2022 Incentive Measure Guide

Claims-Based Measures:

1. **Childhood Immunization Status:** Children who turn two years old in 2022 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 2022 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 2021.
6. **Preventive Dental Services:** Patients ages 1-5 and 6-14 who receive preventive dental services in 2021.
7. **Well-Child Visits (3-6):** Patients ages 3-6 who complete at least one well-child visit during 2021.

Chart Review Measure:

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 a qualified or certified health care interpreter.
10. **Health Aspects of Kindergarten Readiness Measure: System-Level Social-Emotional Health Metric:** CCOs are responsible for developing a comprehensive, multi-year plan to assess and improve social-emotions behavioral health services benefitting children 1-5

Clinical Quality Measures:

11. **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.
12. **Diabetes HbA1c Poor Control:** Patients ages 18-75 with a diagnosis of diabetes whose most recent HbA1c level is > 9.0%.
13. **Cigarette Smoking Prevalence:** Patients ages 13 and older who are screened for tobacco use that identify as cigarette smokers.
14. **Alcohol and Drug Misuse Screening:** (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

2022 Target: 66.3%

2022 Benchmark: 71.1%

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
Hepatitis B – at least 3	08, 44, 45, 51, 110	90723, 90740, 90744, 90747, 90748, G0010
	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)

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

2022 Target: 90.0%

2022 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

*H0019: use of this code counts as both mental and physical health assessment for children in PRTS

*99201-99205— use of this code count as both mental and physical health assessments if paired with one of the following diagnosis codes:

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

2022 Target: 36.9%

2022 Benchmark: 36.9%

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

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

Denominator Exclusions: Patients in hospice during the measurement year.

Numerator: Children 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

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

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

2022 Targets:

- Initiation: 36.5%
- Engagement: 12.6%

2022 Benchmarks:

- Initiation: 43.0%
- Engagement: 13.9%

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 SUD.
SUD Episode Date:	The SUD Episode date of service.
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 date of service to determine the Negative SUD Diagnosis History. • For direct transfers, use the first admission date to determine the Negative SUD Diagnosis History.
Direct transfer	When the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.

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.

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, medically managed withdrawal visit, ED visit, observation visit, acute or non-acute inpatient discharge, telephone visit, e-visit or virtual check-in, 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
- For alcohol-related SUD Episodes only: An alcohol use disorder medication treatment dispensing or administration event within the 14-day Initiation period
- For opioid-related SUD Episodes only: An opioid use disorder medication treatment dispensing or administration event within the 14-day Initiation period
- 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, telephone visit, e-visit, or virtual check-in, or a weekly or monthly opioid treatment service
- *Note that all initiation events except medication treatment dispensing events and medication administration events must be with different providers in order to count for the measure if they occur on the same day as the SUD Episode Date*

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 within the 34-day Engagement period
- For alcohol or opioid-related SUD Episodes only: At least one long-acting SUD medication administration event (such as Naltrexone or Buprenorphine) within the 34-day Engagement period
- At least two of the following (in any combination) occurring within the Engagement period will also satisfy the Engagement component:
    - 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, telephone visit, e-visit or virtual check-in, 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 must be with different providers to count as two separate events if they occur on the same date. 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).*

If the patient's Initiation of SUD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List, AOD Medication Treatment Value Set, or AOD Medication Treatment Value Set), they must have **two** Engagement events in which only one can be a medication treatment event.

If the patient's Initiation of AOD treatment was *not* a medication treatment event, they must have either **one** Engagement medication treatment event, or **two** Engagement visits that are not medication treatment events.

*Appropriate SUD diagnosis codes come from these value sets: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

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

2022 Target: 20.4%

2022 Benchmark: 20.4%

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.

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

2022 Targets:

- Ages 1-5: 43.1%
- Ages 6-14: 52.0%

2022 Benchmarks:

- Ages 1-5: 43.1%
- Ages 6-14: 52.0%

Note: In 2022 CCOs only need to meet improvement target for one component (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).

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

2022 Target: 64.0%

2022 Benchmark: 64.1%

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 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.
- 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.

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

2022 Postpartum Target: 71.5%

2022 Postpartum Benchmark: 80.9%

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, 2020 and October 7, 2021, and continuous enrollment from 43 days prior to EDD and 60 days after EDD with no gaps.

Denominator Exclusions: Patients in hospice 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

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

***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 a qualified or certified health care interpreter.

Measure Specifications:

Data Source: Claims and chart review

2022 Target: Report Only/Must Pass

2022 Benchmark: Report Only/Must Pass

Telehealth Eligibility: This measure is eligible for telehealth, however visits without human interaction will be excluded (i.e., blood pressure readings, 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.

After the 2022 measurement year, OHA will provide a sample of 411 patients, who have self-identified as having interpreter needs. Clinics will need to report at least 80% of the total visits that occurred throughout the metric year. Only visits during a member'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, prescription refill notifications, etc.)
- Visits where a patient refuses interpreter services (must be documented)
    - Member refused because the provider speaks the members preferred language
    - Member confirms interpreter need documented in enrollment file is inaccurate

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

- Member is unsatisfied with the interpreter services available
- Other reasons for refusal

Numerator: Total number of visits provided with interpreter services. In 2023 OHA will require clinics to use OHA recognized qualified or certified interpreters.

Continuous Enrollment Criteria: None

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Prioritize using OHA certified or qualified interpreters when available.

- EOCCO offers no-cost interpreters to eligible members through Passport to Languages (see Provider Manual for more information).
- 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 member files sent by EOCCO for members who have an interpreter need based on OHA enrollment needs.
- Identify staff who are interested in completing the 60-hour Spanish Health Care Qualified Interpreter training program sponsored by EOCCO (anticipated launch in fall of 2022)
- Review the Language Access Report template for changes; develop a workflow or report to ensure all elements are met.
- 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.
- Identify if your Language Service Provider is Oregon-based and familiar with the OHA's requirements for qualified/certified interpreters. For local LSPs (such as Linguava or Passport to Languages) work to see if they can provide patient-level data on invoices.
- Assign a non-billable CPT 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)

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

Measure Description: CCOs are responsible for developing a comprehensive, multi-year plan to assess and improve social-emotions behavioral health services benefitting children 1-5.

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 Coordinated Care Organizations (CCOs), inclusive of four different components. Within Attestation Component 1 there is required review of child-level reach metric data.

2022 Target: Report Only

2022 Benchmark: Report Only for MY 1 (2022) 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 1 (2022) 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 2022 measure requirements please see social-emotional health incentive measure specifications.

Telehealth Eligibility: Not applicable to this Attestation Survey Form

Denominator: N/A*

Denominator Exclusions: N/A*

Numerator: N/A*

Continuous Enrollment Criteria: N/A*

Allowable Enrollment Gaps: N/A*

Anchor Date: N/A*

**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.

Depression Screening and Follow-Up Plan

(CMS 2v11)

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

Starting in 2022, this measure is no longer report-only. This means that clinics and CCOs are now held accountable for meeting a target rate.

2022 Target: 58.8%

2022 Benchmark: 64.6%

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 been diagnosed with depression
- Patients who have been diagnosed with bipolar

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 on the date of the positive screen.

Follow-up Plan:

- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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 additional evaluation or assessment for depression no longer count as appropriate follow-up options.

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:

- 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.

Diabetes HbA1c Poor Control

(CMS 122v10)

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

2022 Target: 31.5% (lower is better)

2022 Benchmark: 27.5% (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 Type 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.

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

2022 Target: 25.0% (lower is better)

2022 Benchmark: 25.0% (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.

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:

- 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: The percentage of patients 12 years and older who are age-appropriately screened for alcohol and drug use and had either a brief screen with a negative result or a full screen for rate 1. Patients with a positive full screen who had a brief intervention, and/or referral to treatment within 48 hours of screen satisfy rate 2.

Measure Specifications:

Data Source: EHR based

Starting in 2022, this measure is no longer report-only. This means that clinics and CCOs are now held accountable for meeting target rates.

2022 Target:

- Rate 1: 59.7%
- Rate 2: 29.7%

2022 Benchmark:

- Rate 1: 68.2%
- Rate 2: 53.5%

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.

Denominator Rate 1: 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 Rate 1: Patients who received an age-appropriate screening using an OHA approved SBIRT tool during the measurement year, and complete either a brief screen with a negative result or a full screen.

Denominator Rate 2: All patients in Rate 1 who had a positive full screen in the measurement year.

Numerator Rate 2: Patients who 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 alcohol or drug dependency before the qualifying visit
- Engagement in alcohol or drug dependence treatment up to one year before the start of the measurement year
- Dementia or mental degeneration before the qualifying visit
- Limited life expectancy before the qualifying visit
- Palliative care before the qualifying visit

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.

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:

- 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.