop the child when the detention placement is opened in ORKids, before MMIS disenrollment occurs. If the child returns to a foster care placement and enrollment to a CCO occurs prior to the foster care episode being open for ninety days, the child will re-appear with a new First Notification Date, whether the CCO has changed or not.

If a child is placed **Out of State** (County Code 999 in MMIS) with no SAE Exception (child is not in placement Cd 133: Child Placed in Mental Health Facility) auto-disenrollment will occur. If the child returns to a foster care placement and enrollment to a CCO occurs prior to the foster care episode being open for ninety days, the child will re-appear with a new First Notification Date, whether the CCO has changed or not.

If a child is in an **OYA Placement** (Cd 1083: OYA Paid Placement – Foster Care or Cd 1084: OYA Paid Placement - Residential) the child will remain on the report and the Count of Days with the CCO will continue. (No new First Notification Date)

If a child is on **Trial Reunification** (Cd 1030) the child will remain on the report and the Count of Days with the CCO will continue. (No new First Notification Date)

Young Children Receiving Social-Emotional Issue-Focused Intervention/Treament Services

Measure Basic Information

Name and date of specifications used: These child-level social emotional issue-focused intervention/treatment specifications were developed by the Oregon Pediatric Improvement Partnership (OPIP).
URL of Specifications: N/A.
Measure Type:

☐HEDIS ☐PQI ☐Survey ■ Other Specify: Specifications developed by OPIP.

Measure Utility:

■ CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other
Data Sources: MMIS

Measurement Period: Calendar Year (2025) January 1, 2025 – December 31, 2025

Benchmark for OHA Measurement Year: To be determined, OPIP will provide input sessions.

Note on telehealth: This measure is eligible for telehealth. Some qualifying services may be delivered via telehealth. These activities as documented in the claims data by the providers is based on their clinical judgment. If the rendering provider documents a qualifying CDT/CPT Measure Basic Information CCO Incentive Measure Specification Sheet for 2025 Measurement Year in the claims form, the visit should be counted in the measure, irrespective if the visit was virtual.

Changes in specifications: Not applicable, this is the first year that this metric will be in the set.

Member type: ■ CCOA ■ CCOB ■CCOE ☐CCOF ■CCOG

Plan Type	*Who is responsible for payment?*		
	Behavioral health	Dental	Physical health
CCOA	CCO	CCO	CCO
CCOB	CCO	OHA	CCO
CCOE	CCO	OHA	OHA
CCOF *	OHA	CCO	OHA
CCOG	CCO	CCO	OHA
None	OHA	OHA	OHA

* ***CCOF note:*** The COFA and Veterans state-funded dental-only programs literally only cover dental benefits, nothing else whatsoever; BH and PH are completely n/a.

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

ISSUEFOCUSINTTX	Claim from Matching CCO	Denied Claims Included
Numerator Event	Yes	Yes

Measure Details

Data elements required denominator: Count of unique members ages 1-5.99 years (kindergarten readiness) on the last day of the measurement year who meet continuous enrollment criteria.

Required exclusions for denominator:

- Members who die any time during the measurement year.

Deviations from cited specifications for denominator: n/a.

Continuous enrollment criteria: The measurement year.

Allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during measurement year.

Anchor Date (if applicable): Enrolled on December 31 of the measurement year

Numerator: Count of unique members in the denominator who received any of the issue-focused intervention/treatment services identified by the following specific CPT codes:

CPT Claim Title	**CPT CLAIM**
Psychiatric Diagnostic Evaluation	90791
Psychiatric Diagnostic Evaluation, by a medically licensed professional	90792
Health behavior assessment, or re-assessment	96156
Mental health assessment, by non-physician	H0031
Health Behavior Intervention	96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Preventive Medicine Counseling	99401-99404, 99411-99412
Adaptive Behavior Treatment	97153-97158
Behavioral health counseling and therapy	H0004
Skills training and development	H2014
Individual psychotherapy	90832-90838
Family psychotherapy	90846, 90847
Group psychotherapy	90849, 90853
Multi-Family Group Training Session	96202, 96203
Behavioral Health Outreach Services (Used for Intensive, In Home Behavioral Health Treatment)	H0023
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)	98960-98962
Activity therapy (music, dance, are or play therapies) related to the care and treatment of patient's disabling mental health problems per session (45 min or more)	G0176

Required exclusions for numerator: Not Appliable

Deviations from cited specifications for numerator: Not applicable.

For More Information: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Health Equity Measure: Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English (LOE) and Persons Who Are Deaf or Hard of Hearing – MY2025

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Health Equity Measure Workgroup.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐Survey ■Other Specify: OHA-developed

Measure Utility:

■CCO Incentive ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: CCO attestation

Measurement Period: Measurement Year (MY) equals calendar year (January 1 – December 31 of the year).

Past Benchmark for OHA measurement year	2023*	2024*	2025
Component 1 – minimum points from must pass questions	77 points	83 points	TBD
Component 2 – reporting method and data collection requirement	Sampled hybrid reporting; must meet 80% data collection rate	Full population	TBD
Component 2 – benchmark for percentage of visits provided with interpreter services by OHA certified or qualified interpreters	75% with Minnesota Method improvement target	75% benchmark with Minnesota (MN) Method improvement target & 5 pct point floor	TBD
Source:	Committee consensus	Committee Consensus	TBD

*Must meet both components to get credit for the measure.

Note on telehealth: This measure is telehealth eligible, however, visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specifications from MY2024 to MY2025:

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-26	Outpatient Clinics	physical	Office Outpatient
O-27	Outpatient Therapy & Rehabilitation	physical	Office Outpatient
O-28	Outpatient Professional Fees	physical	Office Outpatient
O-29	Outpatient Surgery	physical	Office Outpatient
O-30	Preventative Care Covered Service	physical	Office Outpatient
O-31	Preventative Care Non-Covered Service	physical	Office Outpatient
O-99	Outpatient Unbucketed	physical	other
RX-01	Pharmacy Perscription Drugs Basic	exclude	exclude
RX-02	Pharmacy Over The Counter (OTC)	exclude	exclude
RX-03	Pharmacy Family Planning Contraceptives	exclude	exclude
RX-04	Pharmacy Carved-Out Drugs	exclude	exclude
RX-05	Pharmacy Immunization Drugs	exclude	exclude
RX-06	Pharmacy Durable Medical Equipment (Pill Splitters)	exclude	exclude
RX-07	Pharmacy Medication Assisted Treatment (MAT)	exclude	exclude

Step 2: Telehealth visits are identified separately for claims with:

- Procedure code: 98966-98972, 99421-99458, D9995, D9996, G0427, G0508, G0509, G2010, G2012, G2025, or
- Modifier: GT, GQ, G0, 95, or
- Place of Service code: 02

Step 3: Claims are de-duplicated into unique visit dates, but report separately if a member had more than one type of care (physical, mental/behavioral or dental) on the same day.

Step 4: If multiple visit types/care settings occurred on the same day for a given type of care (physical, mental/behavioral or dental), only one category is selected based on the hierarchy: Inpatient Stay > Emergency Department > Office Outpatient > Home Health> Telehealth > Other.

- Changed limited English proficiency (LEP) to prefers a language other than English (LOE). This terminology change does not reflect a change in metric specifications. The change is meant to better reflect a strength-based approach.

Component 1

- Updated self-attestation questions in Appendix 1. Changes are in blue text throughout the appendix. The change from LEP to LOE was not highlighted in blue change since the terminology represents the same population.

Component 2

- Added exclusion for members who died in the measurement year.
- Added refusal reason 5 to capture refusals from the member who does not need interpreter services for the particular visit. Visits with member refusal reason 5 may qualify for denominator exclusion, but this does not exclude other visits from the same member.
- Clarified the definition of in language provider and which provider qualifies for in-language visit numerator credit.
    - Added native speaker and ALTA test for qualifying in language provider visits.
    - When initially verifying in-language providers' proficiency, tests within the last four years instead of three years are valid.
    - Increased proficiency test requirement for Language Line Solutions from 2+ to 3+ to align with current OHA standards.
    - Removed the retesting requirement for proficiency tests.
- For Appendix 3, all changes are in blue text.
- For Appendix 4, claim lines containing modifier code 26 or place of service (POS) 81 are exclude.

Measure Details

Measure Components and Scoring

There are two components in this measure:

(1) CCO language access self-assessment survey
(2) Quantitative language access report

Component 1: CCO language access self-assessment survey

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass all the questions required for that measurement period, and (3) meet the minimum points required for the must pass questions for each measurement year.

Total possible points Year 1 thru 3 =	**102**	
Year 1 total minimum points required =	46	45.1%
Year 2 total minimum points required =	56	54.9%
Year 3 total minimum points required =	77	75.5%
Total possible points Year 4 =	**115**	
Year 4 total minimum points required =	83	72.2%

Total possible points Year 5 thru 6 =	**121**	
Year 5 total minimum points required =	97	80.2%
Year 6 total minimum points required =	99	81.8%

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)		MY2026 (year6)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	28	**23**	3	**3**	2	**2**	**0**	**0**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	57	**42**	10	**3**	1	**11**	**0**	**0**
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing	8	**5**	0	**0**	1	**0**	**0**	**1**

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)		MY2026 (year6)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
members is trained on language access policies and procedures.								
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language assistance services.	9	**7**	0	**0**	2	**1**	**0**	**1**

CCO must attest to have met all the must-pass questions to meet Component 1 each year. No partial credit will be given. OHA reserves the right to request additional documentation and audit whether responses to self-assessment and language access plans are consistent with current workflows and processes for providing quality language access services.

See Appendix 1 for the survey template, and Appendix 2 for point value summary.

Component 2: Percent of member visits with interpreter need in which language access services were provided

Eligible population: Members who self-identified with interpreter needs; all visits for the members in the eligible population need to be included in the reporting denominator.

The CCO must include all members who already have MMIS interpreter flags[1] during the measurement year for the Component 2 full-population reporting. Members can self-identify their spoken or sign language interpreter needs to OHA during the ONE eligibility process; this information is documented in MMIS for members with spoken language interpreter needs (IND_INTERPRETER = Y) or with a non-blank CDE_INTERPRETER_TYPE[2].

Members can also self-identify their interpreter needs to the CCO or the provider through intake questionnaire in different settings or by self-initiating an interpreter service request. If the CCO attests collecting interpreter needs information in Component 1 survey questions 1 and 3 in addition to using the MMIS information and identifies additional members who do not have MMIS flags for interpreter needs, the CCO can include the additional members in the report[3]. When including these individuals in the denominator, all the member's visits for the year must be included even those where interpreter services were not received.

Continuous enrollment criteria: None.

Anchor date: None.

Data elements required denominator: Total number of visits during the measurement year from the Eligible Population (members who self-identified with interpreter needs), regardless of whether interpreter services were provided. Only visits during a member's enrollment span with a CCO are required to be reported.

The CCO is responsible for reporting all visits, at the visit level, using the data system(s) best suited for their collection method. The CCO is also required to indicate the visit date, Medicaid member ID and whether the member already has interpreter needs flag(s) in MMIS/834 file. The following stratifications are required by type of care:

- Physical health
- Mental/behavioral health
- Dental health

By care setting:

- Inpatient Stay
- Emergency Department

[1] Note if a member has incorrect interpreter needs flags in MMIS which have been removed before the end of the measurement year, the member does not need to be included in the Component 2 full-population report. If the interpreter needs flags in error remain in the MMIS through the end of the measurement year, all visits for the member still need to be reported; in this case, the CCO can report Refusal Reason 2 (member confirms interpreter needs flag in MMIS is inaccurate) across all visits for the same member, so that the visits can be excluded from the denominator for the language service and quality rates calculations.

[2] The CCO must utilize MMIS IND_INTERPRETER = Y or a non-blank CDE_INTERPRETER_TYPE to meet the minimum requirements for the OHA denominator volume validation. To note, the additional MMIS field IND_SL_INTERPRETER previously used for the metric was discontinued after October 2022; a new CDE_INTERPRETER_TYPE field has been added to specify the type of interpreter needed by the member.

[3] CCOs can use 'Interpreter need flagged in MMIS' column in the Component 2 reporting template and report 'No' to identify additional members who did not self-identify during the ONE eligibility process. Note that for the additional members who are added to the report, all of their denominator-qualifying visits must be included in the report, regardless of whether the interpreter services were provided.

- Office Outpatient
- Home Health
- Telehealth
- Other

See Appendix 3 for quantitative interpreter services reporting template.

Data elements required denominator exclusion:

- Members who died in the measurement period.
- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.
- CCOs should document the reasons a member refuses the interpreter service, and the visit can be excluded for the first two of the following reasons if the CCO also attests data collection for the corresponding reasons in the self-assessment Question 14:
  1. Member refusal because in-language visit is provided[4]
  2. Member confirms interpreter needs flag in MMIS is inaccurate[5]
  3. Member unsatisfied with the interpreter services available – not eligible for exclusion.
  4. Other reasons for patient refusal – not eligible for exclusion.
  5. Member does not need interpreter services for the visit[6]

Note on OHA validation for the denominator visits: OHA performs validation on the portion of eligible population known to OHA (those with interpreter needs flagged in MMIS) and counts the total denominator visits from MMIS/DSSURS claims. Additional validation effort will be required if, for the members with interpreter needs flagged in MMIS, the CCO reports 15% more or fewer counts of total denominator visits than that of OHA's data. OHA utilizes an existing, homegrown Oregon Health Grouper (OHG) and re-categorize claims into the 'type of care' and 'care setting' stratifications for this measure; certain OHG categories are also identified for denominator exclusion. The grouping method and OHG-to-HEM crosswalk table is provided in Appendix 4. The OHG logic and OHG-to-HEM crosswalk method can be used by CCOs reporting the denominator visits based on claims data, but it is not required as the CCO may have its own data processing logic that can also achieve the type of care and care setting categorization.

[4] If the member confirms the provider for the visit can perform in-language service and therefore no interpreter service is needed, the visit can be excluded. To note, if the in-language service provider is OHA qualified or certified or has documented being a native speaker or passing an approved proficiency test in the members preferred language with the CCO, the visit does not need to be flagged as patient refusal and will be a numerator hit for the metric.

[5] If a member has interpreter needs indicated in MMIS but regularly refuses interpreter services, the CCO could work with the member to submit MMIS member information correction request with OHP member customer service.

[6] The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits. Each visits with refusal reason 5 can be excluded, but the member is not excluded from the measure all together.

Data elements required numerator: Total number of visits provided with interpreter or in language provider services. See Appendix 3 for quantitative interpreter services reporting template.

CCOs are responsible for tracking and reporting the numerator visits on the reporting with the following stratifications:

- Interpreter services provided by OHA certified, qualified, and non-OHA certified or qualified interpreters.
- In-language visits with primary performing providers who are either a native speaker or has passed the proficiency test in the member's preferred language[7] , and those providers who are not a native speaker and have not passed the language proficiency test.

  * Incentive measure based on higher rate of denominator visits with interpreter services provided by OHA-certified or OHA-qualified interpreters, or in-language visit providers who are a native speaker or have passed the proficiency test for the member's preferred language.

- Modality of the interpreter services (in-person, telephonic, video remote) – reporting-only, measure is not incentivized for certain modalities of the services.
- Services provided by clinic staff versus contracted language provider – reporting-only.

The required reporting elements include:

> Report In-person, telephonic or video interpreter services (or in-language provider visits, optional in MY2025) provided:
> => If Yes to any of the three modality fields, answer Was the interpreter (or in-language provider) OHA Certified or Qualified?
> => if the interpreter (or in-language provider) is OHA-certified or qualified, report the OHA Registry number.

[7] Providers who have a degree in high school or above in a country where instruction is primarily in the non-English language and the in-language provider is a native speaker of the non-English language. Reporting visits with an in-language primary performing provider is optional in MY2025. For the proficiency test (also referred to as Oral Proficiency Interview), the Equity & Inclusion Division (E&I) maintains proficiency tests on the Health Care Interpreter Training Programs website. Under Approved Testing Centers for Language Proficiency header, CCOs can find the approved tests (i.e., Language Line Solutions and Language Testing International). After completing the test, the provider would receive a certificate of completion with a score. This document should be sent to CCOs to confirm that the provider qualifies as passing the proficiency test in the member's preferred language. To pass the proficiency test, the provider must pass the proficiency test with a score of:

- 3+ or higher for Language Line Solutions' (LLS) proficiency test
- Advanced-mid level or higher for American Council on the Teaching of Foreign Language (ACTFL) (i.e., Language Testing International's proficiency test)
- ALTA proficiency tests at equivalent of 'advanced mid' ACTFL or above rating scale.

In-language providers that have passed an OHA-approved Oral Proficiency Interview (OPI) also qualify for passing the language proficiency requirement. When initially verifying in-language providers' proficiency, tests must be no more than four years old; after initial verification of proficiency, the test does not have to be retaken. The in-language provider reporting option is not available to general clinic staff, such as receptionist, certified nursing assistants, and schedulers.

=> If No to all three modality fields, answer Did the member refuse interpreter service (Yes/No)[8]

Data elements required numerator exclusion: none.

Incentive Measure Quality Language Access Rate Calculation: Percentage of visits provided by high quality interpreter services (or high quality in-language provider visit[9]) = Total number of visits with interpreter services provided by OHA-certified or qualified interpreters (or in-language visits with providers who are native speakers or have passed the proficiency test for members' preferred languages[10]) / Total number of visits for members in the eligible population[11]

> Note: visits by the eligible members that were not provided with interpreter services (or in language provider services, if reporting), count as '0' for numerator hits; visits with interpreter services by providers that are not OHA certified or qualified and the provider has not documented being native speaker or passing the proficiency test in the members preferred language with the CCO, count as '0' for numerator hits.

OHA will report other non-incentive rates for observations, including 'total percentage of visits provided with any interpreter services or are in-language visit,' percentage of visits provided with interpreter services by visit types (inpatient, outpatient, mental health, dental, etc.), and percentage of interpreter services by different modalities.

Version Control

[8] If no records of member refusal exist, it is considered that the member did not refuse (fill in No in template). If the member refuses interpreter services, reporting the refusal reasons is optional.
[9] Reporting visits with an in-language provider is optional in MY2025.
[10] Reporting visits with an in-language provider is optional in MY2025.
[11] The measure denominator is NOT restricted to only the visits when interpreter services were provided.

Appendix 1: CCO language self-assessment: Meaningful language access to culturally- responsive health care services (starting MY2021)

Introduction

This online survey asks each Coordinated Care Organization (CCO) to conduct a self-assessment on language services available in your organization. Your responses will be used to determine whether your CCO meets the incentive metric reporting requirements. Completion of the survey does not guarantee that CCOs have met the metric.

CCOs must answer all questions and meet the minimum points required for the questions marked as must pass for that measurement year (e.g., Must pass beginning in measurement year 2021 – year 1). Questions have a point value and are organized by measurement year within each of the four domains. In general, each statement is worth one point and some questions have multiple statements.

Answers should be based on language services in place on the December 31st of the measurement year. Survey responses are due on or before the 3rd Monday of January following the measurement year (MY). These dates are as follows:

MY2023: Due January 15, 2024
MY2024: Due January 20, 2025
MY2025: Due January 19, 2026

Self-assessment requirements

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum points required for each measurement year.

Total possible points (Year 1 through 3) = 102

- Year 1 minimum points required = 46 or 45.1%
- Year 2 minimum points required = 56 or 54.9%
- Year 3 minimum points required = 77 or 75.5%

Total possible points (Year 4) = 115

- Year 4 minimum points required = 83 or 72.2%

Total possible points (Year 5 & 6) = 121

- Year 5 minimum points required = 96 or 79.3%%
- Year 6 minimum points required = 98 or 90.3%

Additional Information

OHA reserves the right to request additional or clarifying information to support responses provided through this survey, including but not limited to further detail on data collected, example policies, or translated materials.

For questions about this survey, or the CCO incentive metric, please contact Metrics Questions Metrics.Questions@odhsoha.oregon.gov.

Contact Information

The contact person is the one completing the survey and the first point of contact if OHA has any follow-up or clarifying questions about survey responses. If multiple individuals for the same CCO submit survey responses, OHA will follow-up with the CCO as to which of the respondents should be the primary contact.

Name: _____

CCO Name: _____

Email Address: _____

Domain 1: Identification and assessment for communication needs

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO identifies and tracks services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve. Your responses will help OHA to evaluate how well your CCO is performing these critical and meaningful language access functions.

1) Please answer yes or no for each of the following statements on how your CCO identifies members needing communication access (e.g., LOE, sign language users). *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available =7.*

	Yes	No
A. The CCO has a **process to respond to individual requests** for language assistance services (including sign language).	( )	( )
B. The CCO has a **process for self-identification** by the Deaf or Hard of Hearing person, non-English speaker or individual who prefers a Language Other than English (LOE).	( )	( )
C. The CCO has a **process for using open-ended questions** to determine language proficiency on the telephone or in person.	( )	( )
D. The CCO customer service staff are **trained to use video relay or TTY** for patient services.	( )	( )
E. The CCO **uses "I Speak" language identification cards** or posters.	( )	( )
F. The CCO has a **process for responding to member complaints** about language access and clearly communicates this process to all members.	( )	( )
G. The CCO **uses MMIS/ enrollment data** from OHA about primary language.	( )	( )

2) Please answer yes or no for each of the following statements about collecting data. *Must pass beginning MY2021 (year 1) with minimum points required = 3; total points available =3.*

	Yes	No
A. The CCO collects data on the **number of members served who prefer a Language Other than English (LOE).**	( )	( )
B. The CCO collects data on the **number of members served who are Deaf or Hard of Hearing**.	( )	( )
C. The CCO collects data on the **number and prevalence of languages spoken by members** in your service area.	( )	( )

3) Please answer yes or no for each of the following data sources that your CCO uses to determine the needs and/or population size of the LOE and Deaf or Hard of Hearing members in your service area. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 6.*

	Yes	No
A. OHA MMIS	( )	( )
B. CCO specific enrollment information on members interpreter needs.	( )	( )
C. Local community-based organizations (CBOs), Community Advisory Councils (CACs), or Regional Health Equity Coalitions (RHECs)	( )	( )
D. Online data (e.g., LEP.gov or US Census/American Community Survey (ACS))	( )	( )
E. REALD & SOGI repository	( )	( )
F. Members' interpreter needs collected by providers.	( )	( )

4) Does your CCO use any of the data sources listed in questions 1 and 2 above to assess LOE and Deaf or Hard of Hearing member needs, at least quarterly? *Must answer, no points available.*

( ) Yes

( ) No

5) Does your CCO use data sources in question 3 above to identify system gaps and improve services for LOE and Deaf or Hard of Hearing members, at least quarterly? Must answer, no points available.

( ) Yes

( ) No

6) Does your CCO record the interpreter needs and primary language from LOE or Deaf and hard of hearing members when they first contact your CCO, for example, at the CCO's new enrollee intake survey, or the first encounter with a health care provider and the information is shared back to the CCO? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

7) Does your CCO have a process for sharing information about members who need spoken and sign language interpretation services with all provider networks? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

8) If yes to question 7, please briefly describe how your CCO shares primary spoken language or hearing assistance needs with provider networks or service coordinators. *Must answer this question beginning MY2021 (year 1); total available points = 1.*

9) If yes to question 7, how frequently do you share this information? *Must answer this question beginning MY2021 (year 1); total available points = 1.*

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

10) *Does your CCO have a process for sharing the monthly OHA credentialed health care interpreter registry file from OHA with all your service coordinators and provider network?* *Must pass beginning MY2024 (year 4) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

11) If yes to the previous question, please briefly describe how your CCO shares the monthly registry files with service coordinators and provider networks. *Must answer this question beginning MY2024 (year 4) if Yes to previous question; total available points = 1.*

12) Does your CCO have the capability to identify the number of members needing spoken and sign language interpretation services that were not identified in form 834 from OHA? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

13) What are the top SIX most frequently encountered spoken and sign languages by members in your CCO for the measurement year? *CCOs must rank the languages members often request language services in to meet the must pass criteria for this question beginning MY2021 (year 1); total available points = 1.*

Write in language

14) Please answer yes or no for each of the following statements about members who refused, did not need, needed interpretation services but were not identified as needing interpreter services, or requested and received in language services from bilingual providers. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available =5.*

	Yes	No
A. The CCO collects data on members served **who self-identified as preferring a language other than English (LOE) but refused interpretation services**.	( )	( )
B. The CCO collects data on members served **who are Deaf or Hard of Hearing but refused interpretation services**.	( )	( )
C. The CCO collects data on members served who **did not have MMIS language flag but requested interpreter services**.	( )	( )
D. The CCO collects data on members served who **had an MMIS language flag but did not need interpreter services.**	( )	( )
E. The CCO collects data on the members served who **requested and received in- language services from bilingual providers** and therefore trained interpreters were not needed for the visits.	( )	( )

15) Does your CCO have a process to follow up with and add/remove MMIS flags for members who confirmed the interpreter flag is inaccurate? *Must answer; no points available.*

( ) Yes

( ) No

16) Please answer yes or no for each of the following statements about appointment wait times (not the time to arrange interpreter service at a visit). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Yes	No
A. The CCO collects quality data on average wait times for **LOE members** that need appointments with interpreter services.	( )	( )
B. The CCO collects quality data on average wait times for **Deaf or Hard of Hearing members** that need appointments with interpreter services.	( )	( )

17) Please mark the average wait time for each of the following groups (not the time to arrange interpreter service at a visit). (Choose only one answer per statement). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Same day	1-3 days	4-7 days	More than 7 days
A. The average wait time for members who prefer a language other than English (LOE) needing interpretation services is:	( )	( )	( )	( )
B. The average wait time for Deaf or Hard of Hearing members needing interpretation services is:	( )	( )	( )	( )

18) What is the average wait time (not the time to arrange interpreter service at a visit) for members that do not need interpretation services? *Must answer, no points available.*

( ) A. Same day

( ) B. 1-3 days

( ) C. 4-7 days

( ) D. More than 7 days

( ) E. The CCO does not collect this information

19) Does your CCO verifiably track when members appointments are cancelled or rescheduled due to a lack of interpretation services? *Must answer, no points available.*

( ) Yes

( ) No

20) How frequently do you track the average number of encounters by spoken and sign languages and share the data with provider networks or service coordinators? *Must answer, no points available.*

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

21) Does your CCO have a process for identifying the total number of Deaf or Hard of Hearing members that prefer sign language or assistive communication devices to ensure effective communication in your CCO and provider network? *Must answer, no points available.*

( ) Yes

( ) No

Domain 2: Provision of language assistance services

CCOs should answer questions based on language services in place on December 31 of the measurement year. Questions in this domain assess how well you use data and work processes to effectively communicate with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

22) Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels. *Must pass beginning MY2021 (year 1) with minimum points required = 3; total points available = 3.*

	Yes	No
A. The CCO tracks **the primary language** of persons encountered or served.	( )	( )
B. The CCO tracks **the use of language assistance services** such as interpreters and translators.	( )	( )
C. The CCO tracks **staff time (including bilingual providers) spent providing bilingual spoken and sign language** assistance services.	( )	( )

23) Please select yes or no to the types of language assistance services that are provided by your CCO and provider network. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Bilingual clinic staff and providers	( )	( )
B. CCO in-house interpreters (spoken and sign)	( )	( )
C. CCO in-house translators (for documents)	( )	( )
D. Contracted in-person interpreter services	( )	( )
E. Contracted translators (for documents)	( )	( )
F. Contracted telephonic interpreter services	( )	( )
G. Contracted video interpreter services	( )	( )

24) Please select yes or no to the following care delivery settings in which your CCO provides spoken and sign language interpretation service for member visits. *Must pass beginning MY2021 (year 1) with minimum points required = 6; total points available = 8.*

	Yes	No
A. Medical (in-patient)	( )	( )
B. Medical (office/out-patient)	( )	( )
C. Emergency Department	( )	( )
D. Dental	( )	( )
E. Telehealth	( )	( )
F. Home Health	( )	( )
G. Pharmacy connected to a provider network	( )	( )
H. Lab services connected to a provider network	( )	( )

25) Please select yes or no to indicate whether your CCO provides spoken and sign language interpretation service for member visits in each of the following situations. *Must answer MY2024. Must pass beginning MY2025 (year 5) with minimum points required = 6; total points available = 6.*

	Yes	No
Scheduling appointments	( )	( )
Care navigation	( )	( )
During member appeals process	( )	( )
Customer Service Inquiry	( )	( )
Support for understanding member benefits	( )	( )
Member care consent process	( )	( )

26) Does your CCO utilize language triaging when LOE members call to make an appointment via telephone? *Must pass beginning MY2025 (year 5) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

27) Does your CCO and provider network have policies on the use of family members or friends to provide interpretation services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

28) If yes to the previous question, please briefly describe your policies on when or how family members or friends can provide interpretation services. *Must answer this question beginning MY2021 (year 1); total available points = 1.*

29) Does your CCO provide staff who coordinate interpreter services with information on how to access OHA approved spoken and sign language interpreters? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

30) Does your CCO have a policy that your provider networks work with OHA certified and qualified spoken and sign language interpreters, consistent with OAR 950-050-0160? *Must pass beginning MY2024 (year 4) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

31) Does your CCO staff who coordinate interpreter services have a process for validating the OHA credentials of the following spoken and/or sign language interpreters before allowing the interpreter's visit to be reported as delivered by an OHA-certified and/or qualified health care interpreter? *Must pass beginning MY2025 (year 5) by answering "Yes" with minimum points required = 3; total available points = 3.*

	Yes	No
A. In-person interpreters	( )	( )
B. Telephonic interpreters	( )	( )
C. Video remote interpreters	( )	( )

32) Please select yes or no to each of the following statements about the translation of vital written documents into non-English languages. *Must pass beginning MY2021 (year 1) with minimum points required = 6; total points available = 6.*

	Yes	No
A. Consent forms are translated into non-English languages.	( )	( )
B. Complaint forms are translated into non-English languages.	( )	( )
C. Intake forms are translated into non-English languages.	( )	( )
D. Notices of rights are translated into non-English languages.	( )	( )
E. Notice of denial, loss or decrease in benefits or services are translated into non-English languages.	( )	( )
F. Information on programs or activities to receive additional benefits or services are translated into non-English languages.	( )	( )

33) Does your CCO's contract with interpreting services companies require the companies to work with OHA-credentialed spoken and sign language interpreters consistent with OAR 950-050-0160 when providing interpretation services to your CCO and/or provider network? *Must pass beginning MY2025 (year 5) by answering "Yes" or "*We do not have an interpreter services vendor"*; total available points = 1.*

( ) Yes

( ) No

( ) We do not have an interpreter services vendor

34) Are the translated documents available in alternate formats that include large prints or braille? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

35) When your CCO updates information on its website, does it also include non-English language translation of the content? *Must answer, no points available.*

( ) Yes

( ) No

36) Does your CCO track the following data regarding language assistance services provided by the CCO and provider network? Please mark yes or no for each of the following statements. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available = 6.*

	Yes	No
A. The CCO **validates invoices** from interpreting agencies to ensure they include member level details.	( )	( )
B. The CCO **compares invoice information with an internal data system** (for example MMIS flag) to confirm member level details.	( )	( )
C. The CCO **tracks invoices by service modality** (in-person, telephonic, video remote).	( )	( )
D. The CCO has a system for **tracking the unit cost of each language assistance service provided.**	( )	( )

E. The CCO tracks **the cost of services provided by bilingual staff interpreters.**	( )	( )
F. The CCO tracks the **cost of translation of materials into non-English languages.**	( )	( )

37) Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels. *Must pass beginning MY2023 (year 3) with minimum points required = 3; total points available = 4.*

	Yes	No
A. The CCO tracks training and **OHA credentialing of contracted interpreters**.	( )	( )
B. The CCO tracks training and **OHA credentialing of staff members who interpret for patients** (such as full-time CCO staff interpreters or dual-role interpreters).	( )	( )
C. The CCO tracks the **total cost of interpreter services**.	( )	( )
D. The CCO tracks the **cost of translation of materials** into non-English languages.	( )	( )

38) Please select yes or no to the language assistance services on which your CCO can provide detailed member level information, such as member ID, date of service, and interpreter credentials. *Must pass beginning MY2023 (year 3) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Bilingual clinic staff and providers	( )	( )
B. CCO in-house interpreters (spoken and sign)	( )	( )
C. CCO in-house translators (for documents)	( )	( )
D. Contracted in-person interpreters	( )	( )
E. Contracted translators	( )	( )
F. Contracted telephonic interpretation services	( )	( )
G. Contracted video interpretation services	( )	( )

39) When spoken and sign language interpretation services are provided during member visits, can your CCO collect detailed member level information (such as member ID, date of service, and interpreter credential) for appointments in each of the following care delivery settings? Please select yes or no to the following statements. *Must pass beginning MY2023 (year 3) with minimum points required = 6; total points available = 8.*

	Yes	No
A. Medical (inpatient)	( )	( )
B. Medical (outpatient/office)	( )	( )
C. Emergency Department	( )	( )
D. Dental	( )	( )
E. Telehealth	( )	( )
F. Home Health	( )	( )
G. Pharmacy connected to a provider network	( )	( )
H. Lab services connected to a provider network	( )	( )

40) Please answer yes or no to the following statements related to standardized proficiency assessments for bilingual clinic staff interpreters (this question does not apply to in-language visit providers). *Must pass beginning MY2023 (year 3) with minimum points required = 2; total points available = 2.*

	Yes	No
A. For members who prefer a language other than English (LOE), the CCO requires a standardized proficiency assessment for bilingual clinic staff interpreters before allowing them to interpret or translate documents.	( )	( )
B. For Deaf or Hard of Hearing members, the CCO requires a standardized proficiency assessment for bilingual clinic staff interpreters before allowing them to interpret.	( )	( )

41) Does your CCO track and document the following elements related to standardized proficiency assessments for in-language service providers? *Must answer, no points.*

	Yes	No
A. Type of language proficiency assessment	( )	( )
B. Passing score of language proficiency assessment	( )	( )
C. Specific language assessed	( )	( )

*CCOs must attest 'yes' to A, B, and C to be able to count in language providers for numerator credit in component 2.

42) Does your CCO have a process for validating that the language of the member matches the language of the health care interpreter and the language of the in-language service provider? *Must answer 'yes' beginning MY2025 (year 5); total available points = 1.*

( ) Yes

( ) No

*CCOs must attest 'yes' to be able to count in language providers for numerator credit in component 2.

Domain 3: Training of staff on policies and procedures

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members is trained on language access policies and procedures. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

43) Has your CCO developed a Language Access Plan (LAP) that describes how your CCO and provider network provide language access services to LOE and Deaf and hard of hearing members? *Must pass beginning MY2026 (year 6) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

44) Does your CCO staff procedures handbook include specific instructions on how to provide language assistance services to LOE and Deaf or Hard of Hearing members? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

45) Please select yes or no to each of the following CCO staff groups that receive training at regular intervals on working with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members. *Must pass beginning MY2022 (year 2) with minimum points required = 3; total points available = 6.*

	Yes	No
A. Management or senior staff	( )	( )
B. Employees who interact with or are responsible for interactions with non-English speakers or LOE members	( )	( )
C. Bilingual CCO staff	( )	( )
D. New employees	( )	( )
E. All employees	( )	( )
F. Volunteers	( )	( )

46) Are all CCO staff members who interpret for patients (such as full-time staff interpreters or dual-role interpreters) and/or healthcare professionals who receive funds from your CCO for health care interpreter training certified or qualified by OHA? *Must pass beginning MY2023 (year 3) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

47) Do CCO staff who provide care or services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members receive training at regular intervals on how to request the translation of written documents into other languages and alternate formats? *Must answer, no points available.*

( ) Yes

( ) No

Domain 4: Providing notice of language assistance services

CCOs should answer questions based on language services in place on December 31 of the measurement year.

Questions in this domain assess how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language assistance services. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

48) Does your CCO translate signs or posters announcing the availability of language assistance services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

49) Please answer yes or no to the methods that your CCO uses to inform members and communities in your service area about the availability of language assistance services. *Must pass beginning MY2021 (year 1) with minimum points required = 5; total points available = 7.*

	Yes	No
A. Frontline and outreach by bilingual or multilingual staff (CCO staff and provider staff)	( )	( )
B. Posters in public areas in clinics	( )	( )
C. "I Speak" language identification cards distributed to frontline CCO and provider staff	( )	( )
D. CCO and providers websites	( )	( )
E. Social networking websites (e.g., Facebook, Twitter, other)	( )	( )
F. Email to members or a listserv	( )	( )
G. Community-based organizations (CBOs), Community Advisory Councils (CACs), or Regional Health Equity Coalitions (RHECs)	( )	( )

50) Does your CCO inform LOE and Deaf and hard of hearing members about resources they can use to schedule an appointment with a provider? *Must pass beginning MY2026 (year 6) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

51) Does your CCO inform LOE and Deaf or Hard of Hearing members about the availability of free language assistance services? *Must pass beginning MY2021 (year 1) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

52) Does the main page of your website include non-English information that is easily accessible to LOE members? *Must pass beginning MY2022 (year 2) by answering "Yes"; total available points = 1.*

( ) Yes

( ) No

Thank you for taking our survey. Your response is very important to us.

Appendix 2: CCO self-assessment available points and minimum required point value summary

Total possible points for Year 1 thru 3=	**102**	
Year 1 minimum points required =	46	45.1%
Year 2 minimum points required =	56	54.9%
Year 3 minimum points required =	77	75.5%
Total possible points Year 4 =	**115**	
Year 4 total minimum points required =	83	72.2%
Total possible points Year 5 thru 6 =	**121**	
Year 5 total minimum points required =	97	80.2%
Year 6 total minimum points required =	99	81.8%

	MY2023 (year3)		**MY2024 (year4)**		**MY2025 (year5)**		**MY2026 (year6)**	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to the members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	28	**23**	3	**3**	2	**2**	0	**0**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively	57	**42**	10	**3**	1	**11**	0	**0**

communicate with the members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.								
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve is trained on language access policies and procedures.	8	**5**	0	**0**	1	**0**	0	**1**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language	9	**7**	0	**0**	2	**1**	0	**1**

assistance services.								

Point value for each question

Domain	Old #	New #	Change MY23-MY24	2024	minimum	2025	minimum	2026	minimum
	1	1		7	5				
	2	2		3	3				
	3	3	Change	4	3	2	2		
	4	4		0	0				
	5	5		0	0				
	6	6		1	1				
	7	7		1	1				
	8	8		1	1				
	9	9		1	1				
	10	10		1	1				
	11	11		1	1				
	12	12		1	1				
	13	13		1	1				
	14	14		5	3				
	15		New			0	0		
	16	15		2	2				
	17	16		2	2				
	18	17		0	0				
	19	18		0	0				
	20	19		0	0				
1	21	20		0	0				
	23	21		3	3				
	23	22		7	5				
	24	23		8	6				
	25	24		6			6		
	26		New			1	1		
	27	25		1	1				
	28	26		1	1				
	29	27		1	1				
	30	28		1	1				
	31	29		3			3		
	32	30		6	6				
	33	31		1			1		
2	34	32		1	1				

	35	33		0	0				
	36	34		6	3				
	37	35		4	3				
	38	36	Change	7	5				
	39	37		8	6				
	40	38		2	2				
	41		New			0	0		
	42		New			1	1		
		39	Removed	1	1	-1	-1		
	43		New			1			**1**
	44	40		1	1				
	45	41		6	3				
	46	42	Change	1	1				
3	47	43		0	0				
	48	44		1	1				
	49	45	Change	6	4	1	1		
	50		New			1			1
	51	46		1	1				
4	52	47		1	1				
Total new points by year				**13**	**6**	**6**	**14**	**0**	**2**
Total minimum required by year				**115**	**83**	**121**	**97**	**121**	**99**

Appendix 3: Quantitative Interpreter Services Reporting Template

This template has been updated for full population reporting. CCO should only submit a data table with 'one row per visit' using the columns specified below.

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
CCO Name	CCO Name	Corresponds to Health Analytics reporting CCO Name	Required
Member ID	Member's Medicaid ID		Required
Interpreter need flagged in MMIS	Yes No	Use this field to confirm whether the member has interpreter needs flags in MMIS. CCO can include additional visits from members needing or utilizing interpreter services but do not have interpreter information in OHA's system by selecting No in this field. See specifications, the Eligible Population section for detail.	Required
Type of Care	Physical Mental/Behavioral Dental	The person can have multiple types of care on the same day. See appendix 4 of the technical specifications for reference to potential methodology.	Required
Visit Type/Care Setting	Visit Type: Inpatient Stay Emergency Department Office Outpatient Home Health Telehealth Other	On a given visit date, each type of care should have only one visit type/care setting. The visit type listed is determined based on the following hierarchy: Inpatient Stay Emergency Department Office Outpatient Home Health Telehealth Other For example, if a person had an emergency room visit and was admitted for an inpatient hospital stay, CCOs should report the inpatient visit for one type of care. If a person had an office outpatient visit and a telehealth appointment for only one type of care, CCOs should report the office outpatient visit. If the person has more than one type of care in a day, report each type of care separately. If the member has a physical health office outpatient visit and a dental health office outpatient visit on the same day, report both visits separately. Please see appendix 4 of the technical specifications on the Oregon Health Grouper (OHG).	Required

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Visit Date	YYYY/MM/DD	For an inpatient stay, CCOs should report the admission date as the visit date and one inpatient stay in a facility as one visit regardless of the total length of stay. If the patient is transferred to a different facility, CCOs should count as a separate visit.	Required
In-person Interpreter Service (or in-language visit[1])	Yes No	Answer Yes or No for all three fields. Reporting of in language provider visits is optional in MY2025. Indicate Yes if the CCOs data collection system for the measure indicates Yes for interpreter services (or in-language provider services, if reporting), or all possible data sources were reviewed for the use of language assistance services and it was found the member received interpreter services (or in-language provider services, if reporting) during the visit. Indicate No if the CCOs data collection system for the measure indicates No for interpreter services (or in-language provider services, if reporting), or all possible data sources were reviewed and cannot find any evidence that interpreter service (or in-language provider services, if reporting) was provided for the visit. Leave the modality fields blank if the visit does not exist in the CCOs data collection system for the measure, or there are other known data sources for language services and the CCO is unable to review and report on these data sources. For example, the clinic orders/pays for the interpreter services and keeps the records, but the data is not tracked at the member and visit-level detail (unable to capture the required reporting data elements), or the CCO cannot retrieve the data during the hybrid review process.	Required
Telephonic Interpreter Service (or in-language visit[1])	Yes No		Required
Video Remote Interpreter Service (or in-language visit[1])	Yes No		Required
Language Interpreted	3-Letter ISO 639 Language Code	Fill out field if the member received interpreter services or had an in-language provider visit. Field should reflect what non-English language was primarily spoken with the member during the visit.	Required

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Was the Interpreter (or in-language provider[1]) OHA Certified or Qualified ?	OHA Certified OHA Qualified Not Certified or Qualified Blank - Unknown or Not Applicable	OHA Certified and OHA Qualified should be used for visits with interpreter services where the interpreter, provider, or bilingual staff has an OHA registry number. If OHA Certified or OHA Qualified is indicated, a valid OHA Registry number must be provided in the next field. Indicate Not Certified or Qualified if the interpreter, bilingual staff, or in language provider was not OHA certified or qualified.	Required if Yes for any of the three language service modality fields (In Person, Telephonic, Video Remote).
Interpreter's OHA Registry Number	OHA Registry Number	If multiple OHA certified and/or qualified health care interpreters were used, please report only one interpreter's OHA registry number. OHA will confirm the submitted value exists on the OHA registry number. Only records with valid OHA registry numbers count towards the incentive quality language access rate.	Required if OHA Certified or OHA Qualified is indicated
If visit had in language provider, was the provider a native speaker or did the provider pass a proficiency test[1]?	Yes No Blank	Yes – The primary performing provider was a native speaker or passed proficiency test No – The primary performing provider was not a native speaker and did not pass a proficiency test Blank - Unknown or Not Applicable Only the primary performing provider for the visit qualifies for these two options. This field is not available to other supporting providers or general clinic staff. Indicate yes for a provider who is a native speaker or passed proficiency test. The field should ONLY be indicated if the in-language provider is a native speaker of the same preferred language of the member or has passed the proficiency test in the member's preferred language (see requirements on page 7). The CCO must have documentation that the provider's native language and/or proficiency test languages match (e.g., a provider passed proficiency test for Korean does not qualify for a member with preferred language as Spanish). Only records with the provider meeting these requirements count towards the incentive quality language access rate. CCO must attest to tracking language proficiency tests and matching languages in Component 1 question #41 and #42 to qualify for numerator credits. Indicate No if the provider is not a native speaker of the member's preferred language and has not passed the proficiency test in the member's preferred language. Leave blank if native speaker or proficiency test records are not tracked.	Optional

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Was the Interpreter a Bilingual Staff	Yes No Blank	Yes - Bilingual Staff No - No Bilingual Staff Blank - Unknown or Not Applicable Do not use this field for the primary performing provider who provides an in-language visit. Bilingual staff services do not automatically qualify for numerator hits unless the staff (is OHA qualified or certified for interpreter services, or the in-language visit provider has passed the proficiency test for the member's preferred language. This flag is for information that an outside/contracted interpreter is not used; it helps the CCO to identify staff who may receive training for becoming OHA qualified and certified, or take a proficiency test	Optional
Did the member refuse Interpreter Service	Yes No Blank	Yes - Member Refused Interpreter Services No - Member did not Refuse Interpreter Services Blank - Unknown or Not Applicable If no records of member refusal exists, member did not refuse (fill in No in template) can be indicated.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)
Reason for Member Refusal	1 2 3 4 5 Blank	1 - Member refusal because in-language visit is provided 2 - Member confirms interpreter needs flag in MMIS is inaccurate 3 - Member unsatisfied with the interpreter services available 4 - Other reasons for patient refusal 5 – Member does not need interpreter services for the visit Blank - Unknown or Not Applicable Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore refused interpreter service. To note, if the in-language service provider is OHA certified or qualified or has passed the language proficiency requirements, it could be a numerator hit for the metric. Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)

Column Name	Valid Input Value	Instructions	Field Type
		Scenario 5: The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits. Visits with refusal reasons 1,2 or 5 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question #14. Scenarios 3 and 4 do not qualify for denominator exclusion.	

[1] In language provider who is a native speaker or has passed a proficiency test in member's preferred language reporting is optional in MY 2025. See page 7 for requirements.

Appendix 4: Categorizing Denominator Visits based on Oregon Health Grouper (OHG) and modifications

OHA uses a homegrown Oregon Health Grouper (OHG) with recategorization and modifications to count denominator visits in the required stratifications for the measure[12].

Step1: All MMIS/DSSURS claims data are categorized into OHG categories, then rolled up into larger categories using the following crosswalk table below. Note, only paid claims are used, and claim lines containing modifier code 26 or place of service (POS) 81 are excluded[13].

OHG-to-HEM Crosswalk Table:

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
D-01	Dental Diagnostic	dental	Office Outpatient
D-02	Dental Preventative	dental	Office Outpatient
D-03	Dental Restorative	dental	Office Outpatient
D-04	Dental Endodontics	dental	Office Outpatient
D-05	Dental Periodontics	dental	Office Outpatient
D-06	Dental Prosthodontics Removable	dental	Office Outpatient
D-07	Dental Implants/ Prosthodontics Fixed	dental	Office Outpatient
D-08	Dental Oral Maxillofacial Surgery	dental	Office Outpatient
D-09	Dental Orthodontics	dental	Office Outpatient
D-10	Dental Anesthesia	dental	Office Outpatient
D-99	Dental Adjuctive General Services (Unbucketed)	dental	Office Outpatient
I-08	Inpatient Maternity C-Section Delivery	physical	Inpatient
I-09	Inpatient Maternity Non-Delivery	physical	Inpatient
I-10	Inpatient Maternity Normal	physical	Inpatient
I-11A	Inpatient Newborn Complicated	physical	Inpatient
I-11B	Inpatient Newborn Well	physical	Inpatient
I-12	Inpatient Rehabilitation	physical	Inpatient
I-13	Inpatient Medical/Surgical (Medical Only)	physical	Inpatient
I-14	Inpatient Medical/Surgical (Surgical Only)	physical	Inpatient

[12] More detail documentation in excel format is available on the metrics website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

[13] This exclusion is to avoid counting visits from independent lab claims or providers interpretation of test results without provider and patient interpretation. With the visit setting hierarchy, higher level qualifying visits on the same day can still be identified and be included in the report.

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
I-15	Inpatient Un-Bucketed Missing DRG	physical	Inpatient
I-99	Inpatient Unbucketed	physical	Inpatient
M-01	Emergency Lifeflight	exclude	exclude
M-02	School Based Services	physical	Office Outpatient
M-03	Transportation Ambulance	exclude	exclude
M-04	Outpatient Basic ASC (ASC = Ambulatory Surgical Center)	physical	Office Outpatient
M-05	Physician Primary Care E-M (Evaluation & Management)	physical	Office Outpatient
M-05A	Physician Primary Care E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-06	Physician Other E-M (Evaluation & Management)	physical	Office Outpatient
M-06A	Physician Other E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-07	Evaluation & Management PCP (PCP = Primary Care Phsycian)	mental/behavioral	Office Outpatient
M-08	Mental Health ACT (ACT = Assertive Community Treatment)	mental/behavioral	Office Outpatient
M-09	Mental Health AFC (AFC = Adult Foster Care)	exclude	exclude
M-10	Mental Health Assessment & Evaluation	mental/behavioral	Office Outpatient
M-11	Mental Health Case Management	mental/behavioral	Other
M-12	Mental Health Consultation	mental/behavioral	Office Outpatient
M-13	Mental Health Crisis Services	mental/behavioral	Office Outpatient
M-14	Mental Health Interpretive Services	exclude	exclude
M-15	Mental Health Medication Management	mental/behavioral	Other
M-16	Mental Health Alternative to Inpatient	mental/behavioral	Outpatient
M-17	Mental Health MST (MST = Muti-Systemtic Treatment)	mental/behavioral	Office Outpatient
M-18	Mental Health PAITS (PAITS = Post Acute Intensive Treatment Services)	mental/behavioral	Office Outpatient
M-19	Mental Health PDTS (Psyciatric Day Treatment Services)	mental/behavioral	Office Outpatient
M-20	Mental Health Respite	mental/behavioral	Other
M-21	Mental Health RTF Part A (RTF = Residential Treatment Facility)	exclude	exclude
M-22	Mental Health RTF Part B (RTF = Residential Treatment Facility)	exclude	exclude
M-23A	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-23B	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-24	Mental Health Skills Training	mental/behavioral	Office Outpatient
M-25	Mental Health SRTF (SRTF = Secure Residential Treatment Facility 18+)	exclude	exclude
M-26	Mental Health Sub Acute	mental/behavioral	Office Outpatient
M-27	Mental Health Supportive Employment	exclude	exclude
M-28	Mental Health Therapy	mental/behavioral	Office Outpatient
M-29	Mental Health Therapy Inpatient	mental/behavioral	Inpatient
M-30	Mental Health Wrap-Around Services	mental/behavioral	Other
M-31	Mental Helath Intensive Rehab Services	mental/behavioral	Office Outpatient
M-32A	Physician Therapeutic Abortion Part A	physical	Office Outpatient
M-32B	Physician Therapeutic Abortion Part B	physical	Office Outpatient
M-33	Behavioral Rehab Services	mental/behavioral	Office Outpatient
M-34	Excluded Admin Exams	physical	Other
M-35	Targeted Case Management (TCM) Leveraged	physical	Other
M-36	Non-Emergent Transporation (NEMT)	exclude	exclude
M-37	Checmical Dependency OHP Outpatient (OHP = Oregon Health Plan)	mental/behavioral	Office Outpatient
M-40	Mental Health Outpatient Therapy	mental/behavioral	Office Outpatient
M-41	Mental Health Physician Outpatient	mental/behavioral	Office Outpatient
M-42	Mental Health Supportive Day Treatment	mental/behavioral	Office Outpatient
M-43	Mental Health Supportive Housing	exclude	exclude
M-44	Anesthesia	physical	Office Outpatient
M-45A	Outpatient Dental Anesthesia	dental	Office Outpatient
M-45B	Outpatient Dental Flouride	dental	Office Outpatient
M-46	Physician Family Planning Part B	physical	Office Outpatient
M-47	Physician Family Planning Part C	physical	Office Outpatient
M-48	Physician Hysterectomy	physical	Office Outpatient
M-49	Lab	exclude	exclude
M-50	Other Medical Maternity Management	physical	Office Outpatient
M-51	Other Medical Durable Medical Equipment	exclude	exclude
M-52	Other Medical Supplies	exclude	exclude
M-53	Maternity	physical	Office Outpatient
M-53A	Physcian Maternity Primary Care	physical	Office Outpatient
M-54	Neonate Newborn Care	physical	Office Outpatient
M-55	Radiology	physical	Other
M-56	Physician Sterilization	physical	Office Outpatient
M-57	Surgery	physical	Office Outpatient
M-58	Speech & Hearing	physical	Office Outpatient
M-59	Vision Exams & Therapy	physical	Office Outpatient
M-60	Physician Other Services	physical	Other
M-61	Other Drugs & Supplies	exclude	exclude
M-62	Community Detox	mental/behavioral	Office Outpatient
M-63	Chemical Dependency Assessment Screening	mental/behavioral	Office Outpatient
M-64	Chemical Dependency Methadone Treatment	mental/behavioral	Office Outpatient
M-65	Cemical Dependency Methadone AMH (AMH = Addictions and Mental Health)	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-66	Physicial Somatic Mental Health	mental/behavioral	Office Outpatient
M-67	Not Covered	exclude	exclude
M-68	SBIRT Part A (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-69	SBIRT Part B (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-70	Mental Health Children and Adolescent Needs Assessment	mental/behavioral	Office Outpatient
M-71	ABA Services - Mental Health	mental/behavioral	Office Outpatient
M-72A	Chemical Dependency Residential Treatment Child	mental/behavioral	Inpatient
M-72B	Chemical Dependency Residential Treatment Adult	mental/behavioral	Inpatient
M-72C	Psychiatric Residential Treatment Services	physical	Inpatient
M-75	Urgent Care Visits	physical	Office Outpatient
M-76	Preventative Well Baby Exams	physical	Office Outpatient
M-77	Preventative Immunizations	physical	Office Outpatient
M-78	Preventative Care Covered Service	physical	Office Outpatient
M-79	Preventative Care Non-Covered Service	physical	Office Outpatient
M-80	Inpatient Visits	physical	Inpatient
M-81	Outpatient	physical	Office Outpatient
M98-A		mental/behavioral	Other
M98-B		mental/behavioral	Other
M98-C		mental/behavioral	Other
M-99	Professional Unbucketed	physical	Other
O-01	Outpatient Therapeutic Abortion Outpatient Hospital	physical	Office Outpatient
O-02	Outpatient Excluded Administrative Exams	physical	Other
O-03	Outpatient Prescription Drugs Mental Health	mental/behavioral	Office Outpatient
O-04	Outpatient Mental Health Other Outpatient	mental/behavioral	Office Outpatient
O-05	Outpatient Emergency Room Somatic Mental Health	mental/behavioral	ED
O-06A	Outpatient Chemical Dependency -- Part A	mental/behavioral	Office Outpatient
O-06B	Outpatient Chemical Dependency -- Part B	mental/behavioral	Office Outpatient
O-07	Outpatient Hysterectomy	physical	Office Outpatient
O-08	Outpatient Sterilization -- Female	physical	Office Outpatient
O-09A	Outpatient Family Planning -- Part A -- No Modifier	physical	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-09B	Outpatient Family Planning -- Part B -- With Modifier	physical	Office Outpatient
O-09C	Outpatient Family Planning -- Part C -- With Modifier	physical	Office Outpatient
O-10	Outpatient Maternity	physical	Office Outpatient
O-11	Outpatient Prescription Drugs Basic	physical	Office Outpatient
O-11A	Outpatient Skilled Nursing Facility	physical	Office Outpatient
O-12	Outpatient Post Hospital Extended Care	physical	Office Outpatient
O-13	Outpatient Maternity Case Management	physical	Office Outpatient
O-14	Outpatient Hospice Services	physical	Office Outpatient
O-15	Outpatient Transportation Ambulance	exclude	exclude
O-16	Outpatient Emergency Room	physical	ED
O-17A	Outpatient Lab Services -- Part A	exclude	exclude
O-17B	Outpatient Radiology Services CT -- Part B (CT = Computerized Tomography	physical	Other
O-17C	Outpatient Radiology Services MRI -- Part C (MRI = Magnetic Resonance Imaging)	physical	Other
O-17D	Outpatient Radiology Services PET -- Part D (PET = Positron Emission Tomography)	physical	Other
O-18	Outpatient Home Health	physical	Home Health
O-19	Outpatient Somatic Mental Health	mental/behavioral	Office Outpatient
O-20	Outpatient Physician Administered Drugs	physical	Other
O-21	Outpatient Diagnostic Services Other	physical	Office Outpatient
O-22	Outpatient Lab Injections Other	exclude	exclude
O-23	Outpatient Supplies & Devices	exclude	exclude
O-24	Outpatient Operating Room Other	physical	Office Outpatient
O-25	Outpatient Anesthesia Other	physical	Office Outpatient

Social Determinants of Health: Social Needs Screening and Referral Measure – MY 2025

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Social Determinants of Health Measurement Workgroup Screening for Social Needs.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: Workgroup and OHA-developed

Measure Utility:

■CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Member Type:

■CCO A ■CCO B

Data Source:

- Component 1 – structural measure: CCO attestation (beginning first year of use and continuing through year 3)
- Component 2 – hybrid measure: sample reporting using MMIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources (beginning 2025 and continuing through 2026)

Measurement Period: Component 1 - January 1, 2025 to December 31, 2025

Component 2 – December 15, 2024 to December 14, 2025

Note the cut-off date is on December 14 so referral can occur by the end of 2025.

Past Benchmark for OHA measurement year	2023	2024	2025
Component 1 – minimum points from must pass questions	CCO must attest to completion of all recommended MY2023 must-pass elements in Table 1	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1	TBD
Component 2 – reporting method and data collection requirement	Not required	Not required	TBD
Component 2 – % of members screened and % of members who received a referral	Not required	Not required	TBD
Source:	Committee consensus	Committee consensus	TBD

Note on telehealth: This measure is telehealth-eligible. The Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specification from MY2024 to MY2025:

Component 1:No changes

Component 2:

- OHA is proposing a stratified random sample with a 95% confidence level and a three percent margin of error. The sample size will be approximately 1,067 members.
- Added a completeness threshold of 90% for the sample.
- For Rate 1 Percent Screened, time period clarified for the screening period and continuous enrollment.
- Clarified the footnote for continuous enrollment period and its relationship to the Rate 1 Percent Screened denominator.
- Appendix 1 Template for Component 2 Reporting changes are in blue text.
- Appendix 2 Social Needs Screening Tools Process changes are in blue text.

Measure Details – Component 1, Structural Measure

Measure Components and Scoring – Component 1

Social Needs Screening and Referral CCO Self-Assessment

In recent years, recognition has grown of the profound impact social factors like income, environmental conditions and racism have on a person's health. The goal of the Social Needs Screening and Referral measure is that CCO members have their social needs acknowledged and addressed.

Component 1 of the measure assesses CCOs' action plans to ensure social needs screening and referral is implemented in an equitable and trauma-informed manner. It also ensures CCOs lay the groundwork for data sharing and reporting as required in Component 2. CCOs will complete a self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring CCO members to community resources.

For each measurement year, the CCO must: (1) answer all self-assessment questions and (2) attest to having accomplished all "must-pass" elements required for that year. These elements assess how well CCOs identify and coordinate services for members with social needs in the domains of

1. Food insecurity,
2. Housing insecurity and
3. Transportation needs.

For the self-assessment, **CCOs will answer questions based on services in place on December 31 of the measurement year**. Data collection will occur through a survey tool that OHA will distribute to CCOs.

The CCO must accomplish all required must-pass items for the measurement year. No partial credit will be given. The work to be accomplished increases from year to year. Table 1 reflects the measurement year when each element is a must-pass requirement to satisfy the structural measure.

Descriptions of the elements of work to be accomplished during each measurement year are briefly summarized in this table. **Complete descriptions of each element are provided below Table 1**.

Table 1: Must-Pass Elements for Component 1, by Measurement Year (MY)

	Elements of work to be accomplished	MY 2023	MY 2024	MY 2025
A. Screening practices				
1.	Collaborate with CCO members on processes and policies	Must pass	Must pass	Must pass
2.	Establish written policies on training	Must pass	Must pass	Must pass
3.	Assess whether/where members are screened	Must pass	Must pass	Must pass
4.	Assess training of staff who conduct screening		Must pass	Must pass
5.	Establish written policies to use REALD data to inform appropriate screening and referrals	Must pass	Must pass	Must pass
6.	Identify screening tools or screening questions in use	Must pass	Must pass	Must pass
7.	Assess whether OHA-approved or exempted screening tools are used		Must pass	Must pass
8.	Establish written protocols to prevent over-screening	Must pass	Must pass	Must pass
B. Referral practices and resources				
9.	Assess capacity of referral resources and gap areas	Must pass	Must pass	Must pass
10.	Establish written procedures to refer members to services		Must pass	Must pass
11.	Develop written plan to help increase community-based organization (CBO) capacity in CCO service area		Must pass	Must pass
12.	Enter into agreement with at least one CBO that provides services in each of the three domains	Must pass	Must pass	Must pass
C. Data collection and sharing				
13.	Conduct environmental scan of data systems used in your service area	Must pass	Must pass	Must pass
14.	Set up data systems to clean and use REALD data		Must pass	Must pass
15.	Support a data-sharing approach within the CCO service area		Must pass	Must pass

Elements are grouped together by topic areas A-C from Table 1. Definitions are in Appendix 3.

A. Screening practices

1. **Collaborate with CCO members on processes and policies (MY 2023-2025)**
    - **Intent:** CCO member voices are reflected in the policies and processes established by CCOs regarding screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.
    - **This element is met if** the CCO collects and incorporates input from members on written policies for screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.

- **Examples of activities meeting this element**:
    - The CCO collects and documents member input on social needs screening and referral processes through its Community Advisory Council or member focus groups at least annually.
    - The CCO conducts a member survey with open-ended questions on screening, referral, and data-sharing practices that are analyzed, synthesized, and incorporated into final written policies.

- **Examples of activities *not* meeting this element:**
    - The CCO engages with its members but does not retain documentation of member input on social needs screening, referral, and data sharing practices.
    - The CCO engages with community members generally but is not able to confirm input from CCO members specifically.

2. **Establish written policies on training (establish in MY 2023 and review in MY 2024 & 2025)**
    - **Intent**: Training is well planned, and CCO staff and partners – including contractors, in-network providers, and CBO partners – have access to written protocols and best practices for assessing members' unmet social needs.

    - **This element is met if** the CCO establishes and maintains a written policy on the training for CCO staff members and shares the policy with partners conducting social needs screening. Topics addressed must include patient engagement, empathic inquiry and motivational interviewing, trauma-informed practices, and cultural responsiveness and equitable practices. The training policy also should be clear that members may decline to be screened or to accept referrals.

    - **Examples of activities meeting this element**:
        - A CCO policy manual shared with staff and partners includes a dedicated section on assessing members' unmet social needs.
        - An online website or application displays CCO policies for staff and partners, including a dedicated section on assessing members' unmet social needs.

    - **Examples of activities *not* meeting this element:**
        - Policies on assessing members' unmet social needs not distributed to staff and partners.
        - An online training program described in the policies does not have links to or otherwise share written CCO policies on assessing members' unmet social needs.
        - Written CCO policies do not address critical considerations for assessing members' unmet social needs, including: (1) trauma-informed practices, (2) empathic inquiry or motivational interviewing, (3) culturally responsive and

equitable practices, and (4) clear protocols for referring members to available community resources.

3. **Assess whether and where screenings are occurring (MY 2023-2025)**
    - **Intent**: CCOs understand where screenings occur, so they can coordinate screening and referral activities, identify gaps, and share policies and resources.
    - **This element is met if** the CCO conducts a systematic assessment of screenings that are done by (1) CCO staff, (2) all provider organizations listed in the CCO's Delivery System Network (DSN) report and (3) any CBOs, social service agencies, or other social determinants of health and equity partners with which the CCO has contracts, memoranda of understanding (MOUs), grants, or other agreements for addressing social needs. This assessment should identify where members are predominantly being screened for unmet social needs (e.g., at primary care clinics, upon enrollment with the CCO, at a local housing resources organization). The CCO must be able to determine, at a minimum, whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
    - **Examples of activities meeting this element**: In addition to assessing screenings done within the CCO, the CCO does any of the following:
        - Annually surveys provider organizations listed in the CCO's DSN report, CBOs, social service agencies, and other organizations on social needs assessments,
        - Collects regular reporting from provider organizations listed in the CCO's DSN table, CBOs, and social service agencies specifically on the prevalence of social needs assessments, or
        - Maintains a real-time or near real-time list of services offered by all provider organizations in the DSN table, CBOs, and social service organizations in their service area, with a specific indication for social needs assessments.
    - **Examples of activities *not* meeting this element:**
        - A survey of network providers asks about social needs screenings in general, but not about screening specifically for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
        - Information reported (through a survey or regular reporting) prior to the measurement year.
        - An assessment of screenings occurring in the service area by network providers does not include an assessment of CBOs and social service agencies.
4. **Assess training of staff members who conduct screening (MY 2024 and review in MY 2025)**
    - **Intent**: CCOs ensure that partners – including contractors, in-network providers, and CBO partners – provide training to staff who conduct screenings.

- **This element is met if** the CCO reviews the training policies of its partners and, if needed, provides training resources to partners.

- **Examples of activities meeting this element**:
    - The CCO surveys its partners about training policies and practices. If a partner has a gap in policies or practices, the CCO suggests resources, such as the CCO's training policy as a model or training opportunities such as webinars on trauma-informed screening practices.

- **Examples of activities *not* meeting this element**:
    - The CCO inquires about training policies or practices but offers no recommendations to partners who lack policies or training resources.

5. **Establish written policies for using disaggregated race, ethnicity, language and disability (REALD) data to inform work on social needs screening and referrals (establish in MY 2023 and review in MY 2024 and 2025)**
    - **Intent:** CCOs use disaggregated REALD data to help understand and respond to members' needs in a culturally responsive way.

    - **This element is met if** the CCO has developed and distributed written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs.

    - **Examples of activities meeting this element**:
        - The CCO has established and distributed written policies, as outlined in Element 2 above, including protocols for analyzing and using disaggregated REALD data.

    - **Examples of activities *not* meeting this element:**
        - Generic written CCO policies on use of REALD do not specifically address use of REALD data in social needs screening and referral practices.
        - Policies address only aggregated REALD data use.

6. **Identify screening tools or screening questions in use, including available languages (MY 2023-2025)**
    - **Intent:** CCOs understand how screening is occurring so they can coordinate screening, trainings and other resources.

    - **This element is met if** the CCO has reviewed the screening tools or questions used by CCO staff *and* systematically contacted (1) the provider organizations listed in the CCO's DSN report and (2) any CBOs with whom the CCO has contracts for addressing food

insecurity, housing insecurity, or transportation needs to inquire about screening tools or questions used at these organizations. The CCO should also track the language(s) made available to members for each screening tool or set of questions.

- **Examples of activities meeting this element**:
  - The CCO conducts a survey of these organizations (may be part of the same survey as Element 3, assess whether/ where members are screened) during the measurement year and inquires about screening tools or questions used at these organizations.
  - The CCO combines survey data with relevant, current (within the measurement year) data pulled from a community information exchange system (CIE), health information exchange (HIE), or other system that includes CCO and/or partner information on social needs screening.
  - The CCO maintains real-time or near real-time electronic systems for tracking screening tools and questions in use in the service area.

- **Examples of activities *not* meeting this element:**
  - CCO does not collect information about whether screening tools and questions are able to assess all three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
  - CCO does not collect information about languages in which the screening tools or questions are available.

7. **Assess whether OHA-approved or exempted screening tools are being used (MY 2024-2025)**
   - **Intent:** CCOs understand whether OHA-approved or exempted screening tools are being used.

     Note: Component 2 of this measure requires the use of a screening tool for data reported about screening and referrals from the OHA approved list or exempted by OHA at the organizational level. OHA strongly encourages the use of screening tools from the OHA-approved list. CCOs will have an opportunity to submit tools for exemption at the organizational and/or approval at the statewide level annually (see Appendix 2).

   - **This element is met if** the CCO compares the information collected in Element 6 with the list of OHA-approved or exempted screening tools.

8. **Establish written protocols for preventing over-screening (establish in MY 2023 and review in MY 2024 & 2025)**
   - **Intent:** CCOs establish, implement and maintain processes to prevent over-screening. Over-screening, which could be retraumatizing, may occur if a member is asked to complete screening processes multiple times and in multiple settings in a relatively short period, such as several months.

Note: Conversational follow-up questions are not considered over-screening. For example, if a member screened positive for food insecurity and was given assistance in applying for SNAP benefits, then it would be appropriate follow-up to ask the member if the assistance helped resolve the need.

Beginning in the third year this measure is incentivized, Component 2 requires CCOs to report annual screening for each of the three domains. Members may decline to be screened or decline to accept a referral, and members' choices will not count against the CCO's performance.

- **This element is met if** the CCO analyzes factors that might lead to over-screening, develops strategies to mitigate risk of harm, writes protocols, and distributes them to staff who engage in screening. These protocols may be incorporated into the CCO's training policy (see Element 2, establish written policies on training).

- **Examples of activities meeting this element**:
    - The CCO uses its data about where members are screened, works with partners to identify situations when members are most likely to be over-screened, and develops strategies to avoid potential harm. The strategies are reflected in protocols that are distributed to the CCO's partners. Strategies might include:
        - Technology, such as use of data sharing to check CCO members' social needs screening history prior to conducting a new screening;
        - Processes, such as screening at the household level if, for example, a parent or guardian answering the screening questions indicates that the answers are applicable to multiple children in the household; and
        - Training resources, such as empathic inquiry or other motivational interviewing techniques to determine members' comfort level and history with being screened for unmet social needs.

- **Examples of activities *not* meeting this element:**
    - The CCO skips analysis of potential risk areas, for example, by failing to assess current screening practices before writing its policy.
    - The CCO writes a policy but doesn't distribute it or doesn't include strategies to be used in the screening process to avoid the risk of harm.

B. Referral practices and resources

9. **Assess the capacity of available resources and gap areas (MY 2023-2025)**
    - **Intent:** CCOs understand capacity and gaps in available resources so they can connect members to culturally responsive community resources and they can prioritize investments in building capacity.

- **This element is met if** the CCO conducts an inventory of CBO and other resources in the CCO service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs and then compares the available resources with estimated unmet needs among CCO members.

- **Examples of activities meeting this element**:
    - The CCO creates an inventory of available resources by drawing on information sources such as
        - The CCO's shared Community Health Assessments (CHAs),
        - Data from a CIE, HIE or other resource or referral system or
        - Consultation with organizations that support connections with community resources.

      The CCO compares that inventory with other data on needs. In the first year, this may be county-level or statewide data and subsequently, CCOs might use baseline data from the prior year. These data are compared with available resources to estimate the rate of unmet social needs among CCO members.
    - The CCO has data sharing arrangements that enable a real-time or near real-time dashboard showing available community resources at the time of referrals, with capabilities for exporting reports on available community resources. The CCO compares that dashboard with other data to estimate the rate of unmet social needs among CCO members.

- **Examples of activities *not* meeting this element:**
    - The CCO maintains contracts and/or MOUs with CBOs for housing, food, and transportation needs but has not assessed the timeliness and availability of resources for referred members with unmet social needs.
    - The CCO refers all members to generic community resources without ensuring the resource has capabilities to provide culturally responsive services.

10. **Establish written procedures to refer members to services (establish in MY 2024 and review in MY 2025)**
    - **Intent:** The CCO has a clear process so that when a member screens positive for one or more unmet needs, the member is referred to culturally responsive services to address their needs.

    - **This element is met if** the CCO has written procedures for referring members in a timely manner to services that are culturally responsive and can address their needs. Referrals should occur when a CCO member screens positive for one or more unmet needs in the domains of food insecurity, housing insecurity or transportation needs *and* the member is interested in receiving a referral (that is, the member is offered and does not decline a referral).

- **Examples of activities meeting this element**:
    - The CCO uses the data from its inventory (Element 9, Assess capacity of referral resources and gap areas) to understand available resources and maintains policies or contractual agreements with partners that detail specific responsibilities and protocols for referring members to available, culturally responsive resources.

- **Examples of activities *not* meeting this element:**
    - The CCO refers all members to generic community resources without ensuring the resource has capabilities to provide culturally responsive services.

11. **Develop a written plan to help increase the capacity of CBOs in CCO service area (establish in MY 2024 and review in MY 2025)**
    - **Intent:** CCOs make and implement plans to close gaps in available, culturally responsive resources to meet members' housing, food, and transportation needs.

    - **This element is met if** the CCO develops a written plan to meet members' unmet needs in the domains of food insecurity, housing insecurity, and transportation needs. The plan builds off the CCO's assessment of capacity and includes information about how the CCO will provide resources such as financial or staffing resources to increase CBO capacity. The plan aligns with related work such as the use of Health-Related Services funds and the Supporting Health for All through REinvestment (SHARE) Initiative.

    - **Examples of activities meeting this element**:
        - The CCO publishes a detailed plan, incorporating the assessment of capacity among CBOs in the service delivery area, that outlines specific financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.
        - The CCO updates or expands an existing plan or assessment to include annually updated financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.

    - **Examples of activities *not* meeting this element:**
        - Written plans that do not incorporate specific findings from the assessment of capacity relative to housing, food, and transportation needs.
        - Written plans that do not outline specific financial, infrastructure, and staffing investments planned for increasing CBO capacity.

12. **Enter into an agreement with at least one CBO that provides services in each of the three domains (food, housing, transportation) (MY 2023-2025)**
    - **Intent:** CCOs build partnerships with community organizations to expand capacity and better meet members' needs.

- **This element is met if** the CCO has a fully executed contract, MOU, LOA, grant or other agreement in place with (1) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity; (2) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing housing insecurity; and (3) at least one CBO, social service agency, or other social determinants of health and equity partner for transportation needs. Such agreements may include contracts for case management services or navigation to assist members in applying for SNAP or other benefits to address identified needs.

- **Examples of activities meeting this element**:
    - The CCO has an agreement with one or more CBO, social service agency, or other social determinants of health and equity partner that can provide case management services for housing, food, and transportation and/or can directly supply members with housing, food, and transportation.
- **Examples of activities *not* meeting this element:**
    - Only verbal or informal agreements with CBOs exist between the CCO and CBOs.
    - Agreements with CBOs, taken together, do not address all three domains.

C. Data collection and sharing

13. **Conduct an environmental scan of data systems used in the CCO service area** to collect information about members' social needs, refer members to community resources and exchange social needs data. **(scan in MY 2023 and update in MY 2024 & 2025)**
    - **Intent:** CCOs understand how social needs screening and referral data is collected and exchanged so they can promote effective data-sharing practices.

    - **This element is met if** the CCO systematically reviews how any social needs screening and referral data is captured and exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs. The review identifies any standardized codes being used to capture data about screening and referrals (e.g., LOINC, SNOMED, ICD10, CIE data dictionary).

    - **Examples of activities meeting this element**:
        - The CCO conducts a survey (may be part of the same survey as Element 3, assess whether and where screenings are occurring) of provider organizations and CBOs during the measurement year and asks about data systems used for social needs screening and referral.
        - The CCO collects annual reporting from provider organizations and CBOs with specific requirements for reporting social needs screening and referral data.

- **Examples of activities *not* meeting this element:**
    - The CCO collects information on what data systems are used by providers and CBOs without identifying data collection and data exchange processes.
    - The CCO conducted their latest environmental scan of data systems before the start of the measurement year.

14. **Set up data systems to clean and use REALD data (set up by MY 2024 and maintain in MY 2025)**
    - **Intent:** CCOs set up data systems so they can effectively use REALD data received from OHA and other sources to inform processes for screening and referrals for social needs.
    - **This element is met if** the CCO uses disaggregated REALD data to understand the populations served by your CCO and identify resources to meet members' needs.
    - **Examples of activities meeting this element**:
        - The CCO uses disaggregated REALD data to tailor training on how to provide culturally responsive screening and referrals and to work with community partners to address any gaps in culturally responsive services to meet members' social needs.
    - **Examples of activities *not* meeting this element:**
        - The CCO collects and stores disaggregated REALD data but has not used the data to modify or add new community engagement and/or social needs screening and referral practices.

15. **Support a data-sharing approach (set up by MY 2024 and maintain in MY 2025)**
    - **Intent:** CCOs support networked providers to have access, at the point of care, to screening results and referral(s) made, even if the screening or referral occurs at the CCO level or at another clinic.
    - **This element is met if** the CCO provides access to a tool or tools that enable screening and referral data to be shared among networked providers who care for members or if the CCO otherwise ensures that networked providers use tools to share screening and referral data. Tools may include, for example, a CIE, HIE, or other screening and referral system for networked providers that enables screening and referral data to be shared.
        Note: CCOs will be asked to briefly identify the approach used and its availability to networked providers (e.g., our CCO pays for a subscription to ABC CIE, which has onboarded X# of clinics and Y# of CBOs in our service area).
    - **Examples of activities meeting this element**:
        - The CCO pays, incentivizes, or subsidizes network providers' subscription to a community information exchange (e.g., Unite Us, findhelp, etc.).

- The CCO establishes agreements with network providers that require them to connect to a tool that enables sharing and receiving screening and referral data.

- **Examples of activities *not* meeting this element:**
  - The CCO participates in a HIE or CIE collaborative, but the CCO has not entered into agreements with network providers to enable sharing social needs data or invested in infrastructure for network providers.
  - The CCO is connected to a tool that enables sharing of social needs data, but the CCO has neither made agreements with network providers for their use of the tool nor instituted incentives, subsidies, or other investments in network providers' use of the tool.

Measure Components and Scoring – Component 2

Component 2 will first be reported in Measurement Year (MY) 2025.

In accordance with OHA's commitment to work toward an equitable, transformative healthcare delivery system that addresses social factors impacting members' health status, Component 2 is intended to measure the percentage of CCO members screened and, as appropriate, referred for services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

In MY 2025 through 2026, CCOs will report on an OHA-identified sample of members who met continuous enrollment criteria. The sample size will be 1,067 members for each CCO.[1] The sample will be designed to ensure that children and adults are included in roughly the same proportions as in the overall CCO membership; for example, if children compose 40% of that CCO's membership and the sample is 1067, then the sample would include 427 children.

Appendix 1 Template for Component 2 reporting provides additional information on how and what to report for component 2. For MY2025, the CCO must complete data collection for at least 90% of the sample (the completeness threshold). The CCO must gather and provide screening and referral information in the sample reporting template provided by OHA (see Appendix 1). This includes confirming if no screening and referrals were made. Fields that are required and have a blank or unknown value will not count towards the completeness threshold. All required fields must be completed in each of the domains to receive credit towards the completeness threshold.

Rate 1: The percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains using an OHA-approved or exempted screening tool at least once during the measurement year; and

Rate 2: Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains.

Note: Performance on Rate 2 is not intended to be benchmarked; rather, it is calculated to understand the prevalence of identified needs in the CCO. In addition, Rate 2 is a necessary step in the process to calculate Rate 3.

Rate 3: Of the sample population with an identified need, those who received at least one referral for each identified need.

Note: Rate 3 measures referrals made, not closed loop referrals.

Screening (intake) period: December 15 of the year prior measurement year, to December 14 of the measurement year.[2]

[1] OHA used a stratified random sample with a 95% confidence level and a three percent margin of error with an assumed a screening rate (rate 1) of 50%. The sample size will allow for preliminary race, ethnicity, language, and disability (REALD) results to be examined.

[2] Note the cutoff date is December 14th so the 15 calendar day referral period can occur by the end of the measurement year. This change ensures that all measurement activities for component 2 will be completed by the end of the measurement year.

Continuous enrollment criteria: Continuously enrolled with the CCO for at least 180 days[3] during the screening period.

Allowable gaps in enrollment: None.

Anchor Date (if applicable): Not applicable.

Denominator – Rate 1: All CCO members who meet continuous enrollment criteria. OHA will provide CCOs with the sampling frame for data collection.

Denominator Exclusions – Rate 1: None.

Denominator Exceptions – Rate 1: Member declines to be screened in all three domains with an OHA -approved or exempted screening tool. If a member declines one or two of the three domains, they will not qualify for a denominator exception. The member will remain in the denominator and must be screened in the domains not declined to meet the numerator criteria.

Numerator – Rate 1: Members who were screened at least once during the screening period for all three required domains using an OHA-approved or exempted screening tool(s).

Denominator – Rate 2: Rate 1 numerator

Denominator Exclusions and Exceptions– Rate 2: None.

Numerator – Rate 2: Members who screened positive for one or more needs in the required domains during screenings for the three domains.

Denominator – Rate 3: Rate 2 numerator

Denominator Exclusions – Rate 3: None.

Denominator Exceptions – Rate 3: Member declines all referrals. If a member does not decline all referrals, they will not qualify for a denominator exception and must receive referrals for all remaining positive social need(s).

Numerator – Rate 3: Members who received a referral within 15 calendar days for each domain in which they screened positive.

See Appendix 1: Template for Component 2 Reporting for data collection specifications and guidance.

[3] The 180 days requirement is a minimum. If a member switched from one CCO to another and had 180 continuous days with both CCOs, this member will qualify for denominator for both CCOs in the same year. If the member is only continuously enrolled with one CCO for 180 days or more, the member only counts once towards the denominator. OHA anticipates that for the vast majority of CCO members, each member will only count once.

Appendix 1: Template for Component 2 Reporting

Based on the sample list of CCO members provided by OHA, CCOs will input data separately for each of members identified. The fields required for each member are outlined in the table below.

The screening can occur at any point during the screening period and the subsequent referral for all positive domains has to be made within 15 calendar days of the screening. This measure does not require screening to occur more frequently than once per measurement year, and CCOs should work to avoid re-traumatization through over-screening. Screening for each domain can occur at separate times, but members must be screened in all three domains during the measurement year to meet the Rate 1 criteria. OHA encourages screening for all three domains at the same time.

The name of the screening tool must be documented in the record; however, OHA does not require that information in the data collection template, just that an OHA-approved or exempted screening tool was used. For the screening to count as complete, the measure does not require a specific score to be documented in the record, only that the result is positive or negative for each screened domain. Positive or negative results should be calculated based on the instructions in the approved or exempted screening tool. If the result is unknown, the screening is considered incomplete.

This measure is member-based and is required once per year, not at all encounters with the member. This measure assesses the most recent screening. A member will only be counted once during the measurement year for the metric. Domains will be assessed discretely for most recent screening since screening for all three domains is not required to occur at the same time. However, screening and referral episodes within a domain cannot be mixed.

A referral must be made for each positive domain to qualify for Rate 3 numerator. Whether the referral was accepted or declined for each positive domain must be documented. A member can choose to decline any or all referrals.

OHA strongly encourages CCOs and participating providers to document the screening and referral in alignment of measure specifications within two business days of when each occurs. At this time, OHA does not have documentation timeframe requirements for this measure. CCOs and providers should follow all applicable state and federal requirements for documentation.

Field	Valid Input Value	Definition	Sample Reporting[4]
Coordinated Care Organization name		Corresponds to Health Analytics reporting CCO Name	OHA
Date loaded	YYYYMMDD	Date OHA pulled the sample data	OHA
Member ID	Member's Medicaid ID		OHA
Member name	Last Name, First Name MI		OHA
Member date of	YYYYMMDD		OHA

[4] For full population reporting, CCOs would be required to report OHA assigned fields for coordinated care organization and member id. All other OHA assigned fields will be removed from the full population template.

birth			
Match flag	Yes, No	This field is to be reported by the CCO and only for hybrid reporting. CCOs must report 'Match Flag' (Yes/No) field for all visits sampled by OHA. 'Yes' – was a member of the CCO for 180 consecutive days or more. 'No' – was not a member of the CCO for 180 or more consecutive days.	CCO, Required (If match flag = no, CCOs do not have to complete the Housing, Food, and Transportation domains.)
Housing Domain			
Screened for housing insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed housing screening with member No – CCO or partner did not complete screening for housing need with member and member did not decline Declined – Member declined the housing screening or declined to finish the housing screening. Unknown – Not known whether member completed or declined housing screening	CCO, Required
Approved or exempted housing screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted housing screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the housing domain. No - Age appropriate and OHA-approved or exempted housing screening tool was not offered to member. The tool was not on OHA-approved screening tool list and the organization did not have an exemption from OHA for use of a different housing screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the housing domain.	CCO, Required if screened for housing insecurity 'Yes' or 'Declined'
Date of housing	YYYYMMDD	Date of housing screening completed or	CCO, Required if

screen		declined	screened for housing insecurity 'Yes' or 'Declined'
Result of housing screening	Positive, Negative, Unknown	Positive – Housing screening completed and indicated housing need. Negative – Housing screening completed and did not indicate housing need. Unknown – Result of housing screening is not known.	CCO, Required if screened for housing insecurity 'Yes'
If positive, received housing referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with housing resources. No – Member did not receive a referral to an organization and/or provider that can assist with housing resources. Declined – Member indicated that they did not want and/or need a referral for housing resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received housing referral.	CCO, Required if result of housing screening 'Positive'
Date housing referral made	YYYYMMDD	Date housing referral made or declined	CCO, Required if received housing referral 'Yes' or 'Declined'
Food Domain			
Screened for food insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed food screening with member No – CCO or partner did not complete screening for food insecurity with member and member did not decline Declined – Member declined the food screening or declined to finish the food screening	CCO, Required

		Unknown – Not known whether member completed or declined food screening	
Approved or exempted food screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted food screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the food domain. No - Age appropriate and OHA-approved or exempted food screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different food screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the food domain.	CCO, Required if screened for food insecurity 'Yes' or 'Declined'
Date of food screen	YYYYMMDD	Date of food screening completed or declined	CCO, Required if screened for food insecurity 'Yes' or 'Declined'
Result of food screening	Positive, Negative, Unknown	Positive – Food screening completed and indicated food need. Negative – Food screening completed and did not indicate food need. Unknown – Result of food screening is not known.	CCO, Required if screened for food insecurity 'Yes'
If positive, received food referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with food resources. No – Member did not receive a referral to an organization and/or provider that can assist with food resources. Declined – Member indicated that they did not want and/or need a referral for food resources. Declined can also be used for members who indicate they are already	CCO, Required

		working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received food referral.	
Date food referral made	YYYYMMDD	Date food referral made or declined	CCO, Required if received food referral 'Yes' or 'Declined'
Transportation Domain			
Screened for transportation needs	Yes, No, Declined, Unknown	Yes – CCO or partner completed transportation screening with member No – CCO or partner did not complete screening for transportation need with member and member did not decline Declined – Member declined the transportation screening or declined to finish the transportation screening Unknown – Not known whether member completed or declined transportation screening	CCO, Required
Approved or exempted transportation screener used	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted transportation screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the transportation domain. No - Age appropriate and OHA-approved or exempted transportation screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different transportation screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA-approved screening tool list in the transportation domain.	CCO, Required if screened for transportation need 'Yes' or 'Declined'
Date of	YYYYMMDD	Date of transportation screening	CCO, Required if

transportation screen		completed or declined	screened for transportation need 'Yes' or 'Declined'
Result of transportation screening	Positive, Negative, Unknown	Positive – Transportation screening completed and indicated transportation need. Negative – Transportation screening completed and did not indicate transportation need. Unknown – Result of transportation screening is not known.	CCO, Required if screened for transportation need 'Yes'
If positive, received transportation referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with transportation resources. No – Member did not receive a referral to an organization and/or provider that can assist with transportation resources. Declined – Member indicated that they did not want and/or need a referral for transportation resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received transportation referral.	CCO, Required if result of transportation need 'Positive'
Date transportation referral made	YYYYMMDD	Date transportation referral made or declined	CCO, Required if received transportation need 'Yes' or 'Declined'

Appendix 2: Social Needs Screening Tools Process

Background

To systematically review and evaluate new screening tools, selection criteria are necessary. In 2021, a subcommittee of the Social Determinants of Health Measurement Workgroup first met to review and recommend screening domains, tools, and questions to be used to receive credit for the Component 2 Rate 1 percent of members screened. This Subcommittee initially developed five criteria to be used by OHA to approve new screening tools.[1]

In Spring 2023, a new Screening Tool Committee was convened to 1) review and provide recommendations to improve the current evaluation criteria and 2) discuss the approval process for CCO submitted tools. Committee members included academic subject matter experts, clinical practice based subject matter experts, community based organization representatives, and one Oregon Health Plan (Medicaid) member. Two members of the 2023 Screening Tool Committee were also members of the original 2021 SDOH Workgroup Subcommittee. The 2023 committee met twice to create recommendations that helped to create this SDOH Screening Tool Form and exemption/approval process.

OHA Approved Screening Tool List

OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list. Having a common screening tool across the CCO population can streamline the process administratively and lead to better coordination of care. The approved SDOH screening tool list contains tools that have housing, food, and/or transportation questions that automatically qualify as acceptable for use for the identified SDOH metric domains. These tools do **not** need to be submitted to OHA for exemption to be used by a CCO, practice, CBO, or other SDOH screening partner.

As new tools are added, OHA will post the tools on the Social Needs Screening Tools website and notify CCOs through the CCO TAG (Technical Advisory Group) Listserv and the technical assistance contractor. To be added to the CCO TAG Listserv, please send an email to Metrics.Questions@odhsoha.oregon.gov.

Approved screening tools are no longer separated by adult and pediatric to prevent potential confusion and over screening within the same household. The screening tools should be used for the population the tool was developed. For example, the Accountable Health Communities (AHC) tool can be given to a child's caretaker on behalf of the child.

Screening Tool Review Process

OHA will review new social needs screening tools annually. Two types of reviews may be conducted through this process: 1) exemption to use the tool for a limited group of providers and community partners and 2) addition to the statewide approved SDOH screening tool list. During the tool review, OHA will only examine the domains relevant to the metric, and only those questions identified for the

metric domain require exemption or approval to meet Component 2 Rate 1 percent of members screened requirements.

The deadline for submitting additional tools for a given measurement year is June 30th of the previous year. For example, the tool submission deadline for MY2025 is June 30th, 2024. If providers and community partners wish to submit a tool - including "home grown" tools, they can do so by submitting the tool to their CCO. The CCO will collect the tools and submit them to OHA through an online form. It is recommended that providers and community partners consult their CCO for guidance on evidence-based and approved tools within the CCO system.[2] OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list.

When submitting new tools, the CCO will need to complete the SDOH Screening Tool Form on behalf of the organization. The form will be available online for submission to OHA. CCOs must include the screening tool in the format that the CCO member receives the tool. If the screening is conducted verbally, OHA requires CCOs to submit any instructions read to the member, the questions asked, and each response option. The information requested in the form is vital to aligning with the measure intent and incomplete submissions will be denied.

Organizational Level Exemption:

Requirements for screening tool exemption at the organizational level:

1. Tool applies to at least one of the following domains:
    a. Both housing insecurity and houselessness
    b. Food insecurity
    c. Transportation needs
2. Cultural competency and understandability by population
    a. At a minimum, a 6th grade reading level or less
3. Trauma-informed language and screening methodology (e.g., timing)
4. Tool provides option for member to decline all relevant domains
5. Tool provides clear indication of positive result for all relevant domains

OHA Approved List Additions:

Below is a list of desired qualifications list for all screening tools. To be added to the OHA approved screening tool list, the tool must meet all organizational level exemption requirements as well at least three of the four items listed below.

1. Useable in medical and non-medical settings
2. Tested for validity and reliability
3. Available in multiple languages
4. Input from community and/or OHP members in the development and use of the screening tool

Appendix 3: Definitions

Culturally Responsive: providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Providers must demonstrate awareness of, and sensitivity to, cultural differences and similarities, and the effect on the member's care.

Community Information Exchange: a network of healthcare and human/social service partners using a technology platform with functions such as a shared resource directory, "closed loop" referrals, reporting, social needs screening, and other features to electronically connect people to social services and supports.

Data Sharing: allows doctors, nurses, pharmacists, case managers, other health and social care providers and members to appropriately access and securely share a person's health and service information electronically improving the speed, quality, safety, and cost of services provided.

Environmental Scan: a process of engaging with relevant stakeholders to gain a thorough and comprehensive understanding of experiences, opportunities, barriers, risk, challenges, and successes to inform future planning.

Empathic Inquiry: relating to patients, from a place of non-judgmental curiosity and understanding. Empathic Inquiry is intended to facilitate collaboration and emotional support for both patients and screeners through the social needs screening process, as well as evoke patient priorities relating to social determinants of health needs for integration into subsequent care planning and delivery processes.

Health Equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

Over-screening: includes processes and practices that purposely or inadvertently lead to members repeated or duplicate completion of social needs screenings in a short time period, commonly due to a lack of data sharing across the member's care providers. Changes in life circumstances, loss of employment, and other factors may indicate the need for additional screening. Frequent screening done in a non-traumatizing, patient centered way that supports autonomy to decline is not over-screening in these circumstances.

Screening Tools: assessment questionnaires, either in electronic or paper formats, for identifying individuals' unmet social needs.

Screening Questions: individual questions related to assessing individuals' unmet social needs.

Social needs include things like housing instability, food insecurity, and transportation. *Health*-related social needs make clear that these social needs impact a person's health.

Timely Referral: refers to the reasonable connection of members to available community resources capable of meeting their social needs in a timeframe consistent with the member's expectations and a timeframe that optimizes their overall health and well-being.

Trauma-informed Practices: (1) Realize how trauma affects the experiences and behaviors of the family, groups, organizations, communities, and individuals. (2) Recognize the signs of trauma. These signs may be specific to gender, age, or setting. (3) Respond using language, behaviors, and policies that respect children, adults, and staff members who have experienced traumatic events. (4) Resist re-traumatization. Stressful environments or specific practices can trigger painful memories, interfering with recovery and well-being. Organizations must review and change practices as needed to avoid re-traumatization.

REALD Data: a type of demographic information that stands for race, ethnicity, language, and disability. Additional information and implementation resources are available: https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

Re-traumatization: a person who has experienced previous trauma has heightened vulnerability to further traumatization. They may experience an adverse reaction to services provided that do not recognize and modify practices to account for the past trauma.

Cigarette Smoking Prevalence

Measure Basic Information

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

URL of Specifications:

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

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

Measure Type:

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

Measure Utility:

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

☐ Other. Specify:

Data Source: Electronic Health Records

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

Benchmark: Lower is better for this measure.

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

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

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

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

Changes in Specifications from 2023 to 2024

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

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

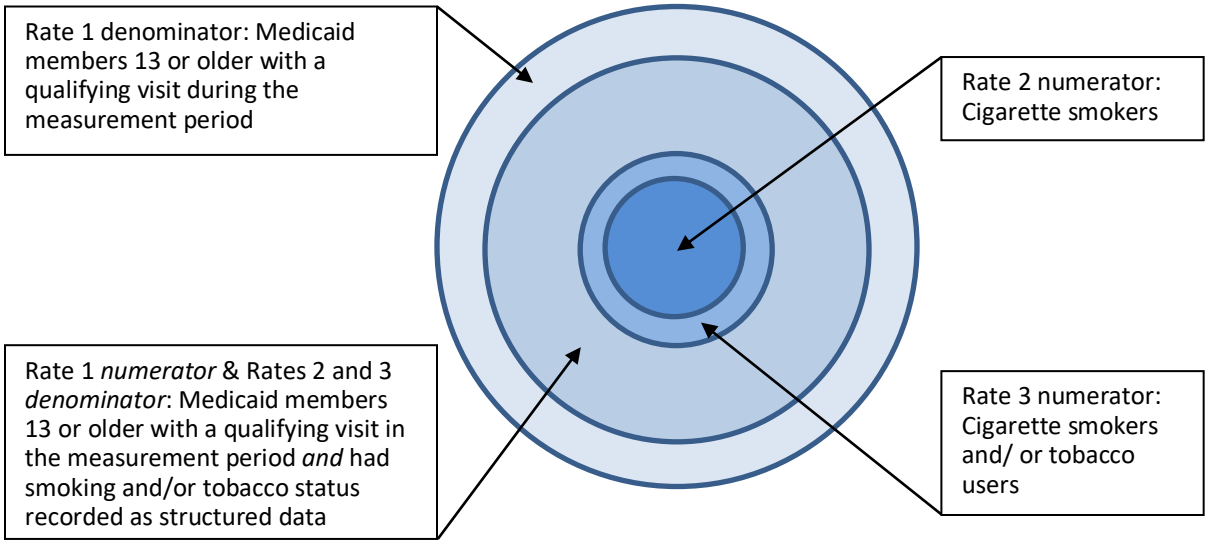
Value Set Name and OID	Status
Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)	Added 4 CPT codes (98980, 98981, 99444, 99457) based on review by technical experts, SMEs, and/or public feedback. Added 3 HCPCS codes (G2250, G2251, G2252) based on review by technical experts, SMEs, and/or public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

Measure Details

Measure Components and Scoring

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

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



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

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

Rate 1:

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

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

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

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

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

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

Rate 2:

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

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

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

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

Numerator Exclusions: See below.

Rate 3:

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

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

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

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

Numerator Exclusions: See below.

Required exclusions for numerator – Rates 2 and 3:

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

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

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

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

Required exclusions for denominator: Patients with:

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

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

What are allowable gaps in enrollment: N/A

Define Anchor Date (if applicable): N/A

Appendix 1: Qualifying Visits (Rate 1 denominator)

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2: Smoking Status and Tobacco Use Status

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

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

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

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

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

For more information:

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

Prenatal and Postpartum Care (NQF 1517)

Measure Basic Information

This specification sheet contains information for both Timeliness of Prenatal Care and Postpartum Care, the two rates associated with the NQF measure Prenatal and Postpartum Care. Prior to 2019, the CCO incentive measure and quality pool payments were only tied to performance on Timeliness of Prenatal Care against benchmarks and improvement targets. Starting in 2019, the Metrics and Scoring Committee decided to change and use the Postpartum Care rate performance against the benchmark for incentive measure purposes. However, CCOs are still required to report on both parts of the measure for the Quality Incentive Program.

Name and date of specifications used: OHA follows HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: This measure is selected in the CMS Medicaid Adult Core Set, as well as the CHIP Medicaid Child Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html

Measure Type:

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive (Postpartum) ■CMS Adult Core Set (age 21 and older) ■CMS Child Core Set (age under 21) ☐Other Specify:

Data Source: MMIS/DSSURS, medical records

Measurement Period: The measure looks for live births with estimated delivery date (EDD) October 8, 2023 - October 7, 2024.

PPC_Post	2022	2023^	2024^
Benchmark for OHA measurement year	80.9%	84.2%	85.9%
Improvement target for OHA measurement year	MN method with no floor	MN method with 3 percentage point floor	MN method with 3 percentage point floor
Source:	MY2019 national Medicaid 75th percentile (hybrid)	MY2021 national Medicaid 90th percentile (hybrid)	MY2022 CCO 90th percentile (hybrid)

^This measure is selected for the Challenge Pool.

Note on telehealth: This measure is telehealth eligible for both prenatal and postpartum care, as long as the required service components are identified. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Measure changes in specifications from MY2023 to MY2024:

- Updated the event/diagnosis criteria to clarify which delivery is counted when there are multiple deliveries.
- Administrative specification revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Administrative specification added a laboratory claim exclusion to value sets for which laboratory claims should not be used.

OHA continues to adopt the full HEDIS hybrid specifications for MY2024/CMS Core Set measurement years. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMR/EHR), registries or claims systems.

1) If using administrative data to identify numerator compliance, CCOs must follow HEDIS MY2024/CMS Core Set specifications for allowable codes and measure logic.
2) If using medical record data to identify numerator compliance, CCOs must follow HEDIS MY2024/ CMS Core Set specifications to conduct the chart review.

See the annual chart review guidance document for additional information on allowable data sources. OHA will provide sampling frames and updated guidance to CCOs on the hybrid methodology for 2024 in fall 2024. Guidance will be posted online at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Denied claims: Included ■ Not included ☐

Member type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

For legislative reporting purposes, HOP and BHP members are still included in the random sampling and the CCOs are required to perform hybrid reporting when HOP or BHP members are sampled.

Measure Details

Definitions:

First trimester	280–176 days prior to delivery (or EDD).

Data elements required denominator: All live birth deliveries with estimated delivery date (EDD) in the 'intake period': between October 8 of the year prior to the measurement year, and October 7 of the measurement year, and the members of the organization who meet the continuous enrollment criteria.

For adopting the HEDIS hybrid method, OHA identifies the live birth deliveries from administrative data and provide CCOs with a random sample delivery list for the chart review. CCOs should perform hybrid record review for all cases in the sample, for both prenatal and postpartum measures.

OHA follows the HEDIS method to identify deliveries:

Step1: Identify deliveries. Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

> Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

Step2: Remove non-live births using Non-live Births Value Set.

Step3: Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Step4: Remove multiple deliveries in a 180-day period. If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

> Note: The denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the denominator.

OHA note: Step 4 of the logic is new to HEDIS starting MY2024, but OHA had implemented a similar 180-day rule in the past to address the issue when a 'single pregnancy and delivery' could result in multiple delivery dates that are close together. OHA is following the new rules prescribed by NCQA starting MY2024 and the only difference is that OHA used to use the latest delivery service date for multiple delivery dates within 180 days, whereas HEDIS MY2024 specifies using the earliest eligible delivery date.

In the hybrid review data submission, OHA also allows CCOs to report the original EDD from the prenatal care providers' perspective, which would help address early or late delivery issues. When a different EDD is reported by the CCO, the eligible window for timely prenatal care is recalculated. If the CCO self-reported EDD is outside of the intake period, the case is excluded.

Note OHA only includes CCO-paid live birth deliveries when sampling, therefore Fee-for-Service paid deliveries such as approved out-of-hospital births are not included in the CCO sample frame.

Required exclusions for denominator:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

OHA also allows CCOs to report 'no confirmed live birth' in the data submission and excludes the cases accordingly.

Deviations from cited specifications for denominator:
See sections above that OHA allows CCOs to self-report EDD and no confirmed birth.

Continuous enrollment criteria:
43 days prior to the Estimated Date of Delivery (EDD) through 60 days after EDD.

Allowable gaps in enrollment: None.

Anchor Date: Enrolled on the Estimated Date of Delivery (EDD).

Timeliness of Prenatal Care Numerator:

Administrative method – A prenatal visit within the eligible time window including required service components. See HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2) or CMS Adult/Child Core Set manual for details.

Hybrid Medical Record Review – Prenatal care services:
A prenatal visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Do not count visits that occur on the date of delivery.

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following:

- Documentation indicating the member is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of last menstrual period (LMP), EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Ultrasound of a pregnant uterus.

Eligible window for timely first prenatal visit:

For members continuously enrolled during the first trimester (176-280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.

For members who were not continuously enrolled in the first trimester:

- For members who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
- For members who were not enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment. Note the qualifying period begins at the start of the first trimester, 280 days prior to delivery.

Postpartum Care Numerator:

Administrative method – A postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery. See HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2) or CMS Adult/Child Core Set manual for details.

Hybrid Medical Record Review – Postpartum Care:
Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following:

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," "6-week check."
  - A preprinted "Postpartum Care" form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for members with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Eligible window for postpartum care visit:

On or between 7 and 84 days after delivery.

Notes:

- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *HEDIS allows using EDD for identifying the first trimester for timeliness of prenatal care, and the delivery date for the postpartum care. OHA allows CCOs to confirm live births and submit different dates for EDD and the date of delivery. When different EDD or delivery date is report by the CCO, the original claims-based EDD is not used.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to HEDIS Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.*
- *For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Screening for Depression and Follow-Up Plan (CMS 2v13)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2024.

URL of Specifications: https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13

Measure Type:

☐ HEDIS ☐ PQI ☐ Survey ■ Other. Specify: eCQM

Measure Utility:

■ CCO Incentive ■ State Quality ■ CMS Adult Core Set ■ CMS Child Core Set
☐ Other. Specify:

Data Source: Electronic Health Records

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

Benchmark:

	2022	2023	2024
Benchmark for OHA measurement year	64.6%	61.0%	68.2%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 2 percentage point floor
Source	MY 2019 CCO 75th percentile	MY 2021 CCO 90th percentile	MY 2022 CCO 90th percentile

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

Note on telehealth: CMS 2024 telehealth guidance states that this electronic clinical quality measure is telehealth eligible. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in Specifications from 2023 to 2024: This summary is provided to help highlight changes. For a complete list, see the Technical Release Notes:
https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13?sort_order=2023vs2024

- Removed depression diagnosis exclusion based on recommendations from clinical experts.
- Updated language from 'Patient refuses to participate' to 'Patient refuses to participate in or complete the depression screening' to clarify that the patient refusal exception is limited to refusal of the depression screening.
- Changed the definition name from 'History of Bipolar or Depression Diagnosis Before Qualifying Encounter' to 'History of Bipolar Diagnosis Before Qualifying Encounter' and revised the logic to remove a prior depression diagnosis from exclusion criteria based on recommendations from clinical experts.
- Updated the timing precision in the 'Most Recent Adult Depression Screening Positive and Follow Up Provided' and 'Most Recent Adolescent Depression Screening Positive and Follow Up Provided' definitions to include that the authorDatetime of the follow-up intervention for a positive depression screen is 2 days or less on or after day of end of QualifyingEncounter to align with the measure intent that follow-up is documented during or up to 2 days after the qualifying encounter.
- Updated the names of CQL definitions, functions, and/or aliases for clarification and to align with the CQL Style Guide.
- Added 'during the measurement period' to the 'Most Recent Adolescent Depression Screening Positive and Follow Up Provided' and 'Most Recent Adult Depression Screening Positive and Follow Up Provided' definitions to ensure that data collection of the follow-up plan occurs during the measurement period.

Value Set Name and OID	**Status**
Value set Adolescent Depression Medications (2.16.840.1.113883.3.526.3.1567)	Added 5 RxNorm codes (903873, 903879, 903884, 903887, 903891) based on review by technical experts, SMEs, and/or public feedback. Added 2 RxNorm codes (2591786, 2605950) based on terminology update.
Value set Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)	Added 4 RxNorm codes (2591786, 2605950, 2605719, 2611260) based on terminology update. Deleted 2 RxNorm codes (1293413, 1945212) based on review by technical experts, SMEs, and/or public feedback.
Value set Bipolar Diagnosis (2.16.840.1.113883.3.600.450)	Replaced value set Bipolar Diagnosis (2.16.840.1.113883.3.600.450) with value set Bipolar Disorder (2.16.840.1.113883.3.67.1.101.1.128) based on applicability of value set and/or OID.
Value set Depression Diagnosis (2.16.840.1.113883.3.600.145)	Removed value set Depression Diagnosis (2.16.840.1.113883.3.600.145) based on review by technical experts, SMEs, and/or public feedback.
Value set Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916)	Added 12 CPT codes based on review by technical experts, SMEs, and/or public feedback. Deleted 12 CPT codes based on terminology update. Added 2 HCPCS codes (G0270, G0271) based on review by technical experts, SMEs, and/or public feedback.
Value set Patient Declined (2.16.840.1.113883.3.526.3.1582)	Replaced value set Patient Declined (2.16.840.1.113883.3.526.3.1582) with direct reference code SNOMED CT code (720834000) based on applicability of a single code to represent clinical data.

Value set Payer (2.16.840.1.114222.4.11.3591)	Added 5 SOP codes (1111, 1112, 142, 344, 141) based on review by technical experts, SMEs, and/or public feedback.
Value set Referral for Adolescent Depression (2.16.840.1.113883.3.526.3.1570)	Added 2 SNOMED CT codes (1186918003, 1186920000) based on terminology update. Deleted 2 SNOMED CT codes (306137002, 306294000) based on terminology update.
Value set Referral for Adult Depression (2.16.840.1.113883.3.526.3.1571)	Added 2 SNOMED CT codes (1186918003, 1186920000) based on terminology update. Deleted 2 SNOMED CT codes (306137002, 306294000) based on terminology update.

Denied claims: n/a

Measure Details

The detailed measure specifications are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ec/2024/cms002v12. Detailed value set contents are available in the Value Set Authority Center. The following abbreviated information from the specifications is provided for convenience.

Data elements required denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period.

Required exclusions for denominator: Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter

Denominator exceptions:
Patient Reason(s)

- Patient refuses to participate or complete the depression screening

OR

Medical Reason(s)

- Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients 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 tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

Note: See specifications guidance statement for additional information on screening and follow-up

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

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

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

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

Version Control

Diabetes: HbA1c Poor Control (CMS122v12)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2024.

URL of Specifications: https://ecqi.healthit.gov/ecqm/ec/2024/cms0122v12

Measure Type:

☐ HEDIS ☐ PQI ☐ Survey ■ Other. Specify: eCQM

Measure Utility:

■ CCO Incentive ■ State Quality ■ CMS Adult Core Set ☐ CMS Child Core Set
☐ Other. Specify:

Data Source: Electronic Health Records

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

Benchmark:

	2022	2023	2024
Benchmark for OHA measurement year	27.5%	24.8%	21.1%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 2 percentage point floor
Source	MY 2019 Commercial median	MY 2021 Nat. Comm. 75th percentile	MY 2022 CCO 90th percentile

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

Note on telehealth: CMS 2024 telehealth guidance states that this electronic clinical quality measure is telehealth eligible. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in Specifications from 2023 to 2024: This summary is provided to help highlight changes. For a complete list, see the Technical Release Notes:
https://ecqi.healthit.gov/ecqm/ec/2024/cms0122v12#quicktabs-tab-tabs_measure-3

- Changed sequence of denominator exclusions in logic to align with the sequence in the Denominator Exclusions section of the header to improve readability.
- Updated the version number of the Palliative Care Exclusion ECQM Library to v3.0.000.
- Updated the version number of the Hospice Library to v5.0.000.
- Updated the names of CQL definitions, functions, and/or aliases for clarification and to align with the CQL Style Guide.
- Replaced direct reference code 'Encounter with palliative care' with 'Palliative Care Diagnosis' value set in the PalliativeCare.Has Palliative Care in the Measurement Period definition to organize capture of patients receiving palliative care, per standards expert input.
- Added 'day of' specificity to the palliative care expressions for consistency.
- Added 'day of' specificity to hospice expressions for consistency.
- Updated the version number of the Advanced Illness and Frailty Exclusion eCQM Library to v8.0.000.
- Added QDM datatype 'Diagnosis' to the Hospice.'Has Hospice Services' definition referencing a new value set containing SNOMED finding codes to provide an additional approach for identifying patients receiving hospice care.

Value Set name and OID	Status
Value set Acute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1083)	Added 3 CPT codes (99236, 99234, 99235) based on review by technical experts, SMEs, and/or public feedback. Added 1 SNOMED CT code (2876009) based on review by technical experts, SMEs, and/or public feedback.
Value set Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)	Added 47 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback.
Value set Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)	Deleted 54 ICD-9-CM codes based on validity of code during timing of look back period. Deleted 3 SNOMED CT codes (190369008, 237618001, 314771006) based on validity of code during timing of look back period.
Value set (2.16.840.1.113883.3.464.1003.101.12.1010)	Renamed to Emergency Department Evaluation and Management Visit based on recommended value set naming conventions.
Value set Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)	Added 1 ICD-10-CM code (L89.000) based on review by technical experts, SMEs, and/or public feedback.
Value set Frailty Symptom (2.16.840.1.113883.3.464.1003.113.12.1075)	Deleted 4 ICD-10-CM codes (R26.0, R26.1, R41.81, R53.83) based on review by technical experts, SMEs, and/or public feedback. Deleted 17 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback.
Value set HbA1c Laboratory Test (2.16.840.1.113883.3.464.1003.198.12.1013)	Added 2 LOINC codes (17855-8, 96595-4) based on review by technical experts, SMEs, and/or public feedback.
Value set Hospice Care Ambulatory (2.16.840.1.113883.3.526.3.1584)	Deleted 3 SNOMED CT codes (170935008, 170936009, 305911006) based on review by technical experts, SMEs, and/or public feedback.

Value set Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165)	Added value set Hospice Diagnosis (2.16.840.1.113883.3.464.1003.1165) based on review by technical experts, SMEs, and/or public feedback.
Value set Hospice Encounter (2.16.840.1.113883.3.464.1003.1003):	Added 2 SNOMED CT codes (305911006, 385765002) based on review by technical experts, SMEs, and/or public feedback.
Value set Outpatient (2.16.840.1.113883.3.464.1003.101.12.1087)	Added 2 SNOMED CT codes (30346009, 37894004) based on review by technical experts, SMEs, and/or public feedback.
	Replaced direct reference code ICD-10-CM code (Z51.5) with value set Palliative Care Diagnosis (2.16.840.1.113883.3.464.1003.1167) based on change in measure requirements/measure specification.
Value set Palliative Care Intervention (2.16.840.1.113883.3.464.1003.198.12.1135)	Deleted 3 SNOMED CT codes (305686008, 305824005, 441874000) based on review by technical experts, SMEs, and/or public feedback.
Value set Payer (2.16.840.1.114222.4.11.3591)	Added 5 SOP codes (1111, 1112, 142, 344, 141) based on review by technical experts, SMEs, and/or public feedback.

Denied claims: n/a

Measure Details

The detailed measure specifications are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ec/2024/cms0122v12. Detailed value set contents are available in the Value Set Authority Center. The following abbreviated information from the specifications is provided for convenience.

Data elements required denominator: Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period

Required exclusions for denominator:

- Exclude patients who are in hospice care for any part of the measurement period.
- Exclude patients 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period.
- Exclude patients 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
    - Advanced illness with two outpatient encounters during the measurement period or the year prior

- OR advanced illness with one inpatient encounter during the measurement period or the year prior
- OR taking dementia medications during the measurement period or the year prior

- Exclude patients receiving palliative care for any part of the measurement period.

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

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

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

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

Initiation and Engagement of Substance Use Disorder Treatment (NQF 0004)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: This measure is selected in the CMS Medicaid Adult Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive ■CMS Adult Core Set (age 18 and older) ☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1 – December 31, 2024 (Intake period: November 15, 2023 – November 14, 2024)

Benchmark for OHA measurement year	2022	2023	2024
IET Initiation - Total - Age 18+	43.0%	43.3%	48.6%
IET Engagement - Total - Age 18+	13.9%	16.3%	18.1%
Improvement target for OHA measurement year	MN method with no floor; must meet both initiation and engagement components for age 18+ to achieve measure	MN method with 1 percentage point floor; must meet both initiation and engagement components for age 18+ to achieve measure	MN method with 2 percentage point floor; must meet both initiation and engagement components for age 18+ to achieve measure
Source:	MY2019 national Medicaid median	MY2021 CCO 90th percentile	MY2021 national Medicaid 75th percentile

Note on telehealth: This measure is telehealth eligible. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specifications from MY2023 to MY2024:

- Added Step 5 'deduplicate eligible episodes' in the denominator logic.

- Removed three value sets: Community Mental Health Center POS, Observation, Partial Hospitalization POS.
- Added Substance Abuse Counseling and Surveillance Value Set.

Member type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

IET	Only use claims from matching CCO that a member is enrolled with	Denied claims included
Denominator event	Y	Y
Numerator event	N	Y

Measure Details

Definitions

Intake Period	November 15 of the year prior to the measurement year–November 14 of the measurement year. The Intake Period is used to capture new SUD episodes.
SUD Episode	An encounter during the Intake Period with a diagnosis of SUD. *For visits that result in an inpatient stay*, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD Episode Date	The date of service for an encounter during the intake period with a diagnosis of SUD. For a visit (not resulting in an inpatient stay), *the SUD episode date is the date of service*. For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, *the SUD episode date is the date of discharge*. For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, *the SUD episode date is the date of service*. For direct transfers, *the SUD episode date is the discharge date from the last admission* (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all

	relevant events (the SUD episode date, negative diagnosis history and numerator events).
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

Data elements required denominator: Members 13 years and older as of the SUD Episode Date who have medical, pharmacy and chemical dependency (inpatient and outpatient) benefits (i.e. CCO-A and CCO-B members). Note, members in hospice are excluded from the eligible population.

Report two **age stratifications** and the total rate:

- 13–17 years
- **18+ years***
- Total
  The total is the sum of age stratifications.

Report the following SUD **diagnosis cohorts** for each age stratification and the total rate:

- Alcohol use disorder
- Opioid use disorder
- Other substance use disorder
- **Total***
  The total is the sum of the SUD diagnosis cohort stratifications.

***Note, only the adult 18 and above age groups and its 'cohort total' rate is incentivized.** Starting 2022 CCOs must meet benchmark or improvement target for both Initiation and Engagement for ages 18+ to achieve measure.

The new episode of SUD during the Intake Period: Follow the steps below to identify the denominator for both Initiation and Engagement rates:

Step 1 Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence

Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set; Substance Abuse Counseling and Surveillance Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A withdrawal management event (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

Step 2 Test for negative SUD diagnosis history. Remove SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a withdrawal management event (Detoxification Value Set) ***with*** a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD episode date.

If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history.

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD episode), use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

For direct transfers, use the first admission date to determine the negative SUD diagnosis history.

Step 3 Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date:

- An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List).
- An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Step 4 Remove SUD episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps.

Step 5 Deduplicate eligible episodes. If a member has more than one eligible episode on the same day, include only one eligible episode. For example, if a member has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed remain in the denominator.*

Step 6 Identify the SUD diagnosis cohort for each SUD episode.

- If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort.
- If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort.
- If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other substance use disorder cohort.

Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusions for denominator:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Deviations from cited specifications for denominator: None.
Note: HEDIS MY2024 specifications include three age groups for the measure: age 13-17, 18-64, 65+. OHA will continue to report a combined result for all age 18+ (age 18-64 and 65+) for the incentive program. Additional age stratification is within the HEDIS Allowable Adjustment rules.

Continuous enrollment criteria: Member must be continuously enrolled from 194 days prior to the SUD Episode Date through 47 days after the SUD Episode Date (242 total days).

Allowable gaps in enrollment: None.

Anchor Date (if applicable): None.

Data elements required numerator:

Initiation of SUD Treatment within 14 days of the SUD Episode Date: Follow the steps below to identify numerator compliance.

Step 1 *If the SUD Episode was an inpatient discharge*, the inpatient stay is considered initiation of treatment and the SUD Episode is compliant.

Step 2 *If the SUD episode was an opioid treatment service that bills monthly* (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

Step 3 For remaining SUD episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD episode date or during the 13 days after the SUD episode date (14 total days).

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set; Substance Abuse Counseling and Surveillance Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

Remove the member from the denominator for both indicators *(*Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment: Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1 Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2 Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3 Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD episode is compliant. Any of the following meet criteria:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List) or a medication administration event (Naltrexone Injection Value Set).

- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

Step 4 For remaining SUD episodes, identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) POS code 52 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set; Substance Abuse Counseling and Surveillance Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set).

Engagement medication treatment events

Either of the following meets criteria for a medication treatment event:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List

Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List

Note: *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

Note HEDIS NDC lists for the medications are available at:
https://www.ncqa.org/hedis/measures/

Childhood Immunization Status

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2). The measure Combo 2 was incentivized in the CCO quality measure program from measurement year 2016 to 2021 but Combo 2 is retired by HEDIS starting MY2022, therefore the CCO incentive program is switching to use Combo 3 starting measurement year 2022.

URL of Specifications: This measure is selected in the CMS CHIP and Medicaid Child Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html

Measure Type:

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive (Combo 3) ☐CMS Adult Core Set ■CMS Child Core Set ☐Other Specify:

Data Source:
MMIS/DSSURS and Public Health Division Immunization Program Registry (ALERT IIS)

See the ALERT IIS Data Use Cases document posted online for additional information about immunization data. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

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

CIS Combo 3	2022	2023	2024
Benchmark for OHA measurement year	71.1%	67.9%	67.9%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 1.5 percentage point floor
Source:	MY2019 national Medicaid median	MY2020 national Medicaid median	MY2020 national Medicaid median

Note on telehealth: This measure is not telehealth eligible.

Changes in specifications from MY2023 to MY2024:

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Expanded the age criteria in the Rules for Allowable Adjustments of HEDIS.
- Six value sets (Disorders of the Immune System, HIV, HIV Type 2, Intussusception, Malignant Neoplasm of Lymphatic Tissue, Severe Combined Immunodeficiency) used in the denominator exclusion logic are combined into a new Contraindications to Childhood Vaccines Value Set.

- Deleted Rotavirus (2 Dose Schedule) Immunization Value Set. Only one CVX code 119 qualifies for the Rotavirus (2 dose) vaccination using ALERT IIS data.

Member type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

- Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Measure Details

Data elements required denominator:
Children who turn 2 years of age during the measurement year.

Required exclusions denominator:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members who had a contraindication to a childhood vaccine (Contraindications to Childhood Vaccines Value Set) on or before their second birthday. Do not include laboratory claims (claims with POS code 81).

Deviations from cited specifications denominator: None.

Continuous enrollment criteria: 365 days prior to the child's 2nd birthday.

Allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the 365 days prior to the child's 2nd birthday.

Anchor Date (if applicable): Enrolled on the child's 2nd birthday.

Data elements required numerator:

Note * below: The Combo 3 rate for the CCO incentive program includes DTap, IPV, MMR, HiB, HepB, VZV, PCV. (HepA, RV and Influenzas are not a part of the incentivized Combo 3 but OHA reports the results for the CMS Medicaid Child Core Set.)

DTaP* Any of the following on or before the child's second birthday meet criteria:

- At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.

- Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).
- Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).

IPV* Either of the following on or before the child's second birthday meets criteria

- At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).

MMR* Either of the following meets criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following anytime on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS code 81).
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).
- Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday

HiB* Either of the following on or before the child's second birthday meets criteria:

- At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Hepatitis B* Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.

- History of hepatitis B illness (Hepatitis B Value Set). Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the Hepatitis B vaccine (SNOMED CT code 428321000124101).

VZV* Any of the following meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday.

Pneumococcal conjugate* Either of the following on or before the child's second birthday meet criteria:

- At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal conjugate vaccine (SNOMED CT code 471141000124102).

Hepatitis A Any of the following meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

Rotavirus Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103).

Influenza Either of the following meets criteria:

- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 180 days after birth.
  - An influenza vaccination recommended for children 2 years and older (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the child's second birthday.

Combination rates Calculate the following rates for Combinations 3, 7 and 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

(See HEDIS MY2024 specifications or CMS Medicaid Child Core Set manual for detail codes in the Value Set.)

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

Note for Anaphylaxis information submission:

The measure recognizes anaphylaxis reactions for numerator hits. However, the records can only be verified by SNOMED CT codes available in EHR, which is not available for OHA's regular calculation using administrative claims and immunization registry (ALERT IIS) data.

OHA accepts CCOs' submission of EHR records with qualifying SNOMED-CT codes indicating anaphylaxis to a vaccine, but the submission is only allowed during the measurement year final validation period in the month of May, and ONLY for those CCOs that do not pass the metric in OHA's preliminary result published in April, but could pass the metric with the supplemental anaphylaxis information incorporated.

The anaphylaxis data submission template (used for both the Childhood and the Adolescent immunization measures) is available on the CCO Metrics website, and includes a code reference table along with more detailed instructions: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

A CCOs must first alert OHA of their intent to submit the anaphylaxis information by emailing metrics.questions@odhsoha.oregon.gov. OHA staff will then initiate a secure email for the CCO to attach the template and the verification documents.

The date for which the data source (EHR) documented the anaphylactic reactions should be reported; OHA will examine the date to determine whether it is within the required time window to qualify for a numerator hit. For example, an anaphylactic reaction for DTaP must be documented in the EHR on or before the member's 2nd birthday.

In addition to filling out the template, the CCO must also provide evidence for each case. The following documents are permitted as the primary sources of verification:

- *A screenshot of the EHR record showing the SNOMED-CT code and documentation date, or*
- *A copy of the clinical report or clinical summary from the visit for service.*

Immunizations for Adolescents (NQF 1407)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: This measure is selected in the CMS CHIP and Medicaid Child Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html

Measure Type:

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive (Combo 2) ☐CMS Adult Core Set ■CMS Child Core Set ☐Other Specify:

Data Source:
MMIS/DSSURS and Public Health Division Immunization Program Registry (ALERT IIS)

See the ALERT IIS Data Use Cases document posted online for additional information about immunization data. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

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

IMA Combo 2	2022	2023	2024
Benchmark for OHA measurement year	36.9%	36.9%	36.9%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 1.5 percentage point floor
Source:	MY2019 national Medicaid median	MY2019 national Medicaid median	MY2019 national Medicaid median

Note on telehealth: This measure is not telehealth eligible.

Changes in specifications from MY2023 to MY2024:

- Removed Tdap Immunization Value Set. Only one CVX code 115 qualifies for the Tdap vaccination using ALERT IIS data.
- Expanded the age criteria in the Rules for Allowable Adjustments of HEDIS.

Member type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

- Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Measure Details

Data elements required denominator:

Adolescents who turn 13 years of age during the measurement year.

Required exclusions for denominator:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Deviations from cited specifications for denominator: None. Note OHA no longer deviates from HEDIS by excluding deceased individuals.

Continuous enrollment criteria: 365 days prior to the adolescent's 13th birthday.

Allowable gaps in enrollment: No more than one gap in enrollment of up to 45 days during the 365 days prior to the adolescent's 13th birthday.

Anchor Date (if applicable): Enrolled on the adolescent's 13th birthday.

Data elements required numerator:

Meningococcal serogroups A, C, W, Y Either of the following meets criteria:

- At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the member's 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday.

Tdap Any of the following meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; Tdap Vaccine Procedure Value Set), with a date of service on or between the member's 10th and 13th birthdays.
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday.
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday.

HPV Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

Combination 1 (Meningococcal, Tdap)	Adolescents who are numerator compliant for both the meningococcal and Tdap indicators.
Combination 2* (Meningococcal, Tdap, HPV)	Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

(See HEDIS MY2024 specifications or CMS Medicaid Child Core Set manual for detail codes in the Value Set.)

Note*: Combo 2 rate is incentivized.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

Note for Anaphylaxis information submission:

The measure recognizes anaphylaxis reactions for numerator hits. However, the records can only be verified by SNOMED CT codes available in EHR, which is not available for OHA's regular calculation using administrative claims and immunization registry (ALERT IIS) data.

OHA accepts CCOs' submission of EHR records with qualifying SNOMED-CT codes indicating anaphylaxis to a vaccine, but the submission is only allowed during the measurement year final validation period in the month of May, and ONLY for those CCOs that do not pass the metric in OHA's preliminary result published in April, but could pass the metric with the supplemental anaphylaxis information incorporated.

The anaphylaxis data submission template (used for both the Childhood and the Adolescent immunization measures) is available on the CCO Metrics website, and includes a code reference table along with more detailed instructions: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

A CCOs must first alert OHA of their intent to submit the anaphylaxis information by emailing metrics.questions@odhsoha.oregon.gov. OHA staff will then initiate a secure email for the CCO to attach the template and the verification documents.

The supplemental anaphylaxis information submission is effective starting with MY2022 final validation (in May of 2023).

The date for which the data source (EHR) documented the anaphylactic reactions should be reported; OHA will examine the date to determine whether it is within the required time window to qualify for a numerator hit. For

example, an anaphylactic reaction for HPV must be documented in the EHR on or before the member's 13th birthday.

In addition to filling out the template, the CCO must also provide evidence for each case. The following documents are permitted as the primary sources of verification:

- *A screenshot of the EHR record showing the SNOMED-CT code and documentation date, or*
- *A copy of the clinical report or clinical summary from the visit for service.*

Child and Adolescent Well-Care Visits (WCV)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2024 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: This measure is selected in the CMS CHIP and Medicaid Child Core Set; the detail manual and Value Set Dictionary can be found on the CMS resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html

Measure Type:

■HEDIS ☐Survey ☐Other Specify:

Measure Utility:

■CCO Incentive ☐CMS Adult Core Set ■CMS Child Core Set ☐Other Specify:

Note: WCV measure sub-age range 3-6, formerly known as the 'Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)' is incentivized in the CCO metrics program starting measurement year 2020.

Data Source: MMIS/DSSURS

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

WCV_Age3-6*	2022^	2023^	2024^
Benchmark for OHA measurement year	64.1%	68.6%	70.2%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 2 percentage point floor
Source:	MY2020 CCO 75th percentile	MY2019 CCO average	MY 2022 CCO 90th percentile

^This measure is selected for the Challenge Pool.

Note on telehealth: 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.

Changes in specifications from MY2023 to MY2024:

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Replaced Well-Care Value Set with Well Care Visit Value Set and Encounter for Well Care Value Set.

Member type: ■CCOA ■CCOB ☐CCOE ☐CCOF ☐CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

WCV	Claim from matching CCO	Denied claims included
Numerator event	Y	Y

Measure Details

Data elements required denominator: Members age 3-21 years as of December 31 of the measurement year. Report four age stratifications and total rate:

- *3-6 Years
- 7-11 Years
- 12-17 Years
- 18-21 Years
- Total

* WCV measure sub-age range 3-6, formerly known as the 'Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) measure' is incentivized in the CCO metrics program starting measurement year 2020. The original HEDIS WCV measure requires reporting three age stratifications: 3-11, 12-17 and 18-21. OHA further stratify the first group to age 3-6 and 7-11 so the incentivized measure age range (3-6) can still be reported separately. Additional age stratification is within the HEDIS Allowable Adjustment rules.

Required exclusions for denominator:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Deviations from cited specifications for denominator: None.

Continuous enrollment criteria: The measurement year.

Allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Anchor Date (if applicable): Enrolled on December 31 of the measurement year.

Data elements required numerator: One or more well-care visits[1] during the measurement year. Either of the following meet criteria:

[1] Note, this measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health).

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

To identify PCPs and OB/GYNs, OHA adopts the Oregon Primary Care Primary Care Provider Types and Specialties list established by Health Systems Division (HSD) with the addition of Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Indian Health Clinics (IHC). This method is approved by NCQA.

Qualifying HSD codes below and can be identified from either the Billing or the Performing Provider. For outpatient and outpatient crossover claims, the Attending Provider is used as a substitution when the Performing Provider information is missing.

HSD Provider type/specialty codes qualify for PCP or OB/GYN:

PROV_TYPE	PROV_SPEC	CDE_PROV_TYPE	CDE_PROV_SPEC
Physician	Adolescent Medicine	34	222
Physician	Clinic	34	238
Physician	Family Practitioner	34	249
Physician	General Practitioner	34	252
Physician	Geriatric Practitioner	34	251
Physician	Gynecology	34	253
Physician	Internist	34	262
Physician	Obstetrics	34	275
Physician	Obstetrics & Gynecology	34	276
Physician	Osteopathic Physician	34	244
Physician	Pediatrics	34	283
Physician	Preventive Medicine	34	296
Physician	Public Health	34	286
Clinic		47	Any
Physician Assistants	Physician Assistants	46	395
Midwife		41	Any
Naturopath		38	Any
Advance Practice Nurse	Advance Practice Nurse	42	360
Advance Practice Nurse	Certified Nurse Midwife	42	367
Advance Practice Nurse	Family Nurse Practitioner	42	364
Advance Practice Nurse	Nurse Practitioner	42	366
Advance Practice Nurse	Nurse Practitioner Clinic	42	361
Advance Practice Nurse	Obstetric Nurse Practitioner	42	363

Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx).

Advance Practice Nurse	Pediatric Nurse Practitioner	42	362
Family Planning Clinic		22	Any
Pharmacist	Pharmacist Clinician	50	109
FQHC		15	Any
Indian Health Clinics		28	Any
Rural Health Clinic		14	Any
Physician	Physician (Default Spec)	34	231

HSD List: https://www.oregon.gov/oha/HSD/OHP/Tools/primary-care-providers-codes.pdf

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

For More Information: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Adults with Diabetes – Oral Evaluation

Measure Basic Information

Name and date of specifications used: Dental Quality Alliance (DQA) *Adults with Diabetes – Oral Evaluation*.

URL of Specifications:
https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_adult_diabetes_oral_evaluation.pdf?rev=7ddeff0f5d8548bb9281ad454b32ec34&hash=7ED06BA92B790BEDE5C8198C681E6DA7

For identifying members with diabetes in DQA's 2024 specifications, it cites HEDIS MY2022 value set and medication list which can be found in the CMS FFY2023 Adult Core Set resource page: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html

Measure Type:
☐HEDIS ☐Survey ■Other Specify: DQA

Measure Utility:
■CCO Incentive ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS

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

DOE	2022	2023	2024
Benchmark for OHA measurement year	20.4%	26.4%	31.9%
Improvement target for OHA measurement year	MN method with no floor	MN method with 1 percentage point floor	MN method with 1 percentage point floor
Source:	MY2020 CCO 75th percentile	MY2021 CCO 90th percentile	MY2019 CCO 90th percentile

Note on telehealth: This measure may be eligible for teledentistry. The intent of the measure is to ensure that members with diabetes had the touchpoint with the dental delivery system and had diagnoses and treatment planning. These activities as documented in the claims data by the dentist/ dental health provider is based on their clinical judgment. If the rendering provider documents a qualifying CDT code (D0120, D0150 or D0180) in the claims form, the visit should be counted in the measure, irrespective if the visit was virtual (Teledentistry) or in person. For further information please see American Dental Association policy on teledentistry.

Changes in specifications from MY2023 to MY2024:

- OHA changed the measure name in this document to *Adults with Diabetes – Oral Evaluation* and the abbreviation to DOE to align with DQA's naming convention.

Member type: ■CCOA ☐CCOB ☐CCOE ☐CCOF ☐CCOG

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

DOE	Only use claims from matching CCO that a member is enrolled with	Denied claims included
Denominator inclusion and exclusion	N[1]	Y
Numerator event	Y	Y

Measure Details

Data elements required denominator:
Unduplicated members age 18 and above as of December 31 of the measurement year with diabetes identified from claim/encounter data or pharmacy data. A member qualifies for the measure denominator if at least one of the following four criteria is met either during the measurement year or the year prior to the measurement year:

Claims/Encounter Data:

Members who met at least one of the following criteria (1, 2, 3, and 4) in either the measurement year or the preceding year:

1. At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

   OR

2. At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
   - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
   - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
   - Identify the discharge date for the stay.

   OR

3. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute

[1] From the two-year period for identifying diabetes members in the denominator, all claims in OHA data warehouse are used regardless of the payer.

inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
- Identify the discharge date for the stay

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

OR

Pharmacy Data:

4. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications List[2]

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	

[2] HEDIS NDC lists are available at: https://www.ncqa.org/hedis/measures/

Description	Prescription		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Required exclusions for denominator:

1. Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year[3]. In other words, this exclusion only applies to members who are identified in denominator solely through diabetes-related pharmacy claims but no medical visits with type I or type II diagnoses.
2. Members in hospice or using hospice services any time during the measurement year. These members are identified using HEDIS MY2022 Hospice Encounter Value Set and Hospice Intervention Value Set, with claims within the measurement year.
3. Members receiving palliative care (HEDIS MY2022 Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
4. Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    a. Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    b. Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year[4].
5. Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
    a. At least one claim/encounter of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
    AND
    b. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

[3] Note this is originally an optional exclusion for the HEDIS Comprehensive Diabetes Care measure, and DQA adopts it as a required denominator exclusion.

[4] The I-SNP exclusion makes use of the Territorial Benefit Query (TBQ) files from CMS to identify the Contract Number and Plan Number of Oregon Medicaid recipients who are dual eligible in Medicare Advantage plans. Dual eligible Medicaid recipients who were enrolled in Medicare Special Needs Plans and institutionalized at any time during the measurement year are excluded.

i. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
    3. Identify the discharge date for the stay.

ii. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

iii. At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.

iv. A dispensed dementia medication (Dementia Medications List).

Dementia Medications List[5]

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Deviations from cited specifications for denominator:

DQA requires exclusion for members who are dual eligible for Medicaid and Medicare, but OHA does not adopt this exclusion. Including dual enrollees is a common practice for all CCO metrics. OHA excludes I-SNP and LTI members to be consistent with other CCO metrics.

Continuous enrollment criteria: The measurement year.

Allowable gaps in enrollment:
No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor Date (if applicable): None[6].

Data elements required numerator:

[5] HEDIS NDC lists are available at: https://www.ncqa.org/hedis/measures/
[6] Note while HEDIS Diabetes-related measures have an anchor date on December 31st of the measurement year; OHA adopts DQA specifications which does not require an anchor date.

Number of unduplicated members in the denominator who received a comprehensive, periodic or periodontal oral evaluation in the measurement year, identified by any of the following CDT codes: D0120, D0150, or D0180.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.