

2023 CCO Quality Incentive Program: Measure Summaries

Measure overview

Each year, coordinated care organizations (CCOs) can earn bonus funds by showing that they have improved care for members of the Oregon Health Plan (OHP). The program through which CCOs can earn these funds is called the CCO Quality Incentive Program (sometimes referred to as the Quality Pool). The program is one of our most effective tools for improving quality for members of the Oregon Health Plan.¹

Since the program began in 2013, over a billion dollars has been distributed to CCOs through the program. To earn these funds, CCOs must improve on a set of health care quality measures selected by the [Metrics & Scoring Committee](#) each year. The Metrics & Scoring Committee reviews the measure set each year and [may drop or add measures](#) to continue to improve care for members of the Oregon Health Plan.

This document provides information about each of the 2023 CCO incentive measures. Each entry answers three questions:

1. What is being measured?
2. Why is it being measured?
3. How is it being measured?

Technical specifications with details on how each measure is calculated are available [here](#).

Important considerations about data sources

Claims or equivalent encounter information. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service. [Learn more at CMS >](#)

Electronic health record (EHR): An electronic health record is a digital version of a patient's medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don't have data about people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important to consider because many people who aren't represented in these data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition,

¹
<https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>

because data we get from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

CCO Incentive Measures for 2023

in alphabetical order

Assessments for Children in DHS Custody

This measure helps us make sure kids who are entering foster care get the age-appropriate physical, mental, and dental health care they need. The Oregon Department of Human Services notifies CCOs when one of their members enters foster care. The CCO then has 60 days to make sure that child gets care.

It's important for us to measure this because timely health assessments are vital to the health and well-being of kids in foster care, according to the American Academy of Pediatrics and the Oregon Department of Human Services.²

We measure this by comparing a list of children in foster care who are enrolled in CCOs with CCO claims or equivalent encounter data to see if the children received a timely health assessment. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Child and Adolescent Well-Care Visits - Age 3-6

We measure the percentage of kids age 3-6 who have at least one well-care visit during the year. Well-care visits are important because they help providers find concerns early, when it's easier to address any possible problems.

This measure is part of a broader effort to make sure children are prepared for kindergarten, which is critical to meeting OHA's health equity goals. To measure this, we look at medical claims or equivalent encounter data for kids ages 3-6 who are enrolled in a CCO. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Childhood Immunization Status (Combo 3)

We measure the percentage of kids who are up to date on vaccines by their second birthday. We look at kids from birth to their second birthday because approximately 300 children die from vaccine-preventable illnesses in the United States each year,³ and vaccines are one of the safest, easiest, and most effective ways to protect kids from disease.⁴ Vaccines we look for include:

² See Child Welfare Policy: [OAR 413-015-0465](https://www.oar.gov/413-015-0465) and American Academy of Pediatrics - see page 22: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Ch2_PP_Primary.pdf#Page=12

³ <https://www.ncqa.org/hedis/measures/childhood-immunization-status/>

⁴ <https://www.hhs.gov/immunization/get-vaccinated/for-parents/five-reasons/index.html>

- diphtheria, tetanus and acellular pertussis (DTaP);
- polio (IPV);
- measles, mumps and rubella (MMR);
- haemophilus influenza type B (HiB);
- hepatitis B (HepB);
- chicken pox (VZV); and
- pneumococcal conjugate (PCV).

To measure this, we:

- check the state’s immunization registry ([ALERT Immunization Information System](#)) and see whether children who are two years old and enrolled in a CCO have all their vaccines, and
- look at medical claims submitted by healthcare providers. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Cigarette Smoking Prevalence

We measure the percentage of people ages 13+ who smoke cigarettes. We measure this for many reasons, including but not limited to:

- Cigarettes continue to be the most widely used tobacco product in the U.S. and Oregon.
- On average, smokers die 10 years earlier than nonsmokers.⁵
- Additionally, tobacco companies have focused their marketing to communities subject to historical and contemporary injustices, which makes cigarette smoking prevalence an important indicator of inequity.^{6,7}

We see how CCOs do on this measure using information from electronic health records (EHR). An electronic health record is a digital version of a patient’s medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don’t have data about people who see providers that use paper charts, and people who didn’t see a provider during the measurement year.

This is important because many people who aren’t represented in these data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because data we get from EHRs shows only overall totals from clinics, we can’t dig deeper into questions about communities included in those totals.

⁵ https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm

⁶ https://www.cdc.gov/tobacco/data_statistics/sgr/1998/complete_report/pdfs/complete_report.pdf

⁷ <https://www.trinketsandtrash.org/>.

Though the data for this measure come from clinic EHRs, effective smoking cessation and prevention strategies is not limited to clinical intervention but includes CCO advocacy for and implementation of community interventions, although these strategies are not measured by this metric. See more about [Evidence-Based Strategies for Reducing Tobacco Use: A Guide for CCOs](#).

Depression Screening and Follow Up Plan

This measure looks at the percentage of people age 12+ who received a depression screening and, if needed, a plan to address their needs. This measure encourages providers to ask their patients about depression, which is important because depression can have serious and lasting impacts on a person's health.

We see how CCOs do on this measure using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. EHRs can provide helpful information to measure quality, but they also have some drawbacks. When we use data from EHRs, we don't have data about people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

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Diabetes: HbA1c Poor Control

This measure looks at the percentage of people ages 18-75 who have diabetes and who also have high blood sugar. Diabetes is a leading cause of death and disability in the United States, so it's important to make sure we help people manage their blood sugar.

We measure whether someone's blood sugar is over healthy levels through a test called the HbA1c. If someone's HbA1c result is higher than 9%, they're at higher risk for complications like nerve damage. The fewer people who have a high result, the better. Because it's so important to make sure providers are monitoring the blood sugar of patients with diabetes, if there is not an HbA1c test record for a patient, that person will be counted in the metric as having high blood sugar.

We measure this using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. Because we use data from EHRs, this means we don't have data about some people, including people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in this data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because the data we get from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency

This measure was created specifically to incentivize health equity by ensuring people who communicate in languages other than English or are hard of hearing are provided with certified and qualified health care interpretation services.

People who communicate in languages other than English or are hard of hearing:

- Face barriers accessing health services,⁸
- Receive lower quality care relative to patients whose preferred language is English,⁹ and
- Are at higher risk for medical errors.¹⁰

Qualified and certified health care interpreters are vital to combating the disparate impact of COVID-19 on communities subjected to historical and contemporary injustices.

We measure this in two ways:

1. CCOs must complete a self-assessment of the language services they provide. CCOs verify whether they meet minimum requirements and provide higher quality and more robust language services over time.
2. CCOs report whether people who've said they want interpreter services get them from a qualified or certified interpreter for each visit to health care.

Immunization for Adolescents (Combo 2)

We measure the percentage of children who are up to date on their vaccines by their 13th birthday. These vaccines include meningococcal, tetanus, diphtheria toxoids and acellular pertussis (Tdap), and human papillomavirus (HPV).

We measure this because immunizations are one of the safest, easiest, and most effective ways to protect youth from potentially serious and sometimes fatal diseases, including cancer, breathing and heart problems, seizures, and nerve damage.¹¹ For example, HPV causes more than 45,000 cases of cancer each year,¹² and more than 90% of these

⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690153/>

⁹ <https://pubmed.ncbi.nlm.nih.gov/19179539/>

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5111827/>

¹¹ <https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/>

¹² <https://www.cdc.gov/cancer/hpv/statistics/index.htm>

cancers are easily preventable with vaccination,¹³ but a person needs to get vaccinated *before* they get the virus.

To measure this, we look at the number of thirteen-year-olds who are enrolled in a CCO and see whether they are fully vaccinated using information from the state’s immunization registry, [ALERT Immunization Information System](#) and medical claims or equivalent encounter data submitted by healthcare providers. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Initiation and Engagement of Substance Use Disorder Treatment – Initiation & Engagement - Total - Adult age 18+

We measure the percentage of adults who are newly diagnosed with substance use disorder and look at whether they enter and continue in treatment. We measure this because less than 20% of people who have substance use disorder get treatment.¹⁴ Treatment is important because it can improve health and well-being, as well as reduce healthcare spending in the long run.

We measure this by looking at medical claims or equivalent encounter data for adult CCO members who are newly diagnosed with substance use disorder to see whether they:

1. began treatment within 14 days and
2. continued treatment for at least another 34 days.

A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service. We look at “new episodes” rather than individual OHP members, which means a person could experience more than one substance use disorder episode in a year and be counted in the metric more than once.

Oral Evaluation for Adults with Diabetes

This measure looks at the percentage of adults with diabetes who received a comprehensive oral health evaluation during the measurement year. People with diabetes have higher rates of periodontal disease,¹⁵ and annual check-ups can help providers catch and treat disease early, resulting in better health outcomes.¹⁶ In addition, poor oral health can make a person’s diabetes more difficult to manage.¹⁷

Measuring oral health care in adults with diabetes is important to our equity goals because we know that that people subjected to historical and contemporary injustices are more likely

¹³ <https://www.cdc.gov/hpv/hcp/protecting-patients.html>

¹⁴ <https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment/>

¹⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3228943/>

¹⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3645457/>

¹⁷ <https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/diabetes/art-20043848>

to be affected by diabetes. For example, non-Hispanic Black people are twice as likely as non-Hispanic white people to die from diabetes.¹⁸

To measure this, we look at CCO members who have diabetes and use dental claims or equivalent encounter data to see if they have had an oral health assessment during the measurement year. A claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Preventive Dental or Oral Service Utilization - Ages 1 to 5 and Ages 6-14

This measure looks at the percentage of kids who received preventive dental or oral health care during the measurement year. We focus on oral health because untreated oral health problems can lead to problems eating, speaking, playing, and learning.¹⁹

The measure is broken into two parts:

1. Ages 1-5 because this is a crucial age in kindergarten readiness, which is important to meeting our health equity goals.
2. Ages 6-14 because we know that poor oral health is one of the leading causes of absences from school.²⁰

We measure this by looking at medical and dental claims or equivalent encounter data to see if kids received preventive dental or oral health care. A claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

Screening & Brief Intervention

We measure the percentage of people ages 12+ who are screened for unhealthy drug and alcohol use and the percentage who receive a brief intervention if they report unhealthy drug or alcohol use. This measure is important because early intervention helps address unhealthy substance use before it becomes a substance use disorder.

We measure this using information from electronic health records (EHRs). An electronic health record is a digital version of a patient's medical history that is kept by clinicians. Because we use data from EHRs, this means we can't capture data about some people, including people who see providers that use paper charts, and people who didn't see a provider during the measurement year.

This is important because many people who aren't represented in this data are more likely to experience health disparities as the result of structural racism, which means the measure may not reflect people who need this care the most. In addition, because the data we get

¹⁸ <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18>

¹⁹ <https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=Untreated%20cavities%20can%20cause%20pain,least%20one%20untreated%20decay ed%20tooth>

²⁰ <https://www.attendanceworks.org/bringing-dental-care-to-schools/>

from EHRs shows only overall totals from clinics, we can't dig deeper into questions about communities included in those totals.

Social Determinants of Health (SDOH)

Ensuring people have access to stable housing, good food, and reliable transportation are key components health and mental well-being. This measure promotes housing, transportation and food need screenings for all CCO members. If a member has one or more needs, the measure encourages CCOs and their providers to give the member a referral to have those needs met.

The measure requires CCOs to create policies with CCO members in a collaborative, trauma informed way. Screenings should not cause harm to members. Screenings can cause harm if needs are never identified and never addressed. Screenings also can cause harm if needs are identified one or more times and never addressed.

We measure progress in two ways:

1. CCOs must complete a self-assessment of the screenings and referrals they provide in partnership with community-based organizations for each need: housing, food, and transportation. CCOs verify whether the CCO meets the measure's minimum requirements in creating a system that supports the screening and referral process.
2. In future years, CCOs will begin reporting on the percent of members screened, percent who have a housing, food and/or transportation need, and percent with a need who receive a referral.

System-Level Social-Emotional Health Metric (kindergarten readiness measure)

This measure holds CCOs accountable to providing supports designed to improve the social emotional health of children from birth to age 5. OHA measures this to help ensure young kids get equitable access to services that support their social-emotional health and are the best match for their needs.

This measure is part of a broader effort to make sure children are prepared for kindergarten, which is critical to meeting our health equity goals. In focus groups of Oregon families, parents reported that the social-emotional health of their children is critical to preparing them for kindergarten.²¹

To achieve the measure, CCOs must:

- Attest that they have
 - Reviewed OHA-provided data on social-emotional health assessments and services;
 - Created an asset map of existing social-emotional health services and resources;

²¹ https://childinst.org/wp-content/uploads/2018/08/KRFG_Summary_Report_with_Cover_Letter_5_2_18.pdf

- Led cross-sector community engagement; and
- Created an action plan to improve social-emotional health service capacity and access.
- And send OHA a copy of the following
 - Asset map and
 - Action plan

Timeliness of Prenatal and Postpartum Care: Postpartum Care Rate

We measure the percentage of people who have given birth who receive post-partum care between one and 12 weeks following the birth. The weeks following birth are critical for long-term health and well-being for the birthing parent and child alike.²² Post-partum care helps birthing parents address complications, like pain and incontinence, as well social-emotional health needs.

This measure supports OHA's health equity goals because high-quality postpartum care is also important for addressing the inequitable maternal health outcomes for people of color. For example, American Indian and Alaska Native (AI/AN) and Black women are 2-3 times more likely to die from pregnancy-related causes than white women.²³

To measure this, we look at CCO members who've given birth in the last year and use medical claims and chart review to see if they had at least one postpartum visit in the one to 12 weeks following the birth. A medical claim is a request for payment that a healthcare provider submits to a CCO or OHA when a member receives a healthcare service.

²² <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>

²³ <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>