2024 Metrics Binder

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2024 CCO Metrics Binder Preamble

These are some of the key features of the 2024 CCO Metrics Binder:

- The Measure Set has been organized and is arranged in sections, based on measure types (IE: eCQM, Alert IIS-based, Claims-based etc.).
- There is a summary of the changes from the 2023 Measure Set compared to the 2024 Measure Set.
- There is a section on "lessons learned" which is comprised of valuable tips that were discovered through communication and collaboration with the provider network. These range from claims workflows & consideration to other strategic reminders.
- Rather than including more than 100 pages of specifications for the CCO-facing measures, a simple summary of these two measures and how providers can be better prepared to address them in the future has been provided.
- The CCO attestation survey for the Language Access measure (pages 8-38) have been trimmed, to keep the binder concise to provider needs.

Quick notes for the CCO Incentive Quality Measure Set for 2024:

- No measures from the 2023 measure set have been retired in 2024.
- There are no new measures in 2024, though the Health Equity Language Access measure (component 2) has moved from CCO facing, to a provider facing measure.
- Plain language summaries of 2024 incentive measures published by OHA been included as an appendix for assisting in understanding the core of each measure.

There was discussion with the provider community on how the measures are developed and that providers have the opportunity to speak to the Metrics & Scoring Committee, to include their own input on the development and scoring of these measures. To that end, this is the URL for the OHA Metrics & Scoring Committee webpage, that includes resources on their processes, as well as a consistently updated calendar that shows their upcoming meetings:

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx

Notable changes from 2023

Changes impacting all or most measures:

- Coverage, Coding & Language (CC&L) updates for many measures.
- 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.

Measures with CC&L changes only:

- Child-and-Adolescent-Well-Care-Visits
- SBIRT
- Members Receiving Preventive Dental or Oral Health Services
- Cigarette Smoking Prevalence
- Diabetes: HbA1c Poor Control
- Initiation and Engagement of Substance Use Disorder Treatment

Depression Screening:

- No longer excludes members with history of depression (still excludes members with a history of any qualifying bi-polar diagnosis)

Immunization (2YO):

- 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.

Immunization (13YO):

- OHA now requires anaphylaxis documentation be submitted to the CCO before the member's 13th birthday.
    - Unlike the 2YO measure, exceptions for recorded anaphylaxis remain the only way to exclude a member other than hospice or death; they have not created a value set for the 13YO immunization measure yet.
- Removed Tdap Immunization Value Set. Only one CVX code 115 qualifies for the Tdap vaccination using ALERT IIS data.

Assessments for Children in DHS Custody:

- Expanded the mental health assessment required age range from 4-17 years old to 3-17 years old, to align with the ODHS policy.

Health Equity Language Access:

- This has become a provider facing measure and providers will be accountable to component 2 of the measure.

Lessons Learned

When UHA is Secondary:

- Even if the primary covers 100% please submit a claim for $0 to UHA.

Immunizations:

- Member must receive all of their age-appropriate immunizations before their birthday.
- Schedule these in advance of their birth month, to allow for rescheduling/no-shows.
- UHA allows for well-child visits to be billed and paid for at 22-23 months, if the prior well-child visit was at 12-13 months. (Useful when a parent wants to cut down on the number of appointments).

Screening Codes VS. Substance Codes:

- Screening for alcohol or drugs and the member indicates they have a drink every now and again, don't diagnose for alcohol use uncomplicated – this will trigger the SUD measures. Some common screening codes are:
- Z13.9 Encounter for screening, unspecified
- Z13.39 Encounter for screening for alcoholism
- Z00.00 Encntr for general adult medical exam w/o abnormal findings
- Z00.01 Encntr for general adult medical exam w abnormal findings

SUD Follow up timelines:

- If you do diagnose someone with one or more SUD codes (alcohol, opioid and/or other substance) the SUD measure will be triggered.
- This means that member is going to need a follow up within 14 days and then another follow-up before 34 days.

A1c Poor Control Measure:

- Test every diabetic patient at least once a year.
- Have their lab results input into the E.H.R. at least twice a year.
- Only the most recent lab result is used for the measure.

Oral Health Evaluations for Diabetic Members:

- Provide the member with direct instruction to go to the dentist.
- Call and schedule the member with Advantage, while they are in your office (Care Coordination Line: 888-237-7778)
- Or send a referral to the Advantage Dental team. (Case Management FAX # 541-516-4356)
- Or send a referral through the Unite-Us platform.

Preventative Dental:

- If you have bandwidth, see about getting certified to perform oral/dental health evals (contact Advantage to coordinate First Tooth training)
- If you have space, see about having an Advantage Dental provider come to your office to perform evaluations for your members (contact Advantage to coordinate)

Cigarette Smoking Prevalence

Overview: CCO incentive EHR based measure.
Measurement period: January 1, 2024 – December 31, 2024
Benchmark: 17.8% *Only the cigarette smoking prevalence rate (Rate 2) will be used for comparison to the benchmark or improvement target.
Target population [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).
Goal: To record the smoking status of all patients, and everyday smokers and/or tobacco users.
Process:

- Record the smoking status of the target population as structured data
- Record the everyday smoking use and/or tobacco use of the members that have met rate 1

Exclusions [Denominator]:

- Members receiving hospice services during measurement year.

Exclusions [Numerator]:

- 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 on telehealth: This measure is telehealth eligible.

Changes in Specifications from 2023 to 2024:

- 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.

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:

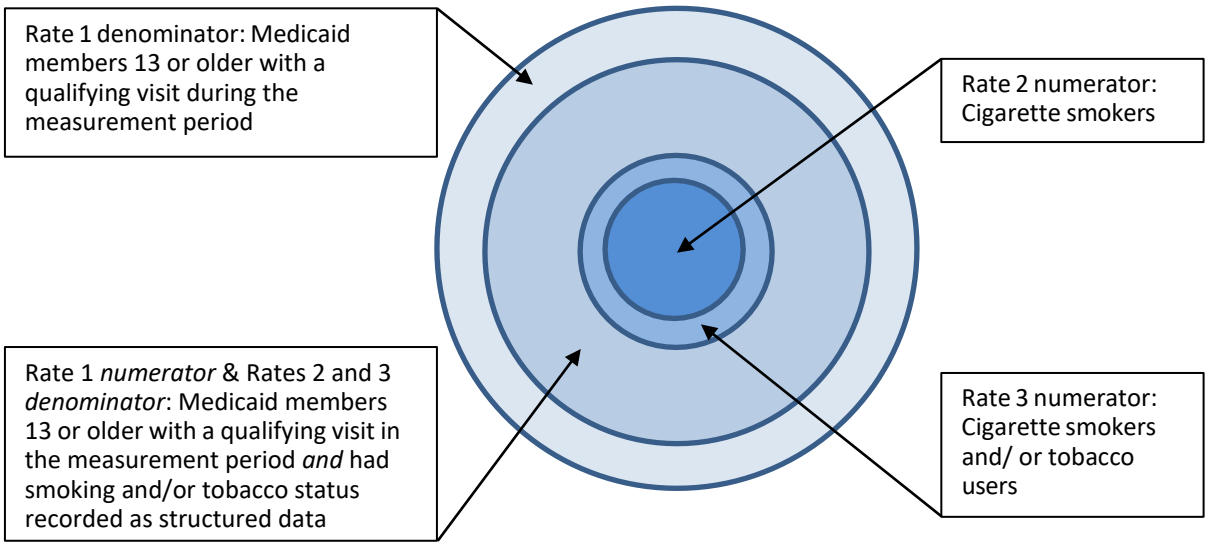
Value Set Name and OID	Status
Online Assessments (2.16.840.1.113883.3.464.1003.101.12.1089)	Added 4 CPT codes (98980, 98981, 99444, 99457) based on review by technical experts, SMEs, and/or public feedback. Added 3 HCPCS codes (G2250, G2251, G2252) based on review by technical experts, SMEs, and/or public 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

Screening for Depression and Follow-Up Plan (CMS 2v11)

Overview: CCO Incentive, State Quality and CMS Adult Core Set measure based on EMR data.

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

Benchmark: 68.2%

Target population [Denominator]: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Goal: Screen patients for depression on the date of the encounter and if positive, document the follow-up plan on the date of the positive screen.

Process:

- Administer age appropriate, standardized screening tool.
- If positive result, set follow-up plan.
- Document follow-up plan on date of positive screen.

Exclusions [Denominator]:

- Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter.

Exceptions [Denominator]:

- Patient refuses to participate in screening.
- OR 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).

Exclusions [Numerator]: None

Note on telehealth: measure is telehealth eligible.

Changes in Specifications from 2023 to 2024:

- Removed depression diagnosis exclusion.
- Clarified that the patient refusal exception is limited to refusal of the depression screening.
- Coding and language changes.

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)

Overview: CCO incentive, state quality and CMS adult core set measure based on EHR data.

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

Benchmark: 21.1%

Target population [Denominator]: Diabetic patients 18-75 years of age by the end of the measurement period, with a visit during the measurement period.

Goal: Record target populations most recent HbA1c level.

Process:
- Order lab test for HbA1c.
- Record test results in EHR once received and reviewed.
- Reorder and perform test as medically appropriate.

Exclusions [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 during 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.

Exclusions [Numerator]: None

Note on telehealth: This measure is telehealth eligible.

Changes in Specifications from MY2023 to MY2024:
- Coding and language changes.

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

Alcohol and Drug Misuse Screening, Brief Intervention and Referral to Treatment (SBIRT)

Overview: CCO Incentive Measure based on Electronic Health Records data.
Measurement period: January 1, 2024 – December 31, 2024
Benchmark – Screening: 66.6%
Benchmark – Brief Intervention: 46.7%
Rate 1 Target Population [Denominator]: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.
Rate 1 Goal: To give all patients 12 years and older an age appropriate SBIRT once per measurement year with follow-up if appropriate.
Rate 2 Target Population [Denominator]: All patients in Rate 1 who had a positive full screen during the measurement period.
Rate 2 Goal: To give all patients with positive results to full screenings needed interventions and/or referrals to treatment.

Process:

- Perform age-appropriate screening (of providers choosing) to patient
- If positive result to brief screen, perform full screen
- If positive result to full screen, give brief intervention, referral to treatment, or both

Exclusions [Denominator]:

- Active diagnosis of alcohol or drug dependency
- Engagement in substance use disorder treatment
- Dementia or mental degeneration
- Hospice care
- Palliative care (includes comfort care)

Exceptions – Denominator:

- Patient refuses to participate with screening.
- Documentation of medical reason for not screening patient (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)

Exclusions [Numerator]: SBIRT services received in an emergency department or hospital setting.

Note on telehealth: This measure is telehealth eligible.

Changes in Specifications from 2023 to 2024: Minor code changes only.

Substance Use Disorder

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a workgroup including CCOs and clinics and included clinical piloting. The measure calls for use of standardized assessment tools.

URL of Specifications: N/A. Value sets used in this measure may be accessed through the Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

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:

	2022	2023	2024
Benchmark for OHA measurement year	Both components must be met. Rate 1, screening: 68.2% Rate 2, brief intervention: 53.5%	Both components must be met. Rate 1, screening: 66.6% Rate 2, brief intervention: 28.7%	Both components must be met. Rate 1, screening: 66.6% Rate 2, brief intervention: 46.7%
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 CCO 2021 75th percentile	MY2021 & MY2022 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 base denominator before exclusions and exceptions for SBIRT rate 1 (screening) is the same as the depression screening and follow-up measure (CMS2), which is telehealth eligible according to CMS 2024 telehealth guidance. 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:

- 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 Name and OID	Status
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 Substance Use Disorder (2.16.840.1.113883.3.464.1003.106.12.1001)	Added 20 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback. Deleted 5 SNOMED CT codes (1142050005, 16236661000119100, 231475006, 191877009, 361150008) based on review by technical experts, SMEs, and/or public feedback.
Value set Dementia & Mental Degenerations (2.16.840.1.113883.3.526.3.1005)	Deleted 3 ICD-10-CM codes (F01.51, F03.91, F02.81) based on new or changed coding guidelines. Deleted 1 SNOMED CT code (230283005) based on terminology update.
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 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 Patient Declined (2.16.840.1.113883.3.526.3.1582)	Added 1 SNOMED CT code (895451009) based on terminology update. Deleted 3 SNOMED CT codes (183944003, 413310006, 413312003) based on terminology update.
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.
	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.

Denied claims: n/a

Measure Details

Measure Components and Scoring

Detailed measure specifications for the depression screening and follow-up measure, which is used in SBIRT for the Rate 1 denominator and for denominator exceptions, are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13. Detailed value set contents are available in the Value Set Authority Center.

Two rates are reported for this SBIRT measure:

(1) The percentage of patients who received age-appropriate screening and

(2) The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Rate 1

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

These denominator criteria for SBIRT Rate 1 are identical to the denominator criteria for the depression screening and follow-up measure (CMS2v13). The denominator *exclusions* for depression screening and follow-up, however, are different from the exclusions for SBIRT. SBIRT exclusions are set out below. Qualifying encounters are identified through the value sets Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916), Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022), and Telephone Visits (2.16.840.1.113883.3.464.1003.101.12.1080).

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients screened on the date of the qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter using an age-appropriate, SBIRT screening tool approved by OHA **AND** had either a brief screen with a negative result or a full screen.

> **Note**: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is **not** numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.
>
> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-

Tools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.

The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in CMS2. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.

Note: The screening(s) and result(s) must be captured as queryable structured data in the EHR. The EHR does not need to capture each response to each question in the screening tool as structured data. It is acceptable to capture the interpretation and the follow-up as structured data, without having a field for each question in the screening tool used. For supporting documentation, keeping a scan or other non-structured documentation of the screening tool (including the name of the screening tool used) is acceptable. The intent of this guidance is that the data elements needed to calculate the measure can be reported out of the EHR, without chart review. OHA does not intend to be prescriptive about how supporting documentation is maintained in a patient's medical record.

Required exclusions for numerator: SBIRT services received in an emergency department (e.g., Place of Service 23) or hospital setting (e.g., Place of Service 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both during the qualifying encounter that is documented on the date of or up to two calendar days after the date of the qualifying encounter.

Note – Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15 minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through

checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Required exclusions for numerator: SBIRT services received in an emergency department (e.g., Place of Service 23) or hospital setting (e.g., Place of Service 21).

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Active diagnosis of substance use disorder	Substance Use Disorder	2.16.840.1.113883.3.464.1003.106.12.1001
Engagement in substance use disorder treatment	Substance Use Disorder Treatment	2.16.840.1.113883.3.464.1003.106.12.1005
Dementia or mental degeneration	Dementia & Mental Degenerations	2.16.840.1.113883.3.526.3.1005
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
Palliative care	Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)	LOINC Code 71007-9
Palliative care	Encounter for palliative care	ICD10CM Code Z51.5
Palliative care	Palliative Care Intervention	2.16.840.1.113883.3.464.1003.198.12.1135
Palliative care	Palliative Care Encounter	2.16.840.1.113883.3.464.1003.101.12.1090

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance use disorder or for early detection. These services are not intended to treat members already diagnosed with an active substance use disorder or those members already receiving substance use treatment services.

The exclusions for active diagnosis of substance use disorder and for dementia or mental degeneration, apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1). The exclusions for hospice or palliative care apply if the patient is in hospice or palliative care for any part of the measurement period.

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception	Grouping Value Set
Patient Reason Patient refuses to participate	Patient Declined 1 (2.16.840.1.113883.3.526.3.1582)
Medical Reason(s) Documentation of medical reason for not screening patient (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)	Medical Reason 1 (2.16.840.1.113883.3.526.3.1007)

Note: For this SBIRT measure, these exception criteria may be captured using the SNOMED-CT codes in the value sets listed above *or* otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

- Patient refuses brief screen = Exception. Patient is not counted in rate 1.
- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.

- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: 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:

- Educational materials and other resources related to EHR-sourced quality measurement 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 Eleven (2024) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Version Control

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

Overview: CCO incentive measure based on claims data.

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

Benchmark: IET Initiation - Total - Age 18+ 48.6%
Benchmark: IET Engagement - Total - Age 18+ 18.1%
***Note, only the adult 18 and above age groups and its 'total cohort' rate is incentivized.** In 2024 CCOs must meet benchmark or improvement target for both Initiation and Engagement for ages 18+ to achieve measure.

Target population [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).

Goal: Initiate SUD treatment within 14 days of the new SUD diagnosis. Patient to have two or more additional services with a matching diagnosis within 34 days of the initiation visit.

Process: Identify patients in denominator. Initiate administration of treatment or referral for treatment of through inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of diagnosis. Engage in two or more additional services or medication treatments addressing the same diagnosis within 34 days of initiation visit.

Exclusions [Denominator]:

- Members in hospice or using hospice services any time during the measurement year.
- Members who died any time during the measurement year.
- Members who had a claim/encounter with a diagnosis of SUD during the 194 days prior to the SUD Episode Date.
- Exclude SUD episodes if any SUD Medication History events occurred during the 194 days prior to the SUD Episode Date

Exclusions [Numerator]: None

Note on telehealth: This measure is telehealth eligible.

Changes in specifications from MY2023 to MY2024:

- Coding and language changes only.

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/

Assessments for Children in DHS Custody

Overview: CCO incentive and state quality measure based on claims data.
Measurement period: November 1, 2023 – October 31, 2024
Benchmark: 93.2%
Target population [Denominator]: Children/adolescents 0 – 17 years of age at the time of the first OHA notification of member entering into DHS custody, who remain in DHS custody for at least 60 days.
Goal: Complete a physical, mental and dental assessment within the required timeline.
Process:

- Complete physical health assessment within 60 days of notification date or 30 days prior to notification date.
- Complete dental assessment within 60 days of notification date or 30 days prior to notification date.
- Complete mental health assessment within 60 days of notification date or 30 days prior to notification date.

Exclusions [Denominator]:

- 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.
- The child entered DHS custody/substitute care more than 30 days prior to OHA notification
- If a CCO is notified more than once for the same case of a child entering DHS custody, only the instance in which the CCO notification date follows most closely the DHS custody date is included and the continuous enrollment and numerator assessment periods are calculated based on this date; this is typically the earliest notification date for a unique case. Any other CCO notification dates for the same child and DHS custody entry are excluded. If the earliest notification to a CCO for a unique case is more than 30 days after the DHS custody entry date, the case is excluded.
- The child's custody was transferred to Oregon Youth Authority (OYA) during the 60 days following CCO notification. A child being in OYA detention does not create an automatic exclusion.
- The child is in a run-away status during the 60 days following CCO notification is 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)

- A child placed in a rehabilitation or residential treatment facility is not an automatic exclusion, unless the placement is out of the service area for the CCO. If requested, OHA can review and determine exclusions on a case-by-case basis.

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 does not start when the CCO is notified (see Continuous Enrollment and Allowable Gap sections for more detail).
- Children who changed their status to 'trial reunification' anytime within the 60-day assessment period as indicated in OR-Kids data.

Exclusions [Numerator]: None

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.

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.
- Included an addendum of different care types that impact this measure – though not technically a change to the measure itself; these provide clarity for some unusual circumstances that can occur when caring for these members.
- Minor coding and language changes.

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)

Child and Adolescent Well-Care Visits (WCV)

Overview: Members age 3-6 years as of December 31st of the measurement year that have had a well-child check.

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

Benchmark: 70.2%

Target population [Denominator]: Members age 3-6 years as of December 31st of the measurement year.

Goal: Perform a well-child check for members age 3-6 years as of December 31 of the measurement year.

Process: Schedule and complete a minimum of 1 comprehensive visit per measurement year for the members in the target population.

Exclusions [Denominator]:

- Members in Hospice.
- Members who died any time during the measurement year.

Exclusions [Numerator]: None

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.

Changes in specifications from MY2023 to MY2024:

- Minor coding changes only.

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

Prenatal and Postpartum Care
(NQF 1517)

Overview: CCO incentive (postpartum), state quality, CMS adult core set (postpartum), and CMS child core set (prenatal) based on claims and EHR data.

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

Benchmark – Prenatal: NA
Benchmark – Postpartum: 85.9%

Target population [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.

Goal – Prenatal: Provide prenatal care with evidence in the first trimester of pregnancy: 280-176 days before delivery.

Goal – Postpartum: Provide a postpartum visit for a pelvic exam or postpartum care on or between 7 and 84 days after delivery a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Process: Refer target population to OB/GYN practitioner, midwife, family practitioner or PCP. (If seen by a PCP, the diagnosis of pregnancy must be present for any prenatal care episodes).

Exclusions [Denominator]:
- Members in hospice care.
- Non-live births. CCO's can also report "no confirmed live birth".
- Members who died any time during the measurement year.

Exclusions [Numerator]: None

Note on telehealth: This measure is telehealth eligible for both prenatal and postpartum care, as long as the required service components are identified.

Measure changes in specifications from MY2023 to MY2024:
- Coding and language changes only.

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.*

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency and persons who are Deaf or Hard of Hearing

Overview: Ensure that appropriate language services are available to; and utilized by members with an established language access need.

Measurement period: 01/01/2024-12/31/2024

Benchmark: 75%

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

Goal [Numerator]: Arrange or provide in-language care, with evidence at every visit with members identified as having a language access need. Providers are required to utilize OHA Certified or Qualified interpreters when they provide care to members with Limited English Proficiency (LEP). Bilingual providers who provide proof of language proficiency to UHA are also eligible to provide in-language services to LEP members.

Process:
Arrange for interpreting services at visits for members with identified needs.
Document interpreter service details as outlined in the full specification.
Provide UHA with these details through our established reporting mechanisms.

Exclusions [Denominator]:

- 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.

Document the reasons a member refuses the interpreter service, and the visit may be excluded for:

- 1. Member refusal because in-language visit is provided
- 2. Member confirms interpreter needs flag in MMIS is inaccurate

Exclusions [Numerator]: None

Note on telehealth: This measure is telehealth eligible.

Measure changes in specifications from MY2023 to MY2024:

- This became a provider-facing measure in 2024.

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency and persons who are Deaf or Hard of Hearing – MY2024

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 ☐PQI ☐Survey ■Other Specify: OHA-developed

Measure Utility:

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

Data Source: Hybrid and CCO attestation

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

Past Benchmark for OHA measurement year	2021	2022	2023	2024
Component 1 – minimum points from must pass questions	46 points	56 points	77 points	TBD
Component 2 – reporting method and data collection requirement	N/A	Sampled hybrid reporting; must meet 80% data collection rate	Sampled hybrid reporting*; must meet 80% data collection rate	TBD
Component 2 – benchmark for percentage of visits provided with interpreter services by OHA certified or qualified interpreters	N/A	None	75%	TBD
Source:	Committee consensus	Committee consensus	Committee consensus	Committee Consensus

* Metrics and Scoring Committee decided to extend the sampled hybrid reporting method for Component 2 for MY2023.

2023 Improvement Target for certified/qualified service rate: Minnesota method with no floor.

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.

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 thru 5 =	**115**	
Year 4 total minimum points required =	83	72.2%
Year 5 total minimum points required =	93	80.9%

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)	
	Total available Points	**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 Limited English Proficient (LEP), and Deaf or Hard of Hearing populations you serve.	28	**23**	3	**3**	0	**0**

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with the Limited English Proficient (LEP), and Deaf or Hard of Hearing populations you serve.	57	**42**	10	**7**	0	**6**
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to Limited English Proficient (LEP), and Deaf or Hard of Hearing populations is trained on language access policies and procedures.	8	**5**	0	**0**	0	**0**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how Limited English Proficient (LEP), and Deaf or Hard of Hearing populations you serve may access available language assistance services.	9	**7**	0	**0**	0	**0**

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 interpreter 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 has MMIS interpreter flags[1] during the measurement year for the Component 2 full-population reporting. Members can self-identify

[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

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 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[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
- Office Outpatient
- Home Health

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 requirement which OHA performs the 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] CCO 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.

- Telehealth
- Other

(See Appendix 3 for quantitative interpreter services reporting template.)

Data elements required denominator exclusion:

- 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.

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.

Rate 1:

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:

[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 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.

- Interpreter services provided by OHA certified, qualified, and non-OHA certified or qualified interpreters.
- In-language visit with a provider who has passed the proficiency test for the member's preferred language[6] or has 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 the in-language visit provider has 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 MY2024) 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.
=> If No to all three modality fields, answer Did the member refuse interpreter service (Yes/No)[7]

Data elements required numerator exclusion: none.

Incentive Measure Rate Calculation: Percentage of visits provided by high quality interpreter services (or high quality in-language provider visit[8]) = Total number of visits with interpreter services provided by OHA-certified or qualified interpreters (or in-language visits with providers who have passed the

[6] Reporting visits with an in-language provider is optional in MY2024. For the proficiency test, 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). Please note, E&I's HCI program is putting a pause on accepting applications for language proficiency testing vendors until further notice. 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:

- 2+ or higher for Interagency Language Roundtable (IRL) (i.e., Language Line Solutions' proficiency test)
- Advanced-mid level or higher for American Council on the teaching of Foreign Language (ACTFL) (i.e., Language Testing International)

In language providers that have passed an OHA approved certification also qualify for passing the language proficiency requirement. The proficiency testing should be completed within the last three years. This reporting option is not available to general clinic staff.

[7] 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.

[8] Reporting visits with an in-language provider is optional in MY2024.

proficiency test for members' preferred languages[9]) / Total number of visits for members in the eligible population[10]

> 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 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

Pages 8-38 have been trimmed from the 2024 CCO Metrics Binder to help keep the document concise to provider needs, as the removed pages cover component 1, the CCO attestation portion of the measure. If you would like to read the 31 pages of requirements for attestation, the full document can be downloaded from the OHA website: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

[9] Reporting visits with an in-language provider is optional in MY2024.
[10] The measure denominator is NOT restricted to only the visits when interpreter services were provided.

Childhood Immunization Status

Overview: CCO incentive, state quality and CMS child core set based on ALERT IIS Registry data.

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

Benchmark: 67.9%

Target population [Denominator]: Children who turn 2 years of age during the measurement year.

Goal: Complete the following specified vaccinations on or before the child's 2nd birthday:

- **DTaP – at least four (4)** DTaP vaccinations (DTaP Vaccine Value Set), with different dates of service on or before the child's second birthday.
- **IPV – at least three (3) IPV vaccinations** (Inactivated Polio Vaccine (IPV) Immunization Value Set), with different dates of service on or before the child's second birthday.
- **MMR – At least one (1) MMR vaccination** (Measles, Mumps and Rubella (MMR) Immunization Value Set), or any of the allowed combination of the allowed MMR vaccines (See Tech Specs)
- **HiB – At least three (3) HiB vaccinations** (Haemophilus Influenzae Type B (HiB) Immunization Value Set), with different dates of service on or before the child's second birthday.
- **Hepatitis B – At least three (3) hepatitis B vaccinations** (Hepatitis B Immunization Value Set), with different dates of service on or before the child's second birthday.
- **VZV – At least one (1) VZV vaccination** (Varicella Zoster (VZV) Immunization Value Set), with a date of service on or between the child's first and second birthdays.
- **PCV – At least four (4) pneumococcal conjugate vaccinations** (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate 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 42 days after birth.

Process:

1. Confirm vaccines due for patient based on ALERT IIS Registry data
2. Administer vaccines patient is due for, if able, before their second birthday
3. Record vaccine with correct code in ALERT Registry and EHR

Exclusions [Denominator]:

- Members in hospice are excluded from this measure.
- Members who died 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).

Exclusions [Numerator]: None

Note on telehealth: This measure is not telehealth eligible.

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.)

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV
Combination 3	✓	✓	✓	✓	✓	✓	✓

Changes in specifications from MY2023 to MY2024:

- 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.
- Minor coding changes.

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)

Overview: CCO Incentive Measure based on MMIS/DSSURS and the ALERT IIS registry.
Measurement period: January 1, 2024 – December 31, 2024
Benchmark: 36.9%
Target population [Denominator]: Adolescents who turn 13 years of age during the measurement year.
Goal:
Complete the following specified vaccinations on or before the member's 13th birthday:

- Meningococcal: At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set).
- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115), with a date of service.
    - OR: 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: At least two HPV vaccines (HPV Immunization Value Set), with different dates of service at least 146 days apart on or between the member's 9th and 13th birthdays.
    - OR: At least three HPV vaccines (HPV Immunization Value Set), with different dates of service on or between the member's 9th and 13th birthdays.
- Record anaphylaxis to any of these in the member's chart note(s) before the member's 13th birthday.

Process:

1. Confirm vaccines due for patient based on ALERT Registry data
2. Administer vaccines patient is due for, if able, on or before their 13th birthday
3. Record vaccine with correct code in ALERT Registry and EHR
   OR: Record adverse reactions contraindicative of administering the immunization(s).

Exclusions [Denominator]:

- Members in hospice are excluded from this measure.
- Members who died any time during the measurement year.

Exclusions [Numerator]: None

Note on telehealth: This measure is not telehealth eligible.

Changes in specifications from MY2022 to MY2023:

- Removed Tdap Immunization Value Set. Only one CVX code 115 qualifies for the Tdap vaccination using ALERT IIS data.

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.*

Oral Evaluation for Adults with Diabetes

Overview: CCO incentive measure based on claims data.

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

Benchmark: 31.9%

Target population [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.

Goal: Give target population a comprehensive, periodic, or periodontal oral evaluation in the measurement year

Process: Refer qualifying patients to assigned dental clinic or develop a program or partnership that allows for these services to be rendered at your practice.

Exclusions [Denominator]:

1. 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 are excluded from this measure.
3. Members receiving palliative care.
4. Medicare members 66 years of age and older as of December 31 of the measurement year who are enrolled in an Institutional SNP (I-SNP), or living long-term in an institution any time during the measurement year.
5. Exclude members age 66 and older as of December 31 of the measurement year with frailty and advanced illness.
6. *See below.

Exclusions [Numerator]: None

Note on telehealth: 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.

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.

*Note from UHA:
The OHA did not list the 6th exception for members who died in the measurement year in the technical specification for MY2024. We have asked for clarity on this, as it is not listed in their changelog.

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.

Members Receiving Preventive Dental or Oral Health Services

Overview: CCO Incentive Measure based on claims data.

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

Benchmark: ages 1-5: 52.9%

Benchmark: ages 6-14: 61%

Target population [Denominator]: Members ages 1-5 and 6-14 receiving preventative dental or oral services.

Goal: Provide any dental service for the target population in the target population

Process:

- Refer qualifying patients to Dental Care Organization (Advantage Dental), or
- Provide qualifying dental/oral health services in primary care setting to qualifying patients

Sub Process:

•Process to begin providing qualifying dental/oral health services in primary care office setting:

1. Complete certification process for one of the approved training programs
    a. Contact Advantage Dental to start this process.
2. Provide qualifying dental/oral health services to cohort populations

Exclusions [Denominator]: None

Exclusions [Numerator]: None

Note on telehealth: This measure is eligible for telehealth/teledentistry.

Changes in specifications from MY2023 to MY2024:

- OHA expands the CCO membership coverage types to CCOA, CCOF, CCOG, to include all members who have dental/oral health coverage through a CCO.

Members Receiving Preventive Dental or Oral Health Services

Measure Basic Information

Name and date of specifications used:
This measure is developed by OHA following dental procedure codes defined in CMS-416 Annual Early and Periodic Screen, Diagnostic and Treatment Participation Report (EPSDT, Dental Lines 12a, 12b, 12c, 12e).

https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf

The measure also follows Dental Quality Alliance (DQA) Dental Services Utilization measure series for the continuous enrollment criteria and the method for reporting three separate rates: Dental Services, Oral Health Services, Dental or Oral Health Services.

https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures

Measure Type:
☐HEDIS ☐Survey ■Other Specify: OHA developed based on DQA similar measures

Measure Utility:
■ CCO Incentive (Preventive Dental or Oral Services for age 1-5 & 6-14) ☐CMS Adult Core Set
☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS

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

Benchmark for OHA measurement year	2022	2023^	2024^
PREV_DENTOR_Age1-5	43.1%	47.2%	52.9%
PREV_DENTOR_Age6-14	52.0%	54.8%	61.0%
Improvement target for OHA measurement year	MN method with no floor; only need to meet one age range to achieve measure	MN method with 1 percentage point floor; must meet both age ranges to achieve measure	MN method with 1 percentage point floor; must meet both age ranges to achieve measure
Source:	MY2020 CCO 75th percentile	MY2021 CCO average	MY2022 CCO 75th percentile

^This measure is selected for the 2024 Challenge Pool.

Note on telehealth: This measure is eligible for telehealth/teledentistry. Some qualifying services such as D1310 'nutritional counseling' and D1330 'oral hygiene instructions' may be delivered in a teledentistry visit, but subject to providers' determination whether required components can be provided equivalent to an in-person visit. 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

code in the claims form, the visit should be counted in the measure, irrespective if the visit was virtual or in person. For further information please see American Dental Association policy on teledentistry.

Changes in specifications from MY2023 to MY2024: None.

- OHA expands the CCO membership coverage types to CCOA, CCOF, CCOG, to include all members who have dental/oral health coverage through a CCO.

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:

PREV_DENT_ORAL	Claim from matching CCO	Denied claims included
Numerator event	Y	Y

Measure Details

Data elements required denominator: Count of unique members age 1-5 (kindergarten readiness) and 6-14 on the last day of the measurement year who meet continuous enrollment criteria.

Required exclusions for denominator: None.

Deviations from cited specifications for denominator: n/a. Note the similar CMS and DQA measures both report members age 0-20.

Continuous enrollment criteria: Continuously enrolled with the CCO for at least 180 days in the measurement year[1].

Allowable gaps in enrollment: None.

Anchor Date (if applicable): None.

Numerator 1 – Preventive Dental Services: Count of unique members in the denominator who received preventive dental services, identified by:

[1] The 180 days requirement is a minimum within a measurement year. If a member enrolled for 360 days with the same CCO in the year, they still only contribute to one denominator hit for the CCO. If within the reporting year a member switched from one CCO to another and had continuous 180 days with both CCOs, this member will qualify for denominator for both CCOs in the same year; numerator services are attributed independently to the CCOs that paid and submitted the claim.

CDT code D1000 – D1999 by providers with taxonomy codes in the Dental Services Provider Table.

Numerator 2 – Preventive Oral Health Services: Count of unique members in the denominator who received preventive oral health services, identified by:

CDT code D1000 – D1999 or CPT code 99188, by providers with taxonomy codes NOT in the Dental Services Provider Table.

Numerator 3 – Preventive Dental or Oral Health Services:** Count of unique members in the denominator who received preventive dental or oral health services, identified by:

CDT code D1000 – D1999 or CPT code 99188 (by ANY providers).

Dental Services Provider Table:

Taxonomy Code	Grouping	Classification	Specialization
122300000X	Dental Providers	Dentist	
1223D0001X	Dental Providers	Dentist	Dental Public Health
1223D0004X	Dental Providers	Dentist	Dentist Anesthesiologist
1223E0200X	Dental Providers	Dentist	Endodontics
1223G0001X	Dental Providers	Dentist	General Practice
1223P0106X	Dental Providers	Dentist	Oral and Maxillofacial Pathology
1223P0221X	Dental Providers	Dentist	Pediatric Dentistry
1223P0300X	Dental Providers	Dentist	Periodontics
1223P0700X	Dental Providers	Dentist	Prosthodontics
1223S0112X	Dental Providers	Dentist	Oral and Maxillofacial Surgery
1223X0008X	Dental Providers	Dentist	Oral and Maxillofacial Radiology
1223X0400X	Dental Providers	Dentist	Orthodontics and Dentofacial Orthopedics
124Q00000X	Dental Providers	Dental Hygienist	
125J00000X	Dental Providers	Dental Therapist	
125K00000X	Dental Providers	Advanced Practice Dental Therapist	
125Q00000X	Dental Providers	Oral Medicinist	
261QF0400X	Ambulatory Health Care Facilities	Clinic/Center	Federally Qualified Health Center (FQHC)
261QR1300X	Ambulatory Health Care Facilities	Clinic/Center	Rural Health
1223X2210X	Dental Providers	Dentist	Orofacial Pain
122400000X	Dental Providers	Denturist	
126800000X	Dental Providers	Dental Assistant	
261QD0000X	Ambulatory Health Care Facilities	Clinic/Center	Dental

Taxonomy Code	Grouping	Classification	Specialization
204E00000X	Allopathic & Osteopathic Physicians	Oral & Maxillofacial Surgery	
261QS0112X	Ambulatory Health Care Facilities	Clinic/Center	Oral and Maxillofacial Surgery

Note: A qualifying taxonomy code can be captured in either the billing provider or the rendering provider information in the claims.

Report each category separately and with age stratification (based on members' age as of the last day of the measurement year):

		1. Preventive Dental Services		2. Preventive Oral Health Services		**3. Preventive Dental or Oral Health Services****	
Age group	Denominator	Numerator 1	Rate 1 (%)	Numerator 2	Rate 2 (%)	**Numerator 3**	**Rate 3 (%)**
1-5**							
6-14**							

**** Starting in measurement year 2021, the measure is incentivized for Rate 3 Preventive Dental or Oral Health Services with children age group 1-5 (kindergarten readiness) and 6-14.*** *Rate 1 and Rate 2 are reporting-only.*

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: n/a.

CCO-Level Reporting Measures

In 2024 there are two CCO-Level measures. These measures are forward looking and developmental in nature. To this end, these are rolled out in stages. Each year adds more CCO requirements to the measures than the prior year. UHA meets these two measures by gathering data and reporting data, developing new programs or building on current programs and developing new or improving upon existing policies.

The long-term goal of these measures is to evolve each into provider facing measures and CCO-wide requirements. With this in mind, a brief statement for each of these measures and some ideas for how providers can assist UHA in meeting the measures is presented hereafter. These also serve as some things that can be done now, to prepare for the future intent of these measures.

Health Aspects of Kindergarten Readiness Measure: System-Level Social-Emotional Health Metric (HAKR/REACH)

This measure aims to Improve Social-Emotional Health Service Capacity and Access for children ages 1-5.
Providers can assist in helping UHA meet this by:

- Feedback loop - surveys, public meetings, attending/completing offered trainings etc.
- Meet criteria for PCPCH 3.C.3

This measure is set to become a provider facing measure in MY2025.

Social Determinants of Health: Social Needs Screening and Referral Measure – MY 2024 (SDoH)

This measure aims to improve CCOs' ability 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 within the domains of SDOH.
Providers can assist in helping UHA meet this by:

- Enroll with at least one information exchange (Unite Us for example) and perform screenings within that platform.
- Implement at least one OHA approved SDOH screening tool such as the PRAPARE, the AAFP SNS or the North Carolina Medicaid screening tools.
- Begin using ICD-10 and CPT codes to document SDOH needs and referrals in chart notes.

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:

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[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.

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

This measure holds CCOs accountable to providing supports designed to improve the social emotional health of children from birth to age 5. OHA measures this to help ensure young kids get equitable access to services that support their social-emotional health and are the best match for their needs.

This measure 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.[21]

To achieve the measure, CCOs must:

- Attest that they have
    - Reviewed OHA-provided data on social-emotional health assessments and services;
    - Created an asset map of existing social-emotional health services and resources;

[21] https://childinst.org/wp-content/uploads/2018/08/KRFG_Summary_Report_with_Cover_Letter_5_2_18.pdf

    - Led cross-sector community engagement; and
    - Created an action plan to improve social-emotional health service capacity and access.
- And send OHA a copy of the following
    - Asset map and
    - Action plan

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