March 20, 2025

CCO Metrics Technical Advisory Group (TAG)

Welcome!

- This meeting is being recorded and the recording will be posted on the CCO TAG webpage
- Housekeeping items
  - Logistical questions: Please use the chat function to message Ashley Walchli
  - Other questions or comments: Please raise your hand
  - Naming convention: Please include your name and your organization name in the participant list
  - Camera convention: If possible, please turn on your camera when you are speaking

Agenda

- Updates
- PERC codes in CCO incentive measures
- SDOH draft 2026 specifications
- Break
- MLA – members with MMIS interpreter flag list, guidance on specific situations, FAQ updates, draft 2026 specifications

OREGON HEALTH AUTHORITY

Updates

Transformation Center technical assistance

Social determinants of health: Social needs screening and referral webinar

Non-medical Transportation: Systems, Barriers and Opportunities

- April 22, 1–2 p.m.
- Audience: CCO staff, community-based organizations
- Register here
- Guest presenters from Oregon Department of Transportation

Contact: Rachel Burdon (Rachel.E.Burdon@oha.oregon.gov)

Metrics & Scoring Committee: 2026 Draft Measure & Benchmark Selection Timeline

March & April	May & June	July	August & September	October
- Pre-measure selection survey - Review Core Set options for adult oral health & diabetes - OHA 2026 measure selection recommendations	- Measure selection survey - Draft 2026 measure selection - Draft 2026 challenge pool selection	- Finalize 2026 measure set - Finalize 2026 challenge pool - OHA benchmark recommendations	- Benchmark selection survey - Draft 2026 benchmark selection	- Finalize 2026 benchmarks

MY2024 Quality Pool Metrics Finalization Process

March 28 – Deadline for claims submission to OHA for inclusion in 2024 results

April 30 – OHA will distribute preliminary CY2024 dashboards via SharePoint

May 21 – CCO questions / validation requests on 2024 metrics due to OHA

Email metrics.questions@odhsoha.oregon.gov

June 20 – Final metrics results distributed to CCOs and quality pool payment amounts disclosed

June 30 – Deadline for CCOs to receive their quality pool funds from OHA

Please see the Metrics Timeline & Due Dates document for more details

MLR and Incentive Payments

CMS Toolkit

- ***Link provider bonus or incentive payments to quality or performance metrics.*** *For a provider bonus or incentive arrangement to be included in the MLR numerator, the payment must require providers to meet clearly defined, objectively measurable, and well-documented clinical or quality improvement standards (42 CFR §438.8(e)(2)(iii)(A)). Contracts should define and link quality or performance metrics that the provider must meet to receive the incentive payment. They should also include a defined performance period tied to the applicable MLR reporting period and specify dollar amounts or a percentage of a verifiable dollar amount that can be linked to the successful completion or achievement of the quality or performance metrics and date of payment (89 FR 41130).*
- ***Establish time periods for payment of provider bonuses or incentives****. States should specify the timeframe within which incentive payments are paid to providers to prevent MCPs from accruing large provider incentives that are paid long after the annual MLR submission and audit. The accruals can be significantly different than the actual amounts paid.*

MLR timing

- CCOs will then be required to submit at the end of the calendar year (either in their Exhibit L Q3 filings or as one page attestation) how much of the incentive payments they have spent as of the time of the attestation.
  - **Is there a preference for 11/30 or 12/31?**

Quality Incentive Program Measure Exclusions

Andy Parker

Metrics Technical Advisory Group
March 20, 2025

Healthier Oregon Overview and Measures

- Healthier Oregon Provides full Oregon Health Plan (OHP) Coverage for Oregon residents who would qualify for Medicaid but for Immigration Status

  https://www.oregon.gov/oha/HSD/OHP/Pages/Healthier-Oregon.aspx

- Healthier Oregon Members include
  - Legacy Cover All Kids (CAK)
  - Legacy Citizenship Waived Medical (CWM) with expanded coverage
- A majority of Healthier Oregon funds are state general funds with a few Emergency services that receive federal match.
  - CCO Non-Medicaid contracts that include Healthier Oregon members currently do not include the quality incentive program
  - HOP members currently are not included in OHA's calculation of metrics for incentive payments
- To help CCOs provide high-quality care, quarterly dashboards will include all members, with identification flags for Healthier Oregon members

OHP Bridge Overview and Measures

- Temporary Medicaid Expansion (TME) provided OHP coverage to adult members whose coverage would have terminated at the end of the COVID Public Emergency due to earnings. Program effective through 6/30/2024. **Included in Quality Incentive Metrics Program in 2023. Excluded from Quality Incentive Metrics Program in 2024 and 2025.**
- OHP Bridge Basic Health Program provides non-Medicaid Federal Funds for OHP coverage to adult members earning between 138% and 200% of FPL. Program effective 7/1/2024. **Excluded from Quality Incentive Metrics Program in 2024 and 2025.**
- OHP Bridge Basic Medicaid provides Medicaid Federal Funds for OHP coverage to adult members in Native American/Alaska Native Race/Ethnicity categories earning between 138% and 200% of FPL. Program effective 7/1/2024. **Included in Quality Incentive Metrics Program from 2024 on.**
- To help CCOs provide high-quality care, quarterly dashboards will include all members, with identification flags for Temporary Medicaid Expansion and OHP Bridge Basic Health Program

Oregon Health Plan Principles

- The baseline expectation is that all enrollees in the Oregon Health Plan whether or not included in Quality Incentive Program measure calculations or how coverage is funded will receive quality coverage and care.

- OHA and CCOs need more time to collaboratively design bonuses for exceptional quality for non-Medicaid OHP populations.

How to Identify HOP Members Using Program Eligibility Resource Codes(PERCs)

- As indicated in TAG Communication from 3/7/2025 a list of PERC codes used to identify members to be excluded from measure calculation is available upon request from OHA
- PERC codes should NOT be used for capitations, payment, identifying the type of coverage a member should receive, or which contract (Medicaid vs Non-Medicaid) someone falls under. It should only be used for this quality incentive measure calculation.
- In Quarterly Dashboard

Field	Description
HOP_FLG	Flag for Healthier Oregon Program members (HOP_FLG = 1 members are excluded for incentive rates)
BHP_FLG	Flag for Basic Health Plan members (BHP_FLG = 1 members are excluded for incentive rates)
INCENT_POP	Flag for member included for the incentive program; INCENT_POP = 1 is based on HOP_FLG = 0 AND BHP_FLG = 0

Identifying HOP and BHP members

- Generally, identification of HOP and BHP members will align with the continuous enrollment period for the measure when the measure denominator includes continuous enrollment criteria
- When a measure does not have a continuous enrollment requirement for denominator inclusion, HOP and BHP exclusion will apply for the entire measurement year.

Identifying HOP and BHP members for specific measures

- DHS Custody – from CCO notification date (Report Date) through 60 days after
- Well Child Visits – Measurement year
- Childhood Immunization Status –12 months through 2nd Birthday
- Immunizations for Adolescents – 12 months through 13th Birthday
- Initiation and Engagement of SUD Treatment (IET) – from 194 days prior to the SUD Episode Date through 47 days after (242 total days)
- Oral Evaluation for Adults with Diabetes (OED) – Measurement year
- Preventive Dental – Measurement year
- Prenatal Postpartum Care - 43 days prior to the Estimated Date of Delivery (EDD) through 60 days after EDD (104 total days)
- Health Equity Meaningful Language Access – Measurement Year

Key Takeaways

- All OHP members, regardless of inclusion in the incentive program, should receive high quality care

- CCOs wanting a list of PERC codes used to exclude members from Quality Incentive Program measure calculations must request the list from OHP

metrics.questions@odhsoha.oregon.gov

Questions?

SDOH Screening and Referral Draft 2026 Specifications

Timeline 2026 Draft Specifications

March 19th: Draft specifications released for public comment

March 20th: CCO TAG presentation on draft

April 16th: Public comment due back to Metrics.Questions@odhsoha.oregon.gov

End of April: Final specifications released

May 22nd: CCO TAG presentation on final

Summary of Changes in 2026 Draft

Component 1: Removed section and reference to two components throughout the measure specifications.

Component 2:

- No longer referred to as component 2 since component 1 has ended.
- Added Rate 4 – Of the sample population with an identified need, those who received at least one closed loop referral for each identified need.
- Added closed loop referral fields to the instructions and data collection template in Appendix 1 Template for Component 2 Reporting.
- Updated community information exchange definition and added closed loop referral definition to Appendix 4 Definitions.

Adding Rate 4 Closed Loop Referral

CCOs, providers, and community based organizations are moving towards Closed Loop Referral adoption for HRSN benefits (food, housing, and climate).

OHA proposes adding closed loop referrals to the SDOH Screening and Referral metric for food, housing, and transportation.

The new fields align with similar fields in the HRSN work.

Definition

Closed Loop Referral: Process of exchanging information between an organization screening for members' social need (food, housing, and/or transportation) to a social service provider to make referrals and communicate about the status of referrals and services for a member.

- The social service provider must notify the referring organization of their acceptance or declination of each social service referred.
- If referral is accepted, social service provider must notify the referring organization that services were provided or that it was determined services could not be provided. This notification completes the Closed Loop Referral process.

Numerator and Denominator

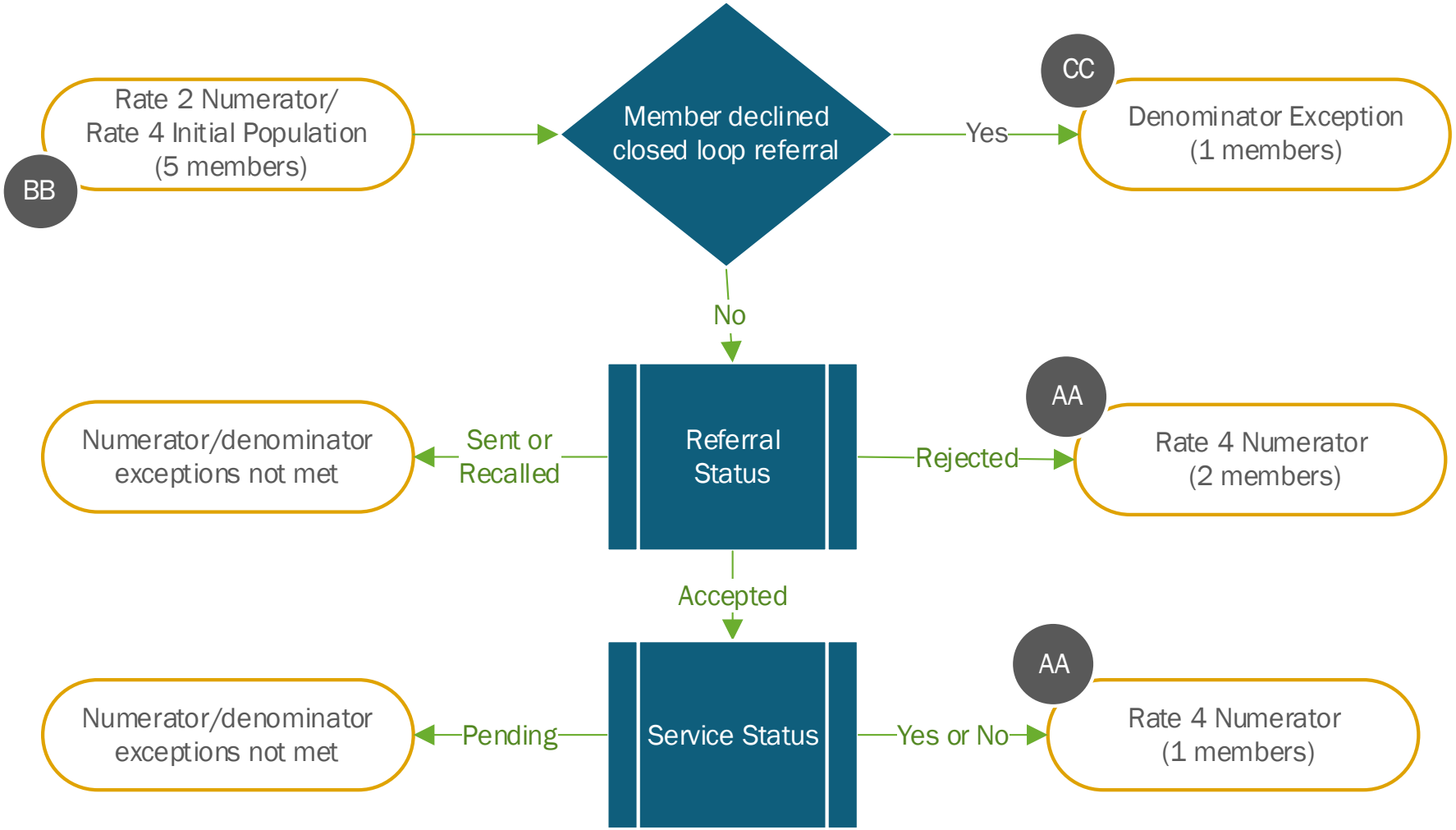
Denominator – Rate 4: Rate 2 numerator

Denominator Exclusions – Rate 4: None.

Denominator Exceptions – Rate 4: Member declines all closed loop referrals. If a member does not decline all closed loop referrals, they will not qualify for a denominator exception and must receive closed loop referral(s) for all remaining positive social need(s).

Numerator – Rate 4: Members who received a closed loop referral within 60 calendar days for each domain in which they screened positive.

Rate 4 Closed Loop Referral Completed



SDOH Rate 4 Closed Loop Referral Completed

Numerator (AA = 2 members + 1 member)/

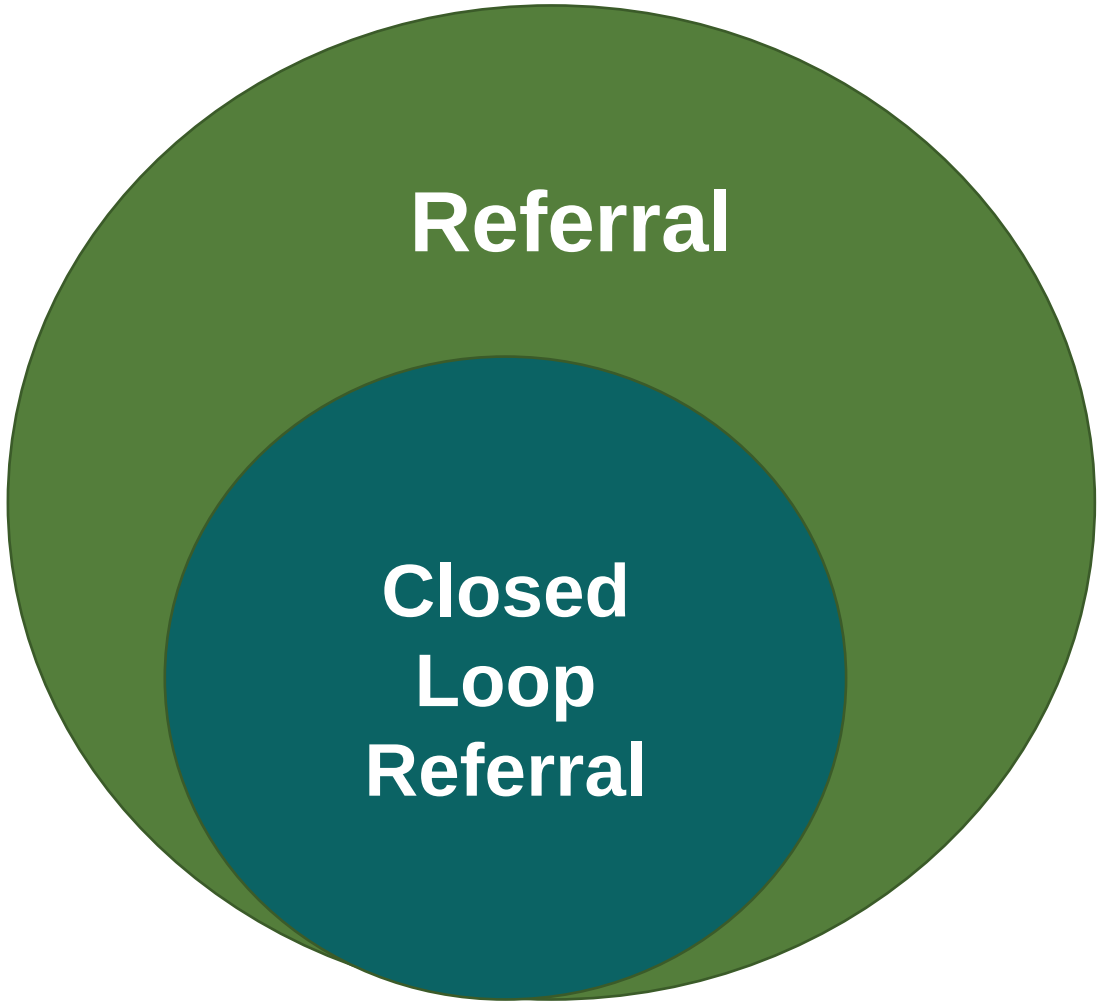
Denominator (BB = 15 members) – Denominator Exceptions (CC = 7 member)

Result: 37.5%

Referral versus Closed Loop Referral

For Rate 3, a referral that meets the referral definition will count even if no closed loop referral is made.

For Rate 4, a closed loop referral occurs when the status is being tracked.



Referral Status

Food Referral Status	Sent Recalled Rejected Accepted	Select the appropriate referral status for food provider as it stands. While only one closed loop referral is needed, multiple closed loop referrals may have been made. For the purposes of the metric, track the closed loop referral with the status in the following hierarchy: Accepted Rejected Recalled Sent For example, if one closed loop referral has a status of recalled and another has a status of accepted, the closed loop referral with the accepted status should be tracked.	CCO, Required if did member decline food closed loop referral 'No'

Service Status

Transportation Service Status	Yes No Pending	Indicate if the transportation service has been rendered by the provider.	CCO, required if transportation referral status 'accepted'

Recommended Glide Path

	2025*	2026	2027	2028
Rate 1 Screening	Report only	Report only	**Benchmark**	**Benchmark**
Rate 2 Screening Result	Report only	Report only	Report only	Report only
Rate 3 Referral	Report only	Report only	**Benchmark**	**Benchmark**
Rate 4 Closed Loop Referral		Report only	Report only	**Benchmark**

*Metrics and Scoring determines report only and when benchmarking begins. For 2025, MSC decided rate 1 through 3 are report only.

Break

Meaningful Language Access

2025 MLA Workgroup Workplan: DRAFT

CCO Technical Advisory Group (TAG)

Every other month on 3rd Thursdays

Topic Schedule

January 23rd – Review of Exceptions and Other Technical Requirements & How to report MMIS equals No flag people (slides and recording)

March 20th – CCO members with MMIS interpreter flag list & Guidance for Specific Situations - Metric Exceptions & FAQ updates & Draft 2026 tech spec timeline

July 24th – Final MLA Metric Technical Specifications 2026

MMIS Interpreter Flag

History of MLA Denominator

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.

MY2024 and MY2025 specified whether visits for the following members were in the eligible population:

Required: MMIS Interpreter Needs Flag is Yes

Optional: MMIS Interpreter Needs Flag is No or Blank and self-identify their interpreter needs to the CCO or the provider.

Quarterly Data Validations & CCO Members with Language Access Needs

The MLA incentive program calculation for MY 2024 and forward uses the *Language Access and Interpreter Services Report* (Ex. B, Pt. 4, Sec. 2, Para. l (2)).

OHA's goal in providing quarterly data validation feedback is to allow for continual quality improvement.

A handful of CCOs have requested the list of CCO members whose MMIS Interpreter Needs Flag is Yes.

MMIS Interpreter Flag List & MY2025 MLA CCO Contract Submissions

OHA will pre-emptively provide the list of CCO members whose MMIS Interpreter Needs Flag is Yes at the end of March.

This list can be used to validate the July 1st submission (Q2 2024 through Q1 2025) data prior to submitting to ensure members with language access needs have visits reported in the data.

OHA will poll CCOs on whether the list was helpful and how it was used. We hope to present the information anonymously at the July CCO TAG meeting.

How the List will be Used

We will use this CCO member list to estimate number of visits for the data validation report for the July 1st Submission (Q2 2024 through Q1 2025).

The data validation for OHA estimated visits remains unchanged at +/- 15% of visits for CCO members with MMIS interpreter flag is Yes.

We are hoping this CCO member list helps CCOs identify ways to improve reporting over time.

CCOs will still have to determine whether a reportable visit occurred for CCO members with MMIS interpreter flag is yes **before** submitting on July 1st.

When MMIS Interpreter Flag is Incorrect

OHA recognizes that CCOs may have verified that a member's MMIS interpreter flag is incorrect but will still be on list we send. Last CCO TAG, we discussed how to verify the MMIS Interpreter Flag.

These individuals should not be passed onto provider networks as needing language access.

In the Meaningful Language Access quarterly reports, CCOs can submit the visits to OHA without interacting with providers and just assign refusal reason 2 'MMIS Flag is Incorrect'.

Beyond MMIS Flag is Yes: Optional Denominator Reporting

Members can also self-identify their interpreter needs to the CCO or the provider, through intake questionnaire at different settings, or self-initiating an interpreter service request. If the CCO attests collecting interpreter needs information in Component 1, survey question 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. 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 (Page 4, MY2024 Technical Specifications).

Why Report Optional Members?

OHA encourages CCOs and affiliated providers to use supplemental sources for identifying members with interpreter needs not captured in MMIS.

This can help increase language access for members who may have been missed during ONE Eligibility Intake or felt uncomfortable disclosing their language preference during the intake process.

Guidance for Specific Situations

Denominator Exclusions

New MY2025 Denominator Exception 5: Member indicates Visits Does Not Need an Interpreter

New for MY2025 Reporting

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
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	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)

Scenario 5: The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits.

Page 38, MY2025 Technical Specifications

Guidance on Determining if Visit Doesn’t Need Language Access – Confirming Patient Preference

Scenario: A patient arrives for a follow-up visit and has previously declined interpreter services.

Guidance Language:

"I remember you mentioned last time that you felt comfortable communicating in English. Can you tell me more about how that’s been working for you during your visits? I want to make sure you feel confident and fully understand everything we discuss today."

Guidance Cont. – Assessing Visit Complexity

Scenario: A patient with limited English proficiency comes for a routine blood pressure check.

Guidance Language:

"Today's visit is focused on checking your blood pressure and discussing any updates. How do you feel about communicating in English for this type of visit? I want to make sure you feel comfortable and supported."

Guidance Cont. – Checking for Written Communication Understanding

Scenario: The patient is asked to review and sign a simple consent form.

Guidance Language:

"We have this consent form available in your preferred language. How do you feel about reading and signing it on your own today? If anything feels unclear, we can bring in an interpreter to go over it with you."

Guidance Cont. – Supporting Patient Self-Advocacy

Scenario: A telehealth visit where the patient has no interpreter present but has previously managed without one.

Guidance Language:

"For today's visit, I see you haven't requested an interpreter. How have you been feeling about managing appointments like this? I want to make sure you feel confident and can get the most out of the conversation."

Upcoming – FAQ & Draft Specifications

Frequently Asked Questions

Updated FAQ will be released tomorrow, March 21st.

This is the update for the 2025 technical specifications.

A larger update will be made mid-year. Please continue to contact us through metrics.questions@odhsoha.oregon.gov

2026 Draft Specifications Timeline

OHA is taking time to be responsive to feedback. Last year, we received feedback from a variety of sources. The 2026 technical specifications are on a slightly delayed timeline as follows:

- **April:** Draft specs released.
- Public comment period will be four weeks.
- **June:** Final specs released.

Correction for MY2024 Specs

- For reporting in language providers who have passed proficiency tests in the Component 2 template, the instruction requires the CCO to attest to tracking language proficiency test information in the Component 1 question **#39** (the existing spec sheet incorrectly referred to #41 and #42 which are new in the MY2025 survey).

Questions?

Thank you.

Next meeting: May 22nd, 1:00 – 3:00pm

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Ashley Walchli at Ashley.m.Walchli@oha.oregon.gov or 503-385-6542 (voice/text). We accept all relay calls.

Health Policy & Analytics Division
Quality Metrics, Surveys & Reporting
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/quality-metrics.aspx

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