2023 Incentive Measure Guide

Claims-Based Measures:

1. **Childhood Immunization Status:** Children who turn two years old in 2023 and complete the following Combo 3 vaccinations on or before their birthdate: DtaP, IPV, MMR, HiB, Hepatitis B, VZV, and PCV.
2. **Assessments for Children in DHS Custody:** Patients ages 0-17 in DHS custody for 60 days who received physical health, mental health, and dental health assessments within 60 days of notification or 30 days prior.
3. **Immunizations for Adolescents*:** Adolescents who turn 13 years of age in 2023 and complete the meningococcal, Tdap, and HPV vaccinations on or before their 13th birthdate.
4. **Initiation and Engagement of Substance Use Disorder Treatment:** Patients ages 18 years and older with a SUD episode who initiate treatment within 14 days of the episode and engage in ongoing treatment within 34 days of initiating treatment.
5. **Oral Evaluation for Adults with Diabetes:** Patients ages 18 and older with a diagnosis of diabetes who received a comprehensive, periodic, or periodontal oral evaluation in 2023.
6. **Preventive Dental Services*:** Patients ages 1-5 and 6-14 who receive preventive dental services in 2023.
7. **Well-Child Visits (3-6)*:** Patients ages 3-6 who complete at least one well-child visit during 2023.

Hybrid/Chart Review Measures:

8. **Timeliness of Prenatal and Postpartum Care*:** Pregnant mothers who received prenatal care in their first trimester or 42 days of enrollment and received postpartum care between 7 and 84 days after delivery.
9. **Meaningful Language Access to Culturally Responsive Health Care Services:** Patients with limited-English proficiency (LEP) who receive interpretation by an OHA qualified or certified health care interpreter or who receive an in-language visit with a provider who has passed a proficiency test in the patient's preferred language.
10. **Health Aspects of Kindergarten Readiness: System-Level Social-Emotional Health:** CCOs are responsible for developing a comprehensive, multi-year plan to assess and improve social-emotional behavioral health services benefitting children from birth to age 5
11. **Social Determinants of Health: Social Needs Screening and Referral:** Patients who are screened for social needs (housing insecurity, food insecurity and transportation) during the measurement year and are referred to services if needed.

Clinical Quality Measures:

12. **Depression Screening and Follow-up Plan:** Patients ages 12 and older who are screened for depression and, if positive, a follow-up plan is documented on the date of the positive screen.

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13. **Diabetes HbA1c Poor Control:** Patients ages 18-75 with a diagnosis of diabetes whose most recent HbA1c level is > 9.0%.
14. **Cigarette Smoking Prevalence:** Patients ages 13 and older who are screened for tobacco use that identify as cigarette smokers.
15. **Alcohol and Drug Misuse Screening (SBIRT):** (1) Patients who received an age-appropriate brief screen with a negative result or a full screen. (2) Patients with a positive full screen who received a brief intervention and/or referral to treatment documented within 48 hours of the screen.

Childhood Immunization Status Combo 3

Measure Description: The percentage of children who turn two years of age in the measurement year and complete the Combo 3 vaccine series on or before their second birthday.

Measure Specifications:

Data Source: ALERT IIS/Claims

2023 Target: 66.5%

2023 Benchmark: 67.9%

Telehealth Eligibility: This measure is not eligible for telehealth visits.

Denominator: Children who turn two years of age during the measurement year.

Denominator Exclusions: Patients in hospice during the calendar year. Patients who had severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma, leukemia, or intussusception on or before their second birthday.

Numerator: Children who turned two years of age in the measurement year and had all of the following vaccinations on or before their second birthday: Dtap, IPV, MMR, HiB, Hepatitis B, VZV, and PCV.

- The MMR and VZV vaccinations must be administered *on or between* the child's first and second birthdays.
- All vaccines except Hepatitis B must be administered more than 41 days after birth to count for this measure.

Coding:

Vaccine Type	CVX	CPT/HCPCS/ICD-10
DTaP – at least 4	20, 50, 106, 107, 110, 120	90698, 90700, 90723
IPV – at least 3	10, 89, 110, 120	90698, 90713, 90723
MMR – at least 1	**MMR**: 03, 94	90707, 90710
	Measles/Rubella: 04	90708
	Measles: 05	90705
	Mumps: 07	90704
	Rubella: 06	90706
	A history of measles, mumps, and rubella illnesses identified via claims on or before the second birthday will also satisfy the MMR vaccine requirement. **Measles disease history**: B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9 **Mumps disease history**: B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9 **Rubella disease history**: B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9	
HiB – at least 3	17, 46, 47, 48, 49, 50, 51, 102, 120, 148	90644, 90647, 90648, 90698, 90748
	08, 44, 45, 51, 110	90723, 90740, 90744, 90747, 90748, G0010

Hepatitis B – at least 3	**Newborn Hepatitis B – can** count as 1 Hepatitis B dose	99.55, 3E0234Z
	A history of Hepatitis B illness identified via claims on or before the second birthday will also satisfy the Hep B vaccine requirements. **Hepatitis B disease history**: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11	
VZV – at least 1	21, 94	90710, 90716
	A history of varicella zoster illness identified via claims on or before the second birthday will also satisfy the VZV vaccine requirement. **Varicella Zoster disease history**: B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.33, B02.34, B02.39, B02.7, B02.8, B02.9	
PCV – at least 4	133, 152	90670, G0009

Continuous Enrollment Criteria: Patient must be enrolled for 12 months prior to their 2nd birthday.

Allowable Enrollment Gaps: No more than 1 gap in enrollment of up to 45 days during the 12 months prior to the patient's 2nd birthday

Anchor Date: Enrolled on the child's 2nd birthday.

Strategies for Improvement:

- Use the outreach rosters on the EOCCO provider progress reports.
- Use ALERT IIS reports to monitor immunizations status.
- Immunize patients during wellness visits.
- Schedule immunization visits well before patient's second birthday.
- Implement an immunization recall workflow.
- Make use of parent education materials available from EOCCO. Contact EOCCOmetrics@modahealth.com for more information or explore resources available on the EOCCO website: https://www.eocco.com/providers/Education.

Assessments for Children in DHS Custody

Measure Description: The percentage of patients 0-17 years of age in DHS custody for 60 days who received a physical health assessment, a mental health assessment, and a dental health assessment within 60 days of the notification date (when CCOs are notified that the patient is in DHS custody), or within 30 days prior to the notification date.

Measure Specifications:

Data Source: Claims

2023 Target: 90.0%

2023 Benchmark: 90.0%

Telehealth Eligibility: This measure is eligible for telehealth as qualifying numerator visits do not need to be in-person.

Denominator: Identified children/adolescents 0-17 years of age as of the first date of OHA notification who remained in custody for at least 60 days. Only children/adolescents that OHA notified CCOs about will be included in the denominator.

Denominator Exclusions: Children will be excluded from the final measure denominator if continuous enrollment is not met, the child is in run-away status following the notification, or the CCO is not properly notified within the designated timeframe. See OHA technical specifications for a complete list of exclusions.

Denominator Exceptions: Children who did not complete all required assessments should be excluded from the final denominator if their enrollment start was delayed or if their status changed to 'trial reunification' during the 60-day assessment period.

Numerator: Depending on the age at CCO notification date, patients in the denominator are required to receive a physical health assessment (all ages 0-17), a dental health assessment (ages 1-17), and a mental health assessment (ages 4-17), within 60 days of the notification date, or within 30 days prior to the notification date.

- Ages < 1 need a physical health assessment
- Ages 1-3 need a physical and dental health assessment
- Ages 4-17 need a physical, dental, and mental health assessment

Coding:

Physical Health Assessment Codes	Mental Health Assessment Codes	Dental Health Assessment Codes
99201-99205[+], 99212- 99215, 99381-99384, 99391-99394, G0438, G0439	90791-90792, 96130, 96131, 96136-96139, H0031, H1011, H2000-TG (needs modifier), H0019[~], H2013, H0037	D0100-D0199

[+] 99201-99205: Use of this code counts as both mental and physical health assessments if paired with one of the ICD-10CM diagnosis codes

[~] H0019: Use of this code counts as both mental and physical health assessment for children in PRTS

ICD-10CM Diagnosis (All diagnosis fields apply)
F03, F20 – F53, F59 – F69, F80 – F99 (total of 291 codes)
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

Continuous Enrollment Criteria: All cases must remain in DHS custody for at least 60 days from the OHA notification date to be included in the measure. Cases with a delayed start of enrollment of up to 7 days are only included if they are numerator compliant.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Prioritize scheduling mental, dental, and physical health visits for children in foster care:
    - Reach out to EOCCOmetrics@modahealth.com to start receiving the OHA notification file via email when a child is assigned to your clinic
        - Use the contact information provided to call the foster parent to schedule assessments.
    - Remind foster parents of the necessary DHS assessments when contact is made.
        - Request foster parent incentive materials and/or DHS stickers from EOCCOmetrics@modahealth.com to help outline the DHS assessment requirements
- Medical providers can become First Tooth trained and provide dental assessments and code the assessment (D0191) when performed during a well-child check.

Immunizations for Adolescents*

(NQF 1407)

Measure Description: The percentage of adolescents who turn 13 years of age in the measurement year and complete the meningococcal, Tdap, and HPV vaccinations on or before their 13th birthdate.

Measure Specifications:

Data Source: ALERT IIS/Claims

2023 Target: 36.9%

2023 Benchmark: 36.9%

Telehealth Eligibility: This measure is not eligible for telehealth visits.

Denominator: Adolescents who turn 13 years of age during the measurement year.

Denominator Exclusions: Patients in hospice during the measurement year.

Numerator: Adolescents who turned 13 years of age in the measurement year and had all of the following vaccinations in the specified time periods:

- Meningococcal: At least 1 meningococcal serogroups A, C, W, Y vaccine on or between the member's 11th and 13th birthdays
- Tdap: At least 1 tetanus, diphtheria toxoids and acellular pertussis vaccine on or between the member's 10th and 13th birthdays
- HPV – Option 1: At least 2 human papillomavirus vaccines with different dates of service at least 5 months apart on or between the member's 9th and 13th birthdays.
- HPV – Option 2: At least 3 human papillomavirus vaccines with different dates of service on or between the member's 9th and 13th birthdays.

Coding:

Vaccine Type	CVX	CPT
Meningococcal – at least 1	108, 114, 136, 147, 167, 203	90619, 90734
Tdap – at least 1	115	90715
HPV – at least 2	62, 118, 137, 165	90649, 90650, 90651

Continuous Enrollment Criteria: Patient must be enrolled for 12 months prior to their 13th birthday.

Allowable Enrollment Gaps: No more than 1 gap in enrollment of up to 45 days during the 12 months prior to the patient's 13th birthday

*2023 Challenge Pool measure

Anchor Date: Enrolled on the adolescent's 13th birthday.

Strategies for Improvement:

- Use the outreach rosters on the EOCCO provider progress reports.
- Use ALERT IIS reports to monitor immunization status.
- Immunize patients during wellness visits.
- Schedule immunization visits well before patient's 13th birthday.
- Implement an immunization recall workflow.
- Make use of parent education materials available from EOCCO. Contact EOCCOmetrics@modahealth.com for more information or explore resources available on the EOCCO website: https://www.eocco.com/providers/Education.

Initiation and Engagement of Substance Use Disorder Treatment

(NQF 0004)

Measure Description: Patients ages 18 years and older with an episode of substance use disorder (SUD) who initiate treatment within 14 days of the episode and engage in ongoing SUD treatment within 34 days of initiating treatment.

Measure Specifications:

Data Source: Claims

2023 Targets:

- Initiation: 39.5%
- Engagement: 15.9%

2023 Benchmarks:

- Initiation: 43.3%
- Engagement: 16.3%

CCOs must meet the improvement target for both Initiation and Engagement for ages 18+ to achieve the measure.

Definitions:

- Intake Period: The period from November 15 of the year prior to the measurement year through November 14 of the measurement year that is used to capture new SUD episodes.
- SUD Episode: An encounter during the Intake Period with a diagnosis of substance abuse or dependence.
- SUD Episode Date: The SUD Episode date of service (DOS).
    - For a visit (not resulting in an inpatient stay), *the SUD episode date is the DOS.*
    - 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 DOS.*
    - 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).
- Negative SUD Diagnosis History: Exclude the SUD episode from the measure if the patient had a claim or encounter with a SUD diagnosis other (than an ED visit or medically managed withdrawal) in the 194 days before the episode.
    - For an inpatient stay, use the admission date to determine Negative SUD Diagnosis History.
    - For visits that result in an inpatient stay, use the earliest DOS to determine the Negative SUD Diagnosis History.
    - For direct transfers, use the first admission date to determine the Negative SUD Diagnosis History.
- Negative SUD Medication History: Exclude the SUD episode from the measure if the patient had a SUD medication treatment dispensing event or a SUD medication administration event in the 194 days before the episode.

Measure Summary:

SUD Episode Type	Initiation Event Options *(Must be billed with substance abuse or dependence diagnosis code)*	Engagement Event Options *(Must be billed with substance abuse or dependence diagnosis code)*
Inpatient Stay	N/A *Episode is already compliant for Initiation*	1 long-acting SUD medication treatment event 1 OUD Weekly or Monthly Office Based Treatment 2 SUD medication treatment events 1 medication treatment event + 1 non-medication treatment visit *May have same DOS and same provider* 2 non-medication treatment visits *May have same DOS but must be with different providers*
OUD Monthly Office Based Treatment	N/A *Episode is already compliant for Initiation*	
All other SUD Episode types	SUD medication treatment event *May have same DOS and same provider as SUD Episode*	
	Non-medication treatment event or visit (i.e. inpatient/outpatient visit, SUD services, telehealth, etc.) *May have same DOS as SUD Episode but must be with different providers*	

Telehealth Eligibility: This measure is eligible for telehealth. For more information see the guidelines provided by the Health Evidence Review Committee.

Denominator: Members 18 years and older as of December 31st of the measurement year with a SUD episode during the Intake Period. The denominator is the same for both rates (Initiation and Engagement).

The following events qualify a patient for the denominator if they are billed with the appropriate SUD diagnosis code(s)[#]: an outpatient visit, telehealth visit, intensive outpatient visit or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, substance use disorder service, withdrawal management event, ED visit, observation visit, acute or non-acute inpatient discharge, or an opioid treatment service. See OHA technical specification guide for a complete list of qualifying diagnosis codes associated with each of these events.

Denominator Exclusions:

- Patients in hospice during the measurement year
- SUD Episodes without Negative Diagnosis History.
- SUD Episodes without Negative Medication History.

Numerator – Initiation: Patients with a SUD Episode who initiate SUD treatment within 14 days of the SUD Episode Date. The following services or events will satisfy the Initiation component of this measure:

- A SUD Episode that was an inpatient discharge or an ED visit that resulted in an inpatient stay is already considered compliant in the Initiation phase.
- A SUD Episode that was an Opioid Treatment Service that bills monthly is already considered compliant in the Initiation phase

[#]Appropriate SUD diagnosis codes come from these value sets: Alcohol Abuse and Dependence, Opioid Abuse and Dependence, Other Drug Abuse and Dependence

- For alcohol-related SUD Episodes only: An alcohol use disorder medication treatment dispensing or administration event.
- For opioid-related SUD Episodes only: An opioid use disorder medication treatment dispensing or administration event.
- The following events will also satisfy the Initiation phase if they are billed with the appropriate SUD diagnosis code(s)[#]: acute or non-acute inpatient discharge, outpatient visit, intensive outpatient visit or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, observation visit, or a weekly or monthly opioid treatment service.
- Note that for all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must occur with different providers in order to count for the measure.

Numerator - Engagement: Patients who are compliant in the Initiation phase *and* who engage in ongoing SUD treatment within 34 days of initiating treatment. The following services or events will satisfy the Engagement component of this measure:

- At least one weekly or monthly opioid treatment service with medication administration.
- For alcohol or opioid-related SUD Episodes only: At least one long-acting SUD medication administration event (such as Naltrexone or Buprenorphine).
- At least two of the following (in any combination) will also satisfy the Engagement phase:
    - Engagement visit billed with the appropriate SUD diagnosis code(s)[#]: an acute or nonacute inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, observation visit, or a weekly opioid treatment service without medication administration
    - Engagement medication treatment event: An alcohol use disorder medication treatment dispensing or administration event (for alcohol-related SUD Episodes only), an opioid use disorder medication treatment dispensing or administration event (for opioid-related SUD Episodes only)
    - Note that two engagement visits occurring on the same date must be with different providers in order to count as two separate events. However, an engagement visit on the same DOS as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Treatment Medications:

Alcohol Use Disorder Treatment Medications

- Disulfiram (oral)
- Naltrexone (oral and injectable)
- Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

- Naltrexone (oral)

[#]Appropriate SUD diagnosis codes come from these value sets: Alcohol Abuse and Dependence, Opioid Abuse and Dependence, Other Drug Abuse and Dependence

- Naltrexone (injectable)
- Buprenorphine (sublingual tablet)
- Buprenorphine (injection)
- Buprenorphine (implant)
- Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

See OHA technical specification guide for a complete list of diagnosis codes, visit codes, and medications that are used in this measure.

Continuous Enrollment Criteria: Patient must be enrolled for 194 days before the SUD Episode Date through 47 days after the IESD (242 total days).

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Ensure that there is an effective communication loop between primary care clinics, behavioral health clinics, and Emergency Departments
- Review and respond promptly to emails from the EOCCO team notifying you of patients that have entered this measure denominator

Oral Evaluation for Adults with Diabetes

Measure Description: The percentage of patients ages 18 and older with a diagnosis of diabetes who received a comprehensive, periodic, or periodontal oral evaluation in the measurement year.

Measure Specifications:

Data Source: Claims

2023 Target: 24.0%

2023 Benchmark: 26.4%

Telehealth Eligibility: This measure may be eligible for teledentistry if the visit contains a documented diagnosis and treatment plan by dentist or dental provider. Visits that include a qualifying CDT code (D0120, D0150 or D0180) should be counted in the measure, regardless of where the visit was conducted.

Denominator: Unduplicated patients ages 18 years and older as of December 31st of the measurement year with diabetes identified from claim/encounter data or pharmacy data, during the measurement year or the year prior to the measurement year.

Denominator Exclusions: Patients who:

- Have gestational diabetes or steroid-induced diabetes
- Are in hospice during the measurement year
- Are receiving palliative care
- Are 66 years of age or older with frailty and advanced illness
- Have died anytime in the measurement year

Numerator: Number of unduplicated patients 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.

Coding:

Qualifying Visits	CDT
Comprehensive, periodic or periodontal oral evaluation	D0120, D0150, D0180

Continuous Enrollment Criteria: Patient must be enrolled for the measurement year.

Allowable Enrollment Gaps: No more than 1 gap in enrollment of up to 45 days.

Anchor Date: None

Strategies for Improvement:

- Discuss the importance of routine oral health care with diabetic patients.
- Ask when the patient's last dental visit was and encourage them to regularly engage with a dental provider.

Preventive Dental Services – Kindergarten Readiness*

Measure Description: The percentage of patients ages 1-5 and 6-14 who receive preventive dental services during the measurement year.

Measure Specifications:

Data Source: Claims

2023 Targets:

- Ages 1-5: 47.2%
- Ages 6-14: 54.8%

2023 Benchmarks:

- Ages 1-5: 47.2%
- Ages 6-14: 54.8%

Note: In 2023 CCOs need to meet improvement target for both components (Preventive Dental ages 1-5 or 6-14) to achieve measure.

Telehealth Eligibility: This measure may be eligible for teledentistry if the visit contains a documented diagnosis and treatment plan by dentist or dental provider. Visits that include a qualifying CDT code (D0120, D0150 or D0180) should be counted in the measure, regardless of where the visit was conducted.

Denominator: Patients ages 1-14 as of December 31st of the measurement year.

Numerator 1: 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.

Numerator 2: 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: 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).

*2023 Challenge Pool measure

Dental Services Provider Table

Provider Grouping	Provider Classification	Taxonomy Code
Dental Providers	Dentist	122300000X, 1223D0001X, 1223D0004X, 1223E0200X, 1223G0001X, 1223P0106X, 1223P0221X, 1223P0300X, 1223P0700X, 1223S0112X, 1223X0008X, 1223X0400X
Dental Providers	Dental Hygienist*	124Q00000X
Dental Providers	Dental Therapist	125J00000X
Dental Providers	Advanced Practice Dental Therapist	125K00000X
Dental Providers	Oral Medicinist	125Q00000X
Ambulatory Health Care Facilities	Clinic/Center	261QF0400X, 261QR1300X

Note: Dental hygienist services do not need to be under the supervision of a dentist.

Coding:

Qualifying Visits	CDT	CPT
Preventive Services	D1000 - D1999	99188

Continuous Enrollment Criteria: Patient must be enrolled for at least 180 days in the measurement year.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- If a PCP is qualified to provide fluoride varnish, they may do so annually to satisfy this measure.
- Ask when the child's last dental visit was and encourage them to schedule a dental exam and cleaning if it has been longer than six months.
- Provide information on and encourage families to participate in local health fairs where dental services are provided.
- Collaborate with local dental offices and provide patients with a list of contracted dental practices for their DCO.

Well-Child Visits (3-6) – Kindergarten Readiness*

(NQF 1516)

Measure Description: The percentage of patients ages 3-6 who complete at least one well-child visit during the measurement year.

Measure Specifications:

Data Source: Claims

2023 Target: 65.6%

2023 Benchmark: 68.6%

Telehealth Eligibility: This measure is telehealth compliant as qualifying numerator visits do not need to be in-person.

Denominator: Patients ages 3-6 as of December 31st of the measurement year.

Denominator Exclusions: Patients in hospice or died anytime during the measurement year.

Numerator: At least one well-child visit during the measurement year provided by a primary care provider or OBGYN.

Numerator Exclusions: Well-child visits that occurred during inpatient or ED visits.

Coding:

CPT	HCPCS	ICD-10
99381-99385, 99391-99395, 99461	G0438, G0439, S0302	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Continuous Enrollment Criteria: Patient must be enrolled for the measurement year.

Allowable Enrollment Gaps: No more than 1 gap in enrollment of up to 45 days.

Anchor Date: December 31st of the measurement year.

Strategies for Improvement:

- Use the outreach rosters on the EOCCO provider progress reports.
- Contact EOCCOmetrics@modahealth.com to get well child visit incentive program materials.
- Convert sick visits into comprehensive wellness exams whenever possible.
- Do not be concerned about providing more than one wellness exam within a one-year period. EOCCO will pay for multiple.
- Hold well-child visit events or designated clinic days.

*2023 Challenge Pool measure

Timeliness of Prenatal and Postpartum Care*

(NQF 1517)

Measure Description: The percentage of pregnant mothers who received prenatal care within the first trimester or within 42 days of enrollment and/or received postpartum care between 7 and 84 days after Estimated Date of Delivery (EDD).

Measure Specifications:

Data Source: Claims and chart review

2023 Postpartum Target: 75.4%

2023 Postpartum Benchmark: 84.2%

Telehealth Eligibility: This measure is eligible for both prenatal and postpartum telehealth as long as required service components are identified.

Denominator: A sample size provided by OHA of 411 patients with live birth deliveries, an EDD in the period between October 8, 2022 and October 7, 2023, and continuous enrollment from 43 days prior to EDD and 60 days after EDD with no gaps.

Denominator Exclusions: Patients in hospice or died anytime during the measurement year.

Numerator:

Prenatal Care: This visit must occur within the first trimester or within 42 days of enrollment. Documentation in the medical record must include a note indicating the date when the prenatal visit occurred and evidence of one of the following:

- Basic physical obstetrical examination (auscultation for fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height).
- Prenatal care procedure (obstetric panel, TORCH antibody panel, rubella antibody test, or ultrasound of pregnant uterus).
- Documentation of LMP, EDD, or gestational age in conjunction with either prenatal risk assessment and counseling/education, or complete obstetrical history).

Postpartum Care: The visit must occur on or between 7 and 84 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and evidence of one of the following:

- Pelvic exam
- Evaluation of weight, blood pressure, breasts and abdomen
- Notation of postpartum care, including, but not limited to “postpartum care,” “PP care,” “PP check,” or “6-week check”, or a preprinted “Postpartum care” form
- Perineal or cesarean incision/wound check
- Screening for mental health disorders, tobacco use, or substance use disorders
- Glucose screening for women with gestational diabetes
- Other discussion of infant care or breastfeeding, birth spacing or family planning, sleep/fatigue, or resumption of physical activity and attainment of healthy weight

*2023 Challenge Pool measure

Continuous Enrollment Criteria: Patient must be enrolled from 43 days prior to EDD through 60 days after EDD.

Allowable Enrollment Gaps: None

Anchor Date: EDD

Strategies for Improvement:

- Notify members that they are eligible for the Cribs for Kids program when they receive either a prenatal or postpartum care visit
- Provide prenatal care as soon as possible after patient is enrolled in the Oregon Health Plan for those not already enrolled.
- Remind patients to return for 1–12-week postpartum check. If patient no shows, try and reschedule the visit as soon as possible.
- Document prenatal and postpartum care services provided and bill when appropriate.
- Bill 0500F-0502F, 99500, or H1000-H1004 at initial prenatal visit to satisfy numerator compliance to reduce chart review burden.
- Bill 57170, 58300, 59430, 99501, 0503F, G0101 at postpartum visit or append the appropriate ICD-10 code such as V24.2 to reduce chart review burden.
- For tracking purposes, EOCCO asks that claims be submitted with both the date of first prenatal visit and postpartum visit.
- When global billing, please remember to submit a claim to notify EOCCO of prenatal and postpartum dates of service. These should be billed as zero-dollar claim lines.

Description	Codes
Prenatal Visits	CPT: 99201 - 99205, 99211 - 99215, 99241 - 99245, 99483 CPT-CAT-II: G0463, T1015
Stand Alone Prenatal Visits	CPT: 99500 CPT-CAT-II: 0500F, 0501F, 0502F HCPCS: H1000, H1001, H1002, H1003, H1004
Cervical Cytology Lab Test	CPT: 88141 - 88143, 88147, 88148, 88150, 88152 - 88154, 88164 - 88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Postpartum Visits	CPT: 57170, 58300, 59430, 99501 CPT-CAT-II: 0503F HCPCS: G0101 ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Note: Table does not include all eligible codes

Meaningful Language Access to Culturally Responsive Health Care Services

Measure Description: The percentage of patients with limited-English proficiency (LEP) who receive quality health care interpretation from an OHA qualified or certified health care interpreter or who receive an in-language visit with a provider who has passed a proficiency test in the patient's preferred language.

Measure Specifications:

Data Source: Claims and chart review

2023 Target: 8.1%[^]

2023 Benchmark: 75.0%

Telehealth Eligibility: This measure is eligible for telehealth, however visits without human interaction will be excluded (i.e., blood pressure readings, remote blood sugar monitoring, online assessments, etc.).

Denominator: Total number of visits during the measurement year for members who self-identified as having an interpreter need, regardless of whether interpreter services were provided.

For 2023, OHA will provide a sample of 411 patients, who have self-identified as having interpreter needs. Clinics will be asked to report[^] health care interpreter use data for all visits that occurred during the 2023 measurement year for each of their patients in the hybrid sample. Only visits during a patient's enrollment span with a CCO are required to be reported.

Denominator Exclusions:

- Visits requiring only pharmacy, labs, DME, ambulance transportation, or other ancillary services
- Telemedicine visits without human interaction (blood sugar readings, remote blood sugar monitoring, prescription refill notifications, etc.)
- Visits where a patient refuses interpreter services (must be documented)
    - Patient refused because the billing provider speaks the patients' preferred language (in-language visit provided)
    - Patient confirms interpreter need documented in enrollment file is inaccurate (patient does not have an interpreter need)

The following reasons do not qualify for exclusion, but need to be documented as a reason for refusal:

- Patient is unsatisfied with the interpreter services available
- Other reasons for patient refusal (e.g. patient's family member interpreted during appointment)

Numerator: Total number of denominator visits provided with interpreter services by an OHA certified or qualified interpreter or a provider with documented language proficiency.

[^]To meet the Language Access measure, CCOs must achieve the 8.1% improvement target and provide data on at least 80% of visits in the hybrid sample. This measure will remain report-only for clinics in 2023.

Continuous Enrollment Criteria: None

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

Language Access Reporting

- Complete the quarterly Language Access reports using the clinic reporting template provided by EOCCO. EOCCO will pull quarterly Language Access report data into the 2023 hybrid sample and will only reach out to clinics to fill any visit information gaps if needed.
- If you are unable to pull data for the quarterly Language Access reports you can ask EOCCO to produce a claims report based on members with an interpreter need (identified at the time of enrollment) who had a visit within the last quarter.
- Review the quarterly Language Access Report template for changes; develop a workflow or report to ensure all elements are met.
- Identify if your Language Service Provider is Oregon-based and familiar with the OHA's requirements for qualified/certified interpreters. For local Language Services Providers (such as Linguava or Passport to Languages) work to see if they can provide patient-level data on invoices.
- Track provider language proficiency testing if applicable, and report proficiency testing results to EOCCO.
- Assign a non-billable CPT code (i.e. a 'dummy code') to track when an interpreter is used during a patient visit
- Record when a patient declines interpreter services and include the reasoning (i.e., member refused because provider speaks the members preferred language, member confirms interpreter need documented in enrollment file is inaccurate, member unsatisfied with the interpreter services available, or other reason for patient refusal)

Provision of Healthcare Interpreter Services

- Prioritize using OHA certified or qualified interpreters when available.
- EOCCO offers no-cost interpreters to eligible members through Passport to Languages and Linguava (see Provider Manual for more information).
- Identify bilingual or multilingual staff who are interested in completing the OHA approved 60-hour Spanish Health Care Qualified Interpreter training program sponsored by EOCCO and Oregon State University (see the Oregon State University website for more information).
- Review clinic schedules a couple days in advance to identify patients who may need language services.
- Ask patients if they would like a professional interpreter when scheduling future appointments or calling with appointment reminders.
- If bilingual/multilingual providers are interested in taking a language proficiency test, please see OHA's list of approved language proficiency testing centers and tests on the Oregon Health Care Interpreter Program Requirements document.

Health Aspects of Kindergarten Readiness: System-Level Social-Emotional Health

Measure Description: CCOs are responsible for developing a comprehensive, multi-year plan to assess and improve social-emotional behavioral health services benefitting children from birth to age 5.

CCOs will develop an asset map and an action plan that will be updated each year based on a review of data and stakeholder feedback.

Measure Specifications:

Data Source: Attestation Survey completed by CCOs, inclusive of four different components. Within Attestation Component 1 there is required review of child-level Social-Emotional Health Reach metric data.

2023 Target: Report Only (CCO)

2023 Benchmark: Report Only for MY 2 (2023). CCOs must submit of the following documents:

a) Attestation survey
b) Asset map
c) Action plan

In addition, CCOs are required to attest to all required components for MY 2 (2023) for the following components:

1) Social-Emotional Health Reach Metric Data Review and Assessment
2) Asset Map of Existing Social Emotional Health Services and Resources
3) CCO-Led Cross-Sector Community Engagement
4) Action Plan to Improve Social-Emotional Health Service Capacity and Access

For additional information on the 2023 measure requirements please see Social-Emotional Health incentive measure specifications.

Telehealth Eligibility: Not applicable to this Attestation Survey Form

Denominator: None

Denominator Exclusions: None

Numerator: None

Continuous Enrollment Criteria: None

Allowable Enrollment Gaps: None

Anchor Date: None

Note: Fulfillment of this metric is not based on the number of members who receive social-emotional health services, but instead whether the CCO is able to complete all of the documents (the attestation survey, asset map and action plan) and demonstrate that they have fulfilled all of the required components.

Strategies for Improvement:

- Clinics may be contacted to provide feedback related to their ability to refer and provide social-emotional health services as needed.

Social Determinants of Health: Social Needs Screening and Referral

Measure Description: Patients who are screened for social needs (housing insecurity, food insecurity, and transportation) during the measurement year and are referred to services if needed.

Measure Specifications:

Data Source: Attestation survey completed by CCOs for Measurement Year 1 (2023), inclusive of three different components.

In Measurement Year 2 (2024), OHA will provide a hybrid sample of 411 youth and adult EOCCO members. Clinics will be asked to report if a member received a screening for each of the three required social need domains: housing insecurity, food insecurity, and transportation.

2023 Target: Report Only (CCO)

2023 Benchmark: For Measurement Year 1 (2023) CCOs must attest to all required components, including:

1) Screening practices
2) Referral practices and resources
3) Data collection and sharing

Telehealth Eligibility: This measure is telehealth eligible.

Denominator: Members who meet continuous enrollment criteria.

Denominator Exclusions: Member declines a social needs screening.

Numerator: Members who were screened at least once in the measurement year for all three required social need domains using an-OHA approved screening tool.

Continuous Enrollment Criteria: Member is continuously enrolled with the CCO for at least 180 days in the measurement year.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Complete the Social Needs Screening survey distributed by EOCCO and provide information on: social needs screening practices, social needs screening tools or questions in use, and screening and referral data capture and exchange.
- Review social needs screening tools or questions in use and assess if questions ask patients about housing insecurity, food insecurity, and transportation needs.
- Prioritize adoption of OHA approved social need screening tools. For a current list of OHA-approved tools see the Social Needs Screening and Referral measure specifications. Alternatively, EOCCO can work to get social needs screening tools or questions approved by OHA. Please contact EOCCOmetrics@modahealth.com if you would like EOCCO to help facilitate approval of a certain social needs screening tool or question set.

- Review or establish social needs screening workflows. Consider: 1) who is responsible for administering or distributing screenings (CHWs, registration, social worker, provider, etc.) 2) when social needs screenings happen (prior to the appointment [online or during check-in], during the appointment, or after the appointment with another staff member), and 3) at what frequency social needs screenings are occurring (annually, biannually, situationally, etc.).
- Review EHR capture of social needs screening data. How are screening attempts and screening results coded [LOINC, SNOMED, ICD10]? Is there a field where screening refusal can be documented (i.e. if a patient was offered a social needs screening but declined the screening)?
- Review social needs referral workflows and processes. How is referral data captured in the EHR? How is referral data exchanged with community-based organizations or social service agencies?
- Consider onboarding onto the Community Information Exchange (CIE) platform **Connect Oregon (Unite US)**. Connect Oregon is shared technology platform that contains a statewide network of health and social needs organizations. This platform enables onboarded organizations to send and receive electronic referrals to address patient's social needs and improve individual and community health. EOCCO offers clinics free licenses for the Connect Oregon (Unite US) CIE, Complete the Unite US Partner Registration Form to get started. Please contact EOCCOmetrics@modahealth.com with any questions.

Depression Screening and Follow-Up Plan

(CMS 2v12)

Measure Description: The percentage of patients 12 years and older who are screened for depression using an age-appropriate standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen.

Measure Specifications:

Data Source: EHR based

2023 Target: 61.0%

2023 Benchmark: 61.0%

Telehealth Eligibility: This measure is eligible for telehealth. For more information see the guidelines provided by the Health Evidence Review Committee.

Denominator: All patients 12 years and older at the beginning of the measurement year with at least one eligible encounter during the measurement year. Eligible encounters are identified through the Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916).

Denominator Exclusions:

- Patients who have ever been diagnosed with depression or bipolar disorder

Denominator Exceptions:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where delay to treatment would jeopardize the patient's health status.
- Patient's functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools.

Numerator: Patients 12 years and older who are 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. If the patient screens positive for depression, a follow-up plan is documented no later than two days after the positive screen. Examples of a follow-up plan include but are not limited to:

- Referral to a provider such as a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, or mental health counselor for further evaluation of depression
- Referral to a mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

Notes:

- The use of a PHQ-9 as follow-up to a positive PHQ-2 no longer counts as additional evaluation and cannot be counted for numerator compliance. If the PHQ-9 is negative, then no follow-up is needed.

- Suicide risk assessment and/or additional evaluation or assessment during the qualifying encounter no longer count as an appropriate follow-up options.
- Detailed measure specifications are available in the eCQI Resource Center. Detailed value set contents are available in the Value Set Authority Center.

Continuous Enrollment Criteria: OHA does not use continuous enrollment criteria for EHR-based measures.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Screen all patients 12 years and older for depression screening at least annually.
- Document screening tool and results in EHR in a reportable format.
- Provide follow-up plan as soon as need is indicated.
- Complete the Workflow for SBIRT & Depression Screenings exercise to ensure your practice's screening and documentation processes align with the measure requirements.

Diabetes HbA1c Poor Control

(CMS 122v11)

Measure Description: The percentage of patients ages 18-75 with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level is >9.0%.

Measure Specifications:

Data Source: EHR based

2023 Target: 24.8% (lower is better)

2023 Benchmark: 24.8% (lower is better)

Telehealth Eligibility: This measure is eligible for telehealth as qualifying numerator visits do not need to specify where the test is completed if it is documented in the medical record.

Denominator: Patients ages 18-75 with Type 1 or 2 diabetes with a visit during the measurement year.

Denominator Exclusions:

- Patients in hospice during the measurement year
- Patients receiving palliative care
- Patients ages 66 and older who are living in a long-term institution for more than 90 consecutive days during the measurement year
- Patients with advanced illness and frailty
- Patients with a diagnosis of secondary diabetes

Numerator: Patients whose most recent HbA1c level during the measurement year is >9.0%.

Notes:

- Patient is numerator compliant if the most recent HbA1c level is >9.0%.
- Patient is numerator compliant if the most recent HbA1c level is missing.
- Patient is numerator compliant if there are no HbA1c tests performed, or results documented during the measurement year.
- Detailed measure specifications are available in the eCQI Resource Center's Technical Release Notes.

Continuous Enrollment Criteria: OHA does not use continuous enrollment criteria for EHR-based measures.

Allowable Enrollment Gaps: N/A

Anchor Date: N/A

Strategies for Improvement:

- Order HbA1c tests every three months for patients with HbA1c levels >9.0% and every six months for patients in the controlled range.
- Ensure HbA1c data is entered into the EHR from the PCP and specialty clinics.
- Use a patient registry to manage this population and refer to diabetes education classes.

Cigarette Smoking Prevalence

Measure Description: The percentage of patients 13 years and older who had a qualifying visit in the measurement year and have their smoking and/or tobacco use status recorded as structured data.

Measure Specifications:

Data Source: EHR based

2023 Target: 22.9% (lower is better)

2023 Benchmark: 22.9% (lower is better)

Telehealth Eligibility: This measure is eligible for telehealth for rate 1 (screening) denominator. For more information see the guidelines provided by the Health Evidence Review Committee.

Denominator: Patients 13 and older who have had at least one qualifying visit during the measurement year determined by the denominator criteria for MU Smoking Status Objective or Code sets included in NQF0028e/CMS138v8 plus adolescent visit codes.

Numerator: Three rates must be queried to determine the prevalence rate (2).

> *Rate 1:* Of all your patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?
>
> *Rate 2:* Of all your patients with their cigarette smoking or tobacco use status recorded [Rate 1 numerator], how many are cigarette smokers?
>
> *Rate 3:* Of all your patients with their cigarette smoking or tobacco use status recorded [Rate 1 numerator], how many are cigarette smokers *and/or* tobacco users?

Numerator Exclusions: This measure does not assess use of e-cigarettes, marijuana, or patients using nicotine replacement therapy (NRT) who no longer smoke cigarettes. Use of these products should be excluded.

Notes:

- The denominator criteria for the Screening and Cessation Intervention measure (NQF0028e/ CMS138v10) may be used to identify visit types for this measure. Because that measure looks for patients ages 18 or older, however, additional work is needed to pick up the denominator population age 13-17.
- Detailed value set contents are available in the Value Set Authority Center.

Continuous Enrollment Criteria: OHA does not use continuous enrollment criteria for EHR-based measures.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Screen all patients 13 years and older for smoking/tobacco use at each visit.

- Follow the 5A's model for treating tobacco use and dependence.
- Utilize the Readiness Ruler and tobacco cessation resources to help with motivational interviewing.
- Refer patients to tobacco resources on eocco.com (English and Spanish resources available).
- Refer patients to local tobacco cessation coach or telephonic health coach (877) 277-7281.
- If patient quits smoking or tobacco use, update this in the EHR.

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

Measure Description: (1) The percentage of patients 12 years and older who are screened for alcohol and drug use and had either a brief screen with a negative result or a full screen. (2) The percentage of patients with a positive full screen who had a brief intervention, and/or referral to treatment within 48 hours.

Measure Specifications:

Data Source: EHR based

2023 Targets:

- Rate 1: 52.9%
- Rate 2: 28.7%

2023 Benchmarks:

- Rate 1: 66.6%
- Rate 2: 28.7%

Telehealth Eligibility: This measure is eligible for telehealth for SBIRT denominator rate 1 (screening) visits. For more information see the guidelines provided by the Health Evidence Review Committee.

Rate 1:

Denominator: Patients ages 12 years and older before the beginning of the measurement year with at least one eligible encounter during the measurement year determined by Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916)
Numerator: Patients who received an age-appropriate screening using an OHA approved SBIRT tool on the date of the eligible encounter or up to 14 days prior and complete either a brief screen with a negative result or a full screen with any result.

Rate 2:

Denominator: All patients from Rate 1 who had a positive full screen.
Numerator: Patients who had a positive full screen and received a brief intervention and/or referral to treatment that is documented within 48 hours of the date of the positive screen.

Denominator Exclusions:

- Active diagnosis of substance use disorder before the qualifying visit
- Active diagnosis of dementia or mental degeneration before the qualifying visit
- Engagement in substance use disorder treatment before the qualifying visit and up to one year before the start of the measurement year
- Patient is in hospice or receiving palliative care at any point during the measurement period.

Denominator Exceptions:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where delay to treatment would jeopardize the patient's health status

- Patient's functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools

Numerator Exclusions: SBIRT services received in an ED or hospital setting.

Notes: Detailed measure specifications for the depression screening and follow-up measure, which is used in SBIRT for the Rate 1 denominator and for denominator exceptions, are available in the eCQI Resource Center. Detailed value set contents are available in the Value Set Authority Center.

Continuous Enrollment Criteria: OHA does not use continuous enrollment criteria for EHR-based measures.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Screen all patients 12 and older for alcohol and drug misuse at least annually.
- Document screening tool and results in EHR in a reportable format.
- Provide brief intervention and/or referral to treatment as soon as need is indicated.
- Complete the Workflow for SBIRT & Depression Screenings exercise to ensure your practice's screening and documentation processes align with the measure requirements.