2026 Incentive Measure Guide

Incentive Program Background:

- **What are incentive measures and why are they important?**
- **2026 PCP Quality Bonus Payment (QBP) Formula**

Claims-Based Measures:

1. **Childhood Immunization Status:** Children who turn two years old in 2026 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 and dental health assessments within 30 days of notification or 30 days prior, and a mental health assessment within 60 days of notification or 30 days prior.
3. **Immunizations for Adolescents:** Adolescents who turn 13 years of age in 2026 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. **Preventive Dental Services*:** Patients ages 1-5 and 6-14 who receive preventive dental services in 2026.
6. **Well-Care Visits*:** Patients ages 3-6 who complete at least one well-care visit during 2026.
7. **Child-Level Social-Emotional Intervention/Treatment Services**: Patients ages 1-5 who receive an issue-focused social emotional health intervention or treatment service during 2026.

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 a preferred language other than English (LOE) 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. **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 period and are referred to services if needed.

*2026 Challenge Pool measure

11. **Glycemic Status Assessment for Patients with Diabetes:** Patients ages 18-75 with a diagnosis of Type 1 or Type 2 diabetes whose most recent glycemic status result during the measurement year was poorly controlled (>9.0%), based on hemoglobin A1c (HbA1c) or glucose management indicator (GMI) testing.

Clinical EHR-Based Quality Measures:

12. **Depression Screening and Follow-up Plan*:** Patients ages 12 and older with a qualifying visit in 2026 who are screened for depression and, if positive, a follow-up plan is documented on the date of or up to two days after the positive screen.

*2026 Challenge Pool measure

What are Incentive Measures and why are they important?

Every calendar year, the Oregon Health Authority (OHA) Quality Incentive Program (QIP) 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 providers (PCPs) can earn funding bonuses based on their incentive measure performance each year [see *2026 PCP 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 2026 measure set. This document covers the CCO incentive measures, technical specifications, reporting requirements, and measure benchmarks for the 2026 calendar year. Please note that EOCCO will publish an updated version of this guide in July of 2026 when OHA announces the final 2026 improvement targets for the incentive measure set. In the meantime, we recommend using the benchmark rates as a general goal for each measure.

2026 Primary Care Provider (PCP) Quality Bonus Payment (QBP) Formula

The PCP Quality Bonus Payment Formula is used to determine the annual Quality Bonus Payments for primary care clinics who participate in EOCCO's Shared Savings Model. Participating clinics can earn points for each of the measures in which they meet minimum denominator size and achieve the improvement target. 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.

Clinic Quality Bonus Payments are distributed in Q4 of the year following the measurement year. Payment amounts are based on the total Quality Pool funds earned at the CCO level and require approval by the EOCCO Board of Directors. At the clinic level bonus payments are calculated using the percentage of eligible points earned multiplied by the clinic's average EOCCO patient enrollment during the year.

Incentive Measure	Measure Type	Minimum Denominator	2025 Points
Assessments for Children in DHS Custody	Claims	5 patients	4
Childhood Immunization Status	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	Claims	10 patients	6
Child-Level Social Emotional Intervention/ Treatment Services	Claims	20 patients	2
Meaningful Language Access	Hybrid	10 encounters#	4 (report only 2)+
Depression Screening & Follow-Up	EHR	10 patients	4
		TOTAL POINTS:	**36**

^Must meet minimum denominator and target for *both* measure components in order to earn points.

#Denominator is calculated by totaling encounters from all Language Access Reports.

+Clinics can receive two points for providing complete data for all 2026 Language Access Reports even if improvement target is not met.

Childhood Immunization Status Combo 3

(NQF 38, CMIT 124)

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

2026 Target: **TBD**

2026 Benchmark: 68.9%

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 services during the measurement year. Patients who die any time during the measurement year. Patients who had a contraindication to a childhood vaccine, or who received an organ or bone marrow transplant 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, 198	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, 198	90644, 90647, 90648, 90697, 90698, 90748
Hepatitis B – at least 3	08, 44, 45, 51, 110, 146, 198	90697, 90723, 90740, 90744, 90747, 90748, G0010
	Newborn Hepatitis B – can count as 1 Hepatitis B dose	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	90670, 90671, 90677, G0009

Continuous Enrollment Criteria: Patient must be enrolled for 12 months prior to their 2nd birthday. Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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 Quality Measures 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.*
    - *Ensure that bundled/combination immunizations are entered into ALERT IIS to reflect all immunizations received during the visit. Patients often receive a DTaP-IPV-Hib-HepB (or other combination) in one injection but are coded as having only received DTaP, showing the patient as non-compliant. We suggest ensuring that data entered into ALERT IIS is verified against the immunizations administered during the visit to ensure accurate recording and greater measure compliance.*
- Immunize patients during wellness visits.
- Schedule immunization visits well before the 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/incentivemeasures. These can be ordered from EOCCO's Print Resource Order Form at no cost.

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 and a dental health assessment within 30 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, and a mental health assessment within 60 days of the notification date or 30 days prior.

Measure Specifications:

Data Source: Claims

2026 Target: **TBD**

2026 Benchmark: 80.0%

2026 Measurement Period: November 1st, 2025-October 31st, 2026

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 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 (notified more than 30 days after child enters DHS custody). 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 CCO enrollment start was delayed, if they had a gap in CCO coverage through the 60 days after notification [with at least 7 total days of CCO enrollment], 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) and a dental health assessment (ages 1-17) within 30 days of the notification date, or within 30 days prior to the notification date; 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
99202-99205, 99212- 99215, 99381-99384, 99391-99394, G0438, G0439	90791-90792, 96130, 96131, 96136-96139, H0031, H1011, H2000-TG (needs modifier)[1], H0019~, H2013, H0037	D0100-D0199

Physical Health Assessments billed using a new patient E&M code: 99202-99205 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 CCO enrollment of up to 7 days and cases with gaps in CCO coverage are only included if they are numerator compliant.

Allowable Enrollment Gaps: None

Anchor Date: None

Strategies for Improvement:

- Refer to EOCCO's DHS Incentive Measure Quick Reference Guide for a summary of recommended assessments by age, EOCCO's outreach process, qualifying assessment codes, and contact information for local Child Welfare offices.
- 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.
        - Order Foster Parent Incentive program materials from EOCCO's Print Resource Order Form at no cost 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.

[1]H2000-TG: Only LPC, LMFT, LCSW, psychologist and QMHP qualify for performing mental health assessments and are eligible for billing H2000-TG

~H0019: Use of this code counts as both mental and physical health assessment for children in Psychiatric Residential Treatment Services (PRTS)

- Contact your local ODHS Child Welfare office if you need more information about a case or want to identify the child's assigned DHS Caseworker. To find your local ODHS Child Welfare office branch, use the "Find an Office" search tool: https://www.oregon.gov/odhs/pages/office-finder.aspx.

Immunizations for Adolescents

(NQF 1407, CMIT 363)

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

2026 Target: **TBD**

2026 Benchmark: 41.6%

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 who use hospice services during the measurement year. Patients who die any time 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 10th 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, 316, 328	90619, 90623, 90624, 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. Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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 Quality Measures 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/incentivemeasures. Visit our Print Resource Order Form to order educational materials for your clinic at no cost.

Initiation and Engagement of Substance Use Disorder Treatment

(NQF 4, CMIT 394)

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

2026 Targets:

- Initiation: **TBD**
- Engagement: **TBD**

2026 Benchmarks:

- Initiation: 49.8%
- Engagement: 19.6%

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). Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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
- Engage Traditional Health Workers in follow-up care for SUD patients—CHWs, PWSs, and PSSs can all complete billable Initiation and Engagement encounters in support of this measure. Please review EOCCO's THW support for IET patients guide for more information.

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

2026 Targets:

- Ages 1-5: **TBD**
- Ages 6-14: **TBD**

2026 Benchmarks:

- Ages 1-5: 66.3%
- Ages 6-14: 70.8%%

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

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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. Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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, CMIT 24)

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

Measure Specifications:

Data Source: Claims

2026 Target: **TBD**

2026 Benchmark: 75.3%

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

Denominator: Patients ages 3-6 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, Z02.84, Z76.1, Z76.2

Continuous Enrollment Criteria: Patient must be enrolled for the measurement year. Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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 Quality Measures reports.
- Advertise EOCCO's WCV incentive program to members. EOCCO will provide a $50 Amazon gift card to parents for children ages 3-6 who complete a well visit during the measure year. Visit our Print Resource Order Form to order Well Care Visit incentive program postcards at no cost.
- Convert sick visits and sports physicals into comprehensive wellness exams whenever possible.
- EOCCO will cover more than one wellness exam within a one-year period.
- Hold well-care visit events or designated clinic days.

*2026 Challenge Pool measure

Child-Level Social-Emotional Intervention/Treatment Services – Kindergarten Readiness

Measure Description: The percentage of patients ages 1-5.99 who have received at least one issue-focused social emotional health intervention or treatment service during the measurement year.

Measure Specifications:

Data Source: Claims

2026 Target**: TBD**

2026 Benchmark: 12.0%

Telehealth Eligibility: This measure is eligible for telehealth services.

Denominator: Count of unique members ages 1-5.99 on the last day of the measurement year who meet continuous enrollment criteria.

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

Numerator: Count of unique members in the denominator who received any of the issue-focused intervention/treatment services within the measurement year identified by specific CPT codes included below.

Numerator Exclusions: Not Applicable

Coding:

CPT Claim Title	CPT Code
Psychiatric Diagnostic Evaluation	90791
Psychiatric Diagnostic Evaluation, by a medically licensed professional	90792
Health behavior assessment, or re-assessment	96156
Mental health assessment, by non-physician	H0031
Health Behavior Intervention	96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171
Preventive Medicine Counseling	99401-99404, 99411-99412
Adaptive Behavior Treatment	97153-97158
Behavioral health counseling and therapy	H0004
Skills training and development	H2014
Individual psychotherapy	90832-90834, 90836-90838
Family psychotherapy	90846, 90847

Group psychotherapy	90849, 90853
Multi-Family Group Training Session	96202, 96203
Behavioral Health Outreach Services (Used for Intensive, In-Home Behavioral Health Treatment)	H0023
Mental health service plan development, by non-physician	H0032
Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)	98960-98962
Activity therapy (music, dance, and/or play therapies) related to the care and treatment of patient's disabling mental health problems per session (>=45min)	G0176

Continuous Enrollment Criteria: Patient must be enrolled for the measurement year. Patient must be assigned to a clinic for at least nine months of the measurement year to count in the measure denominator.

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:

- Utilize standardized age-appropriate social emotional/behavioral screenings or assessments during preventative or well-care visits to identify patients ages 1-5 that may require a higher level of social emotional intervention or treatment service
- Reference Oregon Health Authority's Social Emotional Health Coding and Billing Guide to identify different provider types that can bill for eligible social emotional health services.
    - Consider utilizing Traditional Health Workers (CHWs, Peers) to provide issue-focused social emotional health intervention services for children and their family/caregivers within their scope of practice
    - Questions about THW contracting or billing? Please email: THW@eocco.com
- Develop partnerships or referral pathways with local schools, HeadStart programs, early learning hubs or other community-based organizations that engage with, and provide culturally specific services/supports, to young children and their families

Timeliness of Prenatal and Postpartum Care

(NQF 1517, CMIT 581)

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).

> *Note: Entities must report on both Prenatal and Postpartum rates, but only Postpartum is incentivized for measure performance.*

Measure Specifications:

Data Source: Claims and chart review

2026 Postpartum Target: **TBD**

2026 Postpartum Benchmark: 91.1%

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, 2025, and October 7, 2026, 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
- Patients with no confirmed live birth

Numerator: Because this is a hybrid measure, numerator compliance can be satisfied by properly coded and billed claims OR documentation in a patient's chart.

Prenatal Care – Claims Billing Codes:

Prenatal Service Description	Eligible Codes
Prenatal Bundled Services *(Claim must indicate date when prenatal care was initiated)*	CPT: 59400, 59425, 59426, 59510, 59610, 59618 HCPCS: H1005
Stand Alone Prenatal Visits *(Do not include codes with a modifier)*	CPT: 99500 CPT-CAT-II: 0500F, 0501F, 0502F HCPCS: H1000 - H1004
Prenatal Visits *(Claim must include a pregnancy-related diagnosis)*	CPT: 98000-98016, 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99242-99245, 99421-99423, 99441-99443, 99457, 99458, 99483 HCPCS: G0071, G0463, G2010, G2012, G2250-G2252, T1015

Prenatal Care – Chart Documentation: This visit must occur with a PCP, OB/GYN, or other prenatal care practitioner. Visits 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:
  - 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 – Claims Billing Codes:

Postpartum Service Description	Eligible Codes
Postpartum Bundled Services *(Claim must indicate date when postpartum care was initiated)*	CPT: 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Postpartum Care *(Do not include codes with a modifier)*	CPT: 57170, 58300, 59430, 99501 CPT-CAT-II: 0503F HCPCS: G0101
Encounter for Postpartum Care *(Do not include lab claims)*	ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical Cytology Test or Result	CPT: 88141-88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001 LOINC: 104866-9, 10524-7, 18500-9, 19762-4, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Postpartum Care – Chart Documentation: 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. Cribs for Kids program postcards can be ordered from EOCCO's Print Resource Order Form at no cost.
- Connect your patient with an OHA certified birth doula at no cost to them. When doulas bill for prenatal and postpartum care, it counts towards the measure. Please reach out to THW@eocco.com for more information. Provider- and member-facing flyers on our Birth Doula Program can be ordered at no cost using the Print Resource Order Form.
- Provide prenatal care as soon as possible after a 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.
- 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.

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

2026 Target: **TBD**

2026 Benchmark: 50.0%

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:

- Members who passed away during the measurement period
- Visits involving 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)
        - Patient did not need interpreter services for the particular visit being reported on
- Visits where a good faith effort (GFE) was made to acquire an OHA certified or qualified health care interpreter, but no OHA certified or qualified health care interpreter was available and a non-OHA certified or qualified health care interpreter was provided during the visit
    - To flag a visit for GFE exclusion, all the following criteria must be met:
        - 1) The health care provider (or clinic staff) searched the OHA Health Care Interpreter Registry and is unable to schedule an OHA certified or qualified health care interpreter consistent with OHA guidance.
        - 2) A non-OHA certified or qualified health care interpreter is provided
        - 3) The GFE is documented in the visit chart note, and the process is repeated/reconfirmed with every visit

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	3+ or higher for LLS proficiency test or a score of 'Competent' on Bilingual Fluency Assessment (BFA) or Bilingual Fluency Assessment for Clinicians (BFAC)
Language Testing International	Advanced mid-level or higher on the ACTFL rating scale
ALTA	8 or above rating scale
Oral Proficiency Interview (OPI)	Passing an OHA-approved OPI

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 2026 Language Access reports using the clinic reporting template provided by EOCCO. The 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 reporting period. OHA will utilize data from the 2026 Language Access reports to determine EOCCO's rate for the Language Access Incentive Measure.
- Ensure documentation of good faith efforts (GFE) to provide an OHA certified or qualified interpreter in chart notes in alignment with OHA's GFE guidance document: OCHCI Guidance Document for Compliance with GFE Requirements.pdf
    - Use OHA's Health Care Interpreter Registry to search for OHA certified or qualified health care interpreters in your area: https://hciregistry.dhsoha.state.or.us/
    - You can also find the OHA Health Care Registry published on EOCCO's website as Excel files (updated monthly)
- Review the 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 did not require interpreter services during the visit (preferred to speak English), 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 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 Certified Languages International (see EOCCO's 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 Health Care Qualified Interpreter training program to become an OHA certified/qualified Healthcare Interpreter. This training program is 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, Certified Languages International, 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, EOCCO can assist with scheduling free language proficiency tests for providers.
    - Reference OHA's list of approved language proficiency testing centers and tests on the Health Care Interpreter Training Program website.

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

Measure Specifications:

Data Source: Claims and chart review

2026 Target: **TBD**

2026 Benchmark: **TBD** [will be determined based on 2025 SDOH measure reporting]

Note: *For 2026 reporting, OHA will provide a random sample ('hybrid sample') of 1,067 pediatric and adult EOCCO patients for clinics to report on.*

Telehealth Eligibility: This measure is telehealth eligible.

Rate 1:

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

Rate 2*:

Denominator: Patients from Rate 1 Numerator
Numerator: Patients who screened positive for one or more needs in the required social need domains
Note: *There is no target associated with Rate 2, it is calculated as a necessary step in the process to calculate Rate 3*

Rate 3:

Denominator: Patients from Rate 2 Numerator
Numerator: Patients who received a referral* within 15 calendar days of the positive screening for each social need domain they screened positive for

> ***Note****: 'Referral' is defined as a documented exchange of information, with the patient's consent, to social services that could reasonably address the housing, food, and/or transportation need(s) identified from the screening. A referral should contain information about the patient's:*
>
> - *Housing, food, and/or transportation needs*
> - *Contact information*
> - *Language and cultural preferences*
>
> *If a patient opts to receive a resource guide or list in lieu of an offered referral, that qualifies as a referral for the SDOH measure. For more information, reference the OHA SDOH Metric FAQ Guide.*

Denominator Exceptions:

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

Continuous Enrollment Criteria: Patient 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:

- 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. Additionally, confirm that the screening tool or questions are an OHA-approved Social Needs Screening tool.
- If your clinic is not currently screening patients for social 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.).
        - Consider adding an annual social needs screening reminder into the patient's chart
- 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 a 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. Contact Unite Us to get registered to get started. Please contact EOCCOmetrics@modahealth.com with any questions.

Glycemic Status Assessment for Patients with Diabetes

(NQF 59, CMIT 1820)

Measure Description: The percentage of patients ages 18-75 with Type 1 or Type 2 diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period:

- Glycemic Status <8.0% (with Numerator 1)
- Glycemic Status >9.0% (with Numerator 2)

Note: Entities must report on both <8.0% and >9.0%, but only performance on >9.0% (Numerator 2) is incentivized for measure performance.

Measure Specifications:

Data Source: Claims and chart review

2026 >9.0% Target: **TBD**

2026 >9.0% Benchmark: 19.5% (lower is better)

Telehealth Eligibility: Telehealth is allowed in the measure denominator, but NOT allowed in the numerator. For more information see the guidelines provided by the Health Evidence Review Commission.

Denominator: A sample size provided by OHA of 411 patients ages 18-75 as of the last day of the measurement period, with Type 1 or Type 2 diabetes, who meet continuous enrollment criteria.

Note that either of the following meets criteria to identify patients with a diagnosis of Type 1 or Type 2 diabetes:

- *Claim/encounter data*. At least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period.
- *Pharmacy data*. At least one diagnosis of diabetes and at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication during the measurement period or the year prior to the measurement period.

Denominator Exclusions:

- Death in the measurement period.
- Patients in hospice or using hospice services.
- Patients receiving palliative care.
- Medicare enrollees, 66 years of age and older by the last day of the measurement period in an institutional SNP (I-SNP) or living long-term in an institution (LTI).
- Patients 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.
    - Frailty: At least two indications of frailty with different dates of service during the measurement period.
    - Advanced illness: Either of the following during the measurement period or the year prior to the measurement period:

- Advanced illness on at least two different dates of service.
- Dispensed dementia medication

Numerator 1: **Glycemic status <8.0%.**

The result of the most recent glycemic status assessment (HbA1c or GMI) performed during the measurement period is <8.0% as documented through laboratory data or medical record review.

Notes:

- At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result. The patient is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is <8.0%.
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Use the terminal date in the range to assign assessment date. If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- GMI results collected by the patient and documented in their medical record are eligible for use in reporting (if the GMI does not meet any exclusion criteria). There is no requirement for evidence that GMI was collected by a PCP or specialist.
- The patient is not numerator compliant if the result of the most recent glycemic status assessment during the measurement period is ≥8.0% or is missing, or if a glycemic status assessment was not performed during the measurement period.
    - Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. “Unknown” is not considered a result or finding.

Numerator 2: **Glycemic status >9.0%**.

The result of the most recent glycemic status assessment (HbA1c or GMI) performed during the measurement period is >9.0%, is missing, or was not done during the measurement period, as documented through laboratory data or medical record review.

Notes:

- Documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed, and the result. The patient is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement period.
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Use the terminal date in the range to assign assessment date. If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- GMI results collected by the patient and documented in their medical record are eligible for use in reporting (if the GMI does not meet any exclusion criteria). There is no requirement for evidence the GMI was collected by a PCP or specialist.

- The patient is not numerator compliant if the most recent glycemic status during the measurement year is ≤9.0%. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. “Unknown” is not considered a result or finding.

Continuous Enrollment Criteria: Patient must be enrolled during the measurement period: January 1, 2026 – December 31, 2026

Allowable Enrollment Gaps: No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

Anchor Date: None

Strategies for Improvement:

- Implement EHR reminders or standing orders to ensure at least one HbA1c or GMI result is documented during the measurement year for all patients with diabetes.
- Use pre-visit planning to identify patients overdue for HbA1c testing and schedule labs in advance of visits.
- Generate monthly or quarterly reports of patients with last HbA1c or GMI >9.0% to support targeted outreach.
- Ensure HbA1c and GMI data is entered into the EHR from external clinics.
- Provide culturally responsive education and materials tailored to patient language and literacy needs.
- Encourage patients with diabetes to enroll in the EOCCO-funded Diabetes Management program with Teladoc Health. Please contact EOCCOmetrics@modahealth.com for additional information on Teladoc’s services.

Depression Screening and Follow-Up Plan*

(CMS 2v15)

Measure Description: The percentage of patients 12 years and older with a qualifying visit during 2026 who are screened for depression 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 positive screen.

Measure Specifications:

Data Source: EHR based

2026 Target: TBD

2026 Benchmark: 77.1%

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

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 or an active depression medication overlaps 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.

*2026 Challenge Pool measure

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 a 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.