

Oregon Health System Transformation CCO Metrics 2021 Final Report



MEASUREMENT PERIOD:

Calendar year 2021
Published August 2022, updated August 29, 2022,
September 14, 2022 and December 6, 2022



Executive summary

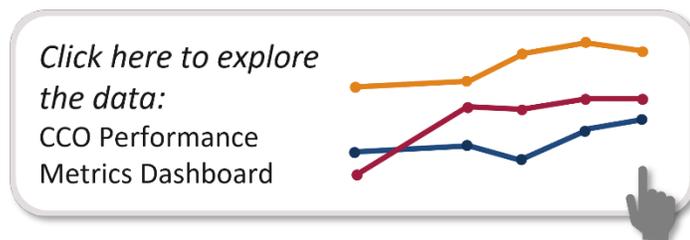
This report is a summary of performance by Oregon’s coordinated care organizations (CCOs) in 2021. It includes highlights of statewide performance and snapshots of CCOs’ performance and payments for 14 incentivized metrics.

Although the COVID-19 public health emergency continued and the Delta variant drove a surge in hospitalizations and deaths, **performance on CCO incentive metrics began to rebound in 2021 after sharp declines in 2020**. For example, after falling sharply in 2020 as clinics suspended services, oral health measures regained substantial ground in 2021. This report shows an encouraging regrowth in quality, consistent with the Metrics and Scoring Committee’s benchmark decisions. After suspending incentive metric benchmarks for 2020, the committee set benchmarks for 2021, though at significantly reduced levels. Restoring aspirational benchmarks is anticipated to be a multi-year process.

The CCO quality incentive program contributes to the strategic goal of eliminating health inequities by 2030. In 2021, the Health equity measure: Meaningful access to health care services for persons with limited English proficiency was incentivized for the first time, following extensive development work by a public workgroup and other partners. The measure’s goal is to achieve meaningful access to health care services for all CCO members through quality communication and language access services, as well as the delivery of culturally responsive care. In Oregon’s [Medicaid 1115 waiver application](#), OHA is planning further changes to the CCO quality incentive program to center equity.

Explore the CCO Performance Metrics Dashboard

This short report shows only the statewide averages for CCO members as a whole, which can mask inequities. In December 2022, OHA published a dashboard of statewide and CCO performance on incentive metrics, as well as state quality and CMS Core measures.¹ The [CCO Performance Metrics Dashboard](#) allows viewers to quickly find their metric of interest and see individual CCO trends over time. The dashboard also adds the option to explore breakouts of many measures by race and ethnicity and language, using Race, Ethnicity, Language and Disability (REALD) standards. The CCO Metrics Program is continuing work with OEI to analyze and report disability data at a later date.



¹ For readers familiar with previous CCO metrics reports, the dashboard contains data previously published as Appendix A and B in the annual report.

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Acknowledgments

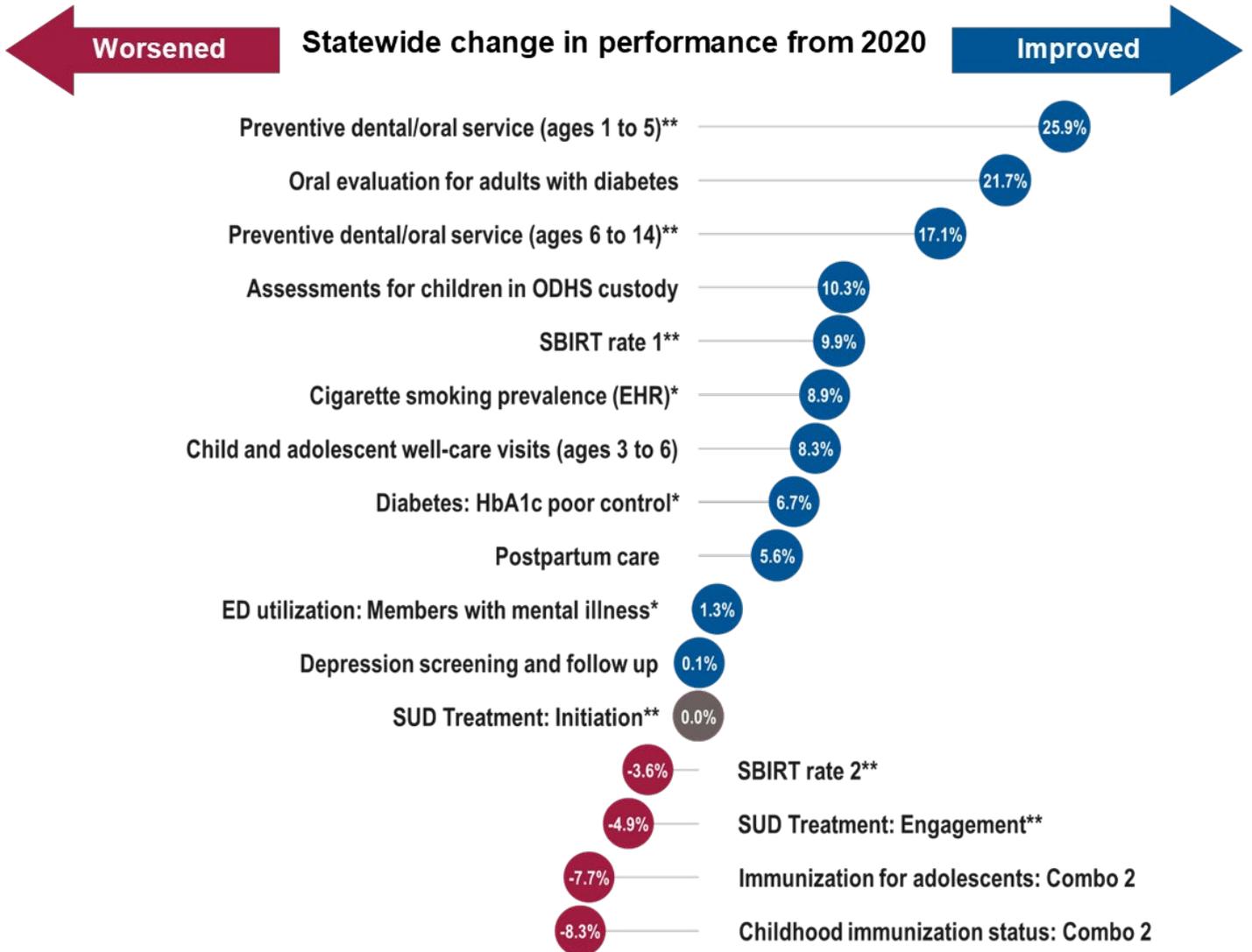
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Key findings

Performance on most CCO incentive metrics improved in 2021 compared with 2020



* For these measures a lower rate indicates better performance. To enable easy comparison across the measure set, measures are listed in the chart based on whether performance moved in the desired direction. For example, performance on the cigarette smoking prevalence measure improved by 8.9%, meaning a 8.9% decrease in the rate of smoking.

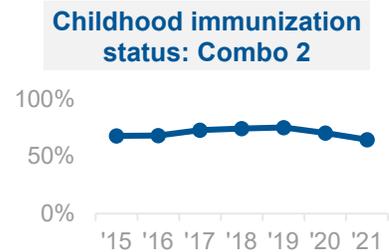
** Each of these three measures (SUD treatment, Preventive dental/oral health, and SBIRT) has two separately reported rates.

Statewide CCO quality incentive metric highlights

This section highlights statewide performance rates on all incentivized metrics and how those rates have changed over time.

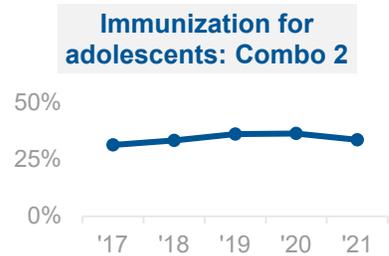
Childhood immunization status: Combo 2

Performance on this measure declined in 2021. This is likely a lingering effect of pandemic-related disruptions during 2020. This measure looks at immunizations received (diphtheria, tetanus and pertussis; polio; measles, mumps and rubella; haemophilus influenzae type B; hepatitis B; varicella zoster) by the child's second birthday. For children who turned two in 2021, that two-year period encompassed the initial stages of the pandemic. Disruptions in care during 2020 thus continued to affect this measure in 2021.



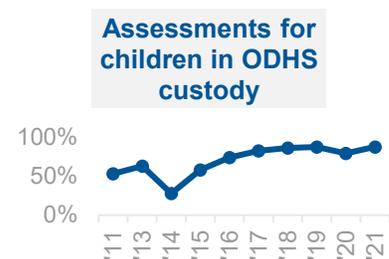
Immunization for adolescents: Combo 2

Like the childhood immunization metric, this metric showed worse performance in 2021 than 2019 or 2020. This metric looks at immunizations received (meningococcal; tetanus, diphtheria and pertussis; HPV) by adolescents who turn 13 during the measurement year, so disruptions in care during 2020 continued to affect this measure in 2021.



Assessments for children in ODHS custody

This measure is an important tool to ensure that children entering foster care receive timely assessments of their physical, oral and behavioral health needs, so they can be provided appropriate care. The measure showed encouraging improvement in 2021, as the statewide average resumed its upward trend, with the average exceeding pre-pandemic performance.

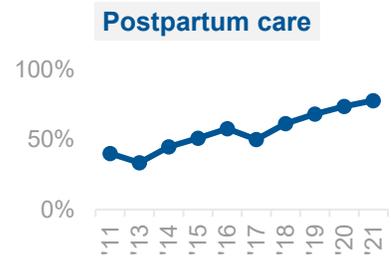


Note: Because of a change in methodology, results prior to 2014 are not directly comparable to later years.

Prenatal and postpartum care: Postpartum care

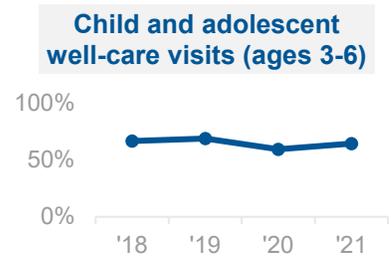
The rate of CCO members who receive postpartum care after giving birth continued to improve in 2021. This care is an important way to support the long-term health and well-being of both parent and child.

Note: Because of a change in methodology, results prior to 2014 are not directly comparable to later years.



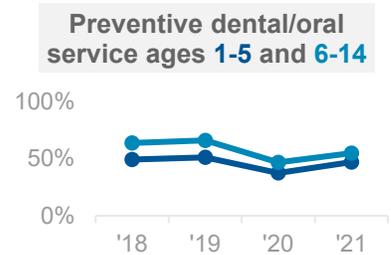
Kindergarten readiness: Child and adolescent well-care visits (ages 3-6)

This measure is part of the multi-measure health aspects of kindergarten readiness strategy. Statewide performance in 2021 notably improved over 2020. This is particularly encouraging, because these well-care visits are a critical opportunity for screening and preventive care. Well-care visits are also an opportunity to catch up on missed vaccinations and other important services for children who missed out on routine care in 2020.



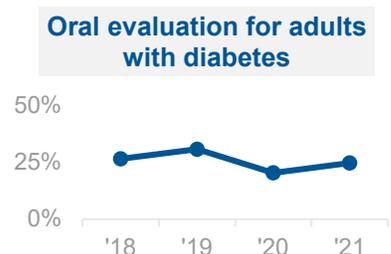
Kindergarten readiness: Preventive dental or oral service utilization (ages 1-5 and 6-14)

The component of this measure focusing on children ages 1-5 is part of the multi-measure health aspects of kindergarten readiness strategy. After dropping sharply in 2020, performance for both age groups improved in 2021. These services help children avoid oral health problems that can impact their health and education.



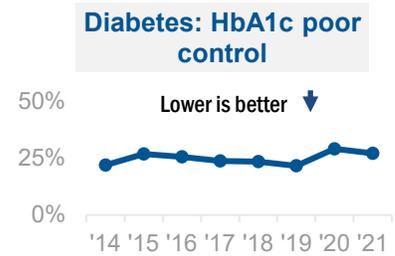
Oral evaluation for adults with diabetes

This measure looks at the percentage of adult CCO members with diabetes who received a comprehensive oral health evaluation, supporting better physical and oral health care. After dropping dramatically in 2020, performance improved in 2021.



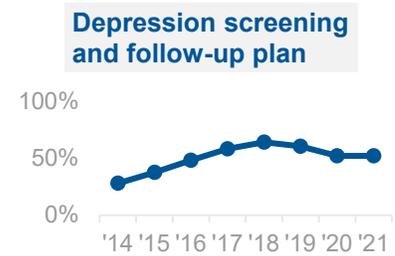
Diabetes care: HbA1c poor control

This measure looks at the percentage of adult CCO members who have diabetes and whose blood sugars are poorly controlled or are not laboratory tested during the measurement year. Because the measure reports poor control, a lower score is better. After worsening dramatically in 2020, performance on this measure improved in 2021.



Depression screening and follow-up plan

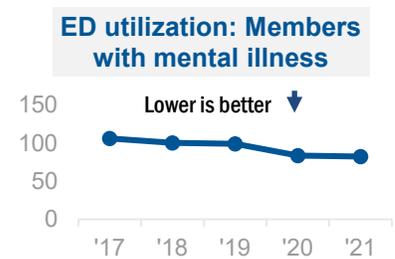
Performance on this measure held steady in 2021, after a large drop in 2020. Because comparable historical data to set performance targets were unavailable, CCOs have not been required to meet a benchmark on this measure for several years, but they will be required to do so again starting in 2022.



Note: Because of a change in methodology, results prior to 2019 are not directly comparable to later years.

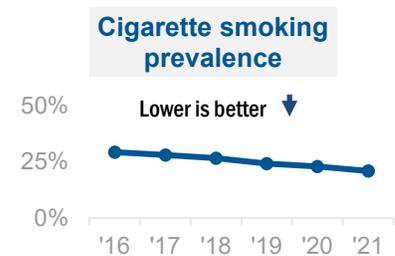
Disparity measure: Emergency Department (ED) utilization among members with mental illness

Because of stigma and poorly coordinated care, people with mental illness often experience worse physical health outcomes. This measure is intended to incentivize better care coordination, which would result in lower ED utilization. Although rates improved in both 2020 and 2021, this report cannot discern how much of that change is related to better care coordination as opposed to reductions in ED utilization across all populations during the pandemic.



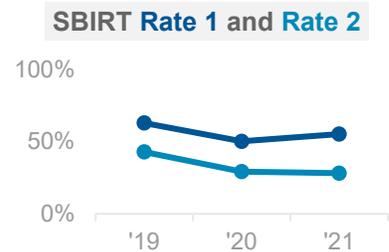
Cigarette smoking prevalence

This measure showed encouraging improvement, as cigarette smoking prevalence among CCO members age 13 and older who visited a primary care provider continued to decline in 2021.



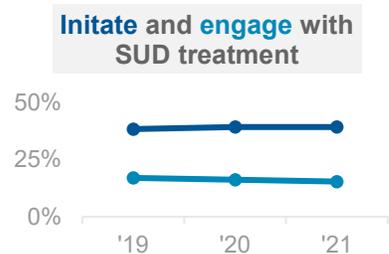
Screening, brief intervention and referral to treatment (SBIRT)

This version of the SBIRT measure was first incentivized in 2019. Because historical data to set performance targets are unavailable, CCOs have not yet been required to meet a benchmark on this measure, but they will be required to do so beginning in 2022. Two rates are reported: (1) screening and (2) brief interventions or referrals for those who screen positive for unhealthy alcohol or drug use. Results on this measure were mixed, as the first rate improved but the second declined.



Initiation and engagement with substance use disorder (SUD) treatment

This measure looks at two aspects of care for adult CCO members who are newly diagnosed with substance use disorder: (1) timely initiation of treatment and (2) engagement in continuing treatment. Although the rate of initiation held steady between 2020 and 2021, with some improvement over 2019, the rate of ongoing engagement fell further. OHA is supporting additional quality improvement on this measure, such as work through a statewide Performance Improvement Plan. The rates shown here are for adults, the age group that is the focus of the incentive metric; the rates for adolescents will be included in the dashboard published later this year.



New measure

Health equity measure: Meaningful access to health care services for persons with limited English proficiency

For the first year of this measure, CCOs were required to conduct a self-assessment of language access and attest to work to identify and assess communication needs, provide language assistance services, train staff and provide notice of language assistance services. All but one of the CCOs met this measure. In 2022, the measure will also require CCOs to report on how often interpreter services were provided when CCO members with identified interpreter needs had physical, behavioral or dental health visits.

2021 incentive measure performance overview

	Advanced Health	AllCare	Cascade	Columbia Pacific	Eastern Oregon	Health Share	IHN-CCO	Jackson	PacificSource Central	PacificSource Gorge	PacificSource Lane	PacificSource Marion Polk	Trillium North	Trillium South	Umpqua	Yamhill
Assessments for children in ODHS custody [^]	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET	Achieved BENCHMARK		Achieved BENCHMARK		Achieved BENCHMARK			Achieved IMPROVEMENT TARGET	Achieved IMPROVEMENT TARGET			Achieved BENCHMARK		Achieved BENCHMARK
Childhood immunization status: Combo 2			Achieved BENCHMARK		Achieved BENCHMARK					Achieved IMPROVEMENT TARGET	Achieved BENCHMARK	Achieved BENCHMARK				
Well-care visits (ages 3-6) [^]	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK		Achieved BENCHMARK					Achieved IMPROVEMENT TARGET					Achieved BENCHMARK	Achieved BENCHMARK
Cigarette smoking prevalence (EHR)		Achieved BENCHMARK										Achieved IMPROVEMENT TARGET	Achieved BENCHMARK	Achieved BENCHMARK		Achieved BENCHMARK
Depression screening (EHR)~	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK							Achieved IMPROVEMENT TARGET					Achieved BENCHMARK	Achieved BENCHMARK
Diabetes: HbA1c poor control (EHR)		Achieved BENCHMARK	Achieved BENCHMARK								Achieved IMPROVEMENT TARGET			Achieved BENCHMARK		Achieved BENCHMARK
ED utilization for members with mental illness	Achieved IMPROVEMENT TARGET	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET		Achieved IMPROVEMENT TARGET					Achieved IMPROVEMENT TARGET			Achieved BENCHMARK	Achieved IMPROVEMENT TARGET	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET
Health equity measure: Meaningful access~	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK		Achieved IMPROVEMENT TARGET					Achieved BENCHMARK				Achieved BENCHMARK		Achieved IMPROVEMENT TARGET
Initiate and engage in SUD treatment [^]		Achieved IMPROVEMENT TARGET	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET	Achieved IMPROVEMENT TARGET				Achieved IMPROVEMENT TARGET	Achieved IMPROVEMENT TARGET						Achieved BENCHMARK
Initiation phase [^]	Achieved IMPROVEMENT TARGET				Achieved IMPROVEMENT TARGET	Achieved IMPROVEMENT TARGET						Achieved BENCHMARK				
Engagement phase [^]		Achieved BENCHMARK	Achieved IMPROVEMENT TARGET													Achieved BENCHMARK
Immunization for Adolescents: Combo 2 [^]			Achieved BENCHMARK					Achieved IMPROVEMENT TARGET		Achieved IMPROVEMENT TARGET			Achieved IMPROVEMENT TARGET		Achieved IMPROVEMENT TARGET	Achieved BENCHMARK
Oral evaluation for adults with diabetes	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK							Achieved IMPROVEMENT TARGET						Achieved BENCHMARK
Postpartum care	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK							Achieved IMPROVEMENT TARGET						Achieved BENCHMARK
Preventive dental or oral service utilization	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK													Achieved BENCHMARK
Ages 1-5	Achieved BENCHMARK	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET													Achieved BENCHMARK
Ages 6-14	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK									Achieved IMPROVEMENT TARGET				Achieved BENCHMARK
SBIRT (EHR)~	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK													Achieved BENCHMARK
Rate 1~	Achieved BENCHMARK	Achieved BENCHMARK	Achieved BENCHMARK						Achieved IMPROVEMENT TARGET							Achieved BENCHMARK
Rate 2~	Achieved BENCHMARK	Achieved IMPROVEMENT TARGET	Achieved BENCHMARK													Achieved BENCHMARK

* Top performing CCO in each measure

Bold indicates CCOs earned 100% Quality Pool

~ indicates must pass measure

[^] indicates Challenge Pool measure

To meet a measure with two rates, CCOs may be required to achieve the benchmark or target for one or both rates.

About benchmarks and improvement targets

Normally, the Metrics and Scoring Committee sets benchmarks that are aspirational goals. Benchmarks typically are set at the 75th or 90th percentile of national performance. To encourage ongoing improvement, CCOs can earn Quality Pool payment by achieving either (1) the aspirational benchmark or (2) a CCO-specific improvement target that rewards progress toward the aspirational benchmark.

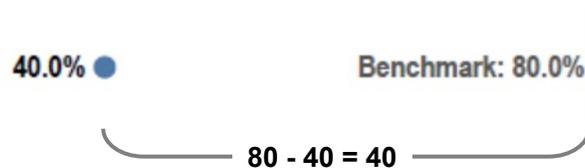
The pandemic upended the usual benchmarking approach for 2020. As described in the [2020 annual report](#), all performance benchmarks were suspended in 2020 as the health system strained to respond to the COVID public health emergency.

In 2021, benchmarks for performance returned, but at lower levels than previous years. The Metrics and Scoring Committee made unprecedented midyear reductions to the benchmarks for multiple measures in 2021, reflecting the ongoing impacts of the public health emergency. In September 2021, the committee voted to substantially reduce 2021 benchmarks for seven of the 14 incentivized metrics and removed the improvement target floor for all measures. Two of the remaining metrics were already report-only. Due to the pandemic, data from 2020 are not appropriate to use in assessing quality improvement. Therefore, the committee also chose to use 2019 as the baseline for assessing metric improvements through 2021.

How improvement targets are calculated

Improvement targets are calculated for each CCO based on the Minnesota Department of Health Quality Incentive Payment System (“Minnesota method”). A CCO meets its improvement target by reducing the gap between its baseline (historically the previous year’s performance) and the benchmark (the aspirational goal). A CCO must show at least a 10 percent reduction in the gap between baseline and the benchmark to meet its improvement target. To ensure meaningful progress toward the benchmark, typically a floor is applied to each CCO’s improvement target.

Suppose CCO A’s performance in **2019** (i.e. baseline) on Measure 1 was 40.0%.



The gap between baseline and the benchmark is $[80-40] = 40\%$

Ten percent of 40 % = 4%. Thus, **CCO A must improve by 4 percentage points in 2021.** Their **improvement target** is $[\text{baseline} + 4\%] = [40\% + 4\%] = 44\%$

Suppose that CCO A's performance in **2021** is 45%; they **achieved their improvement target and will receive Quality Pool payment** on Measure 1.



Stated as a formula:

$$\frac{[\text{Benchmark}] - [\text{CCO baseline}]}{10} = X$$

$$[\text{CCO baseline}] + [X] = \text{Improvement target}$$

In some cases, depending on the difference between the CCO's baseline and the benchmark, the Minnesota method may result in a very small improvement that may not represent a meaningful change. For example, suppose the benchmark was 75 percent, and CCO B's performance in 2019 was 60 percent. In this case, CCO B's improvement target using the formula would be:

$$\frac{75\% - 60\%}{10} = 1.5\%$$

$$60\% + 1.5\% = \mathbf{61.5\%}$$

Where the Minnesota method results in small improvement targets like this, the Metrics and Scoring Committee typically has established a "floor" or minimum level of required improvement before the CCO would meet its improvement target. In this example, suppose the floor is 3 percentage points. The Minnesota method formula results in 1.5% increase. Instead of 61.5%, CCO B's improvement target with the 3% floor applied would be: [baseline + floor] = [60% + 3%] = 63%.

Although a "floor" approach has been used in the past, because of the COVID-19 pandemic, the Metrics and Scoring Committee did not apply floors to the 2021 improvement targets. This meant that CCO improvement targets could be lower than in previous years.

2021 Quality Pool distribution and CCO enrollment

To drive quality improvement, each CCO is paid from the funds in the Quality Pool for reaching benchmarks or demonstrating improvements on incentive measures.

The 2021 Quality Pool for CCO incentive metrics was almost \$235 million, representing 3.75% of the total amount all CCOs were paid in 2021. The share of these funds that a CCO can earn depends on the number of members it serves and its performance on the 14 incentive metrics. These funds are earned in two stages described below.

Stage One: Distribution based on performance on all 14 quality incentive measures

CCOs could earn 100% of their available Quality Pool funds in the first stage of distribution by meeting each of the following requirements:

- Report data for minimum population thresholds as described in OHA reporting guidance for both the Screening, brief intervention and referral to treatment (SBIRT) and Depression screening and follow-up measures (“must pass” measures 1 and 2);
- Complete the self-assessment attestation and earn the minimum number of points stipulated by the Metrics and Scoring Committee on the Health equity measure: Meaningful access to health care services for persons with limited English proficiency (“must pass” measure 3); and
- Meet or exceed the benchmark or the improvement target on at least 75% of the remaining incentive measures (9 of 11 remaining measures).

If a CCO misses a requirement for distribution of funds in phase one, those unearned funds go into the Challenge Pool.

Stage Two: Challenge Pool distribution

The Challenge Pool contains any funds remaining after stage one distribution of the Quality Pool. For 2021, the Challenge Pool also contained unearned funds from the [COVID Emergency Outcome Tracking \(EOT\) Program](#). Challenge Pool funds were distributed to CCOs according to their performance on each of the four Challenge Pool measures:

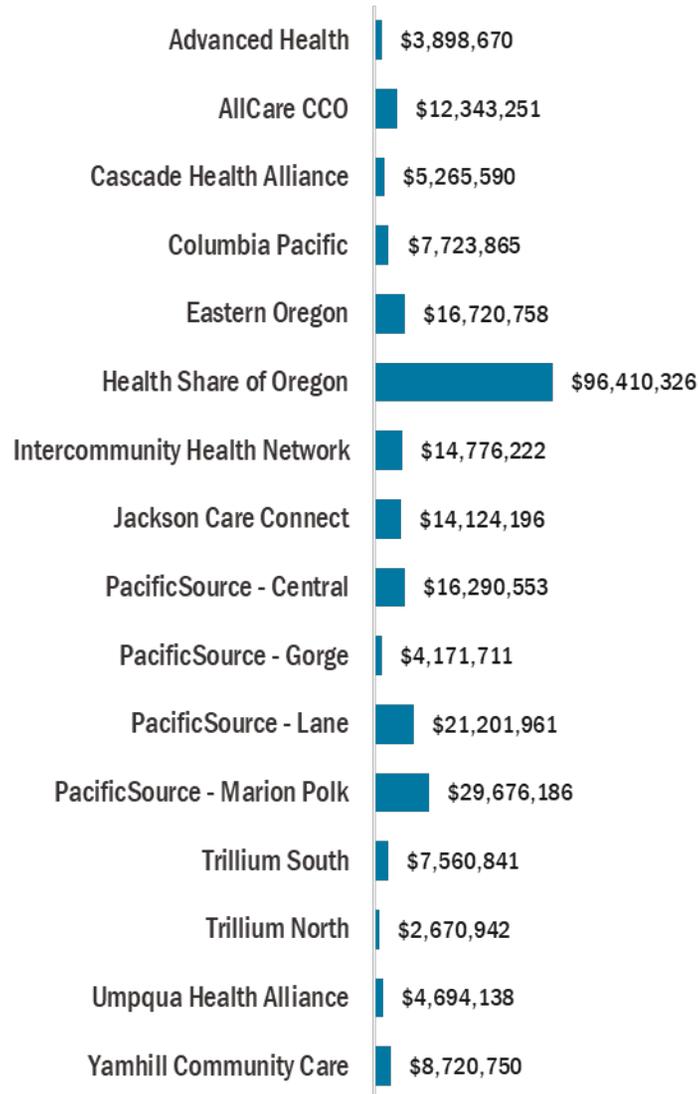
1. Immunizations for adolescents:
Combo 2
2. Child and adolescent well-care visits
(incentivized for ages 3-6)
3. Assessments for children in ODHS
custody
4. Initiation and Engagement of SUD
Treatment

CCO	Stage 1 Distribution			Challenge Pool		Total	
	# Measures met (11 possible)	Total payment earned in Stage 1*	% Quality Pool funds earned	# Challenge Pool measures met (4 possible)	\$ Challenge Pool earned	Total payment (Stage 1 + Challenge Pool + MCO tax + EOT**)	Total % Quality Pool earned
Advanced Health	6	\$3,406,464	60%	2	\$414,233	\$3,898,670	67.3%
AllCare Health Plan	9	\$10,835,854	100%	3	\$1,260,532	\$12,343,251	111.6%
Cascade Health Alliance	10	\$4,498,997	100%	4	\$661,281	\$5,265,590	114.7%
Columbia Pacific	8	\$6,072,302	80%	3	\$586,241	\$7,723,865	87.7%
Eastern Oregon	11	\$14,580,982	100%	4	\$1,805,361	\$16,720,758	112.4%
Health Share of Oregon	9	\$77,043,647	100%	3	\$7,165,986	\$96,410,326	109.3%
Intercommunity Health Network	8	\$11,182,526	70%	2	\$1,168,167	\$14,776,222	77.3%
Jackson Care Connect	10	\$11,415,297	100%	4	\$1,643,652	\$14,124,196	114.4%
PacificSource – Central	9	\$14,775,731	100%	3	\$1,189,011	\$16,290,553	108.0%
PacificSource – Gorge	11	\$3,228,265	100%	4	\$429,577	\$4,171,711	113.3%
PacificSource – Lane	11	\$16,401,287	100%	4	\$2,189,796	\$21,201,961	113.4%
PacificSource – Marion Polk	10	\$23,663,809	100%	3	\$2,263,678	\$29,676,186	109.6%
Trillium South	8	\$5,954,558	80%	2	\$590,238	\$7,560,841	87.9%
Trillium North	6	\$2,021,978	60%	2	\$203,987	\$2,670,942	66.1%
Umpqua Health Alliance	6	\$4,194,862	60%	2	\$405,393	\$4,694,138	65.8%
Yamhill Community Care	10	\$6,736,585	100%	4	\$911,538	\$8,720,750	113.5%
Total		\$216,013,143			\$22,888,671	\$266,249,959	

* Quality Pool distribution is based on number of measures met and CCO size (number of members). See next page for CCO enrollment.

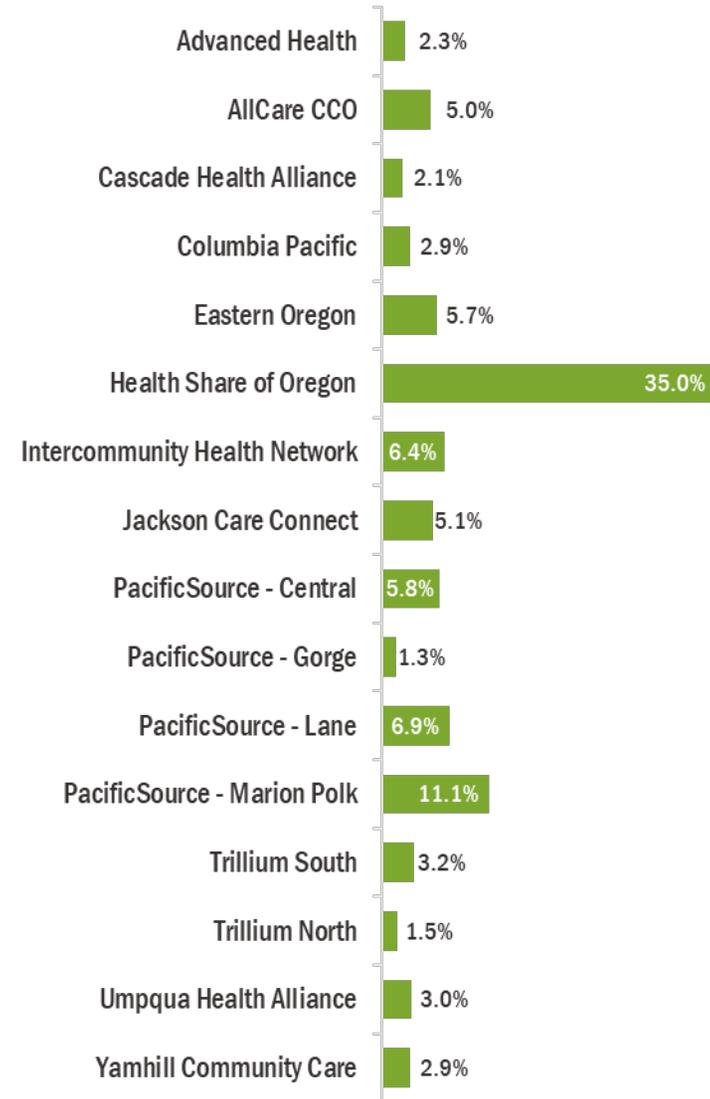
** For 2021, the Challenge Pool also included unearned funds from the COVID Emergency Outcome Tracking (EOT) Program. The EOT Program was implemented in 2021 to reward CCOs for making substantial progress in vaccinating their members against COVID, with a particular focus on ensuring CCOs reached higher vaccination rates across all race/ethnicity groups. Funds remaining after the EOT payout were placed in the Challenge Pool, providing CCOs another opportunity to earn those funds.

Total Quality Pool dollars earned, by CCO



Percent of total enrollment, by CCO

(December 2021 enrollment) n = 1,111,129



Background/context

About the program

The CCO quality incentive program measures performance by coordinated care organizations (CCOs) that serve over one million Oregonians on the Oregon Health Plan (Medicaid). The program is an important part of the coordinated care model. Independent evaluation has shown the program is successful in driving improvements overall. OHA is committed to using the CCO quality incentive program as a tool to improve health equity.

Medicaid

Medicaid is a federal program that provides health coverage for people earning less than 138% of the federal poverty level and people with disabilities. Each state administers Medicaid and must follow certain federal requirements. States may obtain waivers from the federal government. These waivers grant states extra flexibility in how they use federal Medicaid funds in their state, with the goal of improving health care outcomes.

Oregon has had a type of waiver, known as an 1115 waiver, since 1994. The waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include using best practices to manage and coordinate care; transparency in price and quality; and paying for better quality care and better health outcomes, rather than just more services.

In 2022, Oregon is applying to the Centers for Medicare & Medicaid Services (CMS) for a new five-year 1115 Medicaid waiver for the years 2022 through 2027. This waiver creates an opportunity to build on Oregon's health care transformation success and create a more equitable system. In the next waiver period, Oregon plans to build on the CCO quality incentive program to prioritize health equity and redistribute decision-making power to communities that experience health inequities.

Coordinated care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers). Each CCO agrees to work together with their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs were formed in Oregon in late 2012.

CCOs have the flexibility to support new models of care that are patient-centered and team-focused and eliminate health inequities. CCOs are able to better coordinate services and focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services beyond medical benefits.

Requirements for CCOs have evolved over time and a new phase, CCO 2.0, began in 2020. CCO 2.0 priority areas include work to improve the behavioral health system; increase value and pay for performance; focus on social determinants of health and health equity; and maintain sustainable cost growth.

Measure specifications and more information

- Information about the CCO quality incentive program, including specifications for the measures included in this report:
<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>
- Metrics and Scoring Committee:
<https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx>
- Medicaid Demonstration waiver: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/OHP-Waiver.aspx>
- 2022-2027 Medicaid 1115 Demonstration Application:
<https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Waiver-Renewal.aspx>
- This and other metrics reports:
<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>

Version control

August 29, 2022: Corrected transposition of Trillium North and Trillium South in tables on pages 13 and 14.

September 14, 2022: Corrected rate change for SUD Treatment: Engagement in graph on page 4.

December 6, 2022: Updated link and information for the CCO Performance Metrics Dashboard on page 2.



HEALTH POLICY AND ANALYTICS

Quality Metrics, Surveys and Evaluations (QMSE)

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