ADVANCED HEALTH 2026 CCO INCENTIVE MEASURES BINDER

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INTRODUCTION

This binder was developed to support our provider partners in delivering high-quality care to Advanced Health members. Its purpose is to build a shared understanding of the Oregon Health Authority's (OHA) CCO Quality Incentive Measures, why these measures matter, and how clinics can successfully meet them.

The resources included provider practical guidance, best practices, and actionable tips to help clinics track performance, close care gaps, and improve outcomes. This binder is intended to serve as a reference tool to support ongoing quality improvement efforts throughout the year.

Advanced Health Support & Resources

Data & Reporting:

- Monthly performance dashboards for CCO Quality Incentive Measures are sent via secure email and include numerator/denominator counts and performance trends. To receive these reports, contact: naomi.brazille@advancedhealth.com

- Monthly risk adjustment reports identifying members with care gaps are sent via secure email. To receive these reports, contact: naomi.brazille@advancedhealth.com

- Assigned patient gap lists are sent monthly to primary care providers and their staff to support outreach and appointment scheduling. To receive these reports, contact: lisa.castle@advancedhealth.com

- Weekly patient panel assignment reports are posted to clinic SFTP sites. To request SFTP access, contact: dani.thompson@advancedhealth.com

Education & Training

- Virtual and in-person technical assistance sessions are available to review quality measures, coding practices, workflows, and OHA requirements. Sessions can be scheduled by contacting the Quality Department.

- Risk Adjustment Incentive Program training covering CDPS, ICD-10 coding, and Z-codes.

- Provider newsletters that share plan updates, measure changes, and best practices.

Technical Assistance & Collaboration

- One-on-one support to review performance data, workflows, and quality improvement plans.

- Targeted technical assistance for measures performing below benchmarks.

- Inter-Agency Quality & Accountability Committee: A collaborative forum to review performance trends, identify improvement opportunities, and advise on quality strategies. Providers are encouraged to attend. To participate, contact naomi.brazille@advancedhealth.com or lisa.castle@advancedhealth.com

Incentives & Recognition

- Incentive payments for providers who complete services required to meet CCO Quality Incentive Measures.

- Incentive payments for PCPs performing above the 25th percentile in risk adjustment through accurate ICD-10 coding and care gap closure.

- Health Care Interpreter Scholarship and completion bonus for becoming an OHA Qualified or Certified Interpreter. Apply here: https://forms.office.com/r/im7uWFEuZc

- Information about the CCO Quality Incentive Measure Program and OHA requirements is available on:
    - Advanced Health's website: https://advancedhealth.com/providers/
    - OHA's website: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

EHR & Data Support

- Assistance with initiating the EHR data submission process.

- Data validation support for quality measures, available by request and as resources allow. To request validation, contact the Quality Department.

- Support for practices transitioning between claims-based and attestation-based reporting.

- Free licenses for Connect Oregon (Unite Us) to support screening for social determinants of health (SDOH) and electronic referrals to community-based resources.

02

CHANGES FROM MY2025 – MY2026

Changes affecting the CCO Incentive Measures.

Adults with Diabetes - Oral Evaluation

This measure was removed from the incentivized measure set and now it is reported only. The Exclusion criteria was also updated to include palliative care, frailty, and members who died during the measurement year, aligning with NCQA/HEDIS MY2023 specifications.

Assessments for Children in ODHS Custody

- The numerator period for physical and dental health assessment is shortened to within 30 days after the first notification to the CCO.
- Updated the denominator and denominator exception sections for numerator compliant cases to be retained in the denominator even if the case didn't meet the continuous ODHS custody or CCO enrollment criteria.
- Added to numerator criteria if the child refused the health assessment.
- Remove the requirement for numerator claims from the matching CCO.
- Remove the obsolete CPT code 99201 from physical health assessment.
- Added information regarding the daily notification files and upcoming changes to the 834-file method.

Child Well-Care Visits– Ages 3-6

No changes. While the HEDIS MY2026 specifications restructured the denominator criteria sections, the measure requirements remain unchanged.

Childhood Immunization Status (Combo 3)

- Eliminated the legacy Anchor Date rule; the existing requirement is included in the allowable enrollment gap criteria.
- Updated the names of the value sets related to disease history.
- Deleted Hepatitis A Vaccine Procedure Value Set, Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set and Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set; included CPT code 90633, 90681 and 90680 in specs instead, respectively.

Immunizations for Adolescents (Combo 2)

No changes from MY2025 to MY2026.

Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

This measure has been retired and replaced with the Glycemic Status Assessment for Patients with Diabetes (GSD). OHA previously used the eCQM Diabetes: HbA1c Poor Control (CMS122v13) for the incentive program; however, this measure was retired after MY2025. Beginning in MY2026, OHA transitioned to the GSD measure to align with the CMS Medicaid Adult Core Set, which adopted GSD starting in FFY2025 (MY2024) for reporting.

Initiation and Engagement of Substance Use Disorder Treatment

- Reorganized denominator criteria sections in HEDIS MY2026; measure requirements remain unchanged.
- Added asterisks to identify value sets where laboratory claims with POS code 81 should not be used.
- Eliminated the legacy Anchor Date rule; the requirement is now incorporated into allowable enrollment gap criteria.
- Removed legacy medication list tables and integrated medication list names directly into the denominator and numerator criteria sub-bullets.

Meaningful Language Access (Health Equity)

Component 2: Added a Good Faith Effort (GFE) exclusion to the denominator.
Appendices:

- Updated Appendix 3 reporting template to incorporate GFE.
- Updated Appendix 4 to reflect Oregon Health Grouper (OHG) updates, including re-categorization of claims into type of care and care setting stratifications for this measure. Certain OHG categories are now identified for denominator exclusion. The grouping methodology and OHG-to-HEM crosswalk are provided in Appendix 4. While CCOs may use this OHG logic and crosswalk when reporting denominator visits based on claims data, use of this method is optional, as CCOs may apply alternative data processing approaches that achieve the same categorization.

Postpartum Care

- Reorganized denominator criteria sections in HEDIS MY2026; measure requirements remain unchanged.
- Eliminated the legacy Anchor Date rule; the requirement is now incorporated into allowable enrollment gap criteria.
- Updated allowable numerator adjustments for administrative calculation of Timeliness of Prenatal Care, allowing visits at any time during pregnancy when

Prenatal Care numerator steps 1 and 2 (continuous enrollment during pregnancy) are not used.
- Added administrative method specifications to the numerator section to support CCOs using claims data as part of the hybrid review process.

Hybrid Methodology (MY2026 / CMS Core Set):
- OHA continues to adopt the full HEDIS hybrid specifications. CCOs are responsible for identifying numerator compliance using any allowable HEDIS hybrid data source, including claims, paper medical records, audited supplemental databases, or automated systems (EMR/EHR, registries, or claims systems).
- When using administrative data, CCOs must follow HEDIS MY2026/CMS Core Set allowable codes and measure logic.
- When using medical record data, CCOs must follow HEDIS MY2026/CMS Core Set chart review requirements.
- Refer to the annual chart review guidance document for additional details on allowable data sources.
- OHA will provide sampling frames and updated hybrid methodology guidance for MY2026 in fall 2026.

Preventive Dental or Oral Health Services -Ages 1-5 and 6-14

No changes from MY2025 to MY2026.

Screening for Depression and Follow-Up Plan

Updated Guidance:
- Prioritizes which screenings to consider if multiple screenings are submitted with identical date/time stamps.
- Differentiates between screening tools vs. diagnostic tools and clarifies when a treatment or follow-up plan is required.
- Includes additional examples of an acceptable follow-up plan.

Numerator Update:
- Now includes patients who have an active depression medication overlapping the date of the qualifying encounter.

Value Set Updates:
- Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128)
- Deleted 2 SNOMED CT codes (191625000, 191634005) due to updates in the code system/terminology.
- Encounter to Screen for Depression (OID: 2.16.840.1.113883.3.600.1916)
- Added 33 CPT codes (98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 99493, 99385, 99386, 99387, 99395, 99396, 99397, 59425, 59426, etc.) based on SME recommendations and alignment with CQM codes.
- Telephone Visits (OID: 2.16.840.1.113883.3.464.1003.101.12.1080)

- Added 8 CPT codes (98009, 98013, 98010, 98011, 98014, 98008, 98015, 98012) following review by technical experts, SMEs, and public feedback.

Social Determinants of Health: Social Needs Screening & Referral

- Component 1: Removed the section and all references to two components throughout the measure specifications, as Component 1 is no longer used.
- Component 2: No longer referred to as Component 2. Updated community information exchange details in Appendix 4 Definitions.
- December 24, 2025: Updated benchmark information for 2026.

Young Children Receiving Social Emotional Issue Focused Intervention/Treatment Service

No changes from MY2025 to MY2026.

03

ASSESSMENTS FOR CHILDREN IN ODHS CUSTODY

Measurement Period: 11/01/2025 - 10/31/2026
Benchmark/Target: 80% (Benchmark), TDB (Target)
Target Population (Denominator): Members aged 0–17 years who are newly identified in ODHS custody between November 1 of the previous year and October 31 of the measurement year, and for whom the CCO received a valid DHS/OHA notification.
Goal: Ensure members in DHS custody receive age-appropriate physical, dental, and mental health assessments within required timeframes following OHA notification during the measurement year.
Population: The percentage of children ages 0–17 who receive all required assessments within specified timeframes after (or shortly before) the state notifies the CCO that the child has entered Department of Human Services custody.
Why This Measure Matters: Children placed in foster care have experienced trauma which can significantly affect their physical, emotional, and developmental health. Entry into DHS custody signals heightened risk and vulnerability. Timely physical, dental, and mental health assessments help identify unmet needs early, support trauma-informed care planning, and connect children to critical services during a period of transition. Prompt assessments are essential for addressing specialized health needs, preventing further harm, and supporting long-term stability and well-being.

Exclusions

Denominator Exclusions:

- Children who entered DHS custody more than 30 days before the first OHA notification date
- Children who did not remain continuously enrolled with the CCO and in DHS custody for at least 60 days following the notification date
- Children transferred to Oregon Youth Authority (OYA)
- Untimely or invalid DHS/OHA notifications

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOB, CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates.

Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous Enrollment Criteria: All cases must remain in DHS custody and enrolled with the CCO for at least 60 days from the OHA notification date.

Qualifying Visits (How the Measure Is Met)

The CCO coordinates with physical, dental, and mental health providers to ensure required assessments are scheduled within required timeframes. Providers prioritize children in DHS custody for timely appointments, primarily through the FEARsome Clinic and DHS partnership. Ongoing coordination with local DHS field offices supports timely referrals, appointment scheduling, and continuity of care.

All required assessments must be completed within the specified timeframes below, based on the child's age at the time of notification:

- **Physical Health Assessment:**
  - Ages 0–17
  - Within 30 days after OHA notification
  - OR up to 30 days prior to notification

- **Dental Health Assessment:**
  - Ages 1–17
  - Within 30 days after OHA notification
  - OR up to 30 days prior to notification

- **Mental Health Assessment:**
  - Ages 3–17
  - Within 60 days after OHA notification
  - OR up to 30 days prior to notification

The notification date from the DHS/OHA file anchors all measurement timelines.

Coding

Qualifying services are identified using CPT, HCPCS, and CDT codes as defined in OHA technical specifications. When appropriately coded, a single visit may meet more than one assessment requirement.

Physical health assessment codes:

- Outpatient and office evaluation and management codes: 99202- 99205, 99212 – 99215
- Preventative visits: 99381 – 99384, 99391 – 99394
- Annual wellness visits: G0438, G0439

- If a new patient E&M visit (CPT 99202–99205) includes a qualifying mental health or child abuse/neglect diagnosis on the same claim, the visit may count as both a physical and mental health assessment. This allows assessments performed by psychiatric physicians or nurse practitioners to meet both requirements; however, OHA does not verify provider specialty when calculating this measure. Qualifying diagnosis codes must appear in any diagnosis field and include:

Visits with CPT 99202 – 99205 can count as both physical and mental health assessments if paired with following diagnosis codes:	
Source	ICD-10CM Diagnosis (All diagnosis fields apply)
Mental Health Diagnosis Value Set	F03, F20 – F53, F59 – F69, F80 – F99 (total of 291 codes)
Diagnosis related to child abuse or neglect	T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.32xA, T74.32xD, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, T76.32xA, T76.32xD, T76.92xA, T76.92xD

Mental health assessment codes:

- Psychological assessment and intervention codes: 90791, 90792, 96130, 96131, 96136, 96137, 96138, 96139, H0031, H1011
- Mental health assessment performed by a non-physician provider with a CANS assessment during the same visit: H2000-TG (modifier TG required)
    - Eligible providers include Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Social Workers (LCSW), psychologists, and Qualified Mental Health Professionals (QMHP).
    - Qualified Mental Health Associates (QMHA), case managers, and care coordinators do not qualify to perform mental health assessments or bill H2000-TG.
- Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days): H0019.
    - Use of this code counts as both mental and physical health assessment for children in PRTS.
- Psychiatric health facility service, per diem: H2013
- Community psychiatric supportive treatment program, per diem: H0037

Mental health assessment codes:

- Dental diagnostic codes (clinical oral evaluations): D0100-D0199

Compliance Requirements

This measure is telehealth eligible as the qualifying numerator services do not require in-person place of service codes in claims data. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Best Practices to Improve Performance

- Work within an allotted timeline to meet the measure when contacted by the FEARsome Clinic Coordinator to schedule an appointment for a required assessment when required outside of the FEARsome Clinic. This can occur when a FEARsome Clinic provider is unavailable, such as on vacation, or when other various needs or requests arise when working with resource parents and ODHS/Child welfare.
- Schedule physical and dental visits concurrently when possible.
- Ensure accurate, timely claim submission and documentation.
- Regularly validate practice data against Advanced Health Gap reports to confirm assessments are captured.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
Advanced Health Webpage on the FEARsome Clinic: https://advancedhealth.com/community-focus/fearsome-clinic/
FEARsome Clinic Flyer for Resource Parents: https://advancedhealth.com/wp-content/uploads/2023/05/FEARsome-Info-Flyer.pdf

04

CHILD WELL-CARE VISITS– AGES 3-6

(WCV, NQF1516)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 75.3% (Benchmark), TBD (Target)
Target Population (Denominator): Members aged 3-6 years as of December 31 of the measurement year. Only members ages 3–6 are incentivized for the CCO Medicaid Incentive Program.
Goal: Ensure members ages 3–6 complete at least one well-child visit with a PCP or OB/GYN during the measurement year.
Population: Percentage of Children who are 3–6 years-old as of December 31 of the measurement year. Only ages 3-6 are incentivized for the CCO Medicaid Incentive program.

Why This Measure Matters: Regular well-care visits during preschool and early school years support early identification of vision, speech, language, and developmental concerns. Early intervention improves long-term communication, learning, and health outcomes. Annual well-care visits are recommended for children and adolescents ages 2–21 as a key opportunity for screening, anticipatory guidance, and health education (OHA Guidance).

Exclusions

Denominator Exclusions:

- Members who receive hospice services at any time during the measurement year
- Members who die during the measurement year

Numerator Exclusions:

- Telehealth visits

Telehealth Note: This measure is not eligible for telehealth. Beginning in MY2025, telehealth visits are excluded from the numerator.

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.

Qualifying Visits (How the Measure Is Met)

A qualifying well-care visit must occur with a PCP or OB/GYN. The provider does not need to be the member's assigned PCP.

Provider Identification:

OHA uses the Oregon Primary Care Provider Types and Specialties list established by the Health Systems Division (HSD), with the addition of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Clinics (IHCs). This methodology is NCQA-approved.

Provider identification may be based on the Billing or Performing Provider. For outpatient and crossover claims, the Attending Provider may be used if Performing Provider data is missing.

HSD Provider type/specialty codes qualify for PCP or OB/GYN:

PROV_TYPE	PROV_SPEC	CDE_PROV_TYPE	CDE_PROV_SPEC
Physician	Adolescent Medicine	34	222
Physician	Clinic	34	238
Physician	Family Practitioner	34	249
Physician	General Practitioner	34	252
Physician	Geriatric Practitioner	34	251

Physician	Gynecology	34	253
Physician	Internist	34	262
Physician	Obstetrics	34	275
Physician	Obstetrics & Gynecology	34	276
Physician	Osteopathic Physician	34	244
Physician	Pediatrics	34	283
Physician	Preventive Medicine	34	296
Physician	Public Health	34	286
Clinic		47	Any
Physician Assistants	Physician Assistants	46	395
Midwife		41	Any
Naturopath		38	Any
Advance Practice Nurse	Advance Practice Nurse	42	360
Advance Practice Nurse	Certified Nurse Midwife	42	367
Advance Practice Nurse	Family Nurse Practitioner	42	364
Advance Practice Nurse	Nurse Practitioner	42	366
Advance Practice Nurse	Nurse Practitioner Clinic	42	361
Advance Practice Nurse	Obstetric Nurse Practitioner	42	363
Advance Practice Nurse	Pediatric Nurse Practitioner	42	362
Family Planning Clinic		22	Any
Pharmacist	Pharmacist Clinician	50	109
FQHC		15	Any

Coding

Diagnosis codes do not need to be primary. Visits are identified using the Well-Care Visit and Encounter for Well-Care value sets.

CPT:

- New patient - 99382 Ages 1-4 years, 99393 Ages 5-11 years
- Established patient - 99392 Ages 1-4 years, 99393 Ages 5-11 years

ICD-10: Z00.121, Z00.129, Z00.2, Z02.5, Z02.84, Z76.2

Not included:

- Laboratory claims or claims with POS code 81
- Telehealth claims or claims with POS codes 02 or 10

Compliance Requirements

Well-care visits may occur during a sick visit if preventive services and required components are fully documented.

Required components that must be included and documented during a visit to a well-child:

- Health and developmental history (including age- and gender-appropriate history).
- Physical exam (multiple systems).
- Lab tests if appropriate (e.g., lead screening).
- Immunizations (use preventive and sick visits if medically appropriate).
- Health education and anticipatory guidance (including risk-factor reduction and interventions).
- Dental, vision and hearing screening when required and include referral and follow-up, as appropriate

Best Practices to Improve Performance

Monitoring & Outreach:

- Review performance dashboards monthly
- Use gap lists to identify children due or overdue for visits
- Send reminders (text, phone, mail) to families with care gaps
- Verify patient contact information regularly

Visit Optimization:

- Convert sick visits, sports physicals, urgent visits, or immunization-only visits into full well-care visits when possible
- Use standardized visit templates to ensure all required elements are captured
- If time-limited, allow required components to be completed across two visits

Access & Scheduling:

- Offer extended hours, weekend appointments, and block scheduling for families with multiple children
- Address transportation and scheduling barriers

Education & Engagement:

- Educate families on the importance of well-care for growth, development, and school readiness
- Promote the incentive: Advanced Health offers a $50 gift card for completing a well-care visit for children ages 3–6
- Partner with community organizations (schools, cultural centers, faith-based groups, Boys & Girls Clubs) to reinforce messaging

Additional Considerations:

- Advanced Health covers medically appropriate well-care visits per provider discretion within a 12-month period
- Ensure clearinghouses and billing vendors submit all applicable codes, regardless of reimbursement
- Use well-care visits to support other required health maintenance and CCO

Additional Resources

OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

American Academy of Pediatrics Bright Futures:
https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocketguide/Pages/default.aspx

05

CHILDHOOD IMMUNIZATION STATUS (COMBO 3)

(CIS, CMIT #124)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 68.9% (Benchmark), TBD (Target)
Target Population (Denominator): Children who turn 2 years of age during the measurement year.
Goal: Ensure children which turn 2 years old during the measurement year and receive the indicated Dtap, IPV, MMR, HiB, HepB, VZV, and PCV series of immunizations (Combo 3 series) by their second birthday.
Population: All enrolled members who turn 2 years of age during the measurement period.
Why This Measure Matters: Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease. Approximately 300 children in the United States die each year from vaccine preventable diseases.

Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases. (source NCQA)

Exclusions

Denominator Exclusions:

- Members who used hospice services at any time during the measurement year.
- Members who died during the measurement year.

- Members with a documented contraindication to a childhood vaccine on or before their second birthday, including:
    - Severe combined immunodeficiency
    - Immunodeficiency
    - HIV
    - Lymphoreticular cancer, multiple myeloma or leukemia
    - Intussusception
    - Organ and Bone marrow Transplants

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Cover All Kids (CAK) and Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous enrollment required: 365 days prior to the person's second birthday and the second birthday

Qualifying Visits (How the Measure Is Met)

Incentivized Combo 3 Vaccinations (19 total doses):

- 4 DTaP (Diphtheria, Tetanus, Pertussis)
- 3 IPV (Inactivated Polio Vaccine)
- 1 MMR* (Measles, Mumps, Rubella)
- 3 HiB (Haemophilus influenzae type B)
- 3 Hepatitis B
- 1 VZV (Varicella Zoster Vaccine)
- 4 PCV (Pneumococcal Conjugate Vaccine)

Coding

Qualifying services are identified using ALERT IIS Data Use Cases.

DTAP:

CPT: 90697, 90698, 90700, 90723
CVX: 20, 50, 106, 107, 110, 120, 146, 198
Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 428281000124107, 428291000124105
Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 192710009, 192711008, 192712001

IPV:
CPT: 90697, 90698, 90713, 90723
CVX: 10, 89, 110, 120, 146
Anaphylaxis due to the IPV vaccine SNOMED CT code: 471321000124106

MMR:
CPT: 90707, 90710
CVX: 03, 94
ICD-10-CM:
History of measles illness: B05.0- B05.4, B05.81, B05.89, B05.9
History of mumps illness: B26.0- B26.3, B26.81- B26.85, B26.89, B26.9
History of rubella illness: B06.00- B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Anaphylaxis due to the MMR vaccine SNOMED CT code: 471331000124109

HIB:
CPT: 90644,90647, 90648, 90697, 90698, 90748
CVX: 17, 46, 47, 48, 49, 50, 51, 120, 146, 148, 198
Anaphylaxis due to the HiB vaccine SNOMED CT code: 433621000124101

Hep B:
CPT: 90697,90723, 90740, 90744, 90747, 90748
CVX: 08, 44, 45, 51, 110, 146, 198
HCPCS: G0010
History of hepatitis B illness ICD-10-CM: B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11
Newborn Hepatitis B Vaccine Administered
ICD10PCS: [3E0234Z] Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach
Anaphylaxis due to the hepatitis B vaccine SNOMED CT code: 428321000124101

Varicella VZV:
CPT: 90710, 90716
CVX: 21, 94
History of varicella zoster ICD-10-CM: B01.0, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21- B02.24, B02.29, B02.30- B02.34, B02.39, B02.7, B02.8, B02.9
Anaphylaxis due to the VZV vaccine SNOMED CT code: 471341000124104

Pneumococcal Conjugate PCV:
CPT: 90670, 90671
CVX: 109, 133, 152, 215, 216
HCPCS: G0009

Anaphylaxis due to the pneumococcal conjugate vaccine SNOMED CT code: 471141000124102

Compliance Requirements

This measure is not eligible for telehealth.

Acceptable documentation:

- A certificate of immunization prepared by an authorized health care provider or agency, including specific dates and vaccine types.
- A medical record note indicating the specific antigen administered and the administration date.
- Immunizations documented with a generic header (e.g., "polio vaccine" or "IPV/OPV") may be counted as IPV.
- Immunizations documented as "DTaP/DTP/DT" may be counted as DTaP.
- A note indicating the immunization was administered "at delivery" or "in the hospital"; use the date of birth as the administration date.

Not Acceptable:

- Documentation stating the member is "up to date" without listing vaccine names and dates.
- Vaccines documented as adult formulations.
- Influenza vaccines administered before 6 months of age (180 days after birth).
- DTaP, IPV, HiB, PCV, and Rotavirus vaccines administered before 42 days of age.

Best Practices to Improve Performance

Timely Completion and Documentation:

- All required vaccines must be completed by the child's second birthday.
- When scheduling visits, verify the child's age and ensure appointments occur prior to the second birthday.
- For combination vaccines, documentation must support all required antigens.

Operational Strategies:

- Use member gap lists to identify children missing one or more required vaccines.
- Ensure ALERT IIS records are complete, accurate, and up to date.
- Review hospital records for missing doses, including the birth dose of Hepatitis B.
- Schedule immunization visits several months before the second birthday, particularly for children turning two early in the year.
- Begin outreach for children turning one to prepare for the next reporting year.
- Provide patient decision-aid tools and catch-up schedules.

- Schedule follow-up vaccination visits before families leave the office.
- Implement patient recall and reminder workflows for overdue or upcoming vaccines.

Parent Education and Engagement:

- Provide educational handouts on recommended vaccines.
- Discuss vaccine benefits and potential side effects with parents.
- Review immunization records at every visit and administer any due vaccines.

Office Workflow Improvements:

- Align visit scheduling with CDC-recommended immunization timelines.
- Proactively contact families to reschedule missed vaccination appointments.
- Use appropriate measure and exclusion codes when submitting claims to support administrative compliance.
- Document the first Hepatitis B dose administered at birth or in the hospital, including the hospital name when applicable.
- Document all parent refusals; refusals do not exclude the member from the measure.

The following count toward compliance when documented with an event date:

- For DTaP: Encephalitis due to the vaccine
- For all vaccines:
    - Anaphylaxis due to the vaccine
    - Evidence of the antigen or combination vaccine
- For Hepatitis B, MMR, and VZV:
    - Documented history of the illness

Incentive Promotion:

- Inform families that Advanced Health offers a $50 gift card to members who complete the full Combo 3 vaccine series by age 2. Ensure front desk and care teams are aware of the incentive and reinforce the message during patient interactions.

Additional Resources

Vaccines for Children Program:
https://www.oregon.gov/oha/ph/preventionwellness/vaccinesimmunization/immunizationproviderresources/vfc/pages/overview.aspx
OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
American Academy of Pediatrics Bright Futures:
https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocketguide/Pages/default.aspx

CDC Vaccine Timeframe Guidelines: (https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf)

06

IMMUNIZATIONS FOR ADOLESCENTS (COMBO 2)

(IMA, CMIT #363)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 41.6% (Benchmark), TBD (Target)
Target Population (Denominator): Adolescents who turn 13 years of age during the measurement year.
Goal: Ensure members receive all indicated "Combo 2" immunizations before their 13th birthday.
Population: Adolescents 13 years of age who had one-dose of meningococcal vaccine, one-dose tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
Why This Measure Matters: This measure follows the Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. These vaccines are available for adolescents to prevent them from acquiring serious diseases and help protect against disease in populations that lack immunity, such as infants, the elderly and individuals with chronic conditions. (source NCQA)

Exclusions

Denominator Exclusions:

- Members who used hospice services at any time during the measurement year.
- Members who died during the measurement year.

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Cover All Kids (CAK) and Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous enrollment required: 365 days prior to the person's thirteenth birthday.

Qualifying Visits (How the Measure Is Met)

To meet the measure, adolescents must receive the following immunizations within the specified age ranges and prior to their 13th birthday:

Meningococcal (Serogroups A, C, W, Y):

- At least one dose of a meningococcal (A, C, W, Y) vaccine administered on or between the member's 11th and 13th birthdays

Tdap (Tetanus, Diphtheria, and Acellular Pertussis):

- At least one dose of a Tdap vaccine administered on or between the member's 10th and 13th birthdays

Human Papillomavirus (HPV) Vaccine Series

Members must complete one of the following:

- Two HPV vaccine doses administered at least 146 days apart on or between the member's 9th and 13th birthdays
- OR
- Three HPV vaccine doses administered on different dates on or between the member's 9th and 13th birthdays

Coding

Qualifying services are identified using ALERT IIS Data Use Cases.

Meningococcal-serogroup A,C,W, and Y(1 dose):

- CPT: 90619, 90623, 90733, 90734
- CVX: 32, 108, 114, 136, 147, 167, 203, 316
- Anaphylaxis due to the meningococcal vaccine SNOMED CT code: 428301000124106

Tdap (1 dose):

- CPT: 90715
- CVX: 115
- Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 428281000124107, 428291000124105
- Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine SNOMED CT code: 192710009, 192711008, 192712001

HPV (2 or 3 dose series):

- CPT: 90649, 90650, 90651
- CVX: 62, 118, 137, 165

- Anaphylaxis due to the HPV vaccine SNOMED CT code: 428241000124101

Compliance Requirements

Document parent refusals and qualifying medical events (e.g., anaphylaxis or encephalopathy). Documentation must include the event date occurring on or before the member's 13th birthday. These events do not exclude the member from the measure.

The following count toward compliance:

- Anaphylaxis due to the vaccine
- Evidence of the antigen or combination vaccine
- Tdap-related encephalopathy

For the two-dose HPV series, at least 146 days (5 months) must separate the first and second doses.

Acceptable documentation:
A note indicating the name of the specific antigen and the date of the immunization.
A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

Not acceptable:
A note stating the "member is up to date" with all immunizations but does not list the dates and names of all immunizations.

Best Practices to Improve Performance

Timely Completion and Documentation

- All required Combo 2 vaccines (meningococcal, Tdap, and HPV) must be completed by the adolescent's 13th birthday.
- When scheduling visits, verify the member's age and ensure appointments occur well before the 13th birthday.
- For combination vaccines or series, documentation must clearly support all required antigens and doses.

Operational Strategies

- Use member gap lists to identify adolescents missing one or more required Combo 2 vaccines.
- Ensure ALERT IIS records are complete, accurate, and up to date.
- Schedule immunization visits beginning at ages 9–11 to allow sufficient time to complete multi-dose series, particularly HPV.
- Begin outreach to members turning 11 to prepare for timely completion before age 13.

- Provide patient decision-aid tools and CDC-recommended catch-up schedules when vaccines are delayed.
- Schedule follow-up vaccination visits before families leave the office, especially for HPV series completion.
- Implement patient recall and reminder workflows for overdue or upcoming adolescent vaccines.

Parent and Adolescent Education and Engagement

- Provide educational materials on recommended adolescent vaccines.
- Discuss vaccine benefits, safety, and potential side effects with parents and adolescents.
- Review immunization records at every visit and administer any vaccines that are due.

Office Workflow Improvements

- Align visit scheduling with CDC- and ACIP-recommended adolescent immunization timelines.
- Proactively contact families to reschedule missed immunization appointments.
- Use appropriate measure, value set, and exclusion codes when submitting claims to support administrative compliance.
- Document all parent refusals and qualifying medical events (e.g., anaphylaxis or encephalopathy); refusals do not exclude the member from the measure.

Incentive Promotion

- Inform families that Advanced Health offers a $50 gift card to members who complete the full Combo 2 vaccine series by their 13th birthday. Ensure front desk staff and care teams are aware of the incentive and reinforce the message during patient interactions.

Additional Resources

Vaccines for Children Program:
https://www.oregon.gov/oha/ph/preventionwellness/vaccinesimmunization/immunizationproviderresources/vfc/pages/overview.aspx
OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
American Academy of Pediatrics Bright Futures:
https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocketguide/Pages/default.aspx
CDC Vaccine Timeframe Guidelines: (https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf)

07

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

(GSD, CMIT # 1820)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 19.5% (Benchmark), TBD (Target)
Target Population (Denominator): Members 18 and 75 years of age as of December 31 of the measurement year.
Goal: OHA incentives the glycemic status > 9.0% rate (using Numerator 2) of the measure starting MY2026 (lower rate is better), consistent with the previous eCQM Diabetes: HbA1c Poor Control measure.
Population: The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) 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%.
- Glycemic Status >9.0%.

Why This Measure Matters: Diabetes is one of the costliest and highly prevalent chronic diseases in the United States. Approximately 38 million U.S. adults have diabetes; 8.7 million of these cases are undiagnosed. Complications from the disease cost the country nearly $413B annually (1). Diabetes is the eighth leading cause of death in the U.S. and killed approximately 103,294 people in 2021 (2). Many complications such as heart disease, stroke, blindness, kidney failure and amputation can be prevented if diabetes is detected and addressed in the early stages.

Glycemic control is the management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney, and nerve diseases). An A1C goal of <7% (<53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or frequent hypoglycemia affecting health or quality of life. The American Diabetes Association (ADA) recommends assessing glycemic status with HbA1c measurement or GMI using continuous glucose monitoring (CGM) data from a CGM device worn by a patient for at least 14 days. The ADA also recommends standardized reports from CGM devices, such as the ambulatory glucose profile. Guidance for interpreting CGM data, including GMI, is included in the ADA guidelines. (source NCQA)

Exclusions

Denominator Exclusions:

- Members who used hospice services at any time during the measurement year. Codes for Hospice Care:
  - CPT: 99377-99378
  - HCPCS: G0182; G9473-G9479; Q5003-Q5010; S9126; T2042-T2046
- Members who died during the measurement year.
- Persons receiving palliative care or who had an encounter for palliative care (ICD-10-CM code Z51.5*) at any time during the measurement period. Codes for Palliative Care:
  - HCPCS: G9054; M1017
- 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).
  - Enrolled in an Institutional SNP (I-SNP) at any time during the measurement period.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:
  - Frailty. At least two indications of frailty with different dates of service during the measurement year.
  - Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year:
  - Advanced illness on at least two different dates of service or dispensed dementia medication. Dementia Medications: Donepezil, Galantamine, Rivastigmine, Memantine, Donepezil-memantine.
- Living long-term in an institution at any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.
- Do not include laboratory claims (claims with POS code 81).

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Cover All Kids (CAK) and Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous enrollment required: 365 days prior to the person's thirteenth birthday.

Qualifying Visits (How the Measure Is Met)

To meet the measure, a member must have at least one documented assessment of glycemic status during the measurement period (01/01/2026–12/31/2026). The assessment must reflect the most recent glycemic status and be documented using either a laboratory result or CGM-derived metric that meets measure specifications.

The measure is met when the member has one or more qualifying tests during the measurement period indicating:

- Glycemic Status <8.0%, or
- Glycemic Status >9.0% (Numerator 2; lower rate is better for incentive purposes).

The qualifying test may occur in any clinical setting (e.g., outpatient, inpatient, telehealth-supported care) and does not require a specific visit type, as long as the result is documented in the medical record or claims data.

Coding

Qualifying Services Are:

- Laboratory-Based Glycemic Status Assessment
- Hemoglobin A1c (HbA1c) test with a result value
- Glucose Management Indicator (GMI) derived from continuous glucose monitoring (CGM) data

Acceptable Data Sources:

- Claims data
- Electronic health record (EHR) documentation
- Laboratory data feeds
- CGM device reports documented in the medical record

Qualifying Codes Include (not exhaustive):

- ICD-10 codes for diabetes: E10.xxxx, E11.xxxx, E13.xxxx, O24.xxxx
- LOINC codes for HbA1c testing: 59261-8, 17855-8, 17856-6,
- 4548-4, 4549-2, 96595-4
- LOINC codes for Glucose management indicator: 97506-0
- SNOMED: 165679005 (HbA1c less than 7.0%), 451061000124104 (HbA1c greater than/equal to 9.0%)
- CPT/HCPCS codes: 83036, 83037 (HbA1c lab tests); 3044F (Results HbA1c < 7.0), 3046F (Results HbA1c > 9%), 3051F (Results HbA1c ≥ 7.0% to < 8.0%), 3052F (Results HbA1c > 8.0% to ≤ 9.0%)

Diabetes Medications (not exhaustive):

- Alpha-glucosidase Inhibitors: Acarbose, Miglitol
- Amylin Analogs: Pramlintide
- Antidiabetic Combinations: Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Dapagliflozin-saxagliptin,

Empagliflozin-linagliptin, Empagliflozin-linagliptin-metformin, Empagliflozin-metformin, Ertugliflozinmetformin, Ertugliflozin-sitagliptin, Glimepiride-pioglitazone, Glipizidemetformin, Glyburide-metformin, Linagliptin-metformin, Metforminpioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metforminsaxagliptin, Metformin-sitagliptin

- Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin degludec-liraglutide, Insulin detemir, Insulin glargine, Insulin glargine-lixisenatide, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled
- Meglitinides: Nateglinide, Repaglinide
- Biguanides: Metformin
- Glucagon-like Peptide-1 (GLP1) Agonists: Albiglutide, Dulaglutide, Exenatide, Liraglutide, Lixisenatide, Semaglutide
- Sodium Glucose Cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, (Empagliflozin, Ertugliflozin
- Sulfonylureas: Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide
- Thiazolidinediones: Pioglitazone, Rosiglitazone
- Dipeptidyl Peptidase-4 (DDP-4) Inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

Compliance Requirements

- The glycemic status result must be dated within the measurement period.
- The most recent qualifying result during the measurement period is used to determine numerator status.
- Results must include a numeric value sufficient to classify the member as:
    - Glycemic Status <8.0%, or
    - Glycemic Status >9.0%.
- Documentation must be clearly attributable to the member and retrievable for audit purposes.
- Point-of-care HbA1c tests are acceptable if results are documented in the medical record.
- CGM-based GMI values must be derived from at least 14 days of CGM data, consistent with ADA guidance.

Best Practices to Improve Performance

Documentation and Reporting Requirements

- If multiple glycemic status tests are performed during the measurement year, use the most recent result.
- Because the last HbA1c value of the year is used for metrics reporting, repeat elevated tests prior to year-end when clinically appropriate. Avoid testing

during the holiday season if values may not reflect the patient's usual glycemic control.

- Documentation must include the test type (HbA1c or GMI), date performed, and numeric results.
- For GMI results, include the CGM data date range used to calculate the value; the end date of the range serves as the assessment date.
- Member-reported GMI results from CGM devices are acceptable if documented in the medical record and not subject to exclusions.
- If multiple glycemic status results are recorded on the same date, use the lowest value.
- Always document the date of service, test, and result together.
- If results are entered in the vitals section, include the date of the blood draw; the progress note date alone does not qualify.
- Bill for point-of-care HbA1c testing when performed in the office and ensure the result and test date are documented in the chart.

Best Practices to Improve Performance

- Utilize standing HbA1c testing orders for patients with diabetes.
- Review needed diabetes services at every office visit and order labs prior to patient appointments.
- Complete HbA1c testing two to four times per year, as clinically appropriate.
- Adjust therapy to improve HbA1c and blood pressure levels and follow up with patients to monitor changes.
- Educate members on A1c targets and CGM goals.
- Prescribe statin therapy to all patients with diabetes ages 40–75, unless contraindicated.
- Establish protocols for prescribing and managing continuous glucose monitoring (CGM). CGM can reduce or eliminate fingerstick testing and provides comprehensive data on glucose trends, variability, and hypo-/hyperglycemia.
- Identify gaps in care and use EHR flags or reminders to track patients needing follow-up visits or testing.

Coding and Data Submission

- Have coding staff add relevant CPT II codes to claims to reduce the need for medical record requests.
- Submit all HbA1c test results, regardless of value. If a test date is on file, record requests will continue until the value is received. Once any value (compliant or noncompliant) is received, requests for that test date will stop.
- Review applicable denominator exclusions and code appropriately to remove eligible patients from the measure.

Care Coordination Support

Refer members to case management for assistance with managing chronic conditions.

- To submit referrals, contact Customer Service:
- Phone: 541-269-7400

- Hours: Monday–Friday, 8:00 a.m.–5:00 p.m.
- Email: customerservice@advancedhealth.com

Additional Resources

OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

NCQA Diabetes Recognition Program – Provider resources for diabetes care standards and clinical quality improvement: https://www.ncqa.org/programs/health-care-providers-practices/diabetes-recognition-program-drp/

CMS eCQM Resource Center — Diabetes: Glycemic Status Assessment Greater Than 9% Technical quality specification details: https://ecqi.healthit.gov/ecqm/ec/2026/cms0122v14

Oregon Health Authority Diabetes Prevention and Control – General provider and public health resources for diabetes management in Oregon: https://www.oregon.gov/oha/ph/diseasesconditions/chronicdisease/diabetes/pages/index.aspx

American Diabetes Associate - Additional clinical guidance and diabetes resources for healthcare providers: https://diabetes.org/tools-resources/for-professionals/medical-practitioners

08

INITIATION AND ENGAGEMENT OF SUBSTANCE USE DISORDER TREATMENT

(IET, CMIT #394)

Measurement Period: 01/01/2026 – 12/31/2026

Benchmark/Target: Initiation 49.8% (Benchmark), TDB (Target); Engagement 19.6% (Benchmark)

Target Population (Denominator): Members aged 18+ years who new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

Goal: Initiation: SUD treatment within 14 days of the new SUD diagnosis. ·Engagement: Patient to have two or more additional services with a matching diagnosis after the initiation encounter but within 34 days of the new SUD diagnosis.

Population: Percentage of new adult SUD episodes where treatment was initiated, and engagement completed.

Why This Measure Matters: In 2022, 48.7 million individuals in the U.S. 12 years of age or older (approximately 17.3% of the population) were classified as having had an SUD within the past year. Individuals with SUDs are at increased risk of overdose, injury, soft tissue infections, and mortality. In 2021, drug overdose accounted for 106,699

deaths, representing a 14% increase in overdose deaths compared to 2020. Similarly, over 140,000 people die each year from excessive alcohol use.

Evidence-based treatment for SUD includes both psychosocial support and, for opioid and alcohol use disorders, medication. However, despite known and effective treatments, less than 20% of individuals with SUD receive specialty care.

Early treatment engagement is a critical step between accessing care and completing a full course of treatment. Individuals who engage in early SUD treatment have been found to have decreased odds of negative outcomes, including mortality. The intent of this measure is to assess access to evidence-based SUD treatment for individuals beginning a new episode of treatment. (source NCQA)

Exclusions

Denominator Exclusions:

- Members who used hospice services any time during the measurement year.
- Members who died during the measurement year.

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.

Qualifying Visits (How the Measure Is Met)

The Initiation and Engagement of Substance Use Disorder Treatment (IET) measure is met when an adult member with a new episode of substance use disorder (SUD) receives timely treatment following diagnosis.

Initiation of Treatment:

Initiation of treatment is met when a member receives a qualifying substance use disorder (SUD) treatment service within 14 days of a new SUD diagnosis (the episode start date). The following services, occurring on the SUD episode start date or within the 13 days following, qualify as initiation when billed with a qualifying SUD diagnosis: Acute or nonacute inpatient admission

- Outpatient visit
- Intensive outpatient encounter or partial hospitalization
- Non-residential substance use treatment facility visit
- Community mental health center visit
- Substance use disorder treatment service

- Observation stay
- Telehealth visit
- Telephone visit
- E-visit or virtual check-in
- Weekly or monthly opioid treatment service
- Medication-assisted treatment (MAT) visit (applies only to members with alcohol or opioid use disorder)

If the SUD episode begins with an inpatient admission, the inpatient stay itself counts as initiation.
If the SUD episode begins with a monthly-billed opioid treatment service, that service is considered initiation.

Engagement in Treatment:
Engagement in treatment is met when a member receives at least two additional qualifying substance use disorder (SUD) treatment services, with a matching SUD diagnosis, after the initiation encounter and within 34 days of the SUD episode start date.

- At least two engagement services are required.
- No more than one service may be a medication treatment.
- Engagement is only counted if initiation criteria are met.

If initiation of SUD treatment was an inpatient admission, the 34-day engagement window begins the day after discharge. The following services qualify as engagement when billed with a qualifying SUD diagnosis (laboratory-only claims do not count):

- Acute or nonacute inpatient admission
- Outpatient visit
- Intensive outpatient encounter or partial hospitalization
- Non-residential substance use treatment facility visit
- Community mental health center visit
- Substance use disorder treatment service
- Substance use disorder counseling and surveillance
- Observation visit
- Telehealth visit
- Telephone visit
- E-visit or virtual check-in
- Weekly or monthly opioid treatment service
- Medication-assisted treatment (MAT) visit (applies only to members with alcohol or opioid use disorder)
- Long-acting SUD medication administration events, including:
    - Alcohol use disorder medication dispensing or administration events
    - Opioid use disorder medication dispensing or administration events
- SUD episodes that do not meet initiation requirements are not eligible to meet engagement criteria.

Coding

Qualifying services are identified using CPT, HCPCS, and ICD-10 diagnosis codes as defined in OHA technical specifications and NCQA HEDIS guidance.

Claims must include an appropriate primary or secondary SUD diagnosis code, and a qualifying procedure or service code for initiation and engagement services. Diagnosis codes must match across the initial SUD diagnosis, initiation encounter, and engagement encounters to count toward the measure.

Qualifying Codes Include (not exhaustive):
POS Visit Codes:

- Outpatient: 03, 05, 07, 09, 11-20, 22, 33, 49-50, 71-72
- Community Mental Health Center: 53
- Partial Hospitalization: 52
- Telehealth: 02
- Non-residential SUD Facility: 57, 58

Alcohol Abuse and Dependence ICD-10: F10.10–F10.29

Opioid Abuse and Dependence ICD-10: F11.10–F11.29

Other Drug Abuse and Dependence ICD-10:

- F12.10–F12.29 (Cannabis-related disorders)
- F13.10–F13.29 (Sedative, hypnotic, or anxiolytic-related disorders)
- F14.10–F14.29 (Cocaine-related disorders)
- F15.10–F15.29 (Other stimulant-related disorders)
- F16.10–F16.29 (Hallucinogen-related disorders)
- F18.10–F18.29 (Inhalant-related disorders)
- F19.10–F19.29 (Other and unspecified psychoactive substance-related disorders)

Inpatient Stay Revenue Codes: 0100-101, 0110-114, 0116-124, 0126-134, 0136-144, 0146-154, 0156-160, 0164, 0167, 0169-174, 0179, 0190-194, 0199-204, 0206-214, 0219, 1000-1002

Partial Hospitalization/Intensive Outpatient CPT/HCPCS: 90791-90792, 90832-90834, 90836-90840, 90845, 90847,90849, 90853, 90875-90876, 99221-99223, 99231-99233, 99238-99239, 99252-99255, G0410-G0411, H0035, H2001, H2012, S0201, S9480, S9484-S9485

Observation CPT: 99217-99220

Partial Hospitalization/Intensive Outpatient Revenue Codes: 0905, 0907, 0912, 0913

Outpatient Visit Setting Unspecified CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99252-99255

BH Outpatient CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99492-99494, 99510

Withdrawal Management (Detox)HCPCS: H0010-H0014

Substance Use Disorder Service/Substance Abuse Counseling and Surveillance CPT/HCPCS: 99408, 99409, G0396, G0397, G0443, H0001, H0005, H0007, H0015, H0016, H0022, H0047, H2035, H2036, T1006, T1012

Substance Use Disorder Revenue Codes: 0906, 0944, 0955

Telephone Visits CPT/HCPCS: 98966-98968, 99441-99443

Online Assessments (E-visits or Virtual Check-in) CPT/HCPCS: 98970-98972, 98980, 98981, 99421-99423, 99457, 99458, G0071, G2010, G2012, G2250-G2252

Medication Assisted Treatment CPT/HCPCS: 96372. G1028, H0020, J0570-J0575, J0577, J0578, J2315, Q9991, Q9992, T1502, S0109

Alcohol Use Disorder Treatment Medications
Disulfiram (oral)
Naltrexone (oral and injectable)
Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications
Naltrexone (oral & injectable)
Buprenorphine (Sublingual Tablet, Injection, And Implant)
Buprenorphine/Naloxone (Sublingual Tablet, Buccal Film, Sublingual Film)

Compliance Requirements

This measure is telehealth eligible. Qualifying initiation and engagement services do not require in-person place of service codes and may be delivered via telehealth, telephone, or other approved virtual modalities when billed appropriately with a qualifying SUD diagnosis.

Benchmark or improvement target for initiation and engagement must be met in order to achieve the measure.

Claims-based reporting only:
Compliance is determined solely through claims and encounter data. Services must be accurately billed with:

- A qualifying CPT/HCPCS or revenue code, and
- A matching substance use disorder ICD-10 diagnosis code on the same claim.

Diagnosis code consistency is required: The SUD diagnosis used to define the episode start date, the initiation service, and the engagement services must be clinically consistent and aligned in order to count toward the numerator.

Timing requirements must be met exactly:

- Initiation services must occur on the episode start date or within 13 days after (14 total days).
- Engagement services must occur after initiation and within 34 days of the episode start date.
- If initiation occurs via inpatient admission, the 34-day engagement window begins the day after discharge.

Initiation is required for engagement compliance: SUD episodes that do not meet initiation criteria cannot meet engagement criteria, regardless of the number of follow-up services provided.

Medication treatment limitations apply:

- No more than one medication treatment event may be counted toward engagement.
- Medication-assisted treatment (MAT) applies only to members with alcohol or opioid use disorder diagnoses.
- Laboratory-only claims do not count toward initiation or engagement.

Monthly opioid treatment services:

- If the SUD episode begins with a monthly-billed opioid treatment service, that service qualifies as initiation.
- Additional qualifying services must still be completed to meet engagement requirements.

Place of service accuracy matters: Place of service, revenue codes, and procedure codes must align appropriately to ensure services are correctly classified (e.g., outpatient, community mental health center, non-residential SUD facility).

Providers should reference OHA Technical Specifications and NCQA HEDIS guidance annually, as code sets, billing rules, and telehealth allowances may change.

Best Practices to Improve Performance

Screening and Early Identification:

- Use a validated substance use screening tool (e.g., SBIRT, AUDIT-C for alcohol use, DAST-10, CAGE-AID, or 5Ps for perinatal populations), or incorporate targeted substance use questions into routine evaluations to identify alcohol or drug use concerns early.
- Clearly document identified substance use or substance use disorder in the patient's medical record and submit claims using accurate and appropriate diagnosis and procedure codes.
- Avoid inappropriate use of diagnosis codes related to long-term medication use or remission that do not indicate an active SUD episode and may unintentionally exclude members from the measure.

Timely Scheduling and Follow-Up:

- Schedule an initial follow-up appointment within 14 days at the time of the first qualifying service to support timely initiation.
- Discuss with the patient the importance of timely follow-up, including the recommended number and type of follow-up visits needed to support engagement.
- Ensure patients complete at least two additional SUD treatment visits within the engagement window following initiation.
- Make follow-up outreach calls to assist with rescheduling patients who miss appointments and reduce gaps in care.
- Send appointment reminders (e.g., phone call, text, patient portal message) 72 hours prior to scheduled follow-up visits.
- Telephone and telehealth visits meet compliance when completed within required timeframes.

Care Coordination and Case Management:

- Promote collaboration between primary care and behavioral health providers to support coordinated SUD care.
- Refer members to an Advanced Health Care Manager, or collaborate with the assigned clinic care manager, to support treatment access, appointment coordination, and patient motivation.
- Use care coordination staff to track patients through the 14-day initiation window and 34-day engagement window, ensuring services are completed and documented.

Patient Education and Support:

- Educate patients on the importance of follow-up visits and adherence to recommended treatment plans.

- Provide patients with educational materials explaining the SUD treatment process and available options.
- Notify patients of Recovery Talk 24/7 Recovery Support and other available support services.
- Utilize SAMHSA resources for substance abuse prevention, treatment education, and recovery support.
- Refer patients to community-based resources, including mutual support groups (e.g., 12-step programs), peer support, sponsors, and other local services, when appropriate.

Telehealth and Access Optimization:

- Utilize telehealth and home-based therapy services when appropriate to reduce access barriers and improve treatment initiation and engagement rates.
- Ensure telehealth encounters are billed correctly and include a qualifying SUD diagnosis.

Coding and Documentation Considerations:

- Use diagnosis codes accurately and consistently across visits to ensure initiation and engagement services count toward the measure.
- For patients receiving long-term opioid therapy for pain management without an SUD, consider using Z79.891 (Long-term current use of opiate analgesic), which does not denote an SUD.
- When documenting remission, use diagnosis codes ending in "1" to indicate remission status (e.g., F10.11 – Alcohol Use Disorder, Mild, in early or sustained remission), as appropriate.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

Billing Oregon Health Authority for Medication-Assisted Treatment Medications: https://www.oregon.gov/oha/HSD/OHP/Tools/Billing%20the%20Oregon%20Health%20Authority%20for%20Medication-Assisted%20Treatment%20Medications.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/

Oregon Substance Use Disorders Services Directory: https://www.oregon.gov/oha/HSD/AMH/docs/provider-directory.pdf

Advanced Health Provider Directory: https://advancedhealth.com/find-a-provider/

09

MEANINGFUL LANGUAGE ACCESS (HEALTH EQUITY)

Component 2

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 53% (Benchmark), TDB (Target)
Target Population (Denominator): All members, regardless of age, who self-identify with the OHA as having interpretation needs (documented within MMIS file at the time of OHP application), spoken or signed language, and had a health care visit in the measurement year.
Goal: Increasing access to spoken and sign language services are critical tools for advancing equity and meaningful access to health care services.
Population: The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services.
Why This Measure Matters: Meaningful language access is essential for quality health care. Without adequate interpreter services or in-language providers, members with limited English proficiency or who are Deaf/hard of hearing may experience misunderstandings about diagnoses, treatment plans, and informed consent, leading to poorer outcomes and inequitable care. This measure supports equity by incentivizing improved access to effective communication in health care settings. (source OHA)

Exclusions

Denominator Exclusions:
Visits from the denominator may be excluded if any of the following apply:

- Member died during the measurement period.
- Visits involving only pharmacy or ancillary services (e.g., lab, DME, ambulance transportation, supportive housing).
- Telemedicine visits without human interaction (e.g., online self-assessment or remote monitoring without direct interpreter interaction).
- Visits where member refusal is documented for the following valid reasons (and the CCO has attested to collecting these within Component 1 Question 14):
    - Member refusal because an in-language visit was provided.
    - Member indicates interpreter needs flag in MMIS is inaccurate.
    - Good Faith Effort (GFE) visits can be excluded if ALL criteria are met: inability to schedule an OHA qualified/certified interpreter after searching OHA registry, use of non-qualified interpreter, and CCO attests to applicable Component 1 GFE questions.

Numerator Exclusions:

- Visits that meet denominator exclusion criteria above are excluded and thereby are not eligible for the numerator. Only visits that remain in the denominator can be counted for the numerator.

Plan-Type Exclusions:

- Members who died in the measurement period.
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.

Qualifying Visits (How the Measure Is Met)

A qualifying visit is defined as one where a member with a documented spoken or signed language interpreter need has a health care visit (in-person or telehealth with human interaction), and:

- OHA-certified or OHA-qualified interpreter services are provided, OR
- The primary provider is in-language (native speaker or has passed an OHA-recognized proficiency test), OR
- A Good Faith Effort (GFE) visit is documented and excluded per OHA specifications.

Advanced Health Quality staff run quarterly reports to identify qualifying visits. Once identified, health plan staff query the provider office to obtain the following visit details:

- **CCO Name:** Advanced Health
- **Member ID:** Pre-filled
- **Interpreter need flagged in MMIS (Y/N):** Pre-filled
- **Type of Care (select one):** Physical, Mental/Behavioral, Dental
- **Visit Type/Care Setting (select one):** Inpatient Stay, Emergency Department, Office Outpatient, Home Health, Telehealth, Other
- **Visit Date**: Pre-filled
- In**-person Interpreter Service (or in-language visit) (Y/N):**
- **Telephonic Interpreter Service (or in-language visit) (Y/N):**
- **Video Remote Interpreter Service (or in-language visit) (Y/N):**
- **Language Interpreted:**
- **Was the Interpreter (or in-language provider) OHA Certified or**
- **Qualified (chose one):** OHA Certified, OHA Qualified, Not Certified or Qualified, Blank – Unknown, Not Applicable
- **Interpreter's OHA Registry Number:**
- **If visit had in language provider, was the provider a native speaker or did the provider pass a proficiency test (Y/N/Blank):**

- **Was the Interpreter a Bilingual Staff (Y/N/Blank):**
- **Did the member refuse Interpreter Service (Y/N/Blank):**
- **Reason for Member Refusal (chose one):**
    - 1 - Member refusal because in-language visit is provided
    - 2 - Member confirms interpreter needs flag in MMIS is inaccurate
    - 3 - Member unsatisfied with the interpreter services available
    - 4 - Other reasons for patient refusal
    - 5 – Member does not need interpreter services for the visit
    - Blank - Unknown or Not Applicable
- **Hospital Facility Name**: Pre-filled
- **Hospital Facility NPI:** Pre-filled
- **Good Faith Effort (Y/N/Blank):**

All information is collected from the provider's office using an Excel spreadsheet, compiled by Advanced Health staff, and submitted to OHA as required in the metric specifications.

Coding

Qualifying services are identified using CPT, HCPCS, and CDT codes according to OHA technical specifications, as reported in the OHA Component 2 quantitative contract report. CCOs must include visit date, member ID, interpreter provision flag, modality (in-person/video/telephonic), care setting, and interpreter type details

Compliance Requirements

CCOs must submit quarterly contract reports aligning with the calendar year and submit the full population Component 2 report by the annual due date (typically April 1 following the measurement year). Data must include all denominator and numerator elements and documentation of exclusions and GFE flags. CCOs must meet OHA reporting and validation rules, including accurate MMIS interpreter flag use and documentation of interpreter services provided.

Best Practices to Improve Performance

Accurate Identification and Documentation

- Ask members for their preferred spoken and/or signed language at intake and during routine updates and record this information in the members' permanent record and structured EHR fields.
- Ensure interpreter needs are accurately reflected in MMIS and the EHR to support correct denominator identification.

Interpreter Access and Workflow Planning

- Establish a clear, standardized process for offering certified or qualified interpreter services to all members with identified language needs.

- Train front-desk, scheduling, and clinical staff that interpreter services are an essential component of care and require advance planning.
- Schedule interpreters as soon as appointments are made to ensure availability for in-person, telephone, or video visits.
- Interpreters may be clinic staff who are OHA-certified/qualified or provided through contracted interpreter vendors.

Use of Certified and Qualified Interpreters

- Prioritize the use of OHA-certified or OHA-qualified interpreters whenever possible, as the measure is incentivized based on an increasing proportion of services provided by certified/qualified interpreters.
- Verify that language service providers are Oregon-based and meet OHA standards by checking the OHA Interpreter Registry.
- Promote Advanced Health's interpreter scholarship and bonus programs to encourage bilingual staff to pursue certification.

Advanced Health and Contracted Vendor Coordination

- Advanced Health contracts with a language service vendor Linguava who has OHA Qualified/Certified interpreters. Clinics should follow the interpreter scheduling instructions outlined by Advanced Health to arrange interpreter services. To obtain more information, contact our Provider Relations staff: Dani Thompson dani.thompson@advancedhealth.com
- Use billable code T1013 when applicable for interpreter services.

Structured EHR Documentation

- Document interpreter services as structured data in the EHR (not solely in free-text notes).
- Documentation should include:
    - Language provided
    - Modality (in-person, telephone, or video)
    - Interpreter name or vendor
    - Whether the interpreter is certified or qualified
    - Whether the member declined interpreter services
- Review and update EHR workflows to ensure interpreter use is properly tracked (e.g., use of a non-billable CPT or "dummy" code when appropriate).

Interpreter Declinations

- Clearly document interpreter declinations and include the reason, such as:
    - Provider is in-language
    - Interpreter need incorrectly documented
    - Member preference or dissatisfaction

- Accurate documentation of declines supports appropriate exclusions and Good Faith Effort reporting.

Data Quality and Oversight

- Complete all quarterly Language Access chart reviews using the template provided by Advanced Health.
- Conduct regular internal audits to confirm interpreter services are offered, documented correctly, and reported consistently.

Provider Language Proficiency

- If providers are certified or tested in another language, submit language proficiency test documentation to the Advanced Health Quality Team.
- Email test results as required to support in-language provider classification.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
Increasing Language Access in Oregon: A Workbook for Providers: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-1294050.pdf
Find A Health Care Interpreter: https://hciregistry.dhsoha.state.or.us/Search
Become a Qualified or Certified Health Care Interpreter: https://www.oregon.gov/oha/EI/Pages/HCI-Certification.aspx

10

POSTPARTUM CARE

(PPC, CMIT #581)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 91.1% (Benchmark), TDB (Target)
Target Population (Denominator): Members who had live births with an Estimated Date of Delivery from 10/08/2025 – 10/07/2026.
Goal: Ensure members with deliveries of live births have a postpartum visit on or between 7 and 84 days after each delivery.
Population: Percentage of deliveries of live births that occurred between October 8, 2025, and October 7, 2026, that had a postpartum visit between 7 and 84 days after delivery.
Why This Measure Matters: This measure assesses whether timely prenatal or postpartum visits occurred during pregnancy and after delivery. The intent of the measure is to assess whether prenatal and postpartum care were rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

Preventive medicine is fundamental to prenatal care. Ensuring early initiation of prenatal care is an important component of programs that aim to improve maternal and infant health outcomes. Inadequate prenatal care raises the risk of adverse birth outcomes, potentially because the health care provider has fewer opportunities to identify and manage conditions that can have a negative impact.

Lack of prenatal care is often considered a high-risk factor for neonatal complications and post neonatal death. The goal of prenatal contact is to exchange information and identify existing risk factors that may impact the pregnancy. According to the National Institutes of Health (NIH), prenatal care can minimize the risk of pregnancy complications and negative birth outcomes. Similarly, comprehensive postpartum care is critical for setting the stage for the long-term health and well-being of new mothers and their infants. Common issues after birth include lack of sleep, fatigue, pain, stress, breastfeeding difficulties, mental health disorders, and pre-existing health and social concerns. In addition, more than half of maternal deaths occur after birth. (source NCQA)

Exclusions

Denominator Exclusions:

- Members who use hospice services at any time during the measurement year.
- Members who die at any time during the measurement year.
- OHA also allows CCOs to report 'no confirmed live birth' in the data submission and excludes the cases accordingly.

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous Enrollment Criteria: 43 days prior to the Estimated Date of Delivery (EDD) through 60 days after EDD.

Qualifying Visits (How the Measure Is Met)

A delivery is numerator compliant if there is evidence of at least one postpartum visit occurring from 7 through 84 days after delivery.

Coding

Qualifying services that meet the postpartum visit requirement include a postpartum visit, defined as an outpatient encounter specifically documented as postpartum care.

Medical record documentation must include the date of the post-partum visit and at least one of the following components:

- Pelvic examination
- Evaluation of weight, blood pressure, breasts, and abdomen
- Notation of postpartum care
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or pre-existing mental health conditions
- Glucose screening for members with gestational diabetes
- Documentation addressing any of the following topics:
    - Infant care or breastfeeding
    - Resumption of intercourse, birth spacing, or family planning
    - Sleep or fatigue
    - Resumption of physical activity
    - Attainment of a healthy weight

Acceptable Practitioner Types:

- Obstetrician/Gynecologist (OB/GYN)
- Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Physician Assistant (PA) providing prenatal or postpartum care in a specialty setting under the direction of an OB/GYN
- Primary Care Practitioner (PCP), including physicians and non-physician providers (e.g., NP, PA, CNM) who provide primary care medical services.

Coding Guidance:

- This measure is a hybrid. Any care not received via claims during the measurement year will result in medical record requests by the health plan.
- Exclude services provided in an acute inpatient setting.
- Do not include lab-only claims without a qualifying visit.
- Postpartum care must be documented within the 7–84 day window after delivery.
- Bill CPT code 0503F; a Category II tracking code used to identify and document a comprehensive postpartum care visit.
- Postpartum Visits CPT: 57170, 58300, 59430, 99501
- Bundled Postpartum Services CPT: 59400, 59410, 59510, 59515, 59610, 59614 59618 59622
- ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Compliance Requirements

- A postpartum visit must occur on or between days 7 and 84 after delivery.
- Hybrid reporting requires medical record review for documentation of the service and supporting components in the clinical record.
- Administrative (claims) and hybrid sources are permissible for identifying numerator compliance.
- Visits in telehealth settings are acceptable if the required service components are documented.

Best Practices to Improve Performance

- Schedule the Postpartum Visit Early: Encourage scheduling before discharge or during the final prenatal visit to ensure timely follow-up—ideally within 7–21 days postpartum.
- Streamline Scheduling: Offer flexible appointment times, including telehealth when appropriate, to reduce access barriers.
- Use Administrative Billing Codes: Utilize the administrative (dummy) codes to capture visits even if clinical documentation is pending. This reduces the chart review workload.
- Provide Ongoing Patient Education: Throughout pregnancy, reinforce the importance of postpartum care for both physical and mental health. Educate families on what to expect during the visit.
- Conduct comprehensive assessments (e.g., BP, weight, mental health, breastfeeding support).
- Use reminder systems (calls/SMS) to help members keep postpartum appointments.
- Track postpartum visit compliance monthly and follow up promptly on missed visits.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

American College of Obstetricians & Gynecologists - Educational Resources for Providers, Patients, and Families: https://www.acog.org/programs/perinatal-mental-health/educational-resources-for-providers-patients-and-families

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) – Postpartum Care Resources: https://www.awhonn.org/resources-and-information/nurse-resources/postpartum-care-resources/

11

PREVENTIVE DENTAL OR ORAL HEALTH SERVICES -AGES 1-5 AND 6-14

(PREV_DENTOR)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: Ages 1-5: 66.3% (Benchmark), TBD (Target); Ages 6-14: 70.8% (Benchmark), TBD (Target)
Target Population (Denominator): Count of unique members age 1-5 and 6-14 on the last day of the measurement year who meet continuous enrollment criteria.
Goal: Ensure preventative dental services for members ages 1-14 at least annually.
Population: Percentage of enrolled children ages 1-14 who receive a preventive dental or oral health service during the measurement year.
Why This Measure Matters: Oral examinations assess oral health status, evaluate risk for tooth decay, and support early identification and treatment of dental disease. Dental caries is the most common chronic disease among children in the United States. Early detection and preventive services can stop or reverse disease progression, reduce future dental complications, and improve overall health outcomes. Untreated dental disease is associated with pain, infection, increased emergency department utilization, missed school days, and reduced quality of life. Ensuring children receive routine preventive dental or oral health services supports long-term health and well-being. (source NCQA)

Exclusions

Denominator Exclusions:

- None

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOB and CCOE
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Cover All Kids (CAK) and Healthier Oregon Program (HOP) members are also excluded from incentive quality rates.
- Continuous enrollment required following Dental Quality Alliance criteria for utilization measures.

Qualifying Visits (How the Measure Is Met)

To meet the measure, a member must have at least one qualifying preventive dental OR oral health service during the measurement year as identified through claims data. (See the Coding section below.)

Coding

Qualifying services include:

CDT codes D1000–D1999 (services by providers with dental taxonomy in the Dental Services Provider Table)

CPT code 99188 (topical fluoride varnish by ANY provider)

Dental Services Provider Table:

Taxonomy Code	Grouping	Classification	Specialization
122300000X	Dental Providers	Dentist	
1223D0001X	Dental Providers	Dentist	Dentist Dental Public Health
1223D0004X	Dental Providers	Dentist	Dentist Anesthesiologist
1223E0200X	Dental Providers	Dentist	Endodontics
1223G0001X	Dental Providers	Dentist	General Practice
1223P0106X	Dental Providers	Dentist	Oral and Maxillofacial Pathology
1223P0221X	Dental Providers	Dentist	Pediatric Dentistry
1223P0300X	Dental Providers	Dentist	Periodontics
1223P0700X	Dental Providers	Dentist	Prosthodontics
1223S0112X	Dental Providers	Dentist	Oral and Maxillofacial Surgery
1223X0008X	Dental Providers	Dentist	Oral and Maxillofacial Radiology
1223X0400X	Dental Providers	Dentist	Orthodontics and Dentofacial Orthopedics
124Q00000X	Dental Providers	Dental Hygienist	
125J00000X	Dental Providers	Dental Therapist	
125K00000X	Dental Providers	Advanced Practice Dental Therapist	
125Q00000X	Dental Providers	Oral Medicinist	

261QF0400X	Ambulatory Health Care Facilities	Clinic/Center	Federally Qualified Health Center (FQHC)
261QR1300X	Ambulatory Health Care Facilities	Clinic/Center	Rural Health
1223X2210X	Dental Providers	Dentist	Orofacial Pain
122400000X	Dental Providers	Denturist	
126800000X	Dental Providers	Dental Assistant	
261QD0000X	Ambulatory Health Care Facilities	Clinic/Center	Dental
204E00000X	Allopathic & Osteopathic Physicians	Oral & Maxillofacial Surgery	
261QS0112X	Ambulatory Health Care Facilities	Clinic/Center	Oral and Maxillofacial Surgery

Compliance Requirements

- Continuous enrollment criteria must be met (following Dental Quality Alliance method).
- Both age group benchmarks or improvement targets must be met for the measure to be achieved.
- Telehealth/teledentistry services may qualify if all required components of the service can be delivered equivalent to in-person care.

Best Practices to Improve Performance

- **Use Gap Lists for Outreach:** Review assigned member gap lists to identify children ages 1–14 who have not received a preventive dental or oral health service during the measurement year and assist families with scheduling appointments.
- **Promote Routine Dental Exams:** Ask about the child's last dental visit during any medical or care management encounter and initiate referrals if the child has not been seen within the recommended timeframe.
- **Strengthen Referral and Care Coordination:** Refer and coordinate with dental providers for follow-up as part of routine care, including chronic condition management. Promote efficient referral loop-closure workflows to ensure visits are completed and documented.
- **Provide Fluoride Varnish (CPT 99188):** Primary care providers trained in fluoride varnish applications may deliver this preventive service during medical visits. Providers not yet trained may contact Advantage Dental or Advanced Health Quality for First Tooth training opportunities.
- **Support Family Navigation:** Assist families who are unsure of their assigned Dental Care Organization (DCO) by directing them to Advanced Health

Customer Service at 800-264-0014 (TTY 711) for help accessing dental services.

- **Integrate Oral Health into Medical Workflows:** Consider dental integration models such as Smiles for Life or First Tooth certification to embed oral health screening, education, and preventive services into routine care.
- **Leverage Community Resources:** Encourage participation in community health fairs, school-based events, and other local initiatives that offer free or low-cost dental services to improve access and utilization.

Additional Resources

Fill in

OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

American Academy of Pediatrics Bright Futures:
https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocketguide/Pages/default.aspx

Smiles for Life – A national oral health curriculum:
https://www.smilesforlifeoralhealth.org/all-courses/

Advantage Dental – First Tooth Program:
https://www.advantagedentalservices.com/community-care/programs/first-tooth

American Academy of Pediatrics:
https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary

12

SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

(CMS 2v15)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 77.1% (Benchmark), TDB (Target)
Target Population (Denominator): Members aged 12 years and older screened for depression during encounters in the measurement period.
Goal: Screen every member 12 and up for depression at least once per year.
Population: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Why This Measure Matters: Depression is a common and serious health condition that affects people of all ages and can significantly impair quality of life and overall health outcomes. Standardized annual screening for depression in individuals age 12 and older helps identify symptoms early so that appropriate care and support can be offered. When depression is detected and a follow-up plan is documented promptly — such as counseling, referral to behavioral health services, or additional evaluation — patients are more likely to receive timely clinical intervention and ongoing monitoring. Routine screening and follow-up also align with national quality measurement priorities and help ensure consistent mental health care across populations.

Early identification and management of depressive symptoms can reduce the burden of untreated mental illness, decrease unnecessary health care utilization, and improve functional outcomes in daily life, school, and work. For adolescents in particular, recognizing and addressing depression can lower the risk of long-term complications, including worsening anxiety, increased risk of substance use, and suicide. By routinely documenting both screening and follow-up plans, health systems and clinicians can better support whole-person care and contribute to improved population health and well-being. (source NCQA)

Exclusions

Denominator Exclusions:

- Patients who have been diagnosed with bipolar disorder at any time prior to the qualifying encounter.

Exceptions (Denominator):

- Patients that refuse to participate or complete depression screening.
- Documented medical reasons for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accurate results; patients are 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:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG

Qualifying Visits (How the Measure Is Met)

This measure is reported using EHR-based (eCQM) data. A qualifying visit is an eligible encounter during the measurement period for a member aged 12 years and older in which:

- A standardized, age-appropriate depression screening (e.g., PHQ-2, PHQ-9) is completed on the date of the encounter or within 14 days prior to the encounter date, AND
- If the screening result is positive, a follow-up plan is documented on the date of the eligible encounter or within two calendar days after the encounter.

Qualifying encounters may occur in in-person or telehealth settings, provided there is documented clinical interaction, and the required screening and follow-up elements are captured in structured EHR fields consistent with eCQM specifications.

Members with a documented bipolar disorder diagnosis prior to the qualifying encounter are excluded from the denominator. Patients who refuse screening or have a documented medical reason for not completing the screening are considered denominator exceptions and do not negatively impact measure performance.

Coding

To meet the eCQM criteria, clinical documentation must include standardized codes that capture both screening and follow-up actions. For example:

- Depression screening tools: capture completion of an age-appropriate, standardized screening instrument (e.g., PHQ-2, PHQ-9) and document the tool name in the medical record.
- Encounter/assessment codes: Use value sets identified in the CMS2v15 eCQM specification for encounters to screen for depression and assessments performed.
- Follow-up actions: document follow-up plans related to a positive screen, including appropriate referral, treatment planning, or interventions. Appropriate structured data elements and value sets from the eCQM specification must be used in electronic records to support numerator compliance.

Note: Providers are encouraged to work with their EHR and quality measurement teams to ensure that the correct clinical data and code sets (from the eCQI Resource Center value sets) are implemented and mapped for reporting.

Codes to Identify Depression and Follow-Up Visits (not exhaustive):
Depression ICD-10: F01.511, F01.518, F32.0-F32.5, F32.81, F32.89, F32.9, F32.A, F33.0 F33.3, F33.40-F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340-O99.345
Depression or Other Behavioral Health Condition ICD-10: F01.511, F01.518, F06.4, F10.xxx-F16.xxx, F18.xxx, 19.xxx, F20.0-F20.5, F20.81, F20.89, F20.9, F21-F24, F25.x, F28, F29, F30.xx, F30.x, F31.x, F31.xx, F32.x, F32.xx, F33.x, F33.xx, F34.x, F34.xx, F39,

F40.xx, F40.xxx, F40.x, F41.x-F43.x, F43.xx, F42, F42.x, F44.89, F45.21, F51.5, F53, F53.x, F60.x, F60.xx, F63.x, F63.xx, F68.xx, F68.x, F84.x, F90.x, F91.x, F93.x, F94.x, O90.6, O99.340, O99.341-O99.345

Depression Case Management Encounter CPT/HCPCS: 99366, 99492-99494, G0512, T1016, T1017, T2022, T2023

Bipolar Disorder CPT/HCPCS: F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78

Other Bipolar Disorder ICD-10: F31.81, F31.89, F31.9

Behavioral Health Encounter CPT/HCPCS: 90791, 90792, 90832-90834, 90836-90839, 90845-90847, 90849, 90853, 90865, 90867-90870, 90875, 90876, 90880, 90887, 99484, 99492, 99493, G0155, G0176, G0177, G0409-G0411, G0511, G0512, H0002, H0004, H0031, H0034-H0037, H0039, G0040, H2000, G2001, H2010-H2020, S0201, S9480, S9484, S9485

Behavioral Health Encounter Revenue Codes: 0900-0905, 0907, 0911-0917, 0919

Follow Up Visit CPT/HCPCS: 98960-98962, 98966-98968, 98970-98972, 98980, 98981, 99078, 99202-99205, 99211-99215, 99242-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99421-99423, 99441-99443, 99457, 99458, 99483, G0071, G0463, G2010, G2012, G2250-G2252, T1015

Follow Up Visit Revenue Codes: 0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0982, 0983

Bipolar Disorder SNOWMED: 162004, 1499003, 3530005, 4441000, 5703000, 9340000, 10875004, 10981006, 13313007, 13581000, 13746004, 14495005, 16506000, 17782008, 21900002, 22121000, 26203008, 26530004, 28663008, 28884001, 29929003, 30935000, 31446002, 33380008, 35481005, 36583000, 38368003, 40926005, 41552001, 41832009, 41836007, 43769008, 45479006, 46229002, 49468007, 49512000, 51637008, 53049002, 53607008, 54761006, 55516002, 59617007, 61403008, 63249007, 64731001, 65042007, 66631006, 68569003, 70546001, 71984005, 73471000, 74686005, 75360000, 75752004, 78269000, 78640000, 79584002, 82998009, 85248005, 86058007, 87203005, 87950005, 111485001, 191618007, 191620005, 191621009, 191623007, 191627008, 191629006, 191630001, 191632009, 191636007, 191638008, 191639000, 191641004, 191643001, 192362008, 231444002, 371596008, 371599001, 371600003, 723903001, 765176007, 767631007, 767632000, 767633005, 767635003, 767636002, 26100011910, 27100011910, 23741000119, 13309100011

Codes that count as a patient encounter during the performance period (CPT or HCPCS) not exhaustive: 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92622, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97802, 97803, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966,98967, 98968, 99078, 99202, 99203, 99204, 99205, 99212,99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401, 99402,

99403, 99424, 99483, 99484, 99491, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0270, G0271, G0402, G0438, G0439, G0444

Value Set Telephone Visits CPT: 98009, 98013, 98010, 98011, 98014, 98008, 98015, 98012, 98966-98968, 99441-99443,
Value Set Telephone Visits SNOWMED: 185317003, 314849005, 386472008, 386473003, 401267002,

Compliance Requirements

- This measure is telehealth eligible; qualifying screening and follow-up plan documentation may occur during telehealth encounters and are valid for numerator compliance.
- The depression screening must occur on the encounter date or within 14 days prior and be documented with a standardized tool.
- For patients who screen positive, a follow-up plan must be documented on the encounter date or within two calendar days after the encounter.
- All relevant documentation must be captured in structured and discrete form in the EHR to support eCQM data extraction and reporting.

Best Practices to Improve Performance

To improve screening and follow-up plan rates:

- Embed validated tools such as PHQ-2/PHQ-9 directly into clinical workflows, so screening is prompt and visible to care teams.
- Use EHR reminders and alerts to prompt annual depression screening for patients ages 12 and older.
- Train staff (nurses, medical assistants, behavioral health navigators) to administer and document screening and to initiate appropriate follow-up actions when positive screens occur.
- Monitor performance data monthly to identify gaps, missed opportunities, and populations with low screening rates.
- Develop recall and outreach processes for patients without documented screening or follow-up plans, including scheduling or telehealth outreach within the measurement period.

Note: This is an EHR measure; to participate, the practice must submit data to Advanced Health. To participate, email the Quality staff at Advanced Health.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx
Technical Release Notes for eCQMs:
https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13

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SOCIAL DETERMINANTS OF HEALTH: SOCIAL NEEDS SCREENING & REFERRAL

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 90% completeness of required data fields in sample reporting (Benchmark), TDB (Target)
Target Population (Denominator): All CCO members continuously enrolled for at least 180 days in the year (no allowable gaps).
Goal: To ensure Oregon Health Plan members have their social needs systematically screened annually for food insecurity, housing instability, and transportation needs using an OHA-approved or exempted screening tool, and that positive screens result in timely referrals to appropriate resources.
Population: Percentage of sampled CCO members who:

- Were screened at least once for all three domains using an OHA-approved or exempted tool during the measurement period; and
- If screened positive for one or more social needs, receive a referral within 15 calendar days of the positive screen.

Why This Measure Matters: Social determinants of health (SDOH) are the non-medical conditions in which people are born, grow, work, live, and age that shape health outcomes and contribute to health inequities. These include barriers such as food insecurity, unstable or inadequate housing, and lack of reliable transportation, all of which directly affect a person's ability to stay healthy, manage chronic disease, and access appropriate care.

Food insecurity limits access to nutritious food, which can lead to poor diet quality, worsening chronic disease progression, and increased risk of hospitalization. Identifying and referring members with food needs can connect them to resources like food banks and nutrition assistance programs.

Housing instability and inadequacy (for example difficulty paying rent, overcrowding, frequent moves, or homelessness) are strongly linked to poorer physical and mental health, including increased stress, depression, and avoidable emergency care. Timely referrals to housing support and coordination services help stabilize living situations.

Transportation barriers often prevent members from attending medical appointments or accessing essential services, leading to missed preventive care and worse health outcomes. Addressing transportation needs through community partnerships and support programs improves access to care and reduces no-shows.

By screening all members annually for these core social needs using OHA-approved tools and referring those who screen positive within 15 days, this measure supports early identification of barriers that affect health and encourages coordinated connections to community resources. These actions contribute to reducing health inequities and improving overall health outcomes for Oregon Health Plan members. (source NCQA)

Exclusions

Denominator Exclusions:
Members who decline screening in all three required domains

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOE, CCOF, and CCOG
- Continuous Enrollment Criteria: Continuously enrolled with the CCO for at least 180 days during the screening period.

Qualifying Visits (How the Measure Is Met)

- A member qualifies when they are screened at least once during the measurement period for all three domains with an OHA-approved or exempted screening tool.
- Screening may occur in any setting (primary care, behavioral health, hospital, home health, etc.) if the approved screening tool is used and documented.

Advanced Health will report the percentage of screened CCO members through hybrid measure reporting. The data for this component will be pulled using a variety of sources, such as:

- MMIS – OHA's repository of claims where codes represent identified social needs.
- EHR – we can work with your organization to build this reporting capacity.
- Community Information Exchanges (CIE) – Advanced Health sponsors the utilization of the UniteUs platform.

Coding

CCOs and providers must document the name of the approved screening tool used in the record to count toward the measure.
While OHA does not specify exact CPT or ICD code sets for this measure, tools and workflows should support data collection across EHR, CIE/HIE, claims, and other hybrid sources.

If using administrative codes (e.g., social needs codes), ensure they are mapped back to the documented screening results to support reporting validity. (Note: some national SDOH codes may vary over time; align with current guidance).

Compliance Requirements

- This measure is telehealth eligible as the qualifying numerator services do not require in-person place of service codes in claims data. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.
- Screening must occur with an OHA-approved or exempted screening tool; tools not on the OHA list must be submitted for review by the CCO and approved.
- Referrals must be made within 15 calendar days of a positive screen for each domain.
- Data must be reported using the hybrid sampling and reporting template specified by OHA; at least 90% of required fields in the sample must be completed.

Best Practices to Improve Performance

- Standardize screening workflows across clinical and non-clinical settings to ensure all eligible members are screened annually.
- Use trauma-informed, culturally responsive engagement to improve member participation and data quality.
- Establish data sharing agreements and technical infrastructure with providers and community partners (e.g., CIE platforms) to facilitate closed-loop referrals and tracking.
- Monitor data completeness routinely to ensure compliance with the 90% reporting threshold.
- Train staff on approved screening tools, documentation standards, and referral pathways to support reliable data capture and follow-up.

Additional Resources

OHA Technical Specifications: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

OHA-Approved Social Needs Screening Tools List: https://www.oregon.gov/oha/hpa/dsi-tc/pages/social-needs-screening-tools.aspx

Connect Oregon/UniteUs: https://uniteus.com/networks/oregon/

Trauma Informed Oregon's Introduction to Trauma Informed Care (TIC) Online Training Modules: https://traumainformedoregon.org/resources/training/tic-intro-training-modules/

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YOUNG CHILDREN RECEIVING SOCIAL EMOTIONAL ISSUE FOCUSED INTERVENTION/TREATMENT SERVICES (SEM)

Measurement Period: 01/01/2026 – 12/31/2026
Benchmark/Target: 12% (Benchmark), TBD% (Target)
Target Population (Denominator): Members aged 1- 5.99 years (kindergarten readiness) enrolled on 12/31/2026 who meet continuous enrollment criteria.
Goal: To measure and improve access to and receipt of social-emotional issue-focused intervention/treatment services for children ages 1 to 5, promoting social-emotional health.
Population: Count of unique members ages 1-5.99 years (kindergarten readiness) on the last day of the measurement year who meet continuous enrollment criteria.
Why This Measure Matters: This child-level metric, developed by the Oregon Pediatric Improvement Partnership (OPIP), calculates the percentage of children ages 1–5.99 who receive issue-focused intervention/treatment services during the measurement year. The intent is to ensure that children in the eligible cohort who receive any of the specified services are captured, regardless of whether they had a documented treatment need in administrative data.

Exclusions

Denominator Exclusions:

- Members who die during the measurement year

Numerator Exclusions:

- None

Plan-Type Exclusions:

- CCOF
- Members enrolled in the Basic Health Plan (BHP) at any time during the continuous enrollment period are excluded from incentive quality rates. Healthier Oregon Program (HOP) and Cover All Kids (CAK) and members are also excluded from incentive quality rates.
- Allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during measurement year.

Qualifying Visits (How the Measure Is Met)

Measure is met when a child in the denominator receives ≥1 issue-focused intervention/treatment service during the measurement year as identified by the specific CPT/HCPCS codes listed below.

Note: Screening only (e.g., ASQ-SE) does not count as a qualifying service, although it is important for identification and referral.

Services that count toward the measure include assessments and interventions provided in any setting (primary care, integrated behavioral health, specialty behavioral health, community-based organizations) when appropriately coded.

Claims Used:

- Claim must be from the Matching CCO
- Denied claims are included in the numerator if they contain qualifying codes.

Coding

SEM code list includes targeted services codes with no diagnosis requirements, covering the breadth of brief interventions and treatment services most commonly used by the system of providers who address behaviors.

Primary Care & Integrated Behavioral Health	
Code Description	**Codes**
Health behavior assessment, or re-assessment	96156
Health Behavior Intervention	96158, 96159, 96164, 96165, 96158, 96159, 96164, 96165,
Preventive Medicine Counseling	99401-99404, 99411-99412
Primary Care, Integrated Behavioral Health & Specialty Behavioral Health	
Psychiatric Diagnostic Evaluation	90791
Mental health assessment, by non-physician	H0031

Individual psychotherapy	90832-90834, 90836-90838 (removed 90835 given CPT code is expired)
Family psychotherapy	90846, 90847
Group psychotherapy	90849, 90853
Multi-Family Group Training Session	96202, 96203
Specialty Behavioral Health Only	
Psychiatric Diagnostic Evaluation, by a medically licensed professional 90792	90792
Adaptive Behavior Treatment	97153-97158
Behavioral health counseling and therapy	H0004
Skills training and development	H2014
Behavioral Health Outreach Services (Used for Intensive, In Home Behavioral Health Treatment)	H0023
Activity therapy (music, dance, are or play therapies) related to the care and treatment of patient's disabling mental health problems per session (>=45 min)	G0176
Mental health service plan development, by non-physician	H0032
Other Contracted Providers - THWs/CHWs at Community Based Organizations	
Includes some of the codes listed above such as Preventative Medicine Counseling, Group Psychotherapy, Multi-Family Group Training, 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

Compliance Requirements

This measure is eligible for telehealth. If the rendering provider documents a qualifying CPT/HCPCS code on the claim, the service counts toward the numerator, regardless of visit modality.

Best Practices to Improve Performance

- Refer young children with identified social-emotional concerns to appropriate behavioral health services.
- Ensure follow-up and linkage to evidence-based interventions when needs are identified via screening and surveillance (e.g., Bright Futures recommended practices).
- Develop chart review/scrubbing to identify children likely to benefit from issue-focused services.
- Create standardized referral and follow-up workflows tied to screening results (maternal depression, developmental, autism, social-emotional).
- If applicable, align with PCPCH Standard 3.C.3 (Behavioral Health Integration).
- Use integrated behavioral health providers to support PCPs with coaching and clinical guidance.
- Track referrals to services and ensure communication loops back to primary care.

Additional Resources

OHA Technical Specifications:https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx

Oregon Pediatric Improvement Partnership: https://oregon-pip.org/resources/primary-care-provider-role-in-providing-social-emotional-services-for-birth-to-five/primary-care-provider-role-in-providing-social-emotional-services-for-birth-to-five-resource-library/