UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Measurement Year 2025 Technical Assistance Guidance For OHA's CCO-Incentive Measure Program

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3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

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Measure Year 2025 Binder Preface

These are some of the key features of the 2025 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 2024 Measure Set compared to the 2025 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 to diagnosis tips, and other strategic reminders.

Quick notes for the CCO Incentive Quality Measure Set for 2025:

- Two measures from the 2024 measure set have been retired in 2024.
    - Cigarette Smoking Prevalence
    - SBIRT
        - These have been moved into a "report only" status.
        - Like the Prenatal measure, UHA will still be required to collect and report data for these measures, they will simply be lower in priority due to the change from incentive status.
- There are no new measures in 2025, though the Social Emotional Services measure has moved from being a CCO level measure, to a member level measure.
- Plain language summaries of 2025 incentive measures have been added as an appendix to this document.
- 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

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Lessons learned and other practical information:

Coverage Considerations:

- Unless indicated otherwise BHP is excluded from CCO Incentive measures.
- When UHA is Secondary:
    - Even if the primary covers 100% please submit a claim for $0 to UHA. It's a requirement for effective claims measure calculation and not doing so also happens to be unlawful.

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. Use screening codes like:
    - 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.

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A1c 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)

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)

Changes from MY2024 – MY2025

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 in most situations.
    - Some measures allow these in the cohorts, though they are preferred as excluded where it is possible to determine CAK/HOP status.

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Measures with CC&L changes only:

- Depression Screening
- Assessments for Children in DHS Custody
- Prenatal and Postpartum Care
- Preventive Dental/Oral Health Services for members 1-14
- Oral Health Evaluations for Members with Diabetes

Diabetes: HbA1c Poor Control:

- Added glucose management indicator (GMI) as an option to meet Numerator criteria based on guideline updates.

Child-and-Adolescent-Well-Care-Visits:

- Removed telehealth well visits from the numerator. (Added Online Assessments Value Set, Telehealth POS Value Set and Telephone Visits Value Set to the measure to exclude visits using telehealth from the numerator.)

Initiation and Engagement of Substance Use Disorder Treatment:

- Added a separate category for substance use disorder counseling and surveillance (previously included in the substance use disorder service category) for both the denominator episode and initiation/engagement numerator logic.

Children's SE Health

- Following the glide-path designed by the measure stewards and the OHA, this has changed from a CCO-Attestation based measure and become a member-level measure for MY2025.

Oral Evaluations for Adults With Diabetes:

- Updated exclusion criteria for palliative care, frailty and members who died in the measurement year to align with NCQA/HEDIS MY2023

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Immunization (2YO):

- Added Organ and Bone Marrow Transplants Value Set for denominator exclusion.

Immunization (13YO):

- Added the pentavalent meningococcal vaccine (CVX 316 and CPT 90623) to the meningococcal indicator numerator and expanded the age range from 11-13 to 10-13.

Meaningful Language Access:

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

SDoH Screening and Referrals:

- Measure has added Component 2:
    - This is a hybrid measure using a sample population that the OHA will provide.
    - Sample reporting will be done using MMIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources
    - Will continue through Measure Year 2026

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Diabetes: HbA1c Poor Control (CMS122v13)

Overview:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9.0% during the measurement period.

Measurement Period:
01/01/2025 – 12/31/2025. Benchmark: 20% (Inverse Measure - lower is better).

Target Population (Denominator):
aŜYōŜℕå 18-75 years of age by the end of the measurement period, with diabetesΣ with a visit during the measurement period¢

Goal: Record target populations most recent HbA1c level.

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 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 diagnosis 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.

Notes on plan-types: Reporting Healthier Oregon Population is optional. OHA will continue to accept results with the Health Oregon Population included.

Changes in Specification from MY2024 to MY2025: Coding and Language changes primarily.

Diabetes: HbA1c Poor Control (CMS122v13)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2025.

URL of Specifications: https://ecqi.healthit.gov/ecqm/ec/2025/cms0122v13

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, 2025 – December 31, 2025

Benchmark:

	2023	2024	2025
Benchmark for OHA measurement year	24.8%	21.1%	20.0%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 2 percentage point floor	MN method with 2 percentage point floor
Source	MY 2021 Nat. Comm. 75th percentile	MY 2022 CCO 90th percentile	MY 2022 Commercial 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 2025 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 2024 to 2025: This summary is provided to help highlight changes. For a complete list, see the Technical Release Notes: https://ecqi.healthit.gov/ecqm/ec/2025/cms0122v13?qt-tabs_measure=technical-release-notes

- Changed all references from NQF to CBE to identify the consensus-based entity role.

- Added flexibility to prioritize the lowest result among multiple glycemic status assessments on the same day to align with measure intent.
- Reduced the complexity of advanced illness criteria by removing the requirement to have at least two outpatient encounters or one inpatient encounter with the advanced illness diagnosis.
- Added glucose management indicator (GMI) as an option to meet Numerator criteria based on guideline updates.
- Updated the timing comparison precision in the definitions from datetime to date by adding 'day of' operator to align with the measure intent and address time zone issues.
- Updated the version number of the Palliative Care Exclusion Library to v4.0.000 and the library name from 'PalliativeCareExclusionECQM' to 'PalliativeCareQDM.'
- Updated the version number of the Hospice Library to v6.0.000 and the library name from 'Hospice' to 'HospiceQDM.'
- Updated the version number of the Advanced Illness and Frailty Exclusion ECQM Library to v9.0.000 and the library name from 'AdvancedIllnessandFrailtyExclusionECQM' to 'AdvancedIllnessandFrailtyQDM.'
- Updated the version number of the Measure Authoring Tool (MAT) Global Common Functions Library to v8.0.000 and the library name from 'MATGlobalCommonFunctions' to 'MATGlobalCommonFunctionsQDM.'
- Added clarification that reporting Healthier Oregon Population is optional. Providers may not have ability to exclude. OHA will continue to accept results with the Health Oregon Population included.

Value Set name and OID	Status
Value set Acute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1083)	Removed.
Value set Advanced Illness (2.16.840.1.113883.3.464.1003.110.12.1082)	Added 69 ICD-10-CM codes based on review by technical experts, SMEs, and/or public feedback. Deleted 5 ICD-10-CM codes (F01.51, F02.81, F03.91, J84.17, K74.0) based on review by technical experts, SMEs, and/or public feedback. Added 109 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback. Deleted 22 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback.
Value set Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)	Added 3 SNOMED CT codes (86013001, 90526000, 866149003) based on review by technical experts, SMEs, and/or public feedback. Added 1 HCPCS code (G0402) 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 1 SNOMED CT code (314904008) based on review by technical experts, SMEs, and/or public feedback.
Value set Emergency Department Evaluation and Management Visit (2.16.840.1.113883.3.464.1003.101.12.1010)	Removed.
Value set Frailty Device (2.16.840.1.113883.3.464.1003.118.12.1300)	Added 12 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback. Deleted 14 SNOMED CT codes based on review by technical experts, SMEs, and/or public feedback.

Value set Frailty Diagnosis (2.16.840.1.113883.3.464.1003.113.12.1074)	Deleted 7 SNOMED CT codes (414188008, 414189000, 16728003, 162845004, 699215008, 699218005, 459821000124104) 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 10 SNOMED CT codes (267031002, 272062008, 314109004, 271875007, 394616008, 163600007, 163695007, 268964003, 272036004, 225612007) based on review by technical experts, SMEs, and/or public feedback.
Value set Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)	Deleted 1 CPT code (99343) 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)	Added 2 SNOMED CT codes (170935008, 170936009) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 SNOMED CT code (385765002) based on review by technical experts, SMEs, and/or public feedback.
Value set Nonacute Inpatient (2.16.840.1.113883.3.464.1003.101.12.1084)	Removed.
Value set Observation (2.16.840.1.113883.3.464.1003.101.12.1086)	Removed.
Value set Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)	Deleted 2 SNOMED CT codes (30346009, 37894004) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 CPT code (99201) 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)	Removed.
Value set Palliative Care Encounter (2.16.840.1.113883.3.464.1003.101.12.1090)	Added 3 SNOMED CT codes (305686008, 305824005, 441874000) based on review by technical experts, SMEs, and/or public feedback.
Value set (2.16.840.1.114222.4.11.3591)	Renamed to Payer Type based on recommended value set naming conventions.
	Added direct reference code LOINC code (97506-0) based on applicability of a single code to represent clinical data.

Denied claims: n/a

Measure Details

The detailed measure specifications are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ec/2025/cms0122v13Detailed 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 diagnosis 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 glycemic status assessment (HbA1c or GMI) (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.

Reporting Healthier Oregon Population is optional. Providers may not have ability to exclude. OHA will continue to accept results with the Health Oregon Population included.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- For technical assistance, the electronic clinical quality measure (eCQM) Issue Tracker from CMS: https://oncprojectracking.healthit.gov/support/projects/CQM/summary
- 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 Thirteen (2024) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

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umpquahealth.com

Screening for Depression and Follow-Up Plan (CMS 2v14)

Overview:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Measurement Period: 01/01/2025 – 12/31/2025.

Benchmark: 73.8%.

Target Population (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.

Goal: Screen every member 12 and up for depression at least once per year.

Exclusions (Denominator):
Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter.

Exceptions (Denominator):
- Patient Reason(s)
- Patient refuses to participate or complete the depression screening
  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)

Exclusions (Numerator): None.

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
Reporting Healthier Oregon Population is optional. OHA will continue to accept results with the Health Oregon Population included.

Changes in Specification from MY2024 to MY2025: Coding and language primarily.

Screening for Depression and Follow-Up Plan (CMS 2v14)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2025.

URL of Specifications: https://ecqi.healthit.gov/ecqm/ec/2025/cms0002v14

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, 2025 – December 31, 2025

Benchmark:

	2023	2024	2025
Benchmark for OHA measurement year	61.0%	68.2%	73.8%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 2 percentage point floor	MN method with a 2 percentage point floor
Source	MY 2021 CCO 90th percentile	MY 2022 CCO 90th percentile	MY 2023 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 2025 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 2024 to 2025: This summary is provided to help highlight changes. For a complete list, see the Technical Release Notes:

https://ecqi.healthit.gov/ecqm/ec/2025/cms0002v14?compare=2025to2024

- Updated Rationale with new evidence aligning with intent to screen patients with depression.
- Revised the Guidance to align with the logic that intent of the measure is to screen all patients for depression except those with a diagnosis of bipolar disorder.
- Updated the names of CQL definitions, functions, and/or aliases for clarification and to align with the CQL Style Guide.
- Removed ICD-9 extensional value sets from select grouping value sets, leaving codes from active terminologies (ICD-10 and SNOMED), to reduce implementer burden.
- Added clarification that reporting Healthier Oregon Population is optional. Providers may not have ability to exclude. OHA will continue to accept results with the Health Oregon Population included.

Value Set Name and OID	Status
Value set Adult Depression Medications (2.16.840.1.113883.3.526.3.1566)	Added 1 RxNorm code (2605720) based on terminology update. Deleted 2 RxNorm codes (1086789, 2605719) based on terminology update. Deleted 1 RxNorm code (1298857) based on new or changed coding guidelines.
Value set Bipolar Disorder (2.16.840.1.113883.3.67.1.101.1.128)	Deleted 40 ICD-9-CM codes based on applicability of value set and/or OID.
Value set Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916)	Added 1 CPT code (92622) based on review by technical experts, SMEs, and/or public feedback.
Value set Follow Up for Adolescent Depression (2.16.840.1.113883.3.526.3.1569)	Added 1 SNOMED CT code (768835002) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 SNOMED CT code (91310009) based on review by technical experts, SMEs, and/or public feedback.
Value set Follow Up for Adult Depression (2.16.840.1.113883.3.526.3.1568)	Added 1 SNOMED CT code (768835002) based on review by technical experts, SMEs, and/or public feedback. Deleted 1 SNOMED CT code (91310009) based on review by technical experts, SMEs, and/or public feedback.
Value set (2.16.840.1.114222.4.11.3591)	Renamed to Payer Type based on recommended VS naming conventions.
Value set Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)	Deleted 1 SNOMED CT code (33849009) 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/2025/cms0002v14. 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.

Reporting Healthier Oregon Population is optional. Providers may not have ability to exclude. OHA will continue to accept results with the Health Oregon Population included.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- For technical assistance, the electronic clinical quality measure (eCQM) Issue Tracker from CMS: https://oncprojectracking.healthit.gov/support/projects/CQM/summary
- 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 Thirteen (2025) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Version Control

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Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Assessments for Children in DHS Custody (DHS)

Overview:
Percentage of members who enter into DHS custody who receive all age-appropriate assessment required for their age group, within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care).
Measurement Period: November 1, 2024 – October 31, 2025.

Benchmark: 93.2%.

Target Population (Denominator):
Identified members 0 – 17 years of age as of the first date of OHA notification who remained in custody for at least 60 days. Only members that OHA notified CCOs about will be included in the denominator.

Goal: Ensure members in this measure receive all age-appropriate assessment required for their age group, within 60 days of the OHA notifying UHA of placement status.

Exclusions (Denominator): Complex. See full specification for details.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025: Coding and Language changes primarily.

Assessments for Children in DHS Custody (DHS)

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, 2024 – October 31, 2025

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	2023	2024	2025
Benchmark for OHA measurement year	90%	93.2%	93.2%
Improvement target for OHA measurement year	MN method with 2 percentage point floor	MN method with 3 percentage point floor	MN method with 3 percentage point floor
Source:	Metrics & Scoring Committee consensus	MY 2022 CCO 75th percentile	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 MY2024 to MY2025:

- Added clarification for the providers eligible to perform mental health assessment and CANS in the same visit to bill H2000-TG.

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]:

Visits with CPT 99201 – 99205 can count as both physical and mental health assessments if paired with following diagnosis codes:

[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.

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) and CANS assessment at the same visit: H2000-TG (modifier must be included)[2]
- Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days): H0019[3]
- 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] Only Licensed Professional Counselor (LPC), Licensed Marriage Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), psychologist and Qualified Mental Health Professional (QMHP) qualify for performing mental health assessment and eligible for billing H2000-TG. Other providers such as Qualified Mental Health Associates (QMHA), case managers, or care coordinators do not qualify for performing mental health assessment and to use the modifier TG.

[3] 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)

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Child and Adolescent Well-Care Visits (WCV, NQF1516)

Overview: Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 72.0%

Target Population (Denominator):
Members aged 3-6 years as of December 31 of the measurement year.

Goal:
Ensure members aged 3 to 6 have one or more well-child visits with a PCP during the measurement year.

Exclusions (Denominator):
Members who use hospice services any time during the measurement year.
Members who die any time during the measurement year.
Exclusions (Numerator): Exclude visits using telehealth from the numerator.

Note on Telehealth: This measure is not telehealth eligible.

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025:
Removed telehealth well visits from the numerator. (Added Online Assessments Value Set, Telehealth POS Value Set and Telephone Visits Value Set to the measure to exclude visits using telehealth from the numerator.)

Child and Adolescent Well-Care Visits (WCV, NQF1516)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2025 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, 2025 – December 31, 2025

WCV_Age3-6*	2023^	2024^	2025^
Benchmark for OHA measurement year	68.6%	70.2%	72.0%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 2 percentage point floor	MN method with 1.5 percentage point floor
Source:	MY2019 CCO average	MY2022 CCO 90th percentile	MY2023 CCO 90th percentile

^This measure is selected for the Challenge Pool.

Note on telehealth: Telehealth visits no longer qualify for the measure starting MY2025.

Changes in specifications from MY2024 to MY2025:

- Removed telehealth well visits from the numerator. (Added Online Assessments Value Set, Telehealth POS Value Set and Telephone Visits Value Set to the measure to exclude visits using telehealth from the numerator.)
- Removed the data source reporting requirement from the race and ethnicity stratification.

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 during the measurement year. Either of the following meet criteria:

- 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).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set). Note that OHA applies the telehealth exclusion at the unique claim level.

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
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

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

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

Overview:
Members 18 years and older as of the SUD Episode Date who have medical, pharmacy and chemical dependency benefits, with a qualifying new SUD diagnosis require initiation and engagement services within 13 and 34 days of the initial encounter respectively.

Measurement Period: 01/01/2025 – 12/31/2025 (Intake period: 11/15/2024 – 11/14/2025)

Benchmarks/Targets:
- Initiation: 49.0%
- Engagement: 18.8%

Target Population (Denominator):
- Initiation: Members 18 years and older as of the SUD Episode Date, with a qualifying new SUD diagnosis episode.
- Engagement: The cohort population who have initiated treatment as outlined above.

Goals:
- Initiation: SUD treatment within 13 days of the new SUD diagnosis.
- Engagement: Patient to have two or more additional services with a matching diagnosis after the initiation encounter but within 34 days of the new SUD diagnosis.

Exclusions (Denominator):
- Members who use hospice services any time during the measurement year.
- Members who die any time during the measurement year.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
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.
Changes in Specification from MY2024 to MY2025:
Added a separate category for substance use disorder counseling and surveillance (previously included in the substance use disorder service category) for both the denominator episode and initiation/engagement numerator logic.

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

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2025 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, 2025 (Intake period: November 15, 2024 – November 14, 2025)

Benchmark for OHA measurement year	2023	2024	2025
IET Initiation - Total - Age 18+	43.3%	48.6%	49.0%
IET Engagement - Total - Age 18+	16.3%	18.1%	18.8%
Improvement target for OHA measurement year	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	MN method with 2 percentage point floor; must meet both initiation and engagement components for age 18+ to achieve measure
Source:	MY2021 CCO 90th percentile	MY2021 national Medicaid 75th percentile	MY2022 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 MY2024 to MY2025:

- Added a laboratory claim exclusion to a value set for which laboratory claims should not be used.

- Added a separate category for substance use disorder counseling and surveillance (previously included in the substance use disorder service category) for both the denominator episode and initiation/engagement numerator logic. Laboratory claims are not allowed in this category.
- Updated the language for negative SUD history.

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[1]	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).

[1] Including claims used for all potential SUD events and events in the negative diagnosis history period.

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) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (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. Do not include laboratory claims (claims with POS code 81).
- 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 the member had a SUD diagnosis (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. Do not include ED visits (ED Value Set), withdrawal management events (Detoxification Value Set) or lab claims (claims with POS code 81).

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 MY2025 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) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (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. Do not include laboratory claims (claims with POS code 81).
- 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) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (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. Do not include laboratory claims (claims with POS code 81).
- 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/

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services (SEM)

Overview:
These child-level social emotional issue-focused intervention/treatment specifications were developed by the Oregon Pediatric Improvement Partnership (OPIP). Measure calculates the percentage of children ages 1-5 (kindergarten readiness) who received an issue-focused intervention/treatment service.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 11.0%

Target Population (Denominator):
Count of unique members ages 1-5.99 years (kindergarten readiness) on the last day of the measurement year who meet continuous enrollment criteria.

Goal: Despite the lack of any "identified need for treatment/intervention" for the denominator population, the intent is to ensure members within the overall cohort who receive any of the issue-focused intervention/treatment services outlined in the full specification within the measure year.

Exclusions (Denominator): Members who die any time during the measurement year.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025: Benchmark year – transitioning from a system-level measure to a member level measure in MY2025.

Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services (SEM)

Measure Basic Information

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

URL of Specifications: N/A.

Measure Type:

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

Measure Utility:

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

Data Sources: MMIS

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

Benchmark for OHA Measurement Year:

SEM	2025
Benchmark for OHA measurement year	11.0%
Improvement target for OHA measurement year	MN method with 0.5 percentage point floor
Source:	Committee concensus

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

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

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

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

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

Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous

enrollment period are excluded from the incentive quality rates. Note that the Cover All Kids (CAK) and Healthier Orgon Program (HOP) recipients have also been excluded from the incentive quality rates.

Specify claims used in the calculation:

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

Measure Details

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

Required exclusions for denominator:

- Members who die any time during the measurement year.

Deviations from cited specifications for denominator: n/a.

Continuous enrollment criteria: The measurement year.

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

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

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

CPT Claim Title	**CPT Code in Claims**
Psychiatric Diagnostic Evaluation	90791
Psychiatric Diagnostic Evaluation, by a medically licensed professional	90792
Health behavior assessment, or re-assessment	96156
Mental health assessment, by non-physician	H0031
Health Behavior Intervention	96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Preventive Medicine Counseling	99401-99404, 99411-99412
Adaptive Behavior Treatment	97153-97158
Behavioral health counseling and therapy	H0004
Skills training and development	H2014
Individual psychotherapy	90832-90834, 90836-90838 (removed 90835 given CPT code is expired)
Family psychotherapy	90846, 90847
Group psychotherapy	90849, 90853
Multi-Family Group Training Session	96202, 96203
Behavioral Health Outreach Services (Used for Intensive, In Home Behavioral Health Treatment)	H0023
Mental health service plan development, by non-physician	H0032

Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)	98960-98962
Activity therapy (music, dance, are or play therapies) related to the care and treatment of patient's disabling mental health problems per session (>=45 min)	G0176

Required exclusions for numerator: Not Appliable

Deviations from cited specifications for numerator: Not applicable.

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

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Prenatal and Postpartum Care (PPC, NQF 1517)

Overview:
Percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery. Note: The denominator for this measure is based on deliveries, not on members.

Measurement Period: Live births with an Estimated Date of Delivery from 08/08/2024 – 08/07/2025.

Benchmark/Target: 87.0%

Target Population (Denominator): All live birth deliveries with estimated delivery date (EDD) in the 'intake period' (10/08/2024-10/07/2025)

Goal:
Ensure members with deliveries of live births have a postpartum visit on or between 7 and 84 days after each delivery.

Exclusions (Denominator):
- Members who use hospice services any time 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.

Exclusions (Numerator): Do not include postpartum care provided in an acute inpatient setting.

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
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.
Note that if the CCO has 411 or fewer total live birth deliveries in the year, all cases need to be reviewed and reported, with HOP/BHP members being excluded from the incentive rate.

Changes in Specification from MY2024 to MY2025: Coding and language primarily.

Prenatal and Postpartum Care (PPC, 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. Starting in 2019, the Metrics and Scoring Committee decided to incentivize the Postpartum Care rate performance with hybrid specifications. However, CCOs are required to report on both parts of the measure for the Quality Incentive Program.

Name and date of specifications used: OHA follows HEDIS® MY2025 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, 2024 - October 7, 2025.

PPC_Post	2023^	2024^	2025^
Benchmark for OHA measurement year	84.2%	85.9%	87.0%
Improvement target for OHA measurement year	MN method with 3 percentage point floor	MN method with 3 percentage point floor	MN method with 3 percentage point floor
Source:	MY2021 national Medicaid 90th percentile (hybrid)	MY2022 CCO 90th percentile (hybrid)	MY2023 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 MY2024 to MY2025:

- OHA adds a hybrid sample size section (which only appeared in the hybrid review guidance document in the past) to clarify the methodology for replacing the non-incentive Healthier Oregon Program (HOP) and Basic Health Plan (BHP) population.

OHA continues to adopt the full HEDIS hybrid specifications for MY2025/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 MY2025/CMS Core Set specifications for allowable codes and measure logic.
2) If using medical record data to identify numerator compliance, CCOs must follow HEDIS MY2025/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 MY2025 in fall 2025. 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 estimated delivery date [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).

Hybrid review sample size: OHA follows the HEDIS sample size guidance to randomly draw 411 cases per CCO (if the CCO has more than 411 total live births in the intake period), but uses the additional steps below to compensate the HOP/BHP exclusion from the incentive program rate:

> Step1: OHA randomly draws 411 cases for each CCO, across all CCO-paid live birth deliveries (following the HEDIS steps to identify live birth deliveries) to create the initial sample.
>
> Step2: Among the initial sample, OHA identifies the number of HOP and BHP members and samples the same number of additional non-HOP/BHP members to the final sample. The goal is to reach 411 total cases non-HOP/BHP members to use for the incentive rate. The CCO is still responsible for reviewing and reporting PPC measure results for the HOP/BHP members in the initial sample.

For example, if there are 40 HOP/BHP members randomly selected among the CCO's initial sample of 411 cases, OHA will randomly select additional 40 non-HOP/BHP members to CCO's final sample. The CCO is responsible for reviewing and reporting on all 451 cases in the final sample, where only the results from the 411 non-HOP/BHP members are used for the incentive program. If the CCO has fewer than 40 remaining non-HOP/BHP cases after the initial sample, all the remaining non-HOP/BHP cases will be added to the final sample and included in the incentive rate.

Note that if the CCO has 411 or fewer total live birth deliveries in the year, all cases need to be reviewed and reported, with HOP/BHP members being excluded from the incentive rate.

Timeliness of Prenatal Care Numerator:

Administrative method – A prenatal visit within the eligible time window including required service components. See HEDIS® MY2025 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® MY2025 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.*

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Members Receiving Preventive Dental or Oral Health Services (PREV_DENTOR)

Overview: Percentage of enrolled children ages 1-14 who receive a preventive dental or oral health service during the measurement year.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target:
- Ages 1-5: 60.6%
- Ages 6-14: 67.3%

Target Population (Denominator): All members, ages 1-14 (as of 12/31/2025).

Goal:
Ensure preventative dental services for members ages 1-14 at least annually. Identified by: CDT code D1000 – D1999 or CPT code 99188 (by ANY providers).

Exclusions (Denominator): N/A

Exclusions (Numerator): N/A

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

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025: Coding and language primarily.

Members Receiving Preventive Dental or Oral Health Services (PREV_DENTOR)

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 CMS and 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, 2025 – December 31, 2025

Benchmark for OHA measurement year	2023^	2024^	2025^
PREV_DENTOR_Age1-5	47.2%	52.9%	60.6%
PREV_DENTOR_Age6-14	54.8%	61.0%	67.3%
Improvement target for OHA measurement year	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	MN method with 2 percentage point floor; must meet both age ranges to achieve measure
Source:	MY2021 CCO average	MY2022 CCO 75th percentile	MY2023 CCO 90th percentile

^This measure is selected for 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.

Changes in specifications from MY2024 to MY2025: None.

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:

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

[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.

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
204E00000X	Allopathic & Osteopathic Physicians	Oral & Maxillofacial Surgery	

Taxonomy Code	Grouping	Classification	Specialization
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.

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Adults with Diabetes – Oral Evaluation (DOE)

Overview: Percentage of adults with diabetes who received at least one oral evaluation within the reporting year.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 35.0%

Target Population (Denominator): Members age 18 and above as of 12/31/2025 with diabetes.

Goal:
Ensure that members with diabetes have a touchpoint with the dental delivery system for periodic or periodontal oral evaluation in the measurement year, identified by any of the following CDT codes: D0120, D0150, or D0180.

Exclusions (Denominator):
- Members who use hospice services any time during the measurement year.
- Members receiving palliative care any time during the measurement year.
- Members who die any time during the measurement year.
- Members who do not have a diagnosis confirmed in encounters.
- Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness criteria.

Exclusions (Numerator): N/A

Note on Telehealth:
This measure is telehealth eligible. 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 (Tele-dentistry) or in person.

Notes on plan-types:
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.
OHA excludes I-SNP and LTI members to be consistent with other CCO metrics.

Changes in Specification from MY2024 to MY2025: Coding and language primarily.

Adults with Diabetes – Oral Evaluation (DOE)

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/2025/2025_adult_diabetes_oral_evaluation_final.pdf?rev=07e3a03f79874d218f9f768ed4a1042a&hash=BFD4DC5F23F1618E1DA84E65A0C5F399

For identifying members with diabetes in DQA's 2025 specifications, it cites HEDIS MY2023 value set and medication list which can be found in the CMS FFY2024 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, 2025 – December 31, 2025

DOE	2023	2024	2025
Benchmark for OHA measurement year	26.4%	31.9%	35%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 1 percentage point floor	MN method with 2 percentage point floor
Source:	MY2021 CCO 90th percentile	MY2019 CCO 90th percentile	Committee consensus

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.

Changes in specifications from MY2024 to MY2025:

- Updated exclusion criteria for palliative care, frailty and members who died in the measurement year to align with NCQA/HEDIS MY2023.

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. Adults with diabetes (type I or type II) can be identified by either claims/encounter data that include a diagnosis of diabetes or by pharmacy data. Both claims/encounter data and pharmacy data must be checked, but a patient needs to be identified by only one method for inclusion in the denominator.

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. Exclude members who died during the reporting year.
2. Exclude members who do not have a diagnosis from the Diabetes Value Set (type I or type II Diabetes), in any setting, and are in the Diabetes Exclusion Value Set (e.g., have a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid/drug induced diabetes) in the reporting year or the year prior to the reporting 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.
3. Members in hospice or using hospice services any time during the measurement year. These members are identified using HEDIS Hospice Encounter Value Set and Hospice Intervention Value Set, with claims within the measurement year.
4. Members receiving palliative care (HEDIS Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10_CM code Z51.5) any time during the measurement year.
5. 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].
6. 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 two 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

[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.

b. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
    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 (see identification 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.

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Childhood Immunization Status (CIS, NQF 38)

Overview: Percentage of children that turn 2 years old during the measurement year and receive the indicated Dtap, IPV, MMR, HiB, HepB, VZV, and PCV series of immunizations (Combo 3 series) by their second birthday.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 69.0%

Target Population (Denominator):
All members who turn two during the measurement period.

Goal:
Ensure members receive all indicated "Combo 3" immunizations before their second birthday. Note: numerator can be met through documentation of anaphylaxis and/or encephalitis. See full specification for additional information.

Exclusions (Denominator):

- Members who use hospice services any time during the measurement year.
- Members who die any time during the measurement year.
- Members who had a contraindication to a childhood vaccine on or before their 2nd birthday.
- Members who had a bone marrow transplant.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is not telehealth eligible.

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025:
Added Organ and Bone Marrow Transplants Value Set for denominator exclusion.
Deleted Newborn Hepatitis B Vaccine Administered Value Set; the deleted value set only contains one ICD-10-PCS code 3E0234Z which is now directly called out in the specifications.

Childhood Immunization Status (CIS, NQF 38)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2025 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, 2025 – December 31, 2025

CIS Combo 3	2023	2024	2025
Benchmark for OHA measurement year	67.9%	67.9%	69.0%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 1.5 percentage point floor	MN method with 1.5 percentage point floor
Source:	MY2020 national Medicaid median	MY2020 national Medicaid median	MY2022 national Medicaid 75th percentile

Note on telehealth: This measure is not telehealth eligible.

Changes in specifications from MY2024 to MY2025:

- NCQA/HEDIS has retired the original administrative and hybrid version of this measure and is only keeping the Electronic Clinical Data Systems (ECDS) version of the measure starting MY2025. OHA continues to utilize available ALERT IIS registry and administrative claims data to calculate the measure and allows CCOs to provide additional information available from electronic health record (EHR).

- Added Organ and Bone Marrow Transplants Value Set for denominator exclusion.
- Deleted Newborn Hepatitis B Vaccine Administered Value Set; the deleted value set only contains one ICD-10-PCS code 3E0234Z which is now directly called out in the specifications.

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 period.
- Members who die any time during the measurement period.
- Members who had a contraindication to a childhood vaccine on or before their second birthday. Either of the following meet criteria:
  - Contraindications to Childhood Vaccines Value Set. Do not include laboratory claims (claims with POS code 81).
  - Organ and Bone Marrow Transplants Value Set.

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.)

Numerator 1 - 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).

Numerator 2 - 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).

Numerator 3 - MMR*

Any 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

Numerator 4 - 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).

Numerator 5 - 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 (ICD-10-PCS code 3E0234Z) 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).

Numerator 6 - 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.

Numerator 7 - 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).

Numerator 8 - 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.

Numerator 9 - 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).

Numerator 10 - Influenza

Either of the following on or before the child's second birthday 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 (e.g., LAIV) (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).

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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

*** Combination 3 rate is incentivized for the OHA CCO quality program.**

(See HEDIS MY2025 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.*

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

Immunizations for Adolescents (IMA, NQF 1407)

Overview: Percentage of adolescents that turn 13 years old during the measurement year and receive the indicated meningococcal, Tdap, and HPV (Combo 2) vaccines by their 13th birthday.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 40.9%

Target Population (Denominator): Members that turn 13 years old during the measurement year.

Goal:
Ensure members receive all indicated "Combo 2" immunizations before their 13th birthday. Note that numerator compliance can be established through documentation of anaphylaxis and/or encephalitis due to the immunization in question. See full specification for additional information.

Exclusions (Denominator):
Members who use hospice services any time during the measurement year.
Members who die any time during the measurement year.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is not telehealth eligible.

Notes on plan-types:
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.

Changes in Specification from MY2024 to MY2025:
Added the pentavalent meningococcal vaccine (CVX 316 and CPT 90623) to the meningococcal indicator numerator and expanded the age range from 11-13 to 10-13.

Immunizations for Adolescents (IMA, NQF 1407)

Measure Basic Information

Name and date of specifications used: OHA follows HEDIS® MY2025 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, 2025 – December 31, 2025

IMA Combo 2	2023	2024	2025
Benchmark for OHA measurement year	36.9%	36.9%	40.9%
Improvement target for OHA measurement year	MN method with 1 percentage point floor	MN method with 1.5 percentage point floor	MN method with 1.5 percentage point floor
Source:	MY2019 national Medicaid median	MY2019 national Medicaid median	MY2022 national Medicaid 75th percentile

Note on telehealth: This measure is not telehealth eligible.

Changes in specifications from MY2024 to MY2025:

- NCQA/HEDIS has retired the original administrative and hybrid version of this measure and is only keeping the Electronic Clinical Data Systems (ECDS) version of the measure starting MY2025. OHA continues to utilize available ALERT IIS registry and administrative claims data to calculate the measure and allows CCOs to provide additional information available from electronic health record (EHR).
- Added the pentavalent meningococcal vaccine (CVX 316 and CPT 90623) to the meningococcal indicator numerator and expanded the age range from 11-13 to 10-13.

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 period.
- Members who die any time during the measurement period.

Deviations from cited specifications for denominator: None.

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:

Numerator 1 - 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 10th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday.

Numerator 2 - 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.

Numerator 3 - 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 (meningococcal, Tdap, HPV) 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.*

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

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

Overview:
The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services.

Measurement Period: 01/01/2025 – 12/31/2025

Benchmark/Target: 50.0%

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: Where there is an identified need ensure member visits are provided with a qualifying interpreter or as qualified in-language provider services.

Exclusions (Denominator):
- Members who died in the measurement period.
- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.

Providers should document the reasons a member refuses the interpreter service. The visit can be excluded for these two reasons:
- Member refusal because in-language visit is provided.
- Member confirms interpreter needs flag in MMIS is inaccurate.

Exclusions (Numerator): N/A

Note on Telehealth: This measure is telehealth eligible.

Notes on plan-types:
Starting MY2024, CCO members under the Basic Health Plan (BHP) anytime during the required continuous enrollment period are excluded from the incentive quality rates.

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

Measure Basic Information

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

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐Survey ■Other Specify: OHA-developed

Measure Utility:

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

Data Source: CCO attestation (annual survey for Component 1 and quantitative contract language access for Component 2)

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

Benchmark for OHA measurement year	2023*	2024*	2025*
Component 1 – minimum points from must pass questions	77 points	83 points	97 points
Component 2 – reporting method and data collection requirement	Sampled hybrid reporting; must meet 80% data collection rate	Full population	Full population
Component 2 – benchmark for percentage of visits provided with interpreter services by OHA certified or qualified interpreters	75% with Minnesota Method improvement target	75% benchmark with Minnesota (MN) Method improvement target & 5 pct point floor	50% benchmark with Minnesota (MN) Method improvement target & 5 pct point floor
Source:	Committee consensus	Committee Consensus	Committee Consensus

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

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

Changes in specifications from MY2024 to MY2025:

- Changed limited English proficiency (LEP) to prefers a language other than English (LOE). This terminology change does not reflect a change in metric specifications. The change is meant to better reflect a strength-based approach.
- Added a section to clarify the applicable CCO population for reporting and for the incentive performance rate.

Component 1

- Updated self-attestation questions 3, 15, 26, 41, 42, 43, 46, 49, 50 in Appendix 1, including new questions, point requirement changes and clarifications. Summary of changes in Appendix 2, second table.

Component 2

- Added section for data source (contract report) and submission due date.
- Added exclusion for members who died in the measurement year.
- Added refusal reason 5 to capture refusals from the member who does not need interpreter services for the particular visit. Visits with member refusal reason 5 may qualify for denominator exclusion, but this does not exclude other visits from the same member.
- Clarified the definition of in language provider and which provider qualifies for in-language visit numerator credit.
    - Added native speaker and ALTA test for qualifying in language provider visits.
    - When initially verifying in-language providers' proficiency, tests within the last four years instead of three years are valid.
    - Increased proficiency test requirement for Language Line Solutions from 2+ to 3+ to align with current OHA standards.
    - Removed the retesting requirement for proficiency tests.
- Updates throughout Appendix 3 including hospital related fields, optional reporting for MY2025, required starting MY2026.
- For Appendix 4, claim lines containing modifier code 26 or place of service (POS) 81 are exclude. Some previously missing inpatient OHGs are added to the documentation. Additional codes are added to the telehealth identification logic.
- Added Appendix 5 for hospital fields.

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.

CCOs are required to report services and data collection for all CCO members in Component 1, as well as all visits in Component 2 for all CCO members who have language access needs (defined in the Eligible Population and Denominator sections). OHA will flag the BHP and HOP/CAK members during the measurement period when reviewing the data submitted by the CCO and exclude them from the quality rate for the incentive program use.

Measure Details

Measure Components and Scoring

There are two components in this measure:

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

Component 1: CCO language access self-assessment survey

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

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

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

Domain Name	MY2023 (year3)		MY2024 (year4)		MY2025 (year5)		MY2026 (year6)	
	Total available Points	**Minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**	Additional available points	**Additional minimum required**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve.	57	**42**	10	**3**	1	**11**	**0**	**0**
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members is trained on language access policies and procedures.	8	**5**	0	**0**	1	**0**	**0**	**1**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how members who prefer a language other than English (LOE) and Deaf or Hard of Hearing members you serve may access available language assistance services.	9	**7**	0	**0**	2	**1**	**0**	**1**

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

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

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

Data source and submission: CCOs are required by the contract to report full population quantitative language access data quarterly, for a rolling 12-month period. Starting MY2024, MLA uses the quarterly contract report that aligns with the calendar year period. For example, the calendar year 2025 period in the contract report due on April 1, 2026 is used for MLS MY2025 quality rate review.

Note the other three quarterly reports required by the contract (e.g., 2024Q2 – 2025Q1 period due on July 1, 2025) are not used for MLA annual results, but OHA uses them for providing quality reviews.

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

> The CCO must include all members who already have MMIS interpreter flags[1] during the measurement year for the Component 2 full-population reporting. Members can self-identify their spoken or sign language interpreter needs to OHA during the ONE eligibility process; this information is documented in MMIS for members with spoken language interpreter needs (IND_INTERPRETER = Y) or with a non-blank CDE_INTERPRETER_TYPE[2].
>
> Members can also self-identify their interpreter needs to the CCO or the provider through intake questionnaire in different settings or by self-initiating an interpreter service request. If the CCO attests collecting interpreter needs information in Component 1 survey questions 1 and 3 in addition to using the MMIS information and identifies additional members who do not have MMIS flags for interpreter needs, the CCO can include the additional members in the report[3]. When including these individuals in

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

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

[3] Reporting members who self-identify (MMIS interpreter flag equals No) continues to be optional. If CCOs choose to report, 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.

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
- Telehealth
- Other

See Appendix 3 for quantitative interpreter services reporting template.

Data elements required denominator exclusion:

- Members who died in the measurement period.
- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.
- CCOs should document the reasons a member refuses the interpreter service, and the visit can be excluded for the first two of the following reasons if the CCO also attests data collection for the corresponding reasons in the self-assessment Question 14:
  1. Member refusal because in-language visit is provided[4]
  2. Member confirms interpreter needs flag in MMIS is inaccurate[5]

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

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

3. Member unsatisfied with the interpreter services available – not eligible for exclusion.
4. Other reasons for patient refusal – not eligible for exclusion.
5. Member does not need interpreter services for the visit[6]

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

Data for supporting Hospital QDP program: To support the hospital Qualified Directed Payments (QDP) program, OHA has added two additional fields to the language access reporting template (see Appendix 3), optional reporting starting MY2025 and required beginning MY2026:

- QDP Facility Name
- QDP Facility National Provider Identification (NPI)

These fields need to be reported when the visit is with a hospital or emergency department facility. See Appendix 5 for the hospitals.

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

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

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

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

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

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

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

The required reporting elements include:

Report In-person, telephonic or video interpreter services (or in-language provider visits, optional in MY2025) provided:
=> If Yes to any of the three modality fields, answer Was the interpreter (or in-language provider) OHA Certified or Qualified?
=> if the interpreter (or in-language provider) is OHA-certified or qualified, report the OHA Registry number.
=> If No to all three modality fields, answer Did the member refuse interpreter service (Yes/No)[8]

Data elements required numerator exclusion: none.

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

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

proficiency test in the member's preferred language. To pass the proficiency test, the provider must pass the proficiency test with a score of:

- 3+ or higher for Language Line Solutions' (LLS) proficiency test or a score of 'Competent' on LLS Bilingual Fluency Assessment (BFA) or LLS Bilingual Fluency Assessment for Clinicians (BFAC)
- Advanced-mid level or higher for American Council on the Teaching of Foreign Language (ACTFL) (i.e., Language Testing International's proficiency test)
- ALTA proficiency tests at 8 or above rating scale.
- In-language providers that have passed an OHA-approved Oral Proficiency Interview (OPI) also qualify for passing the language proficiency requirement.

When initially verifying in-language providers' proficiency, tests must be no more than four years old; after initial verification of proficiency, the test does not have to be retaken. The in-language provider reporting option is not available to general clinic staff, such as receptionist, certified nursing assistants, and schedulers.

[8] If no records of member refusal exist, it is considered that the member did not refuse (fill in No in template). If the member refuses interpreter services, reporting the refusal reasons is optional.

[9] Reporting visits with an in-language provider is optional in MY2025.

[10] Reporting visits with an in-language provider is optional in MY2025.

[11] The measure denominator is NOT restricted to only the visits when interpreter services were provided.

speaker or passing the proficiency test in the members preferred language with the CCO, count as '0' for numerator hits.

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

Version Control

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

Introduction

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

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

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

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

Self-assessment requirements

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

Total possible points (Year 1 through 3) = 102

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

Total possible points (Year 4) = 115

- Year 4 minimum points required = 83 or 72.2%

Total possible points (Year 5 & 6) = 121

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

Additional Information

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

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

Contact Information

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

Name: _____

CCO Name: _____

Email Address: _____

Domain 1: Identification and assessment for communication needs

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

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

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

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

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

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

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

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

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

( ) Yes

( ) No

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

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

( ) Yes

( ) No

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

Write in language

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

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

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

( ) Yes

( ) No

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

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

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

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

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

( ) A. Same day

( ) B. 1-3 days

( ) C. 4-7 days

( ) D. More than 7 days

( ) E. The CCO does not collect this information

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

( ) Yes

( ) No

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

( ) A. Weekly

( ) B. Monthly

( ) C. Quarterly

( ) D. Annually

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

( ) Yes

( ) No

Domain 2: Provision of language assistance services

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

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

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

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

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

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

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

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

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

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

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

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

( ) Yes

( ) No

( ) We do not have an interpreter services vendor

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

F. The CCO tracks the **cost of translation of materials into non-English languages.**	( )	( )

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

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

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

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

39) When spoken and sign language interpretation services are provided during member visits, can your CCO collect detailed member level information (such as member ID, date of service, and interpreter credential) for

appointments in each of the following care delivery settings? Please select yes or no to the following statements. *Must pass beginning MY2023 (year 3) with minimum points required = 6; total points available = 8.*

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

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

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

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

	Yes	No

A. Type of language proficiency assessment	( )	( )
B. Passing score of language proficiency assessment	( )	( )
C. Specific language assessed	( )	( )

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

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

( ) Yes

( ) No

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

Domain 3: Training of staff on policies and procedures

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

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

Domain 4: Providing notice of language assistance services

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

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

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

( ) Yes

( ) No

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

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

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

( ) Yes

( ) No

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

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

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

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

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

assistance services.								

Point value for each question

Domain	New #	Old #	Change MY24-MY25	2024	minimum	2025	minimum	2026	minimum
	1	1		7	5				
	2	2		3	3				
	3	3	Change	4	3	2	2		
	4	4		0	0				
	5	5		0	0				
	6	6		1	1				
	7	7		1	1				
	8	8		1	1				
	9	9		1	1				
	10	10		1	1				
	11	11		1	1				
	12	12		1	1				
	13	13		1	1				
	14	14		5	3				
	15		New			0	0		
	16	15		2	2				
	17	16		2	2				
	18	17		0	0				
	19	18		0	0				
	20	19		0	0				
1	21	20		0	0				
	22	21		3	3				
	23	22		7	5				
	24	23		8	6				
	25	24		6			6		
	26		New			1	1		
	27	25		1	1				
	28	26		1	1				
	29	27		1	1				
	30	28		1	1				
	31	29		3			3		
	32	30		6	6				
	33	31		1			1		
2	34	32		1	1				

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

Appendix 3: Quantitative Interpreter Services Reporting Template

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

Data submission deadline is April 1st of the year following the measurement year:

MY2024: Due April 1, 2025
MY2025: Due April 1, 2026
MY2026: Due April 1, 2027

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

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

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

Column Name	*Valid Input Value*	*Instructions*	*Field Type*
Was the Interpreter a Bilingual Staff	Yes No Blank	Yes - Bilingual Staff No - No Bilingual Staff Blank - Unknown or Not Applicable Do not use this field for the primary performing provider who provides an in-language visit. Bilingual staff services do not automatically qualify for numerator hits unless the staff (is OHA qualified or certified for interpreter services, or the in-language visit provider has passed the proficiency test for the member's preferred language. This flag is for information that an outside/contracted interpreter is not used; it helps the CCO to identify staff who may receive training for becoming OHA qualified and certified, or take a proficiency test	Optional
Did the member refuse Interpreter Service	Yes No Blank	Yes - Member Refused Interpreter Services No - Member did not Refuse Interpreter Services Blank - Unknown or Not Applicable If no records of member refusal exists, member did not refuse (fill in No in template) can be indicated.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)
Reason for Member Refusal	1 2 3 4 5 Blank	1 - Member refusal because in-language visit is provided 2 - Member confirms interpreter needs flag in MMIS is inaccurate 3 - Member unsatisfied with the interpreter services available 4 - Other reasons for patient refusal 5 – Member does not need interpreter services for the visit Blank - Unknown or Not Applicable Scenario 1: The member confirms the provider for the visit can perform in-language service and therefore refused interpreter service. To note, if the in-language service provider is OHA certified or qualified or has passed the language proficiency requirements, it could be a numerator hit for the metric. Scenario 2: OHA recommends initiating correction of the interpreter flag in MMIS. Scenario 5: The member decides to refuse interpreter service for this reported visit, but the member may need language services for other visits. Visits with refusal reasons 1,2 or 5 can be excluded IF the CCO attests collecting corresponding information in the CCO self-assessment survey question #14. Scenarios 3 and 4 do not qualify for denominator exclusion.	Required if No for all of the three language service modality fields (In Person, Telephonic, Video Remote)

Column Name	Valid Input Value	Instructions	Field Type
Hospital Facility Name	Text	Report facility name when the visit is with a hospital facility. See Appendix 5 for facility name reference table.	Hospital and Emergency Department visits2 only; optional MY2025, required starting MY2026
Hospital Facility NPI	numeric	Report facility name when the visit is with a hospital facility. Provide the facility's NPI for the hospital location the patient is receiving services, as specified in OAR 410-120-0000(198). DO NOT provide the NPI or any other identifier associated with a health care professional. "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.	Hospital and Emergency Department visits2 only; optional MY2025, required starting MY2026

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

[2] Hospital visit means the member received a qualifying visit from an on or off campus-based hospital facility inclusive of inpatient, outpatient, emergency room, ambulatory surgery, and telehealth services.

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

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

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

OHG-to-HEM Crosswalk Table:

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
D-01	Dental Diagnostic	dental	Office Outpatient
D-02	Dental Preventative	dental	Office Outpatient
D-03	Dental Restorative	dental	Office Outpatient
D-04	Dental Endodontics	dental	Office Outpatient
D-05	Dental Periodontics	dental	Office Outpatient
D-06	Dental Prosthodontics Removable	dental	Office Outpatient
D-07	Dental Implants/ Prosthodontics Fixed	dental	Office Outpatient
D-08	Dental Oral Maxillofacial Surgery	dental	Office Outpatient
D-09	Dental Orthodontics	dental	Office Outpatient
D-10	Dental Anesthesia	dental	Office Outpatient
D-99	Dental Adjuctive General Services (Unbucketed)	dental	Office Outpatient
I-01	Ip-Ther-Abort-Ip-Hosp	physical	Inpatient
I-02A	Ip-Mh-Acute-Ip-A	mental/behavioral	Inpatient
I-02B	Ip-Mh-Acute-Ip-B	mental/behavioral	Inpatient
I-03	Ip-Acute-Detox	mental/behavioral	Inpatient
I-04	Ip-Steril-Maternity	physical	Inpatient
I-05	Ip-Hyster-Hosp	physical	Inpatient
I-06	Ip-Steril-Hosp-F	physical	Inpatient
I-07	Ip-Post-Hosp-Ext-Care	physical	Inpatient
I-08	Inpatient Maternity C-Section Delivery	physical	Inpatient
I-09	Inpatient Maternity Non-Delivery	physical	Inpatient
I-10	Inpatient Maternity Normal	physical	Inpatient
I-11A	Inpatient Newborn Complicated	physical	Inpatient

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

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

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
I-11B	Inpatient Newborn Well	physical	Inpatient
I-12	Inpatient Rehabilitation	physical	Inpatient
I-13	Inpatient Medical/Surgical (Medical Only)	physical	Inpatient
I-14	Inpatient Medical/Surgical (Surgical Only)	physical	Inpatient
I-15	Inpatient Un-Bucketed Missing DRG	physical	Inpatient
I-15A	Ip-Or-Spec-Drg-Rehab	physical	Inpatient
I-15B	Ip-Or-Spec-Drg-NeoNates	physical	Inpatient
I-99	Inpatient Unbucketed	physical	Inpatient
M-01	Emergency Lifeflight	exclude	exclude
M-02	School Based Services	physical	Office Outpatient
M-03	Transportation Ambulance	exclude	exclude
M-04	Outpatient Basic ASC (ASC = Ambulatory Surgical Center)	physical	Office Outpatient
M-05	Physician Primary Care E-M (Evaluation & Management)	physical	Office Outpatient
M-05A	Physician Primary Care E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-06	Physician Other E-M (Evaluation & Management)	physical	Office Outpatient
M-06A	Physician Other E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-07	Evaluation & Management PCP (PCP = Primary Care Phsycian)	mental/behavioral	Office Outpatient
M-08	Mental Health ACT (ACT = Assertive Community Treatment)	mental/behavioral	Office Outpatient
M-09	Mental Health AFC (AFC = Adult Foster Care)	exclude	exclude
M-10	Mental Health Assessment & Evaluation	mental/behavioral	Office Outpatient
M-11	Mental Health Case Management	mental/behavioral	Other
M-12	Mental Health Consultation	mental/behavioral	Office Outpatient
M-13	Mental Health Crisis Services	mental/behavioral	Office Outpatient
M-14	Mental Health Interpretive Services	exclude	exclude
M-15	Mental Health Medication Management	mental/behavioral	Other
M-16	Mental Health Alternative to Inpatient	mental/behavioral	Outpatient
M-17	Mental Health MST (MST = Muti-Systemtic Treatment)	mental/behavioral	Office Outpatient
M-18	Mental Health PAITS (PAITS = Post Acute Intensive Treatment Services)	mental/behavioral	Office Outpatient
M-19	Mental Health PDTS (Psyciatric Day Treatment Services)	mental/behavioral	Office Outpatient
M-20	Mental Health Respite	mental/behavioral	Other

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-21	Mental Health RTF Part A (RTF = Residential Treatment Facility)	exclude	exclude
M-22	Mental Health RTF Part B (RTF = Residential Treatment Facility)	exclude	exclude
M-23A	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-23B	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-24	Mental Health Skills Training	mental/behavioral	Office Outpatient
M-25	Mental Health SRTF (SRTF = Secure Residential Treatment Facility 18+)	exclude	exclude
M-26	Mental Health Sub Acute	mental/behavioral	Office Outpatient
M-27	Mental Health Supportive Employment	exclude	exclude
M-28	Mental Health Therapy	mental/behavioral	Office Outpatient
M-29	Mental Health Therapy Inpatient	mental/behavioral	Inpatient
M-30	Mental Health Wrap-Around Services	mental/behavioral	Other
M-31	Mental Helath Intensive Rehab Services	mental/behavioral	Office Outpatient
M-32A	Physician Therapeutic Abortion Part A	physical	Office Outpatient
M-32B	Physician Therapeutic Abortion Part B	physical	Office Outpatient
M-33	Behavioral Rehab Services	mental/behavioral	Office Outpatient
M-34	Excluded Admin Exams	physical	Other
M-35	Targeted Case Management (TCM) Leveraged	physical	Other
M-36	Non-Emergent Transporation (NEMT)	exclude	exclude
M-37	Checmical Dependency OHP Outpatient (OHP = Oregon Health Plan)	mental/behavioral	Office Outpatient
M-40	Mental Health Outpatient Therapy	mental/behavioral	Office Outpatient
M-41	Mental Health Physician Outpatient	mental/behavioral	Office Outpatient
M-42	Mental Health Supportive Day Treatment	mental/behavioral	Office Outpatient
M-43	Mental Health Supportive Housing	exclude	exclude
M-44	Anesthesia	physical	Office Outpatient
M-45A	Outpatient Dental Anesthesia	dental	Office Outpatient
M-45B	Outpatient Dental Flouride	dental	Office Outpatient
M-46	Physician Family Planning Part B	physical	Office Outpatient
M-47	Physician Family Planning Part C	physical	Office Outpatient
M-48	Physician Hysterectomy	physical	Office Outpatient
M-49	Lab	exclude	exclude
M-50	Other Medical Maternity Management	physical	Office Outpatient
M-51	Other Medical Durable Medical Equipment	exclude	exclude
M-52	Other Medical Supplies	exclude	exclude
M-53	Maternity	physical	Office Outpatient
M-53A	Physcian Maternity Primary Care	physical	Office Outpatient
M-54	Neonate Newborn Care	physical	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-55	Radiology	physical	Other
M-56	Physician Sterilization	physical	Office Outpatient
M-57	Surgery	physical	Office Outpatient
M-58	Speech & Hearing	physical	Office Outpatient
M-59	Vision Exams & Therapy	physical	Office Outpatient
M-60	Physician Other Services	physical	Other
M-61	Other Drugs & Supplies	exclude	exclude
M-62	Community Detox	mental/behavioral	Office Outpatient
M-63	Chemical Dependency Assessment Screening	mental/behavioral	Office Outpatient
M-64	Chemical Dependency Methadone Treatment	mental/behavioral	Office Outpatient
M-65	Cemical Dependency Methadone AMH (AMH = Addictions and Mental Health)	mental/behavioral	Office Outpatient
M-66	Physicial Somatic Mental Health	mental/behavioral	Office Outpatient
M-67	Not Covered	exclude	exclude
M-68	SBIRT Part A (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-69	SBIRT Part B (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-70	Mental Health Children and Adolescent Needs Assessment	mental/behavioral	Office Outpatient
M-71	ABA Services - Mental Health	mental/behavioral	Office Outpatient
M-72A	Chemical Dependency Residential Treatment Child	mental/behavioral	Inpatient
M-72B	Chemical Dependency Residential Treatment Adult	mental/behavioral	Inpatient
M-72C	Psychiatric Residential Treatment Services	physical	Inpatient
M-75	Urgent Care Visits	physical	Office Outpatient
M-76	Preventative Well Baby Exams	physical	Office Outpatient
M-77	Preventative Immunizations	physical	Office Outpatient
M-78	Preventative Care Covered Service	physical	Office Outpatient
M-79	Preventative Care Non-Covered Service	physical	Office Outpatient
M-80	Inpatient Visits	physical	Inpatient
M-81	Outpatient	physical	Office Outpatient
M-98A		mental/behavioral	Other
M-98B		mental/behavioral	Other
M-98C		mental/behavioral	Other
M-99	Professional Unbucketed	physical	Other
O-01	Outpatient Therapeutic Abortion Outpatient Hospital	physical	Office Outpatient
O-02	Outpatient Excluded Administrative Exams	physical	Other
O-03	Outpatient Prescription Drugs Mental Health	mental/behavioral	Office Outpatient
O-04	Outpatient Mental Health Other Outpatient	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-05	Outpatient Emergency Room Somatic Mental Health	mental/behavioral	ED
O-06A	Outpatient Chemical Dependency -- Part A	mental/behavioral	Office Outpatient
O-06B	Outpatient Chemical Dependency -- Part B	mental/behavioral	Office Outpatient
O-07	Outpatient Hysterectomy	physical	Office Outpatient
O-08	Outpatient Sterilization -- Female	physical	Office Outpatient
O-09A	Outpatient Family Planning -- Part A -- No Modifier	physical	Office Outpatient
O-09B	Outpatient Family Planning -- Part B -- With Modifier	physical	Office Outpatient
O-09C	Outpatient Family Planning -- Part C -- With Modifier	physical	Office Outpatient
O-10	Outpatient Maternity	physical	Office Outpatient
O-11	Outpatient Prescription Drugs Basic	physical	Office Outpatient
O-11A	Outpatient Skilled Nursing Facility	physical	Office Outpatient
O-12	Outpatient Post Hospital Extended Care	physical	Office Outpatient
O-13	Outpatient Maternity Case Management	physical	Office Outpatient
O-14	Outpatient Hospice Services	physical	Office Outpatient
O-15	Outpatient Transportation Ambulance	exclude	exclude
O-16	Outpatient Emergency Room	physical	ED
O-17A	Outpatient Lab Services -- Part A	exclude	exclude
O-17B	Outpatient Radiology Services CT -- Part B (CT = Computerized Tomography	physical	Other
O-17C	Outpatient Radiology Services MRI -- Part C (MRI = Magnetic Resonance Imaging)	physical	Other
O-17D	Outpatient Radiology Services PET -- Part D (PET = Positron Emission Tomography)	physical	Other
O-18	Outpatient Home Health	physical	Home Health
O-19	Outpatient Somatic Mental Health	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-20	Outpatient Physician Administered Drugs	physical	Other
O-21	Outpatient Diagnostic Services Other	physical	Office Outpatient
O-22	Outpatient Lab Injections Other	exclude	exclude
O-23	Outpatient Supplies & Devices	exclude	exclude
O-24	Outpatient Operating Room Other	physical	Office Outpatient
O-25	Outpatient Anesthesia Other	physical	Office Outpatient
O-26	Outpatient Clinics	physical	Office Outpatient
O-27	Outpatient Therapy & Rehabilitation	physical	Office Outpatient
O-28	Outpatient Professional Fees	physical	Office Outpatient
O-29	Outpatient Surgery	physical	Office Outpatient
O-30	Preventative Care Covered Service	physical	Office Outpatient
O-31	Preventative Care Non-Covered Service	physical	Office Outpatient
O-99	Outpatient Unbucketed	physical	other
RX-01	Pharmacy Perscription Drugs Basic	exclude	exclude
RX-02	Pharmacy Over The Counter (OTC)	exclude	exclude
RX-03	Pharmacy Family Planning Contraceptives	exclude	exclude
RX-04	Pharmacy Carved-Out Drugs	exclude	exclude
RX-05	Pharmacy Immunization Drugs	exclude	exclude
RX-06	Pharmacy Durable Medical Equipment (Pill Splitters)	exclude	exclude
RX-07	Pharmacy Medication Assisted Treatment (MAT)	exclude	exclude

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

- Procedure code: 98966-98972, 99421-99458, 99473, 99474, 99091, D9995, D9996, G0425-G0427, G0508, G0509, G2010, G2012, G2025, G2061-G2063, Q3014 or
- Modifier: GT, GQ, G0, 95, or
- Place of Service code: 02 or 10

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

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

Appendix 5: Hospital Facility Names and NPI

This list is not an exhaustive of all hospital facility NPIs in use and is meant to provide general guidance. NPIs will be updated on an annual basis. As previously noted, if choosing to report the hospital facility name and NPI, report the facility NPI of the hospital and not the professional health care provider level NPI. A known hospital facility NPI should still be reported even if it is not on the list below.

Facility Name	Primary NPI	Secondary NPI
Adventist Columbia Gorge Medical Center	1275880148	1306842752
Adventist Medical Center	1801887658	
Adventist Tillamook Regional Medical Center	1871575225	1184607020
Asante Ashland Community Hospital	1386644029	1407271398
Asante Rogue Valley Medical Center	1770587107	
Asante Three Rivers Medical Center	1801891809	1598895690
Bay Area Hospital	1225016561	
Blue Mountain Hospital	1356414395	
Columbia Memorial Hospital	1134146939	
Coquille Valley Hospital	1730223967	
Curry General Hospital	1487696985	
Good Shepherd Medical Center	1295789667	
Grande Ronde Hospital	1467446195	
Harney District Hospital	1285742338	
Kaiser Sunnyside Medical Center	1124182902	
Kaiser Westside Medical Center	1891048807	
Lake District Hospital	1376698522	
Legacy Emanuel Medical Center	1831112358	
Legacy Good Samaritan Hospital	1780608216	1679597108
Legacy Meridian Park Medical Center	1184647620	
Legacy Mount Hood Medical Center	1255354700	
Legacy Silverton Medical Center	1669424354	
Lower Umpqua Hospital	1003874819	1538249081
McKenzie-Willamette Medical Center	1568413573	
Mercy Medical Center	1023306800	1477590198
OHSU Health Hillsboro Medical Center	1275591984	
OHSU Hospital	1609824010	
PeaceHealth Cottage Grove Medical Center	1902892391	
PeaceHealth Peace Harbor Medical Center	1578552402	
PeaceHealth Sacred Heart Medical Center - Riverbend	1083888515	
Pioneer Memorial Hospital - Heppner	1376572099	
Providence Hood River Memorial Hospital	1255429338	

Providence Medford Medical Center	1689755670	
Providence Milwaukie Hospital	1215168711	1366536963
Providence Newberg Medical Center	1952482275	
Providence Portland Medical Center	1003991845	
Providence Seaside Hospital	1578500492	1952449985
Providence St Vincent Medical Center	1114015971	1083866933
Providence Willamette Falls	1912282369	
Saint Alphonsus Medical Center - Baker City	1386636355	1326313305
Saint Alphonsus Medical Center - Ontario	1891891792	1013276831
Salem Health Salem Hospital	1265431829	
Salem Health West Valley Hospital	1245237486	
Samaritan Albany General Hospital	1154372340	
Samaritan Good Samaritan Regional Medical Center	1962453134	1811235070
Samaritan Lebanon Community Hospital	1689625980	1790928125
Samaritan North Lincoln Hospital	1306897491	
Samaritan Pacific Communities Hospital	1801847066	
Santiam Memorial Hospital	1154302214	
Shriners Hospital for Children	1982793139	
Sky Lakes Medical Center	1659340370	
Southern Coos Hospital & Health Center	1417094145	1588684484
St Anthony Hospital	1649276734	
St Charles - Bend	1982621447	
St Charles - Bend Redmond Campus	1225056146	
St Charles - Madras	1356389894	
St Charles - Prineville	1972699106	1710160445
Wallowa Memorial Hospital	1558366229	
Willamette Valley Medical Center	1346269982	

UMPQUA HEALTH

3031 NE Stephens St.
Roseburg, OR 97470

Phone: 541.229.4842
umpquahealth.com

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

Overview:
CCOs will collect and report social needs screening and referral data for a population sample, reporting social needs screening and referral data.
Measurement Period: Component 2, intake (screening): 12/15/2024 – 12/14/2025

Benchmark/Target: 90.0% completeness threshold for sample.

Target Population (Denominator):
- Rate 1: All members.
- Rate 2: Rate 1 numerator.
- Rate 3: Rate 2 numerator.

Goal:
Ensure screening for the three outlined social needs is administered to members at least annually and if any domains are screened positive for, a referral is placed to address the identified need(s) within 15 days of the date that the positive screening occurs.

Exclusions (Denominator): N/A
Exclusions (Numerator): N/A

Note - A referral must be made for each positive domain to qualify for Rate 3 numerator. Whether the referral was accepted or declined for each positive domain must be documented.
- A member can choose to decline any or all referrals.
- Member refusal of all screenings is an exception to Rate 1 **for that encounter**.
- Member refusal of all referrals for positively identified domains of need is an exception to Rate 3 **for that encounter.**

Note on Telehealth: This measure is telehealth eligible.

Changes in Specification from MY2024 to MY2025: MY2025 is the first year for reporting component 2.

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

Measure Basic Information

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

URL of Specifications: N/A.

Measure Type:

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

Measure Utility:

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

Member Type:

■CCO A ■CCO B

Data Source:

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

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

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

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

Past Benchmark for OHA measurement year	**2023**	**2024**	**2025**
Component 1 – minimum points from must pass questions	CCO must attest to completion of all recommended MY2023 must-pass elements in Table 1	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1
Component 2 – reporting method and data collection requirement	Not required	Not required	Sample with 90% completeness threshold
Component 2 – % of members screened and % of members who received a referral	Not required	Not required	Not required
Source:	Committee consensus	Committee consensus	Committee consensus

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

Changes in specification from MY2024 to MY2025:

Component 1:No changes

Component 2:

- OHA is proposing a stratified random sample with a 95% confidence level and a three percent margin of error. The sample size will be 1,067 members.
- Added a completeness threshold of 90% for the sample.
- For Rate 1 Percent Screened, time period clarified for the screening period and continuous enrollment.
- Clarified the footnote for continuous enrollment period and its relationship to the Rate 1 Percent Screened denominator.
- Allow unknown values count towards Component 2 completeness threshold.
- Appendix 1 Template for Component 2 Reporting changes are in blue text. Added Screened for Social Needs field and made clarifications based on December public comment. Removed requirement that recorded annual screening be most recent one in the measurement year. Clarified that unknown screening outcome meant that the record would not be a numerator hit for rate 1.
- Appendix 2 Social Needs Screening Tools Process changes are in blue text.
- Appendix 3 Good Faith Effort added.
- Appendix 4 referral definition added to the glossary and made clarifications based on December public comment.

Measure Details – Component 1, Structural Measure

Measure Components and Scoring – Component 1

Social Needs Screening and Referral CCO Self-Assessment

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

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

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

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

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

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

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

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

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

Elements are grouped together by topic areas A-C from Table 1. Definitions are in Appendix 4.

A. Screening practices

1. **Collaborate with CCO members on processes and policies (MY 2023-2025)**

- **Intent:** CCO member voices are reflected in the policies and processes established by CCOs regarding screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.

- **This element is met if** the CCO collects and incorporates input from members on written policies for screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.

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

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

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

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

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

    - **Examples of activities *not* meeting this element:**
        - Policies on assessing members' unmet social needs not distributed to staff and partners.

- An online training program described in the policies does not have links to or otherwise share written CCO policies on assessing members' unmet social needs.
- Written CCO policies do not address critical considerations for assessing members' unmet social needs, including: (1) trauma-informed practices, (2) empathic inquiry or motivational interviewing, (3) culturally responsive and equitable practices, and (4) clear protocols for referring members to available community resources.

3. Assess whether and where screenings are occurring (MY 2023-2025)

- **Intent**: CCOs understand where screenings occur, so they can coordinate screening and referral activities, identify gaps, and share policies and resources.

- **This element is met if** the CCO conducts a systematic assessment of screenings that are done by (1) CCO staff, (2) all provider organizations listed in the CCO's Delivery System Network (DSN) report and (3) any CBOs, social service agencies, or other social determinants of health and equity partners with which the CCO has contracts, memoranda of understanding (MOUs), grants, or other agreements for addressing social needs. This assessment should identify where members are predominantly being screened for unmet social needs (e.g., at primary care clinics, upon enrollment with the CCO, at a local housing resources organization). The CCO must be able to determine, at a minimum, whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

- **Examples of activities meeting this element**: In addition to assessing screenings done within the CCO, the CCO does any of the following:
  - Annually surveys provider organizations listed in the CCO's DSN report, CBOs, social service agencies, and other organizations on social needs assessments,
  - Collects regular reporting from provider organizations listed in the CCO's DSN table, CBOs, and social service agencies specifically on the prevalence of social needs assessments, or
  - Maintains a real-time or near real-time list of services offered by all provider organizations in the DSN table, CBOs, and social service organizations in their service area, with a specific indication for social needs assessments.

- **Examples of activities *not* meeting this element:**
  - A survey of network providers asks about social needs screenings in general, but not about screening specifically for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
  - Information reported (through a survey or regular reporting) prior to the measurement year.

- An assessment of screenings occurring in the service area by network providers does not include an assessment of CBOs and social service agencies.

4. **Assess training of staff members who conduct screening (MY 2024 and review in MY 2025)**
    - **Intent**: CCOs ensure that partners – including contractors, in-network providers, and CBO partners – provide training to staff who conduct screenings.
    - **This element is met if** the CCO reviews the training policies of its partners and, if needed, provides training resources to partners.
    - **Examples of activities meeting this element**:
        - The CCO surveys its partners about training policies and practices. If a partner has a gap in policies or practices, the CCO suggests resources, such as the CCO's training policy as a model or training opportunities such as webinars on trauma-informed screening practices.
    - **Examples of activities *not* meeting this element**:
        - The CCO inquires about training policies or practices but offers no recommendations to partners who lack policies or training resources.
5. **Establish written policies for using disaggregated race, ethnicity, language and disability (REALD) data to inform work on social needs screening and referrals (establish in MY 2023 and review in MY 2024 and 2025)**
    - **Intent:** CCOs use disaggregated REALD data to help understand and respond to members' needs in a culturally responsive way.
    - **This element is met if** the CCO has developed and distributed written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs.
    - **Examples of activities meeting this element**:
        - The CCO has established and distributed written policies, as outlined in Element 2 above, including protocols for analyzing and using disaggregated REALD data.
    - **Examples of activities *not* meeting this element:**
        - Generic written CCO policies on use of REALD do not specifically address use of REALD data in social needs screening and referral practices.
        - Policies address only aggregated REALD data use.

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

    - **This element is met if** the CCO has reviewed the screening tools or questions used by CCO staff *and* systematically contacted (1) the provider organizations listed in the CCO's DSN report and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs to inquire about screening tools or questions used at these organizations. The CCO should also track the language(s) made available to members for each screening tool or set of questions.

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

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

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

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

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

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

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

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

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

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

    - **Examples of activities *not* meeting this element:**
        - The CCO skips analysis of potential risk areas, for example, by failing to assess current screening practices before writing its policy.

- The CCO writes a policy but doesn't distribute it or doesn't include strategies to be used in the screening process to avoid the risk of harm.

B. Referral practices and resources

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

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

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

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

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

10. **Establish written procedures to refer members to services (establish in MY 2024 and review in MY 2025)**

- **Intent:** The CCO has a clear process so that when a member screens positive for one or more unmet needs, the member is referred to culturally responsive services to address their needs.

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

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

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

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

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

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

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

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

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

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

C. Data collection and sharing

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

    - **This element is met if** the CCO systematically reviews how any social needs screening and referral data is captured and exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs. The review identifies any

standardized codes being used to capture data about screening and referrals (e.g., LOINC, SNOMED, ICD10, CIE data dictionary).

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

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

14. **Set up data systems to clean and use REALD data (set up by MY 2024 and maintain in MY 2025)**
    - **Intent:** CCOs set up data systems so they can effectively use REALD data received from OHA and other sources to inform processes for screening and referrals for social needs.

    - **This element is met if** the CCO uses disaggregated REALD data to understand the populations served by your CCO and identify resources to meet members' needs.

    - **Examples of activities meeting this element**:
      - The CCO uses disaggregated REALD data to tailor training on how to provide culturally responsive screening and referrals and to work with community partners to address any gaps in culturally responsive services to meet members' social needs.

    - **Examples of activities *not* meeting this element:**
      - The CCO collects and stores disaggregated REALD data but has not used the data to modify or add new community engagement and/or social needs screening and referral practices.

15. **Support a data-sharing approach (set up by MY 2024 and maintain in MY 2025)**
    - **Intent:** CCOs support networked providers to have access, at the point of care, to screening results and referral(s) made, even if the screening or referral occurs at the CCO level or at another clinic.

    - **This element is met if** the CCO provides access to a tool or tools that enable screening and referral data to be shared among networked providers who care for members or if

the CCO otherwise ensures that networked providers use tools to share screening and referral data. Tools may include, for example, a CIE, HIE, or other screening and referral system for networked providers that enables screening and referral data to be shared.

Note: CCOs will be asked to briefly identify the approach used and its availability to networked providers (e.g., our CCO pays for a subscription to ABC CIE, which has onboarded X# of clinics and Y# of CBOs in our service area).

- **Examples of activities meeting this element**:
  - The CCO pays, incentivizes, or subsidizes network providers' subscription to a community information exchange (e.g., Unite Us, findhelp, etc.).
  - The CCO establishes agreements with network providers that require them to connect to a tool that enables sharing and receiving screening and referral data.

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

Measure Components and Scoring – Component 2

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

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

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

Appendix 1 Template for Component 2 reporting provides additional information on how and what to report. For MY 2025, the CCO must complete data collection for at least 90% of the sample (the completeness threshold). The CCO must gather and provide screening and referral information in the sample reporting template provided by OHA (see Appendix 1). All required fields must be completed in each of the domains to receive credit towards the completeness threshold. This includes confirming if no screening and referrals were made. Unknown will also count towards the completeness threshold if a good faith effort is made (see Appendix 3). Records, where required fields are blank, will not count.

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

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

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

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

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

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

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

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

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

Allowable gaps in enrollment: None.

Anchor Date (if applicable): Not applicable.

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

Denominator Exclusions – Rate 1: None.

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

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

Denominator – Rate 2: Rate 1 numerator

Denominator Exclusions and Exceptions– Rate 2: None.

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

Denominator – Rate 3: Rate 2 numerator

Denominator Exclusions – Rate 3: None.

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

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

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

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

Appendix 1: Template for Component 2 Reporting

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

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

The name of the screening tool must be documented in the record; however, OHA does not require that information in the data collection template, just that an OHA-approved or exempted screening tool was used. For the screening to count as complete, the measure does not require a specific score to be documented in the record, only that the result is positive or negative for each screened domain. Positive or negative results should be calculated based on the instructions in the approved or exempted screening tool. If the result is unknown, the screening is considered incomplete and will not count towards the numerator for Rate 1.

This measure is member-based and is required once per year, not at all encounters with the member. OHA encourages CCOs to report the most recent screening for the measurement year. However, CCOs can choose which screening and referral episode to record for each domain. A member will only be counted once during the measurement year for the metric. Domains will be assessed discretely for each domain's screening episode since screening for all three domains is not required to occur at the same time. However, screening and referral episodes within a domain cannot be mixed. This means referrals must be within 15 days of the screening for each domain.

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

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

Field	Valid Input Value	Definition	Sample Reporting[4]
Coordinated Care Organization name		Corresponds to Health Analytics reporting CCO Name	OHA
Date loaded	YYYYMMDD	Date OHA pulled the sample data	OHA, Sample Only

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

Member ID	Member's Medicaid ID		OHA
Member name	Last Name, First Name MI		OHA
Member date of birth	YYYYMMDD		OHA
Match flag	Yes, No	This field is to be reported by the CCO and only for hybrid reporting. CCOs must report 'Match Flag' (Yes/No) field for all visits sampled by OHA. 'Yes' – was a member of the CCO for 180 consecutive days or more. 'No' – was not a member of the CCO for 180 or more consecutive days.	CCO, Required, Sample Only (If match flag = no, CCOs do not have to complete Screened for Social Needs question and the Housing, Food, and Transportation domains.)
Screened for Social Needs	Yes, No, Unknown	Yes – a social needs screening occurred during the measurement year for food, housing, or transportation. Indicate even if member declined the screening in full or part of the screening. No – a social needs screening did not occur during the measurement year. This can be indicated if a member had a known interaction and no record can be found for a screening for food, housing, or transportation. Unknown – member did not interact with a screening or referral partner CCOs should leave blank when member was not reviewed by CCO staff to determine if screening and referral occurred or when a good faith effort was not made to screen and collect data for sample.	CCO, Required, Sample Only
Housing Domain			
Screened for housing insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed housing screening with member No – CCO or partner did not complete screening for housing need with member and member did not decline	CCO, Required

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

		Declined – Member indicated that they did not want and/or need a referral for housing resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received housing referral.	
Date housing referral made	YYYYMMDD	Date housing referral made or declined	CCO, Required if received housing referral 'Yes' or 'Declined'
Food Domain			
Screened for food insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed food screening with member No – CCO or partner did not complete screening for food insecurity with member and member did not decline Declined – Member declined the food screening or declined to finish the food screening Unknown – Not known whether member completed or declined food screening	CCO, Required
Approved or exempted food screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted food screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the food domain. No - Age appropriate and OHA-approved or exempted food screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different food screening tool.	CCO, Required if screened for food insecurity 'Yes' or 'Declined'

		Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the food domain.	
Date of food screen	YYYYMMDD	Date of food screening completed or declined	CCO, Required if screened for food insecurity 'Yes' or 'Declined'
Result of food screening	Positive, Negative, Unknown	Positive – Food screening completed and indicated food need. Negative – Food screening completed and did not indicate food need. Unknown – Result of food screening is not known.	CCO, Required if screened for food insecurity 'Yes'
If positive, received food referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with food resources. No – Member did not receive a referral to an organization and/or provider that can assist with food resources. Declined – Member indicated that they did not want and/or need a referral for food resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received food referral.	CCO, Required
Date food referral made	YYYYMMDD	Date food referral made or declined	CCO, Required if received food referral 'Yes' or 'Declined'
Transportation Domain			
Screened for transportation needs	Yes, No, Declined, Unknown	Yes – CCO or partner completed transportation screening with member No – CCO or partner did not complete screening for transportation need with member and member did not decline	CCO, Required

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

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

Appendix 2: Social Needs Screening Tools Process

Background

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

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

OHA Approved Screening Tool List

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

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

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

Screening Tool Review Process

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

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

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

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

Organizational Level Exemption:

Requirements for screening tool exemption at the organizational level:

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

OHA Approved List Additions:

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

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

Appendix 3: Good Faith Effort

Good faith effort is required when using unknown values to count towards the Component 2 completeness threshold for each CCO's sample. Measurement Year (MY) 2025 is the first year that CCOs are required to systematically screening and referring members for housing, food, and transportation in alignment with these measure specifications. The following information should be used to complete the template in Appendix 1.

Unknown, No, and Blank Values

Completing data collection is vital to inform SDOH metric quality improvement strategies and, in future years, goal setting by the Metrics and Scoring Committee. Below is clarification on when unknown, no, and blank should be used in the Appendix 1 template.

- An **"unknown"** response should only be used when the data collection method failed to find the information needed. Unknowns will count towards the completion threshold as long as a good faith effort (as defined below) is made.
- A **"no"** response should be used when it is reasonable to assume the activity did not occur or there is documentation that activity did not occur. For example, it would be reasonable to assume that no screening occurred if a visit occurs and no screening was documented. If a screening occurred and no record of a referral can be found, it is reasonable to assume a referral did not occur. However, if a screening and/or referral did occur and an aspect related to a specific field was not documented, unknown should be used.
- Data fields should be left **blank** when a good faith effort has not been made to collect the data. Any required field that is left blank will invalidate the record from counting towards the competition threshold.

Defining Good Faith Effort

To meet the requirements of a good faith effort for data collection, each of these four characteristics must be present:

1. ***CCO must have an established screening and referral process for housing, food, and transportation*.** The sample data collection for screening and referral begins in MY 2025, the third year of the measure. CCOs should have established screening and referral processes by the beginning of MY 2025. Screening only in primary care clinics will not be enough to meet the measure as it progresses and goals set for performance. CCOs should continue to build screening and referral processes that will achieve universal screening of all members once a year.
2. ***CCO must have data collection and workflow protocols to gather screening and referral information aligned with the component 2 template*** *(Appendix 1).* The first two years, MY 2023 and MY 2024, required CCOs to establish policies, workflows, and data collection through component 1 must pass requirements. CCOs will continue to refine component 1 requirements in MY 2025, the last year of the structural component. This is why new requirements were not

added in MY 2025. Instead, all component 1 requirements should be refined as the component 2 screening, referral, and data collection is implemented.

3. ***CCO must provide and/or support access to a tool or tools that enable screening and referral data to be shared in their network*** *per component 1 item 15 requirements.* CCOs should have established protocols and platforms to track and share data needed for the sample per component 1 MY 2024 and MY 2025 requirements.
4. ***CCO must gather data from partners with whom they have an established relationship to complete SDOH measure screening and referrals, and from sources internal to the CCO.*** For example, if a CCO has established plans to complete screenings and referrals with a community-based organization and a health care clinic, CCOs will need to make a systematic effort to collect data from those groups. CCOs should be working with screening and referral partners throughout the year to ensure data will be received in the correct format. Establishing automated processes and protocols that streamline data collection can reduce administrative burden on CCOs and their partners.

CCOs are **not** required to collect data from those with whom the CCO does **not** have an established relationship to complete SDOH metric screening and referrals.

Appendix 4: Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Referral: a documented exchange of information, with the member's permission, to social services that could reasonably address the social need of food, housing and/or transportation identified from the screening. Ideally, member should be given information on the social service as well. The member may opt to receive contact information to the social services only.

A referral should contain information about the member's contact information and their housing, food, and/or transportation needs. If approved by the member, the referral should also include language and cultural preferences. If a member opts to receive contract information for the social service agency, the referral should have the agency's contact information and what services the agency can provide in relation to the member's social need.

A member may decline to receive a referral for one or all identified social needs. To receive numerator credit for rate 3 percent of members referred, the referral must be made for all identified social needs that the member wants referrals for within 15 days of the screening.

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

2025 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 2025 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 2025

in alphabetical order

Adults with Diabetes - Oral Evaluation

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,[2] and annual check-ups can help providers catch and treat disease early, resulting in better health outcomes.[3] In addition, poor oral health can make a person's diabetes more difficult to manage.[4]

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 to be affected by diabetes. For example, non-Hispanic Black people are twice as likely as non-Hispanic white people to die from diabetes.[5]

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.

Assessments for Children in ODHS 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.[6]

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 timely health assessments. 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.

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3228943/
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3645457/
[4] https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/diabetes/art-20043848
[5] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18
[6] 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

Oregon Health Authority

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

We measure the percentage of kids ages 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,[7] and vaccines are one of the safest, easiest, and most effective ways to protect kids from disease.[8] Vaccines we look for include:

- 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.

[7] https://www.ncqa.org/hedis/measures/childhood-immunization-status/
[8] https://www.hhs.gov/immunization/get-vaccinated/for-parents/five-reasons/index.html

Diabetes Care: Hemoglobin A1c (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 no record of an HbA1c test 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.

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.[9] For example, HPV causes more than 45,000 cases of cancer each year,[10] and more than 90% of these cancers are easily preventable with vaccination,[11] 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

[9] https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/
[10] https://www.cdc.gov/cancer/hpv/cases.html
[11] https://www.cdc.gov/hpv/hcp/clinical-overview/?CDC_AAref_Val=https://www.cdc.gov/hpv/hcp/protecting-patients.html

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

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 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.

Meaningful Language Access (Health Equity)

This measure was created to ensure people who communicate in languages other than English or are hard of hearing can understand the information in their health care appointment. This means having appointments with either a provider who speaks their preferred language well or an Oregon certified or qualified health care interpreter.

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

- Face barriers accessing health services,[12]
- Receive lower quality care relative to patients whose preferred language is English,[13] and
- Are at higher risk for medical errors.[14]

Qualified and certified health care interpreters and language providers who speak other languages are vital to increasing access and quality at appointments.

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690153/
[13] https://pubmed.ncbi.nlm.nih.gov/19179539/
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5111827/

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 can communicate in their preferred language through a certified/qualified interpreter or with a language provider for each health care visit.

Prenatal and Postpartum Care: Postpartum Care Rate

We measure the percentage of people who have given birth who receive timely post-partum care following the birth. The weeks following birth are critical for long-term health and well-being for the birthing parent and child alike.[15] Postpartum 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 people are 2-3 times more likely to die from pregnancy-related causes than white people.[16]

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.

Preventive Dental or Oral Health Services - 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.[17]

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.

[15] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care
[16] https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html
[17] https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=Untreated%20cavities%20can%20cause%20pain,least%20one%20untreated%20decayed%20tooth

2. Ages 6-14 because we know that poor oral health is one of the leading causes of absences from school.[18]

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 for Depression and Follow Up Plan

This measure looks at the percentage of people age 12+ with a health care visit 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.

Social Determinants of Health: Social Needs Screening & Referral

This measure looks at the percentage of people who were screened for their social needs and referred (as appropriate) to services. Ensuring people have access to stable housing, good food, and reliable transportation are key components of health and mental well-being.

The measure also requires CCOs to create policies that support social needs screening and referral in a collaborative, trauma informed way. This is important because screenings can cause harm if needs are never identified, or 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,

[18] https://www.attendanceworks.org/bringing-dental-care-to-schools/

and transportation. CCOs also verify whether they meet the minimum requirements in creating a system that supports the screening and referral process.

2. CCOs must report 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.

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

This measure looks at the percentage of children ages 1-5 who received an issue-focused intervention or treatment service. 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.[19]

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