2024 Incentive Measure Guide

Incentive Program Background:

- **What are incentive measures and why are they important?**
- **2024 Quality Bonus Payment (QBP) Formula**

Claims-Based Measures:

1. **Childhood Immunization Status:** Children who turn two years old in 2024 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 2024 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 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 up with a diabetes diagnosis who received a comprehensive, periodic, or periodontal oral evaluation in 2024.
6. **Preventive Dental Services*:** Patients ages 1-5 and 6-14 who receive preventive dental services in 2023.
7. **Well-Care Visits*:** Patients ages 3-6 and 7-21 who complete at least one well-care visit during 2024.

Hybrid/Chart Review Measures:

8. **Timeliness of Prenatal and Postpartum Care*:** Pregnant people 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 benefiting children from birth to age 5.

*2024 Challenge Pool measure

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 EHR-Based 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.
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 who 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.

What are Incentive Measures and why are they important?

Every calendar year, the Oregon Health Authority (OHA) selects a set of incentive measures and benchmarks for the Medicaid Coordinated Care Organizations (CCOs) to focus on. Each year's measure set is carefully chosen to ensure that a range of age-appropriate physical, mental, and dental services are addressed. The OHA also selects 3 to 4 of these metrics as high priority "Challenge Pool" measures that are tied to additional incentive funds for CCOs.

CCOs receive quality pool funds for achieving a certain percentage of incentive measure targets for the year. EOCCO reinvests the majority of these quality pool funds back into the clinics and community-based programs that work hard to improve health outcomes of our Medicaid population. Primary care clinics earn funding bonuses based on their incentive measure performance each year [see the *2024 Quality Bonus Payment Formula*]. Through the incentive measure program, CCOs and clinics work together to address health disparities and improve accessibility and quality of care.

EOCCO has created this Incentive Measure Guide to help primary care clinic staff understand the 2024 measure set. This document covers the CCO incentive measures, technical specifications, reporting requirements, and measure benchmarks for the 2024 calendar year. Please note that EOCCO will publish an updated version of this guide in July of 2024 when OHA announces the final improvement targets for the incentive measure set. In the meantime, we recommend using the benchmark rates as a general goal for each measure.

2024 Quality Bonus Payment (QBP) Formula

The Quality Bonus Payment Formula is used to determine the annual Quality Bonus Payment for primary care clinics who participate in EOCCO's Shared Savings Model. Participating clinics will earn points for each of the measures in which they meet minimum denominator size* and achieve the improvement target. For some measures, clinics can receive two points for reporting data to EOCCO even if the measure improvement target is not achieved. Clinic quality bonus payments are based on the percentage of eligible points earned multiplied by their average EOCCO patient enrollment during the year.

Incentive Measure	Measure Type	Minimum Denominator	2024 Points
Assessments for children in DHS custody	Claims	5 patients	4
Childhood immunizations	Claims	10 patients	4
Immunizations for Adolescents	Claims	10 patients	4
Initiation and Engagement of SUD Treatment	Claims	10 patients	4
Preventive Dental Services – Ages 1-5 & 6-14	Claims	10 patients	4
Well-care visits, Ages 3-6 & 7-21	Claims	10 patients	4
Meaningful Language Access	Hybrid	10 encounters	4 (report only 2)
Cigarette smoking prevalence	EHR	10 patients	4
Depression screening	EHR	10 patients	4
Diabetes A1c poor control	EHR	10 patients	6 (report only 2)
SBIRT	EHR	10 patients	4
		TOTAL POINTS:	**46**

If clinics **do not meet the minimum denominator size for a measure they will not be held accountable for their performance on that measure. Points associated with that measure will be deducted from their total eligible QBP points.*

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

2024 Target: **66.4%**

2024 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 who use hospice during the calendar year. Patients who die any time during the measurement year. Patients who had a contraindication to a childhood vaccine on or before their second birthday.

Numerator: Children who turned two years of age in the measurement year and received all of the following vaccinations on or before their second birthday: DtaP, IPV, MMR, HiB, Hepatitis B, VZV, & 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, 146	90697, 90698, 90700, 90723
IPV – at least 3	10, 89, 110, 120, 146	90697, 90698, 90713, 90723
MMR – at least 1	03, 94	90707, 90710
	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, 120, 146, 148	90644, 90647, 90648, 90697, 90698, 90748
Hepatitis B – at least 3	08, 44, 45, 51, 110, 146	90697, 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	109, 133, 152, 215, 216	90677, 90670, 90671, 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.
    - *Note that Oregon's ALERT IIS system may show that a vaccine series is complete before a patient has received all doses required by the Oregon Health Authority measure specifications. This tends to happen for the PCV vaccine series in particular. For the Childhood Immunization Status measure, it is recommended that children receive four doses of PCV. We suggest ensuring your patients receive all recommended doses in each vaccine series whenever appropriate.*
- 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 the 30 days prior to the notification date.

Measure Specifications:

Data Source: Claims

2024 Target: **93.2%**

2024 Benchmark: 93.2%

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 who 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, if the CCO is notified more than once for the same child, 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 child's 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 3-17), within 60 days of the notification date, or within 30 days prior to the notification date.

- Ages < 1 need a physical health assessment
- Ages 1-2 need a physical and dental health assessment
- Ages 3-17 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 Psychiatric Residential Treatment Services (PRTS)

Physical Health Assessments billed using a new patient E&M code: 99201-99205 and including a qualifying mental health or child abuse/neglect diagnosis (see table below) on the same claim will count as both a mental and physical health assessment.

ICD-10CM Diagnosis (All diagnosis fields apply)	
Mental Health Diagnosis	F03, F20 – F53, F59 – F69, F80 – F99 (total of 291 codes)
Diagnosis Related to Child Abuse or Neglect	T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.32xA, T74.32xD, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, T76.32xA, T76.32xD, T76.92xA, T76.92xD

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. For physical health visits, aim to schedule the patient for a Well Child Visit type if possible. EOCCO will cover multiple well care visits for a patient per year
    - 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

2024 Target: **36.9%**

2024 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 received 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	32, 108, 114, 136, 147, 167, 203	90619, 90733, 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.
    - *Note that Oregon's ALERT IIS system may show that a vaccine series is complete before a patient has received all doses required by the Oregon Health Authority measure specifications. We suggest ensuring your patients receive all recommended doses in each vaccine series whenever appropriate.*
- 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

2024 Targets:

- Initiation: **36.0%**
- Engagement: **14.6%**

2024 Benchmarks:

- Initiation: 48.6%
- Engagement: 18.1%

Note: Clinics must meet minimum denominator size and improvement targets for both phases (Initiation and Engagement) to achieve measure overall.

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, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, withdrawal management event, ED 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.

Deduplicate eligible episodes: If a member has more than one eligible episode on the same day, include only one eligible episode. For example, if a member has two eligible episodes on January 1st, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1st.

- Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed remain in the denominator.

Denominator Exclusions:

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

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

- 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. (Please note: "14 days" = SUD Episode date + 13 days. E.g. If a patient's SUD Episode is on 1/1/24, they must Initiate by 1/14/24). 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.
- 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 codes: acute or non-acute inpatient discharge, outpatient visit, intensive outpatient visit or partial hospitalization, non-residential substance abuse treatment facility visit, substance abuse counseling and surveillance, telehealth visit, substance use disorder service, 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 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, substance abuse counseling and surveillance, telehealth visit, substance use disorder service, 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 to count as two separate events. However, an engagement visit on the

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

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

- Acamprosate (oral)
- Disulfiram (oral)
- Naltrexone (oral and injectable)

Opioid Use Disorder Treatment Medications

- Methadone (oral)
- Naltrexone (oral and injectable)
- Buprenorphine (oral, injectable, implant)
- Buprenorphine/naloxone (oral)

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 in your area
- Review and respond promptly to emails from the EOCCO team notifying clinics of patients who 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

2024 Target: **28.5%**

2024 Benchmark: 31.9%

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 may have had a diabetes diagnosis but also:

- Have gestational diabetes, polycystic ovarian syndrome, 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, or are enrolled in a long-term care institution

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

2024 Targets:

- Ages 1-5: **52.9%**
- Ages 6-14: **61.0%**

2024 Benchmarks:

- Ages 1-5: 52.9%
- Ages 6-14: 61.0%

Note: Clinics must meet minimum denominator size and improvement targets for both age groups (ages 1-5 and 6-14) to achieve measure overall.

Telehealth Eligibility: This measure may be eligible for teledentistry if the rendering provider determines the required components are equivalent to an in-person visit. Visits that include a qualifying CDT code (D1000 – D1999) 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: Count of unique members in the denominator who received preventive dental or oral health services, identified by CDT code D1000 – D1999 (by any of the dental provider types listed below) or CPT code 99188 (by ANY provider).

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 , 1223X2210X
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, 261QS0112X, 261QD0000X

*2024 Challenge Pool measure

Dental Providers	Denturist	122400000X
Dental Providers	Dental Assistant	126800000X
Allopathic & Osteopathic Physicians	Oral & Maxillofacial Surgery	204E00000X

~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 (CPT code 99188), they may do so annually to satisfy this measure.
    - Contact EOCCOmetrics@modahealth.com if you are interested in setting up a First Tooth training to qualify your providers to provide topical fluoride varnish.
- 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.
    - If a patient does not know their assigned dental care organization (DCO) or provider they can contact EOCCO Customer Service at 888-788-9821 (TTY users, call 711).
- 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-Care Visits – Kindergarten Readiness*

(NQF 1516)

Measure Description: The percentage of patients ages 3-6 and 7-21 who complete at least one well-care visit during the measurement year.

Measure Specifications:

Data Source: Claims

2024 Targets:

- Ages 3-6: **69.4%**
- Ages 7-21: **36.5%**

2024 Benchmark:

- Ages 3-6: 70.2%
- Ages 7-21: 36.5%

Note: Clinics must meet minimum denominator size and improvement targets for both age groups (ages 3-6 and 7-21) to achieve measure overall.

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

Denominator: Patients ages 3-21 as of December 31st of the measurement year.

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

Numerator: Patients who receive at least one well-care visit during the measurement year provided by a primary care provider or OB/GYN.

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

Coding:

CPT	HCPCS	ICD-10
99381-99385, 99391-99395, 99461	G0438, G0439, S0302, S0610, S0612, S0613	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, 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.

*2024 Challenge Pool measure

- Contact EOCCOmetrics@modahealth.com to get Well Care Visit Amazon gift card incentive program materials for children ages 3-6.
- Convert sick visits into comprehensive wellness exams whenever possible.
- Comprehensive well-woman exams will count toward this measure as well. Encourage older teens to complete a well-woman exam if appropriate.
- Do not be concerned about providing more than one wellness exam within a one-year period. EOCCO will pay for multiple.
- Hold well-care visit events or designated clinic days.

Timeliness of Prenatal and Postpartum Care*

(NQF 1517)

Measure Description: The percentage of pregnant people 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

2024 Postpartum Target: **78.7%**

2024 Postpartum Benchmark: 85.9%

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

Denominator: A sample size provided by OHA of 411 patients with live birth deliveries with estimated delivery date (EDD) in the 'intake period': between October 8, 2023, and October 7, 2024, and continuous enrollment from 43 days prior to delivery through 60 days after delivery, with no gaps.

Note that the denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed remain in the denominator.

Denominator Exclusions:

- Patients who were in hospice or died anytime during the measurement year
- More than one delivery in a 180-day period

Numerator:

Prenatal Care: This visit must occur with a PCP, OB/GYN, or other prenatal care practitioner. Visit should occur within the first trimester (280-176 days prior to delivery or EDD), on or before the enrollment start date, or within 42 days of enrollment, depending on the date of enrollment and gaps in enrollment during the pregnancy. Do not count visits that occur on the date of delivery. Documentation in the medical record must include a note indicating the date when the prenatal visit occurred and evidence of one of the following:

- Documentation indicating the member is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flowsheet, **or**
  - Documentation of last menstrual period (LMP), EDD or gestational age, **or**
  - A positive pregnancy test result, **or**
  - Documentation of gravidity and parity, **or**
  - Documentation of complete obstetrical history, **or**
  - Documentation of prenatal risk assessment and counseling/education
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flowsheet may be used).
- Evidence that a prenatal care procedure was performed, such as:

*2024 Challenge Pool measure

- Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
- TORCH antibody panel alone, **or**
- A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
- Ultrasound of a pregnant uterus

Postpartum Care: This visit must occur with a PCP, OB/GYN, or other prenatal care practitioner. The visit must take place 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 "breastfeeding" is acceptable for the "evaluation of breasts" component
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," or "6-week check"
  - A preprinted "Postpartum Care" form in which information was documented during the visit
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for members with gestational diabetes
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing or family planning
  - Sleep/fatigue
  - Resumption of physical activity
  - Attainment of healthy weight

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

Allowable Enrollment Gaps: None

Anchor Date: Enrolled on the Estimated Date of Delivery (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 one 12-week postpartum check. If patient no-shows, try and reschedule the visit as soon as possible.
- Document all 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 and 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 HCPCS: G0463, T1015
Stand Alone Prenatal Visits	CPT: 99500 CPT-CAT-II: 0500F, 0501F, 0502F HCPCS: H1000 - H1004
Cervical Cytology Lab Test	CPT: 88141 - 88143, 88147, 88148, 88150, 88152, 88153, 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. Please see the OHA technical specification guide for a complete list of codes and value sets that are used in this measure.

Meaningful Language Access to Culturally Responsive Health Care Services

Measure Description: The percentage of patients with a self-identified sign or spoken language interpreter need 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 is proficient in the patient's preferred language.

Measure Specifications:

Data Source: Claims and chart review

2024 Target: **17.1%**

2024 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.

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)
    - Allowable Exclusions:
        - Patient refused because the billing provider speaks the patients' preferred language (in-language visit provided)
        - Patient confirms interpreter need documented in OHP 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 by a provider with documented proficiency* in the member's preferred language.

> ***Proficiency is defined as:***
> *1) Providers who have a degree in high school or above in a country where instruction is primarily in the non-English language, and the provider is a native speaker of the non-English language*
> *2) A provider has completed and passed an OHA approved language proficiency test within the past four years. EOCCO must have the provider's language proficiency test completion certificate and test score on file. A current list of approved language proficiency tests and passing scores is included below:*

Proficiency Test	Passing Test Score
Language Line Solutions	2+ or higher
Language Testing International	Advanced mid-level or higher on the ACTFL rating scale
ALTA	Advanced mid-level or higher on the ACTFL rating scale

Continuous Enrollment Criteria: None

Allowable Enrollment Gaps: Only visits that occurred when a member was actively enrolled in EOCCO are required to be reported.

Anchor Date: None

Strategies for Improvement:

Language Access Reporting

- Complete all the 2024 quarterly Language Access reports using the clinic reporting template provided by EOCCO. The quarterly Language Access reports will contain information on all visits members with a self-identified interpreter need (according to OHA enrollment data) had at your clinic within a given quarter. OHA will utilize data from the 2024 Quarterly Language Access reports to determine EOCCO's rate for the Language Access Incentive Measure.
- Review the quarterly Language Access Report template for changes; develop a data capture or reporting workflow within your EHR system to ensure all required reporting elements are met.
    - Ex: 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)
- 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 OHA certified/qualified interpreter information during interpreter visits or on invoices.
    - OHA's Health Care Interpreter Registry can also be used to identify if a health care interpreter is OHA qualified/certified
- If any of your providers have taken language proficiency tests, provide documentation of each provider's completed language proficiency test and test score to EOCCO. Email EOCCOmetrics@modahealth.com to submit language proficiency testing documentation.

Provision of Healthcare Interpreter Services

- Prioritize using OHA certified or qualified interpreters when available.
- EOCCO offers no-cost interpreter services for EOCCO members through Passport to Languages and Linguava (see Provider Manual for more information on how to access these interpreter services).
- Identify bilingual or multilingual staff at your clinic who are interested in completing the OHA approved 60-hour Spanish Health Care Qualified Interpreter training program to become an OHA certified/qualified Healthcare Interpreter. This training program sponsored by EOCCO and Oregon State University (see the Oregon State University website for more information).

- Review clinic schedules several days in advance to identify patients who may need language services. This will ensure availability of clinic staff interpreters or allow staff to pre-schedule interpreter services through Passport to Languages, Linguava, or your own contracted language service.
- Ask patients if they would like a health care interpreter when scheduling future appointments or when calling with appointment reminders.
- If bilingual/multilingual providers are interested in taking a language proficiency test, please contact EOCCOmetrics@modahealth.com and reference OHA's list of approved language proficiency testing centers and tests on the Health Care Interpreter Training Program website.

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 benefiting 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 (data provided by the Oregon Health Authority).

2024 Target: Report Only (CCO)

2024 Benchmark: Report Only (CCO). CCOs must submit the following documents:

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

In addition, CCOs are required to attest to completing all required activities for the Year 3 (2024) components:

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

For additional information on the 2024 measure requirements please see the full OHA Social-Emotional Health incentive measure specifications.

Note: *Clinics do not need to report on this measure for Year 3 (2024).* 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 submit all of the documents (the attestation survey, asset map and action plan) and demonstrate that they have fulfilled the four required metric components.

Telehealth Eligibility: Not applicable to this Attestation Survey Form

Denominator: None

Denominator Exclusions: None

Numerator: None

*2024 Challenge Pool measure

Continuous Enrollment Criteria: None

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Clinics may be contacted to provide feedback related to their ability to refer and provide social-emotional health services as needed.
    - If your clinic has attested to PCPCH Standard 3.C.3 (Behavioral Health Integration), your clinic will be contacted to participate in the 2024 Social Emotional Health Services Asset Mapping Process

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 using an OHA approved or exempted social needs screening tool and are referred to services if needed.

Measure Specifications:

Data Source: Attestation survey completed by CCOs for Measurement Years 1, 2 and 3 (2023-2025), inclusive of three different components

2024 Target: Report Only (CCO)

2024 Benchmark: For Measurement Year 2 (2024) CCOs must attest to all required components, including:

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

Note: *Clinics do not need to report on this measure for Measurement Year 2 (2024). The information below is provided for planning and informational purposes only. Starting in Measurement Year 3 (2025), OHA will provide a hybrid sample of 1,067 pediatric and adult EOCCO members. Clinics will be asked to report: (Rate 1) which of the members in the sample received a screening for each of the three required social need domains: housing insecurity, food insecurity, and transportation. Clinics will also report (Rate 3) which of the members from Rate 1 who screened positive for social need(s) received at least one referral to address each identified need.*

Telehealth Eligibility: This measure is telehealth eligible.

Rate 1:

Denominator: All EOCCO members in the hybrid sample who meet continuous enrollment criteria. Include members screened from December 15th of the prior measurement year to December 14th of the measurement year.
Numerator: Members who were screened at least once in the measurement year for all three required social need domains using an OHA approved or exempted social needs screening tool.

Rate 2*:

Denominator: Members from Rate 1 Numerator
Numerator: Members who screened positive for needs in any of the three required social need domains
**Note*: *There is not a target associated with Rate 2, it is calculated as a necessary step in the process to calculate Rate 3*

Rate 3:

Denominator: Members from Rate 2 Numerator social need domains
Numerator: Members who received a referral within 15 calendar days for each social need domain they screened positive for

Denominator Exceptions:

- Rate 1: Member declines a social needs screening in all three social need domains (housing insecurity, food insecurity, and transportation)
- Rate 2: None
- Rate 3: Member declines all referrals to services/resources for any social needs identified

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 mid-2024 and provide information on: social needs screening practices, social needs screening tools or questions in use, and screening and referral data capture and exchange.
- If your clinic currently screens patients for social needs, 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 and use of OHA approved social need screening tools. For a current list of OHA-approved tools see the Social Needs Screening Tools website. Alternatively, EOCCO can work to get social needs screening tools or questions approved or exempted by OHA. Please contact EOCCOmetrics@modahealth.com if you would like EOCCO to help facilitate approval or exemption 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)
    - 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 2v13)

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

2024 Target: **68.2%**

2024 Benchmark: 68.2%

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

Denominator: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period. Qualifying 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 bipolar disorder at any time prior to the qualifying encounter.

Denominator Exceptions:

- Patient refuses to participate or complete the depression screening.
- Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).

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 AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. 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 appropriate follow-up options.
- Previous diagnosis of depression is no longer eligible for denominator exclusions.
- 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 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 122v12)

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

2024 Target: **21.1% (lower is better)**

2024 Benchmark: 21.1% (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 18-75 years of age by the end of the measurement period who have diabetes and a visit during the measurement period.

Denominator Exclusions:

- Patients who are in hospice care or receiving palliative care for any part of the measurement period
- Patients ages 66 and older by the end of the measurement period who are living long term in a nursing home any time on or before the end of the measurement period
- Patients ages 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria:
    - Advanced illness with two outpatient encounters during the measurement period of the year prior
    - OR advanced illness with one inpatient encounter during the measurement period or the year prior
    - OR taking dementia medications during the measurement period of the year prior

Numerator: Patients whose most recent HbA1c level performed during the measurement period is >9.0%, is missing, or was not performed during the measurement period.

Notes:

- Patient is numerator compliant if there are no HbA1c tests performed, or results documented during the measurement year.
- Lab-only encounters are not an eligible visit type.
- 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.
- Encourage patients with diabetes to enroll in the EOCCO-funded Diabetes Self-Management program with Livongo.

Cigarette Smoking Prevalence

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

Measure Specifications:

Data Source: EHR based

2024 Target: **17.8% (lower is better)**

2024 Benchmark: 17.8% (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 by the beginning of the measurement year, who have had at least one qualifying visit during the measurement year as determined by the denominator criteria for MU Smoking Status Objective or Code sets included in NQF0028e/CMS138v12 plus adolescent visit codes.

Denominator Exclusions: Patients who are in hospice care or receiving palliative care for any part of the measurement period.

Numerator: Three rates must be queried to determine the prevalence rate (2). Only Rate 2 is incentivized for this measure.

> *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/ CMS138v12) 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 other motivational interviewing resources on EOCCO's Provider Education webpage to assist patients who may want to quit tobacco use.
- Refer patients to tobacco cessation and Health Coaching resources on eocco.com (English and Spanish resources available).
- 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

2024 Targets:

- Rate 1: **57.2%**
- Rate 2: **28.3%**

2024 Benchmarks:

- Rate 1: 66.6%
- Rate 2: 46.7%

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: All patients aged 12 years and older before the beginning of the measurement period with at least one qualifying encounter during the measurement period determined by Depression Screening Encounter Codes Grouping Value Set (2.16.840.1.113883.3.600.1916)
Numerator: Patients screened on the date of the qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter using an age-appropriate, OHA approved SBIRT tool **AND** had either a brief screen with a negative result or a full screen.

Rate 2:

Denominator: All patients in Rate 1 denominator who had a positive full screen.
Numerator: Patients who received a brief intervention, a referral to treatment, or both during the qualifying encounter that is documented on the date of or up to two calendar days after the date of the qualifying encounter.

Denominator Exclusions:

- Active diagnosis of substance use disorder before the qualifying encounter
- Active diagnosis of dementia or mental degeneration before the qualifying encounter
- Engagement in substance use disorder treatment before the qualifying encounter 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
- Documentation of medical reason for not screening patient (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent

situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

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.