

Oregon Health System Transformation

CCO Metrics 2018 Final Report

 July 2019

Executive summary	6
Background/context	10
Incentive measure performance overview	12
Quality pool distribution	13
CCO service areas and enrollment	16
Appendix A: CCO incentive metrics	
About benchmarks and improvement targets	18
Access to care: Adults (CAHPS)	19
Access to care: Children (CAHPS)	21
Adolescent well-care visits	23
Ambulatory care: Emergency department utilization	25
Assessments for children in DHS custody	27
Childhood immunization status	29
Cigarette smoking prevalence	31
Colorectal cancer screening	33
Controlling high blood pressure	35
Dental sealants on permanent molars for children (all ages)	37
Dental sealants on permanent molars for children (ages 6-9)	39
Dental sealants on permanent molars for children (ages 10-14)	41

Depression screening and follow-up plan	43
Developmental screening in the first 36 months of life	45
Diabetes care: HbA1c poor control	47
Disparity measure: Emergency department utilization among members with mental illness *NEW*	49
Effective contraceptive use among women at risk of unintended pregnancy (ages 15-50)	51
Effective contraceptive use among women at risk of unintended pregnancy (adolescents ages 15-17)	53
Effective contraceptive use among women at risk of unintended pregnancy (adults ages 18-50)	55
Patient-centered primary care home enrollment	57
Prenatal and postpartum care: Timeliness of prenatal care	59
Weight assessment, nutrition, and activity counseling for children and adolescents *NEW*	61
Appendix B: State Quality and CMS CORE metrics	
All-cause readmissions	64
Ambulatory care: Avoidable emergency department utilization	66
Ambulatory care: Outpatient utilization	68
Any dental service *NEW*	70
CAHPS: Access to dental care (adults) *NEW*	72
CAHPS: Access to dental care (children) *NEW*	74
CAHPS: Getting needed care (adults) *NEW*	76
CAHPS: Getting needed care (children) *NEW*	78

TABLE OF CONTENTS

CAHPS: Health status (adults)	80
CAHPS: Health status (children)	82
CAHPS: How well doctors communicate (adults) *NEW*	84
CAHPS: How well doctors communicate (children) *NEW*	86
CAHPS: Medical assistance with smoking and tobacco use cessation: Advised to quit	88
CAHPS: Medical assistance with smoking and tobacco use cessation: Medications to quit	90
CAHPS: Medical assistance with smoking and tobacco use cessation: Strategies to quit	92
CAHPS: Overall ratings (adults) *NEW*	94
CAHPS: Overall ratings (children) *NEW*	96
CAHPS: Satisfaction with care (customer service composite) (adults)	98
CAHPS: Satisfaction with care (customer service composite) (children)	100
Child and adolescent access to primary care providers	102
Chlamydia screening	104
Comprehensive diabetes care: HbA1c testing	106
Follow-up after emergency department visit for mental illness (7 day) *NEW*	108
Follow-up after emergency department visit for mental illness (30 day) *NEW*	110
Follow-up after emergency department visit for non-traumatic dental reasons (7 day) *NEW*	112
Follow-up after emergency department visit for non-traumatic dental reasons (30 day) *NEW*	114
Follow-up after hospitalization for mental illness	116

TABLE OF CONTENTS

Follow-up care for children prescribed ADHD medication (initiation phase)	118
Follow-up care for children prescribed ADHD medication (continuation and maintenance)	120
Immunizations for adolescents: Combo 1	122
Immunizations for adolescents: Combo 2 *NEW*	124
Initiation and engagement of alcohol or other drug treatment (initiation phase)	126
Initiation and engagement of alcohol or other drug treatment (engagement phase)	128
PQI 01: Diabetes short-term complication admission rate	130
PQI 05: Chronic obstructive pulmonary disease or asthma in older adults admission rate	132
PQI 08: Congestive heart failure admission rate	134
PQI 15: Asthma in younger adults admission rate	136
Prenatal and postpartum care: postpartum care rate	138
Topical fluoride varnish *NEW*	140
Well-child visits in the first 15 months of life	142

EXECUTIVE SUMMARY

This report lays out the progress of Oregon’s coordinated care organizations (CCOs) on quality measures in 2018. Measuring quality and access to care are key to moving health system transformation forward to ensure high-quality care for Oregon Health Plan members. Measuring quality and holding CCOs accountable to key metrics is a cornerstone of Oregon’s health system transformation. According to the Center for Health Care Effectiveness at Oregon Health and Sciences University, CCO incentive measures are among the most important tools for health care system transformation and quality improvement in Medicaid service delivery ([Demonstration Waiver Summative Report, 2017](#)).

In 2018, 12 of 15 CCOs earned 100 percent of their quality pool dollars. The amount a CCO can earn through the program is based on a percentage of their capitated payments each year. In 2018, the quality pool was 4.25 percent of monthly payments, resulting in more than \$188 million. This pay-for-performance model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon’s vision for better health, better care, and lower costs.

As CCOs made large strides on existing measures in the first few years of the program, sustained quality improvement efforts are required to achieve the aspirational benchmarks, which are often based on the most exceptional national performance. The results in this report demonstrate that as the quality pool model continues, the targets and benchmarks become even harder to meet or exceed. This ensures that CCOs continue to focus on metrics and strive toward improvement and better health outcomes for members.

Highlighting the role that the health sector can play in preparing children for kindergarten and educational success, the 2018 incentive program provided additional focus on early childhood health through its challenge pool. The Metrics & Scoring Committee would like to include measure(s) of kindergarten readiness in a future CCO incentive measure set. While there is not currently such a measure, the Committee chose to have the 2018 challenge pool focus on measures with an impact on early childhood health: Assessments for children in DHS custody; Childhood immunization status; Developmental screening; and Timeliness of prenatal care. This strategy aligns with the vision of the new CCO contracts, to begin in 2020, which include a focus on the social factors of health.

Report Highlights

This report shows CCO performance across three categories of measures: CCO incentive metrics; state quality metrics; and CMS core metrics. Across these measures, this report shows that the coordinated care model has resulted in improvements in multiple areas, including:

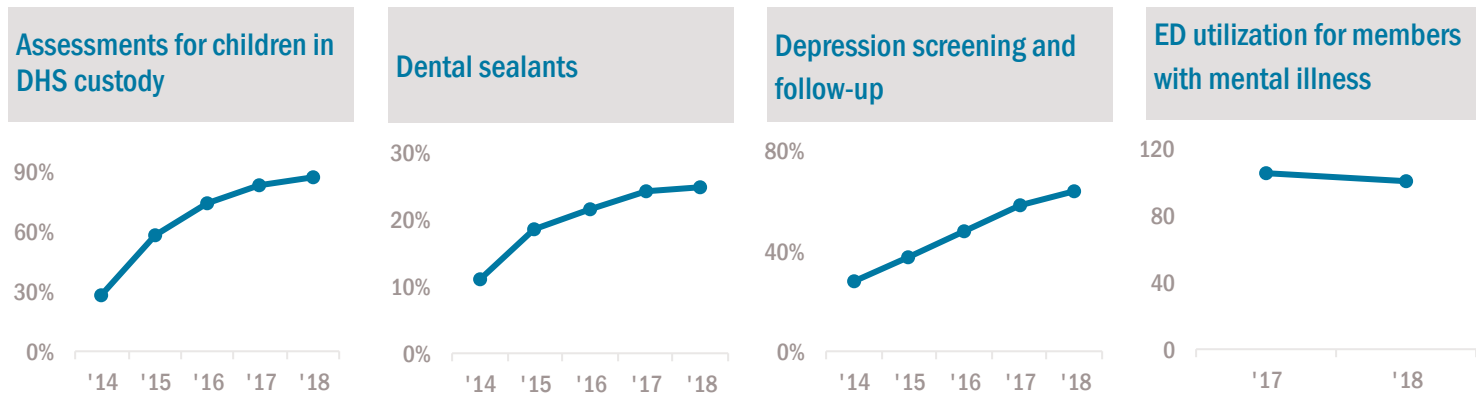
Assessments for children in DHS custody. The percentage of children in foster care who received mental, physical, and dental health assessments continues to increase. CCO performance on this measure has improved by over 200% since the measure was first incentivized, increasing from 27.9% in 2014 to 86.8% in 2018.

EXECUTIVE SUMMARY

Dental sealants for children ages 6-14. CCOs continued to increase the number of children receiving dental sealants. Since this measure was first incentivized, the proportion of children receiving a sealant improved from 18.5% in 2015 to 24.8% in 2018, a 34% increase. This change is particularly important given national data showing that in 2016 Oregon was among the bottom quintile of states in terms of children on Medicaid accessing dental care.

Emergency department utilization for members with mental illness. This is the first year of the incentive measure on Emergency department utilization among members with mental illness. This measure is meant to incentivize CCOs to better coordinate care for members with mental illness, thereby reducing physical health disparities for this population. While emergency department utilization decreased for *all members* from 2017 to 2018, the decline was greater for members with mental illness. In an average month in 2017, there were 46.7 visits per 1,000 CCO members, decreasing to 46.4 in 2018. Among members *with mental illness*, in an average month in 2017 there were 106.3 visits to the emergency department per 1,000 CCO members with mental illness; this declined to 100.3 in 2018.

Depression screening and follow-up. CCOs continue to make large strides on this measure, with all CCOs achieving the measure in 2018. Statewide, over 64% of members ages 12+ were screened for depression in 2018, and as appropriate, a follow-up plan was created. CCO performance on this measure has more than doubled since it was first incentivized, increasing from 27.9% in 2014 to 64.0% in 2018.



EXECUTIVE SUMMARY

Measures to watch: The following measures exhibit interesting or concerning results in 2018. While in most instances it is too soon to discern a trend, future performance on these measures should be monitored.

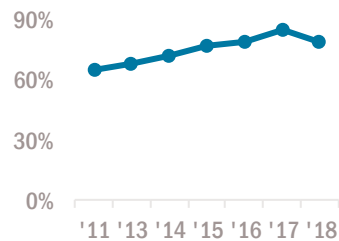
Follow-up after hospitalization for mental illness. This is a former incentive measure that was last incentivized in 2017. After retirement, performance on this measure declined by 6.1% (from 84.7% in 2017 to 79.5% in 2018). This measure should be monitored to determine if this decrease reflects a real decline in care, or if other factors account for this change.

Diabetes management. While statewide performance on the incentive measure Diabetes care: HbA1c poor control remained stable from 2017 (23.6%) to 2018 (23.4%), performance slipped among 9 of the 15 CCOs over this time period. In addition, statewide performance on the non-incentivized prevention quality indicators related to diabetes (diabetes short-term complication admission rate and diabetes short-term complications) waned in this time period.

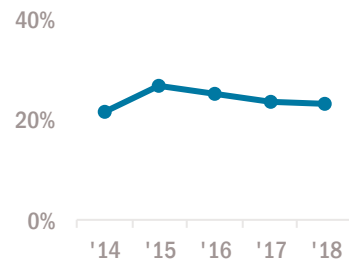
Reproductive health. Statewide performance on Effective Contraceptive Use increased steadily from 2015 (35.4%) to 2018 (46.8%); however, performance declined among 8 of the 15 CCOs in 2018. Performance on the Timeliness of prenatal care incentive measure increased slightly from 90.6% in 2017 to 92.6% in 2018. While this measure is an incentive measure for 2018, in 2019 it is no longer pay-for-performance. However, it is a state quality measure which OHA will continue to monitor and report.

Initiation and engagement of alcohol or other drug treatment. After declining from 2014 to 2016, the percentage of members newly diagnosed with alcohol or other drug dependencies who *initiated* treatment within 14 days increased in the following three years (34.4% in 2016; 36.5% in 2017; and, 37.8% in 2018). However, while performance at the statewide level improved, performance from 2017 to 2018 declined among eight of the 15 CCOs. Likewise, after a precipitous fall from 2013 - 2016 (from 18.9% to 11.1%), the percentage of members who *continued* their treatment improved from 2017 to 2018 (11.3% to 13.1%). However, this still represents a 39% decrease in statewide performance since 2013, and performance among seven of the 15 CCOs declined from 2017 to 2018.

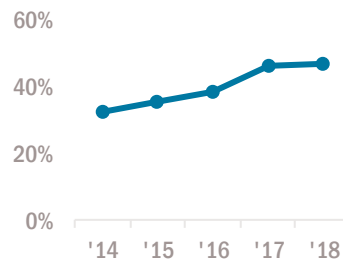
Follow-up after hosp. for mental illness



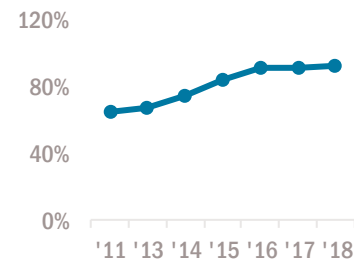
Diabetes care: HbA1c poor control



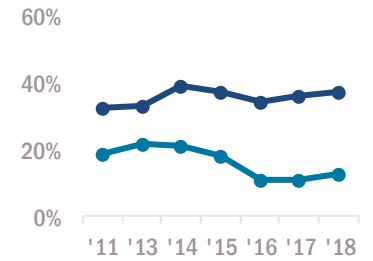
Effective contraceptive use



Timeliness of prenatal care



Initiation and engagement of alcohol or drug treatment



EXECUTIVE SUMMARY

New in this report: In the 2018 Deeper Dive Report, OHA considered geography as a way of analyzing locations of key populations. Similarly, in this report we have added information about metric performance broken out by geographic regions of the state. Geographic differences might indicate that performance differences are due to environmental, social, or other factors.

The table to the right shows how CCO performance is mapped to regional performance. Regional performance is weighted based on the denominator of each CCO for a particular measure.

In addition, there are many new quality measures that have never been reported here before: Fifteen new State Quality measures reported under Oregon’s 1115 demonstration waiver, which was renewed in 2017; and two new CCO incentive measures. New measures are highlighted in the table of contents and marked with an orange star icon throughout the report.

A note about reporting race and ethnicity data: In last year’s annual report, categories of race and ethnicity were shared with high rates of missing data (approximately 40% of all members had either missing or unspecified race ethnicity categories.) Health equity is a very important focus for OHA, and accurate data is paramount to this effort. In this report, OHA elected to report race and ethnicity data for CAHPS measures only. Race and ethnicity for CAHPS measures is self-reported by members and is much more complete than enrollment-based data. OHA continues to work to improve our collection and reporting of race and ethnicity data with the intention of providing data for more measures in future reports.

Oregon is a leader in the nation in transforming our health care system to create better access and better care at a lower cost for all Oregonians. We have long had a national reputation for innovative health system solutions and the reforms that we have made in recent years continue to show Oregon’s innovation and leadership. The CCO pay-for-performance model is a hallmark of Oregon’s health transformation and a key component of our commitment to transparency and accountability. By measuring Oregon’s progress and identifying both success and challenges, the state can identify how we can continue to push for greater health transformation and ways to create better health outcomes for Oregon Health Plan members.

Region	CCOs
Northern Coast	Columbia Pacific
Tri-County	Health Share of Oregon
Willamette Valley	Intercommunity Health Network Trillium Willamette Valley Community Health Yamhill Community Care
Southern OR	Advanced Health AllCare CCO Jackson Care Connect PrimaryHealth of Josephine County Umpqua Health Alliance
Central OR	Cascade Health Alliance PacificSource Central PacificSource Gorge
Eastern OR	Eastern Oregon CCO

BACKGROUND / CONTEXT

Medicaid waiver

Medicaid (health coverage for people earning less than 138 percent of the federal level, and people with disabilities) is administered by individual states but must follow certain federal requirements. States may obtain an 1115 Medicaid Demonstration waiver from the federal government, which grants them extra flexibility in how they use federal Medicaid funds in their state, with the goal of improving health care programs. Oregon has had such a waiver since 1994. The 1115 Medicaid 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. So what does coordinated care mean?

Coordinated care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers) who have agreed to work together in 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. In 2018, there were 15 CCOs operating in communities around Oregon.

CCOs have the flexibility to support new models of care that are patient-centered, team-focused, and reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP medical benefits with the goal of meeting the triple aim of better health, better care and lower costs for the population they serve. Before Oregon's CCOs were formed, physical, behavioral and other care were not integrated, making things more difficult for patients and providers and more expensive for the state.

Medicaid expansion

Beginning in 2014 many more Oregonians were able to join the Oregon Health Plan because of the Affordable Care Act, which increased the income eligibility limit. The number of people covered by CCOs increased by 63 percent, from about 614,000 in 2013 to almost 1 million in 2014.

Measuring progress

The measures in this report are an important piece of the coordinated care model. They increase transparency and help us know how well CCOs are improving the quality of care. The measures fall into three categories (see next page).

BACKGROUND / CONTEXT



State quality metrics

OHA has agreed to measure and report these measures to the Centers for Medicare & Medicaid Services (CMS) as part of the 1115 Medicaid waiver.



CMS core metrics

The Centers for Medicare and Medicaid Services (CMS), together with commercial plans, managed care plans, physicians, consumers, and others have identified core quality measures to help promote alignment and harmonization of measure use and collection across payers in both the public and private sectors.



CCO incentive metrics

CCOs receive payment based on their performance on incentive metrics, which are selected by the Metrics and Scoring Committee. This is part of Oregon's commitment to pay for better quality care and health outcomes. For more information on the committee, visit <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

Note that there is often crossover between the measure sets; a metric can fall into more than one category. To help readers identify which metrics belong in which measure set, each metric is accompanied by the icons shown.



Additionally, measures that are brand new to this report are also accompanied by an orange star icon.

Measure specifications and more information

- Information about the CCO 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/Background.aspx>
- This and other metrics reports: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>

2018 INCENTIVE METRIC PERFORMANCE OVERVIEW

	Advanced Health	AllCare	Cascade	Columbia Pac.	Eastern Oregon	Health Share	IHN	Jackson	PacSource Central	PacSource Gorge	PrimaryHealth	Trillium	Umpqua	WVCH	Yamhill
<ul style="list-style-type: none"> ■ CCO achieved BENCHMARK in 2018 ■ CCO achieved IMPROVEMENT TARGET in 2018 * Top performing CCO in each measure Bolded CCOs earned 100% quality pool ^ indicates challenge pool measure															
Access to care (CAHPS)	■				■						*				
Adolescent well-care visits	■		■		■	■			■	■				■	*
Ambulatory care - ED utilization		■			■	■	■	■		■	*		■	■	
Assessments for children in DHS custody ^	■	■	■	■		■		■		*	■	■	■	■	■
Childhood immunization status ^	■		*			■				■		■		■	■
Cigarette smoking prevalence (EHR)	■	■	■	■	*	■	■	■	■	■	■	■	■	■	■
Colorectal cancer screening	*	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Controlling high blood pressure (EHR)	■	■	■	■		■	■	■						*	■
Dental sealants for children	■	■	■		■	■	■	■	■	■	■		*	■	■
Depression screening and follow up (EHR)	■	■	■	■	■	■	■	■	*	■	■	■	■	■	■
Developmental screening ^	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■
Diabetes HbA1c poor control (EHR)		■		■	■			■		■	*	■			
Disparity measure: ED utilization for members w mental illness		■	■		■	■	■	■		■	*	■	■	■	■
Effective contraceptive use (ages 15-50)	*	■	■		■	■			■	■		■	*		■
Prenatal and postpartum care: Prenatal care ^	■	■	■	■	■	■		■	■	■	■	■	■	■	*
Patient-Centered Primary Care Home (PCPCH) enrollment	■	■	■	■	■	■	■	■	■	■	*	■	■	■	■
Weight assmt., nutrition, and activity counseling for kids (EHR)	*	■	■	■	■	■	■	■	■	■	■	■	■	■	■

2018 QUALITY POOL DISTRIBUTION

The Oregon Health Authority has established the quality pool—Oregon's incentive payments to coordinated care organizations. Each CCO is being paid for reaching benchmarks or making improvements on incentive measures. This is the fifth time Oregon has paid CCOs for better care, rather than just the volume of services delivered.

The 2018 quality pool is more than \$188 million. This represents 4.25 percent of the total amount all CCOs were paid in 2018. The quality pool is divided among all CCOs based on their number of members ([see page 16](#) for CCO enrollment numbers) and their performance on the 17 incentive metrics.

Quality Pool: Phase One Distribution

CCOs can earn 100 percent of their quality pool in the first phase of distribution by meeting or exceeding:

- The benchmark or improvement target on 12 of 16 measures; and
- The .60 threshold score on the PCPCH enrollment measure, which uses a weighted methodology to ensure members are not just enrolled in a PCPCH, but are enrolled in the higher PCPCH tiers.

CCOs must meet both of these conditions to earn 100 percent of their quality pool.

In 2018 FamilyCare CCO closed and its members were reassigned to other nearby CCOs, primarily Health Share of Oregon. How this impacts the bonus pool: The Metrics and Scoring Committee, together with OHA and CCOs, reviewed several methods for dealing with the large and unplanned influx of members into CCOs. Several methodologies were presented to the Metrics and Scoring Committee in July 2018. The Committee decided that the measures would not be rebased to account for the new members; instead, CCOs whose membership increased 25% or more should “hold performance steady” from the prior year, meaning they would be required to meet prior year improvement targets.

The month of January 2018 was a transition month. FamilyCare bonus pool dollars accrued in January 2018 followed members into their new CCOs. If members had services under Family Care CCO in January 2018 but left Medicaid coverage entirely, the unaffiliated member’s funds were placed into the Challenge Pool.

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The 2018 challenge pool is just under \$11 million. Challenge pool funds are distributed to CCOs according to their performance on each of the four challenge pool measures:

1. Assessments for children in DHS custody
2. Childhood immunization status (combo 2)
3. Developmental screenings in the first 36 months of life
4. Timeliness of prenatal care

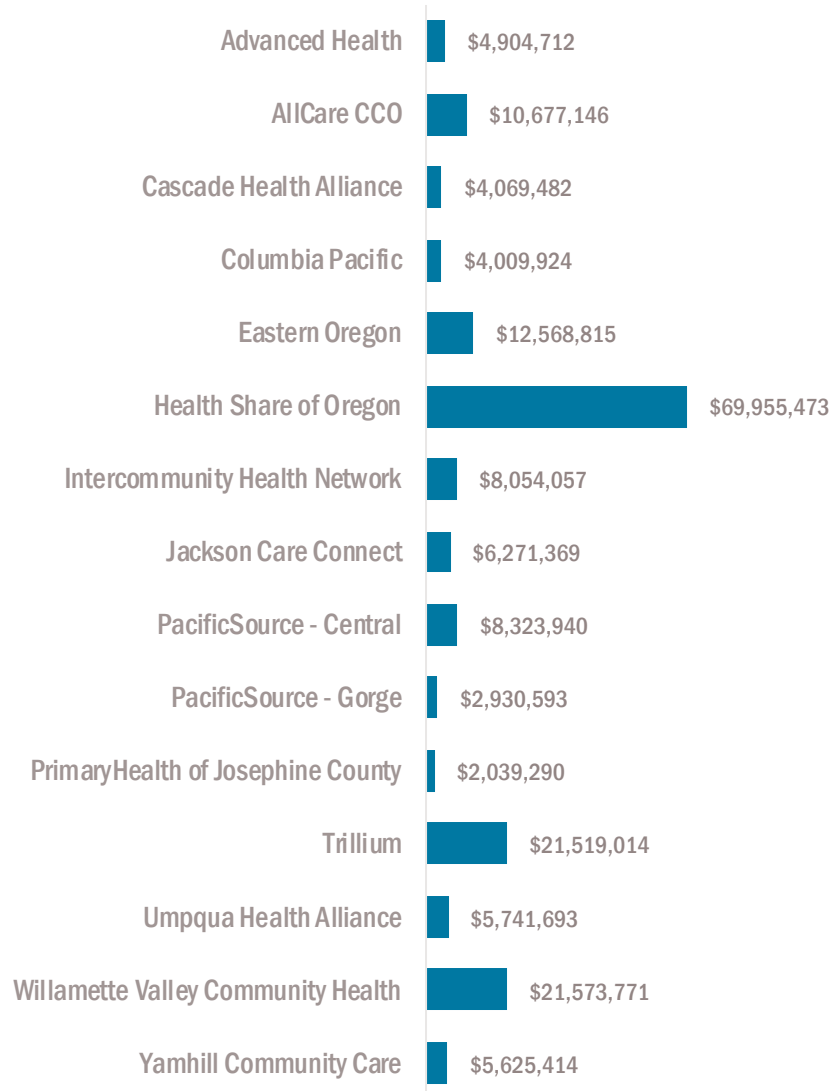
2018 QUALITY POOL DISTRIBUTION

CCO	Phase 1 Distribution			Challenge Pool		Total	
	# Measures met (of 17 possible)	Payment earned in Phase 1*	% Quality pool funds earned	# Challenge measures met	\$ Challenge pool earned	Total payment (Phase 1 + Challenge pool + MCO tax)	Total % quality pool earned
Advanced Health	14	\$ 4,550,457	100%	4	\$ 280,684	\$ 4,904,712	106.1%
AllCare Health Plan	14	\$ 9,944,618	100%	3	\$ 572,370	\$ 10,677,146	105.7%
Cascade Health Alliance	14	\$ 3,760,644	100%	4	\$ 247,796	\$ 4,069,482	106.6%
Columbia Pacific	10	\$ 3,672,158	60%	3	\$ 277,617	\$ 4,009,924	64.5%
Eastern Oregon	14	\$ 12,002,400	100%	2	\$ 377,883	\$ 12,568,815	103.1%
Health Share of Oregon	15	\$ 64,511,211	100%	4	\$ 4,394,929	\$ 69,955,473	106.8%
Intercommunity Health Network	10	\$ 7,724,349	60%	1	\$ 208,897	\$ 8,054,057	61.6%
Jackson Care Connect	13	\$ 5,824,153	100%	3	\$ 353,145	\$ 6,271,369	106.0%
PacificSource – Central Oregon	11	\$ 7,630,948	70%	3	\$ 568,132	\$ 8,323,940	75.2%
PacificSource – Gorge	15	\$ 2,712,920	100%	4	\$ 173,714	\$ 2,930,593	106.4%
PrimaryHealth of Josephine County	14	\$ 1,894,422	100%	3	\$ 114,278	\$ 2,039,290	106.0%
Trillium	14	\$ 19,936,807	100%	4	\$ 1,259,421	\$ 21,519,014	106.3%
Umpqua Health Alliance	13	\$ 5,343,796	100%	3	\$ 311,771	\$ 5,741,693	105.8%
Willamette Valley Community Health	14	\$ 19,810,422	100%	4	\$ 1,439,743	\$ 21,573,771	107.2%
Yamhill Community Care	13	\$ 5,202,039	100%	4	\$ 338,994	\$ 5,625,414	106.5%
Total		\$ 174,521,345			\$ 10,919,376	\$ 188,264,693	

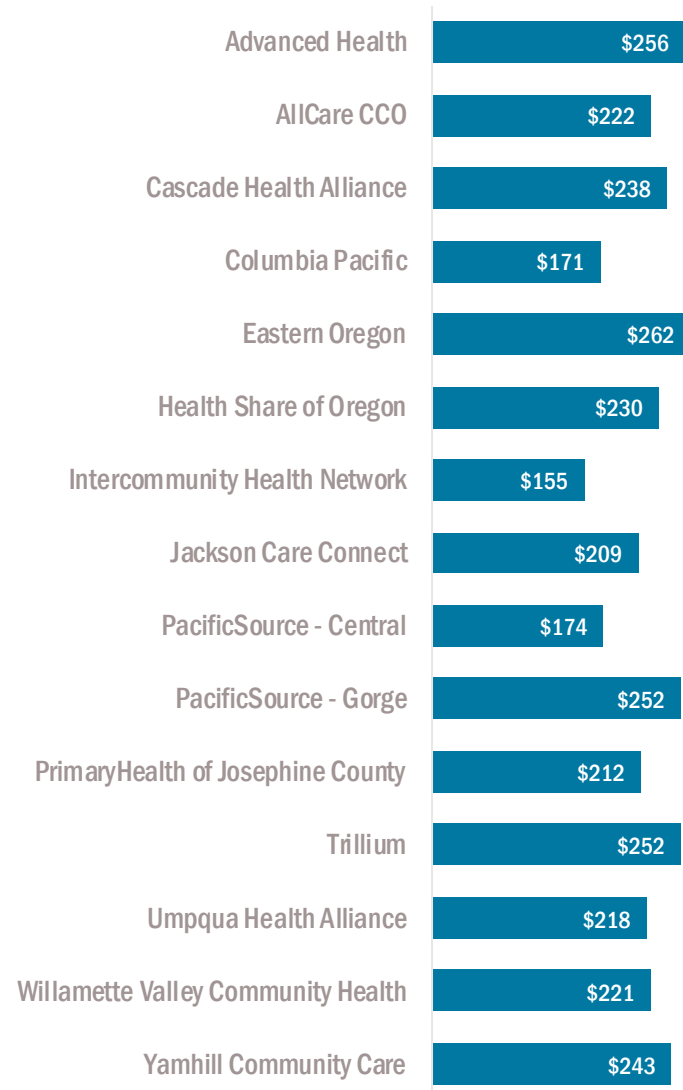
* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 16 for CCO enrollment.

2018 QUALITY POOL DISTRIBUTION

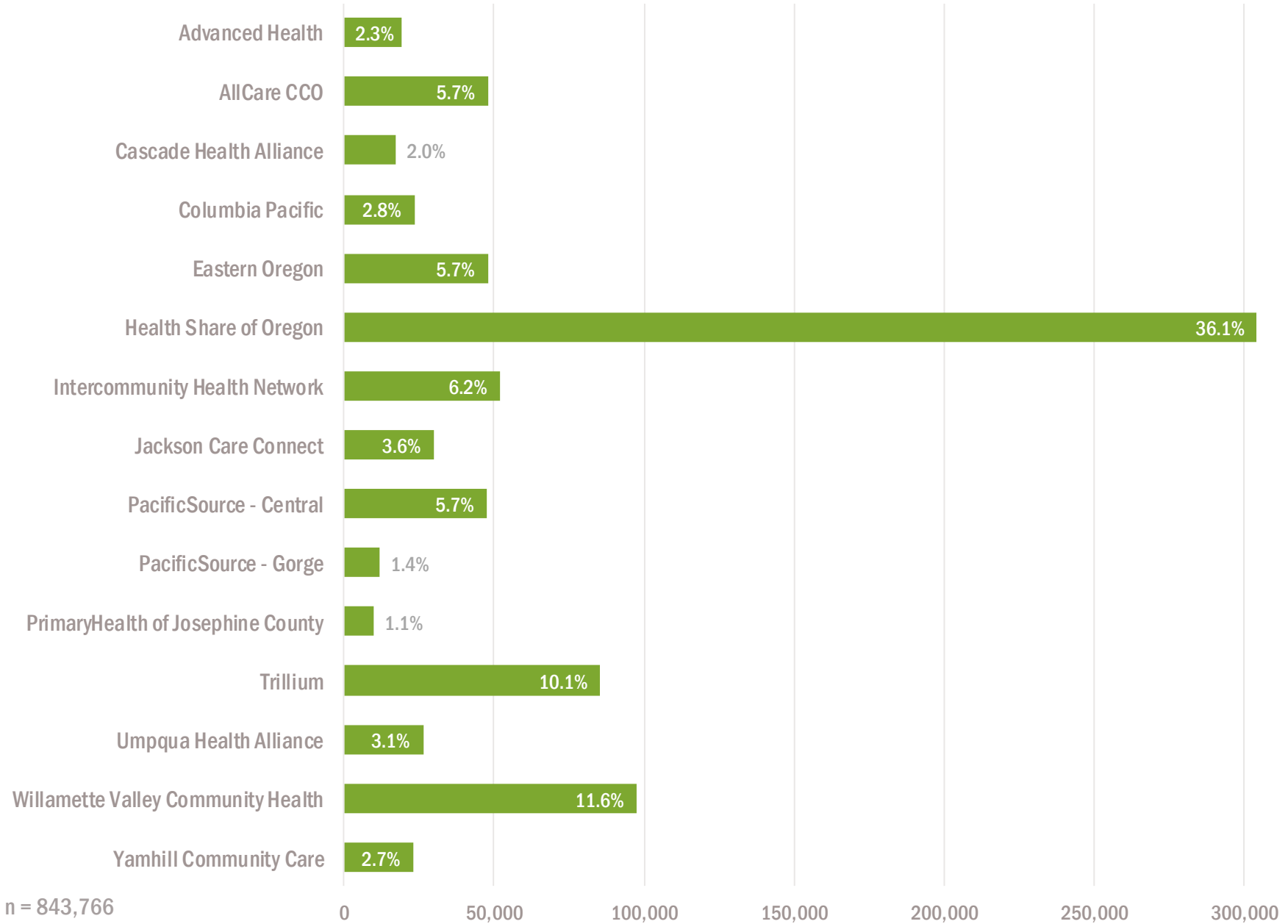
Total quality pool dollars earned, by CCO.



**Quality pool earned per member.
(December 2018 enrollment)**



TOTAL CCO ENROLLMENT (December 2018)



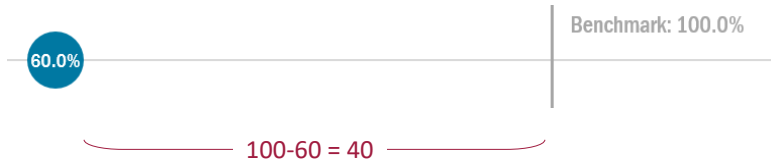
Appendix A

CCO Incentive Measures

ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. That is, CCOs are not expected to meet the benchmark each year, but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) achieving the benchmark or b) achieving their individual *improvement target*. Improvement targets are based on the Minnesota Department of Health Quality Incentive Payment System (“Minnesota method”), which requires at least a 10 percent reduction in the gap between baseline and the benchmark to qualify for incentive payments.

Suppose CCO A’s performance in **2017** (i.e. baseline) on Measure 1 was 60.0%



The gap between baseline and the benchmark is $[100-60] = 40\%$

Ten percent of 40 % = 4%. Thus, **CCO A must improve by 4 percentage points in 2018**. Their **improvement target** is $[baseline + 4\%] = [60\% + 4\%] = 64\%$

CCO A’s performance in **2018** is 65%; they **achieved their improvement target and will receive quality pool payment** on Measure 1.



Stated as a formula:
$$\frac{[\text{Benchmark}] - [\text{CCO baseline}]}{10} = X \longrightarrow [\text{CCO baseline}] + [X] = \text{Improvement target}$$

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 statistically significant change. Using the example above, suppose the benchmark was only *75 percent*. In this case, CCO A’s improvement target using the formula would be:

$$\frac{75\% - 60\%}{10} = 1.5\% \longrightarrow 60\% + 1.5\% = \mathbf{61.5\%}$$

Where the Minnesota method results in small improvement targets like this, the Committee 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 A’s improvement target with the 3% floor applied would be: $[baseline + floor] = [60\% + 3\%] = 63\%$.

On the following measure pages, CCO results are arranged in order of greatest percentage improvement to lowest percentage improvement.



ACCESS TO CARE (CAHPS SURVEY) - ADULTS

Access to care (CAHPS) - Adults

Percentage of adult members who thought they received appointments and care when they needed them.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

2017 national Medicaid 75th percentile

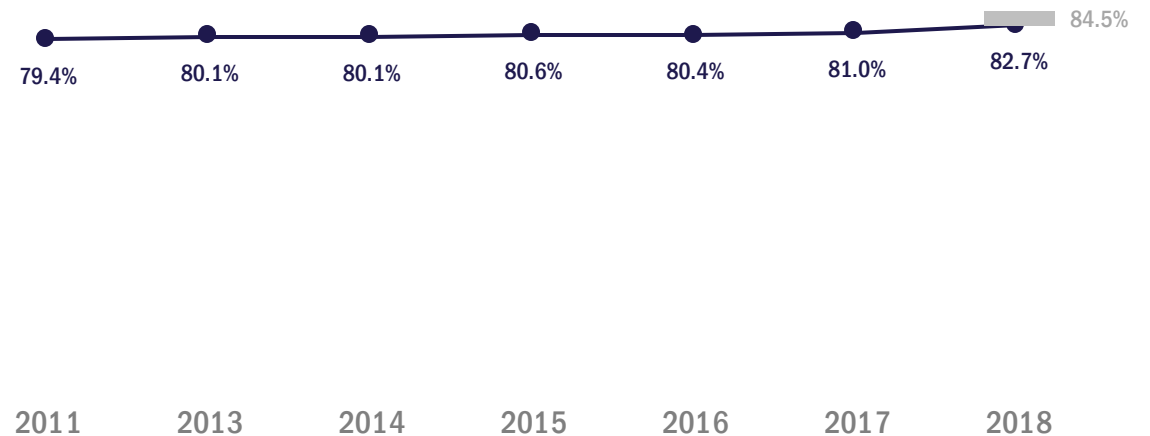
2018 data (N=2,244)

- Statewide change since 2017: **+2.1%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **7**

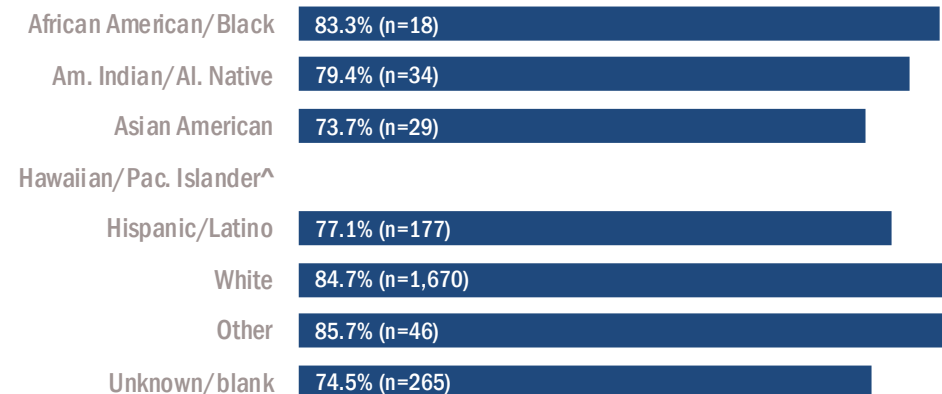
CCOs must achieve benchmark or improvement target for both adults *and* children to receive credit for this metric.

[Back to table of contents.](#)

Statewide



By race/ethnicity



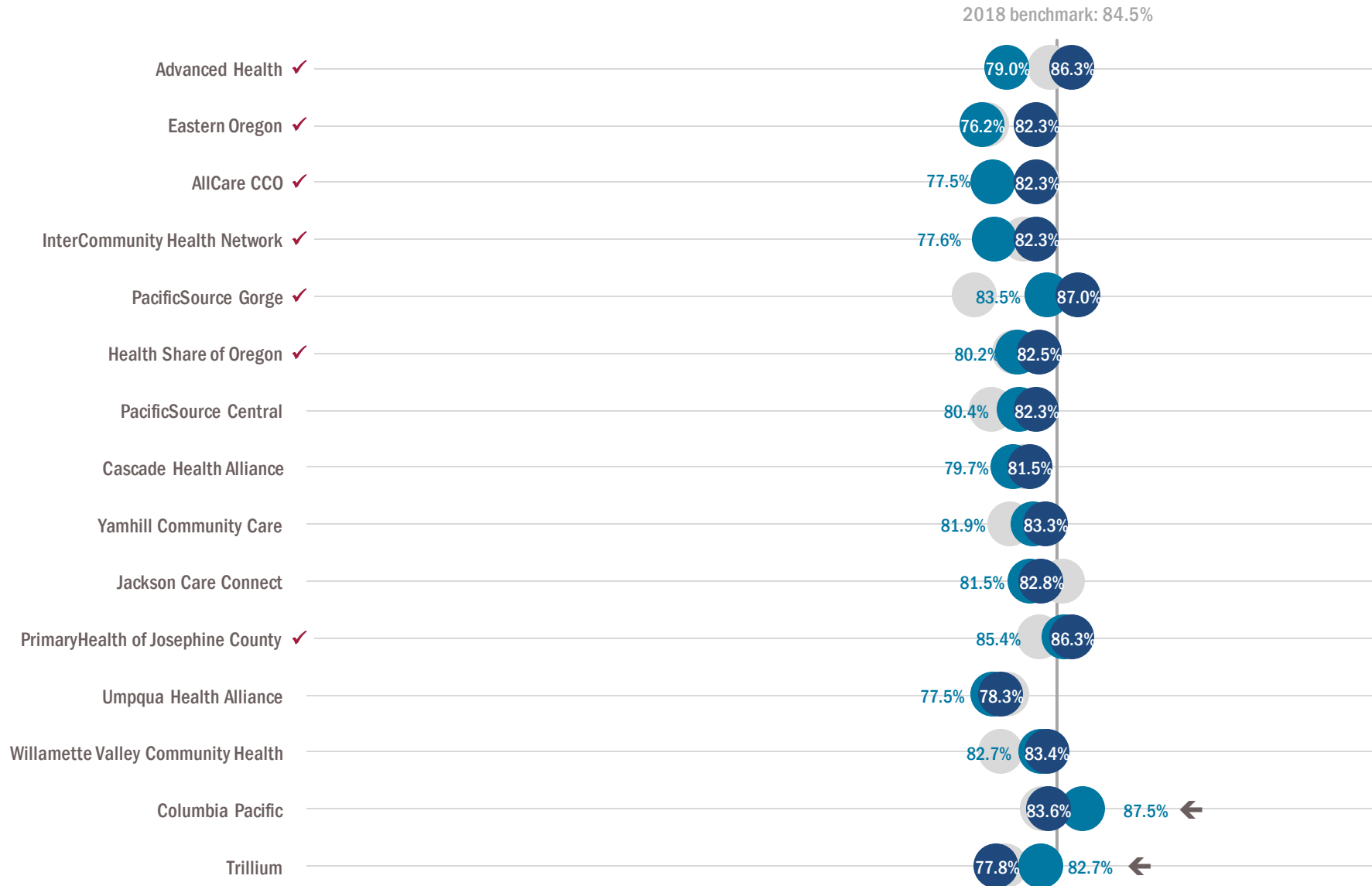
^ data suppressed (n<10)
 n = subpopulation denominator
 Each race category excludes Hispanic/Latino



ACCESS TO CARE (CAHPS SURVEY) - ADULTS

Access to care among adults in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





ACCESS TO CARE (CAHPS SURVEY) - CHILDREN

Access to care (CAHPS) - Children

Percentage of child members whose parents answered that their children received appointments and care when they needed them.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

2017 national Medicaid 75th percentile

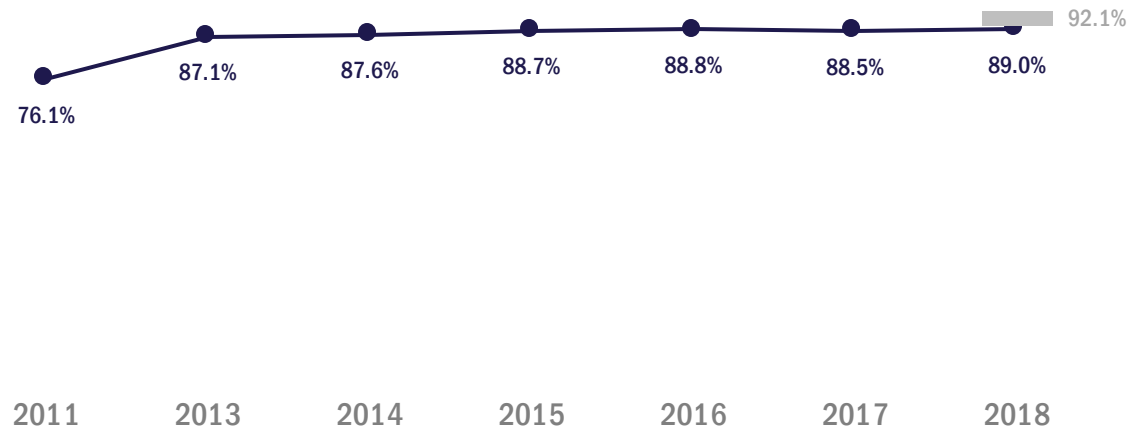
2018 data (N=2,522)

- Statewide change since 2017: **+0.6%**
- Number of CCOs that improved: **9**
- Number of CCOs achieving target: **5**

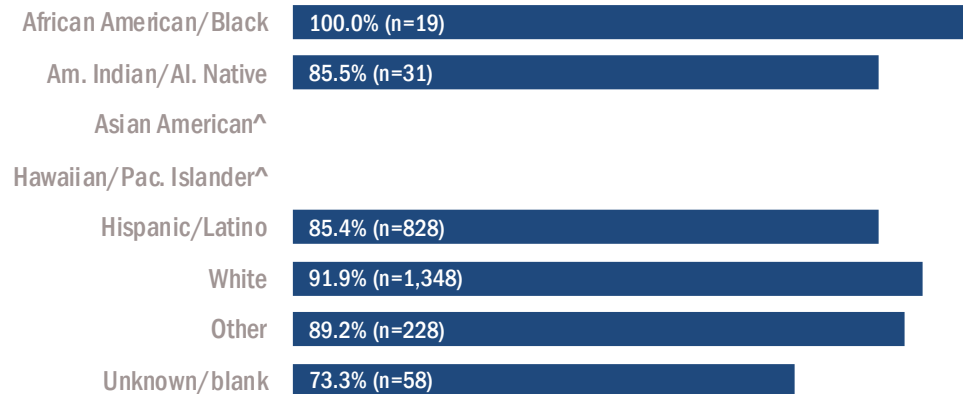
CCOs must achieve benchmark or improvement target for both adults *and* children to receive credit for this metric.

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

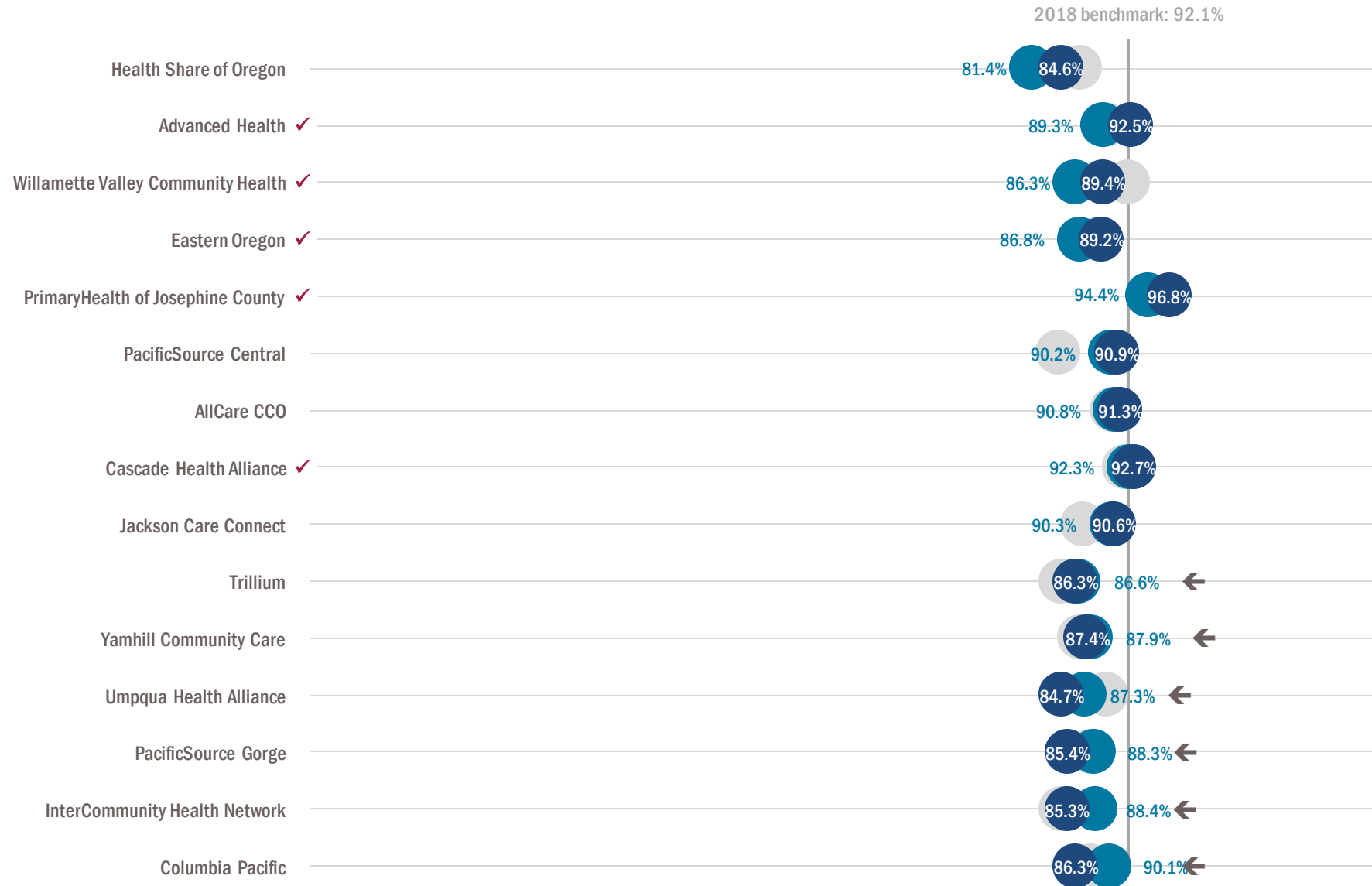
Each race category excludes Hispanic/Latino



ACCESS TO CARE (CAHPS SURVEY) - CHILDREN

Access to care among children in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

Percentage of adolescents and young adults (ages 12-21) who has at least one well-care visit during the measurement year.

Data source:

Administrative (billing) claims

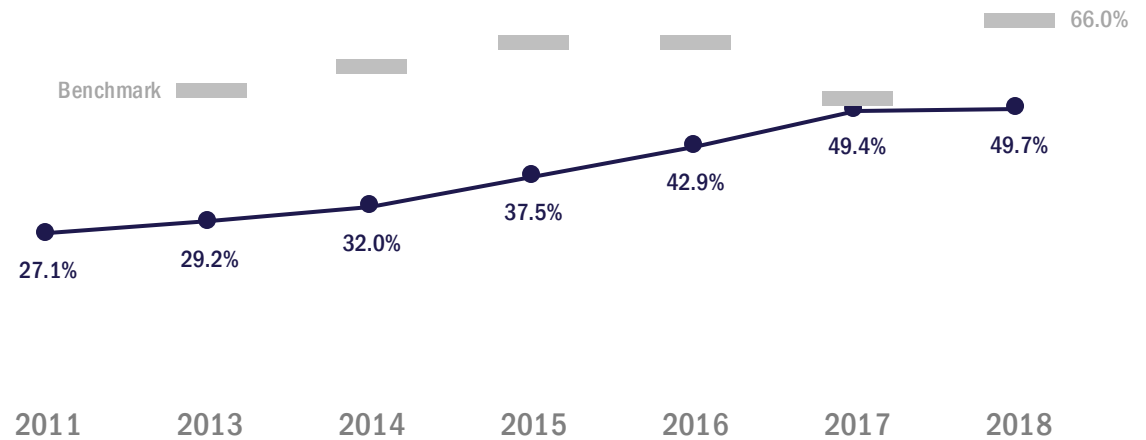
2018 benchmark source:

2017 national Medicaid 75th percentile

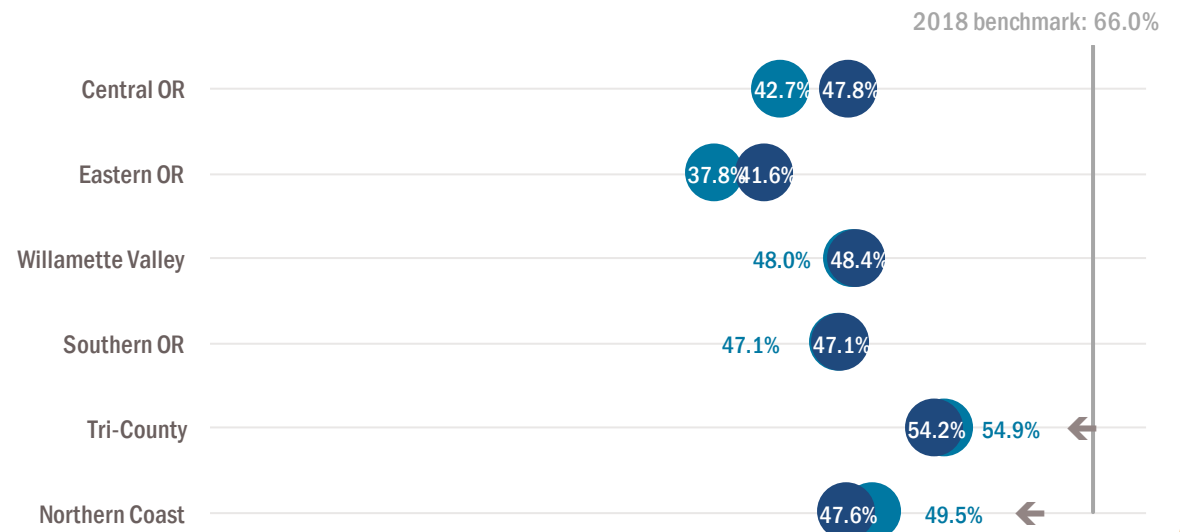
2018 data (N=119,852)

- Statewide change since 2017: **+1.6%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **7**

Statewide



By region



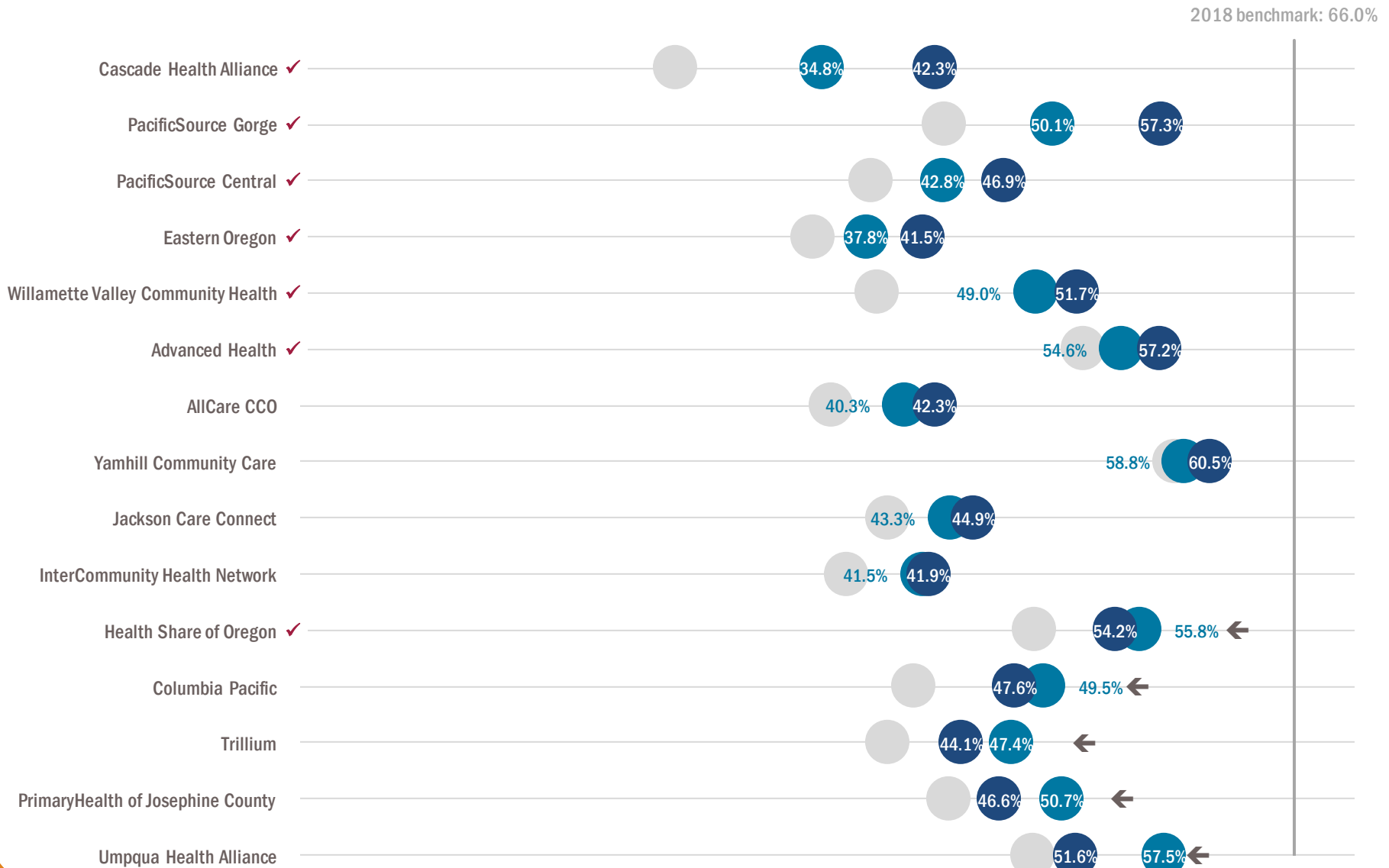
[Back to table of contents.](#)



ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.



AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization

Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of care.

Data source:

Administrative (billing) claims

2018 benchmark source:

2017 national Medicaid 90th percentile

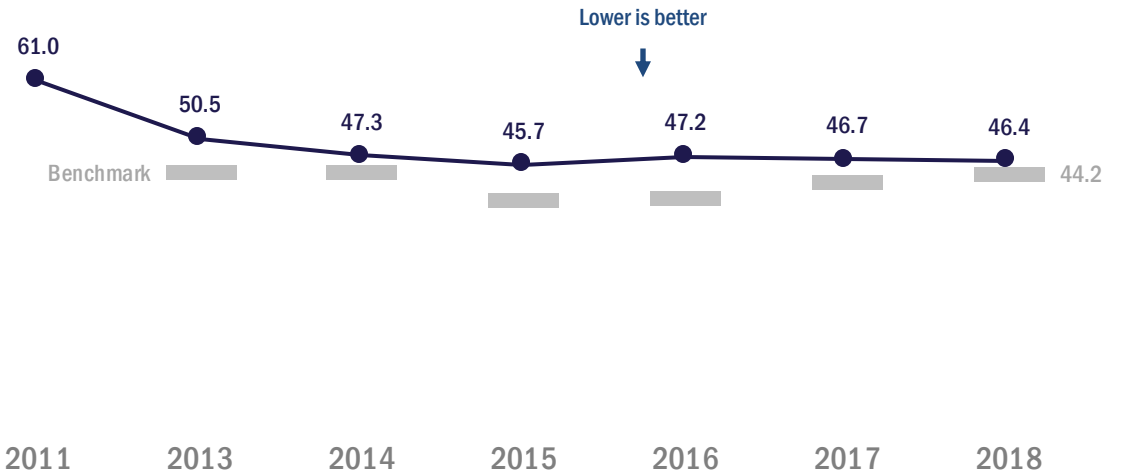
2018 data (N=9,989,010 member months)

- Statewide change since 2017: **-1.9%**
- Number of CCOs that improved: **8**
- Number of CCOs achieving target: **8**

Rates are shown per 1,000 member months, which means that in one month, there are on average X visits occurring per 1,000 CCO members.

[Back to table of contents.](#)

Statewide



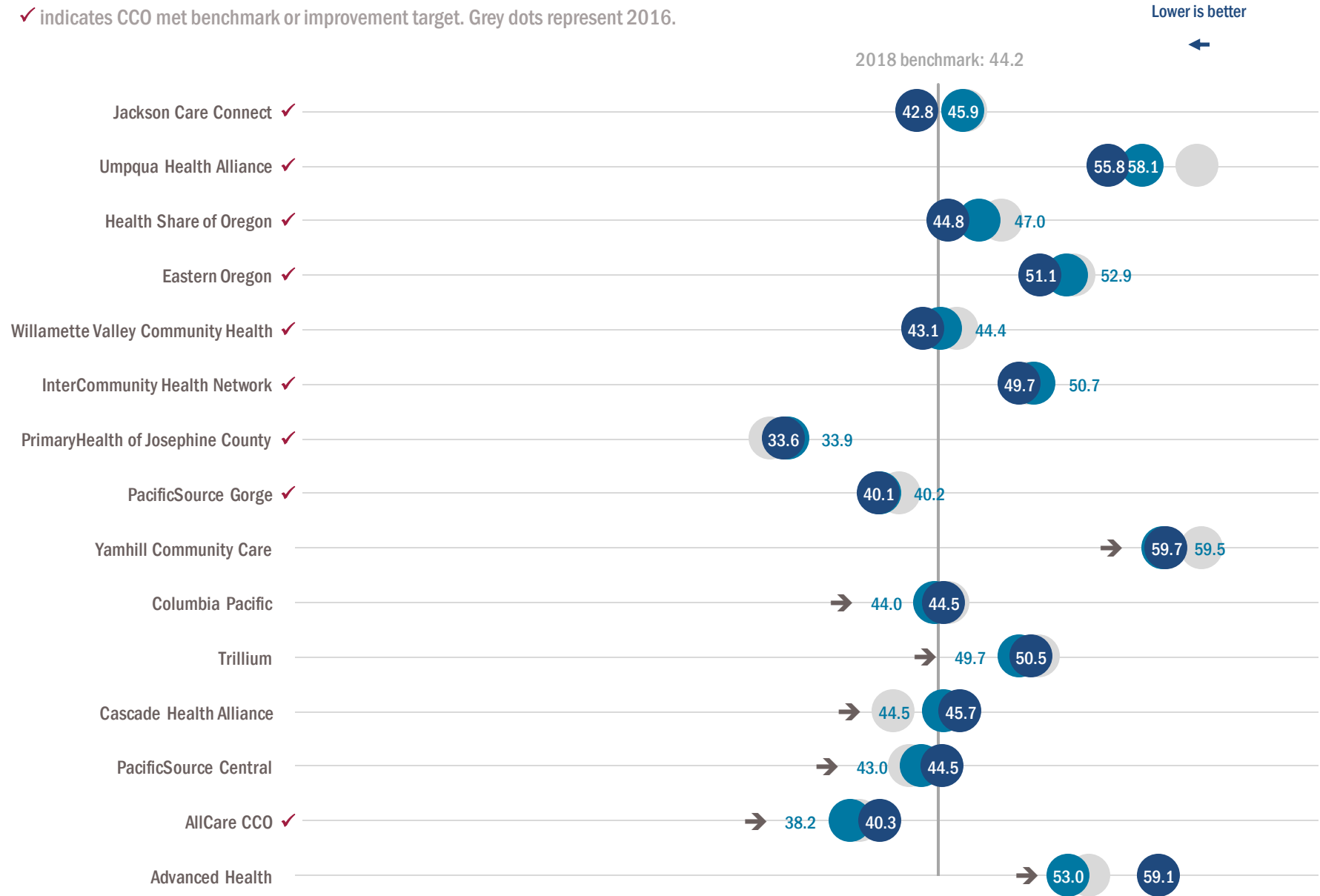
By region



\$ **↗** **⚙️** **AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION**

Emergency department utilization in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

Data source:

Administrative (billing) claims + ORKids (state system for tracking and managing children in foster care)

2018 benchmark source:

Committee consensus

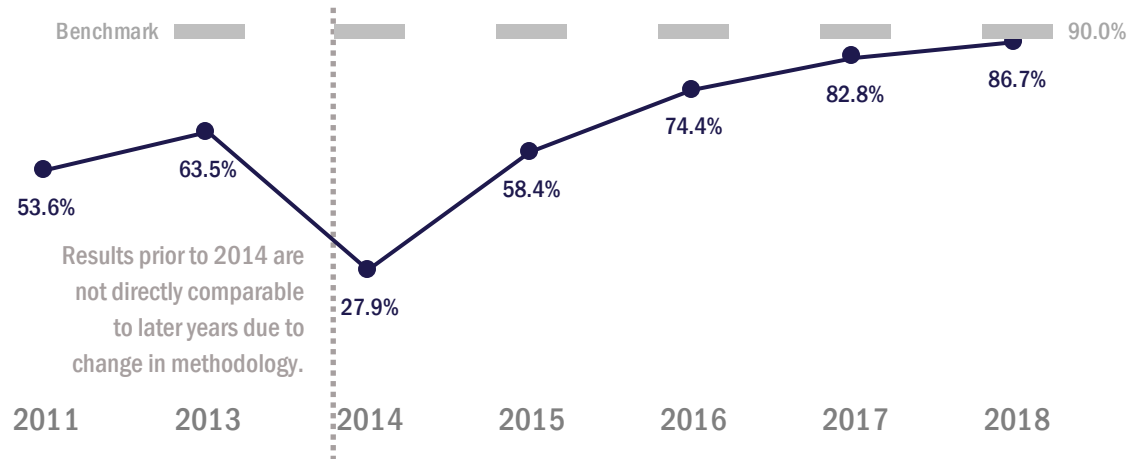
2018 data (N=1,892)

- Statewide change since 2017: **+4.3%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **13**

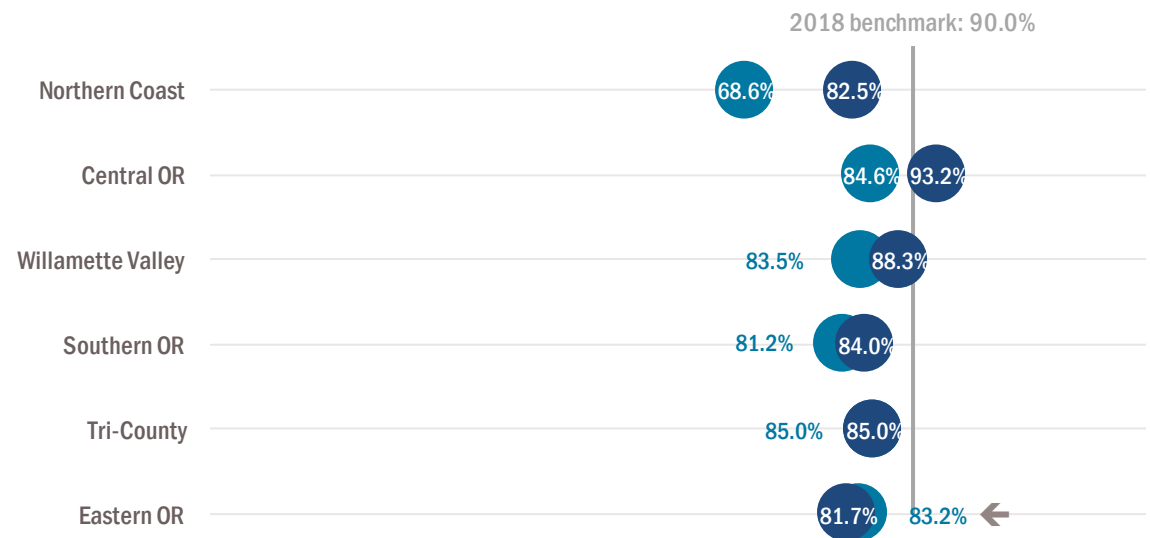
Results prior to 2014 are not comparable to later years due to change in methodology.

[Back to table of contents.](#)

Statewide



By region





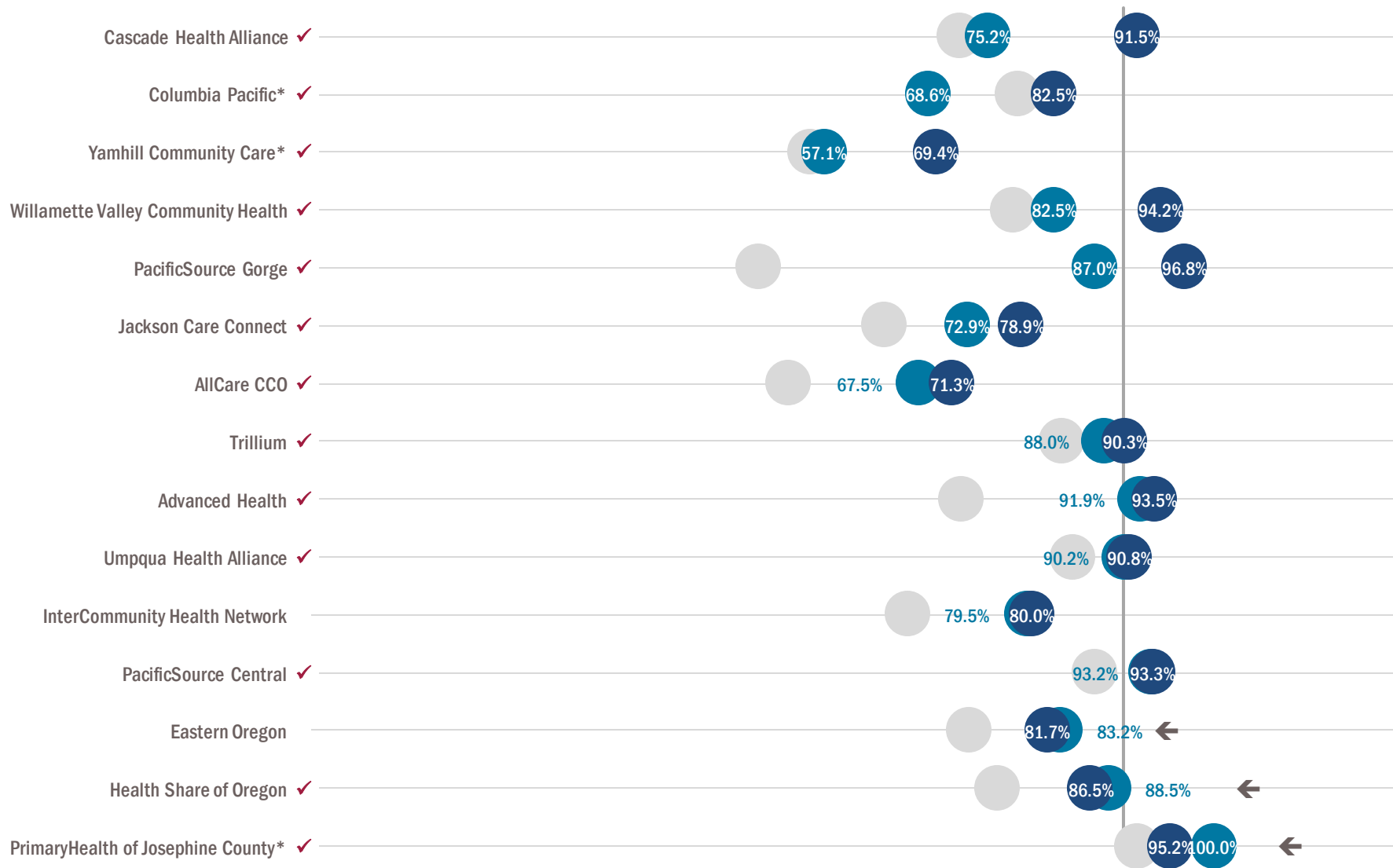
ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.

* note small denominator (n<30)

2018 benchmark: 90.0%





CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

Data source:

Administrative (billing) claims and ALERT immunization data

2018 benchmark source:

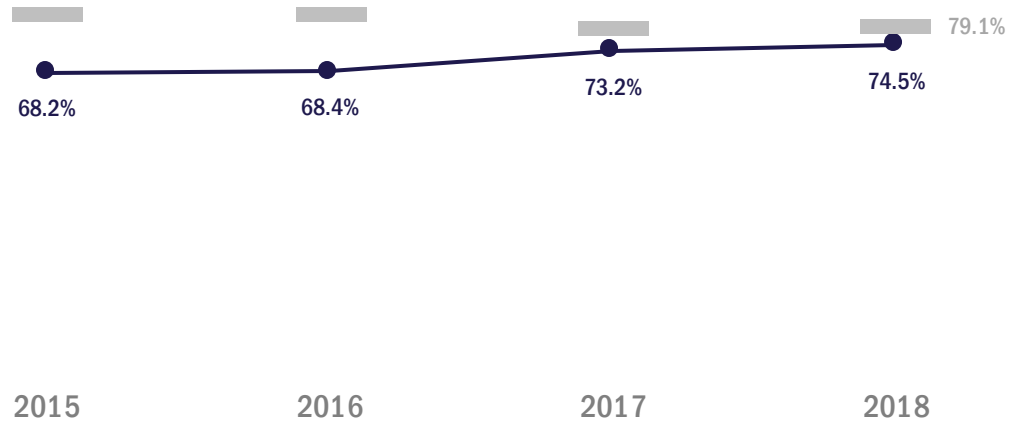
2017 national Medicaid 75th percentile

2018 data (N=12,155)

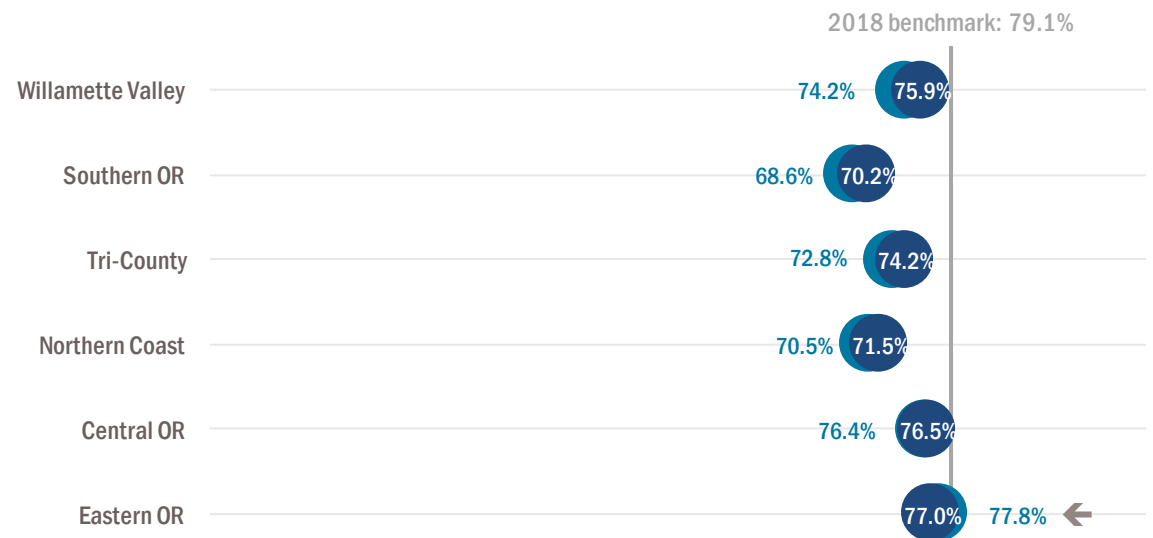
- Statewide change since 2017: **+1.8%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **7**

[Back to table of contents.](#)

Statewide



By region

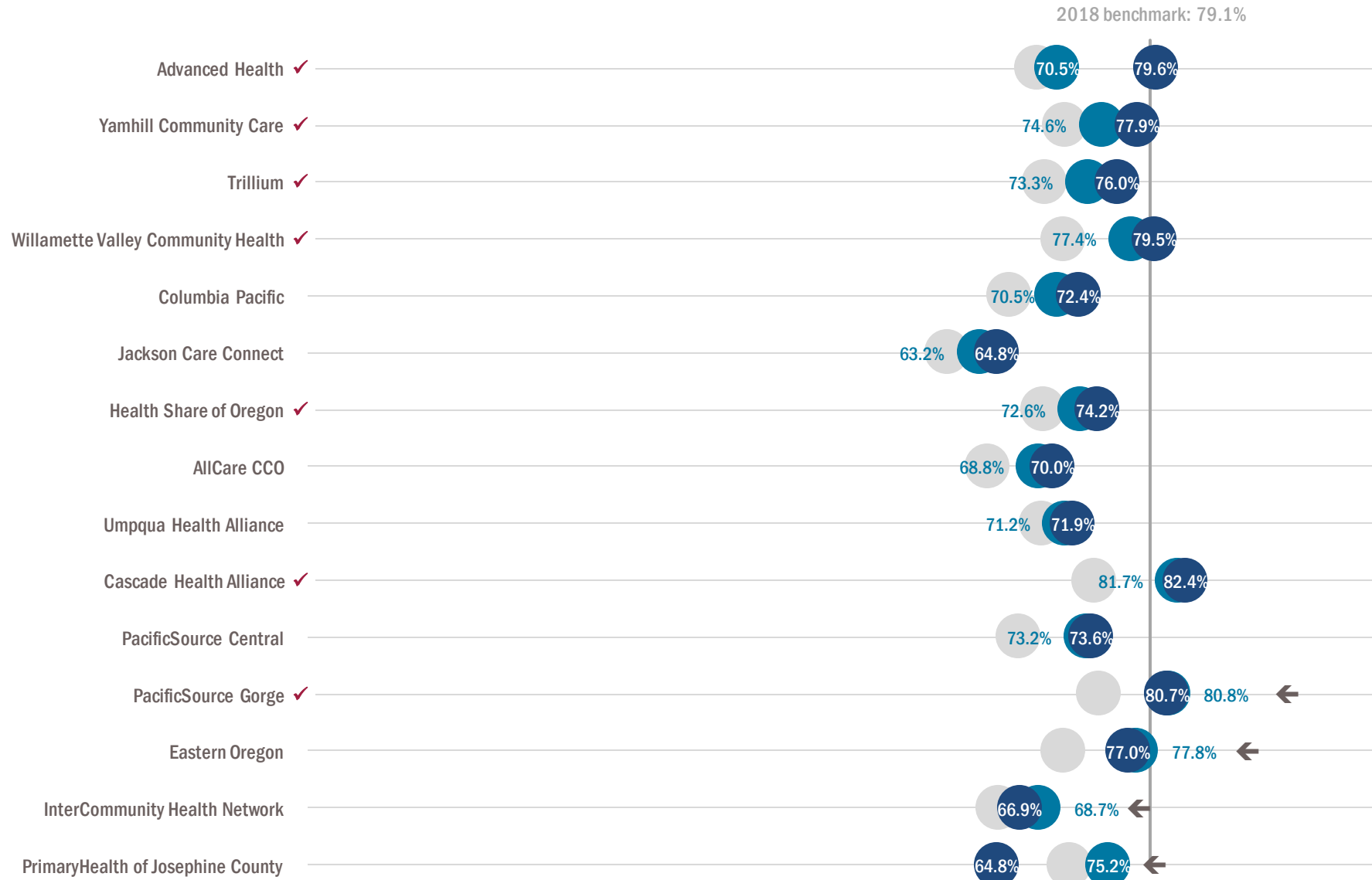




CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





CIGARETTE SMOKING PREVALENCE

Cigarette smoking prevalence

Cigarette smoking prevalence is a bundled measure intended to address both cessation benefits offered by CCOs and cigarette smoking prevalence. For 2018, all CCOs met the cessation benefit requirement portion of the measure. The data on this page reflect cigarette smoking prevalence.

Data source:

Electronic Health Records

2018 benchmark source:

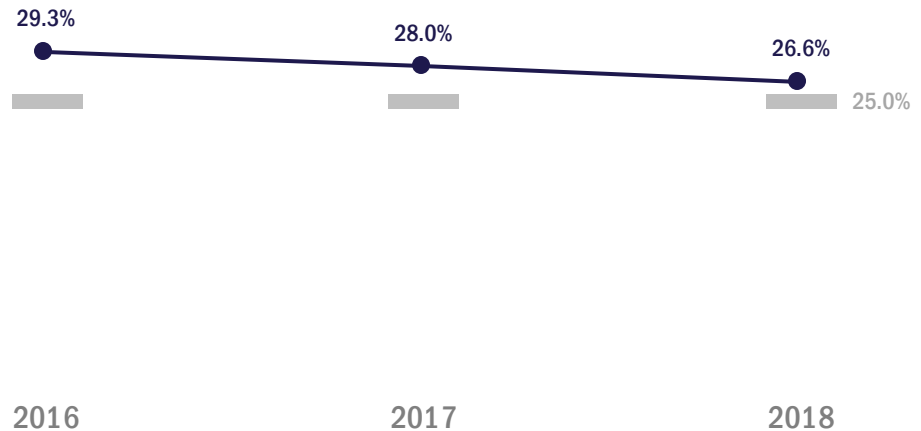
Committee consensus

2018 data (N=254,111)

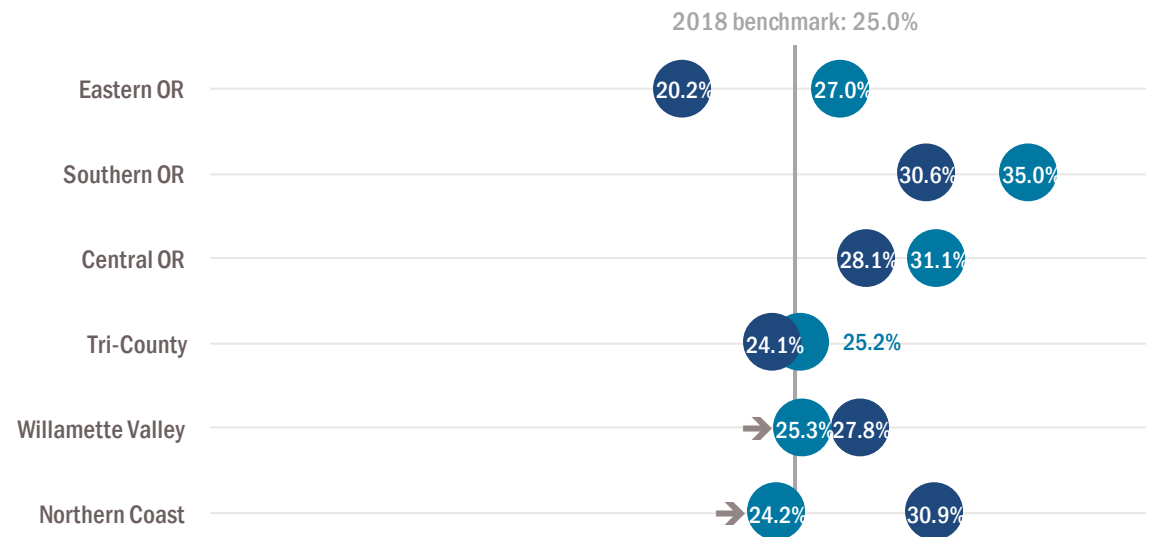
- Statewide change since 2017: **-5.1%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **15**

[Back to table of contents.](#)

Statewide



By region

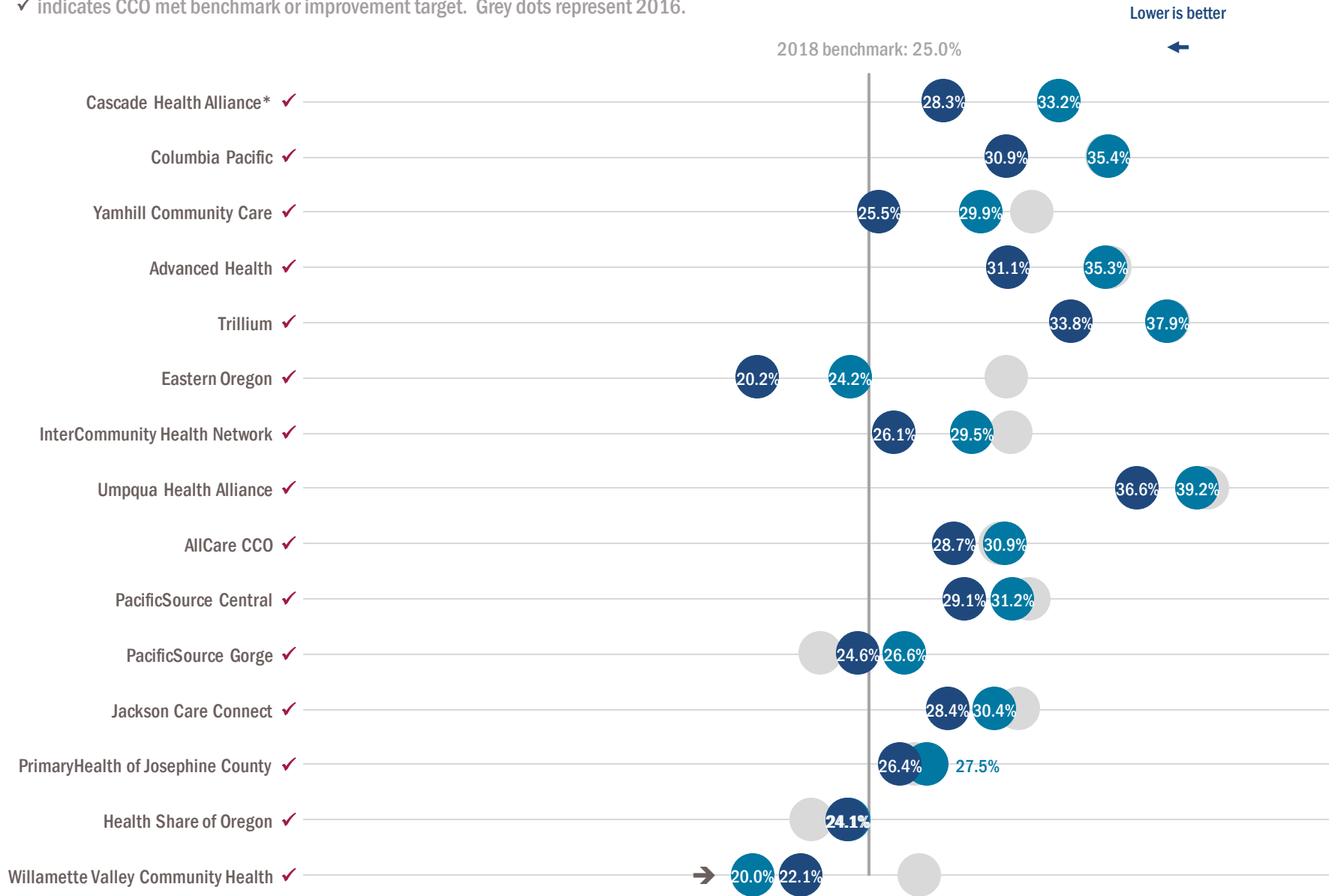




CIGARETTE SMOKING PREVALENCE

Cigarette smoking prevalence in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.



*2016 results excluded as invalid



COLORECTAL CANCER SCREENING

Colorectal cancer screening

Percent of adult members (ages 50-75) who had appropriate screening for colorectal cancer.

Data source:

Administrative (billing) claims and medical record review

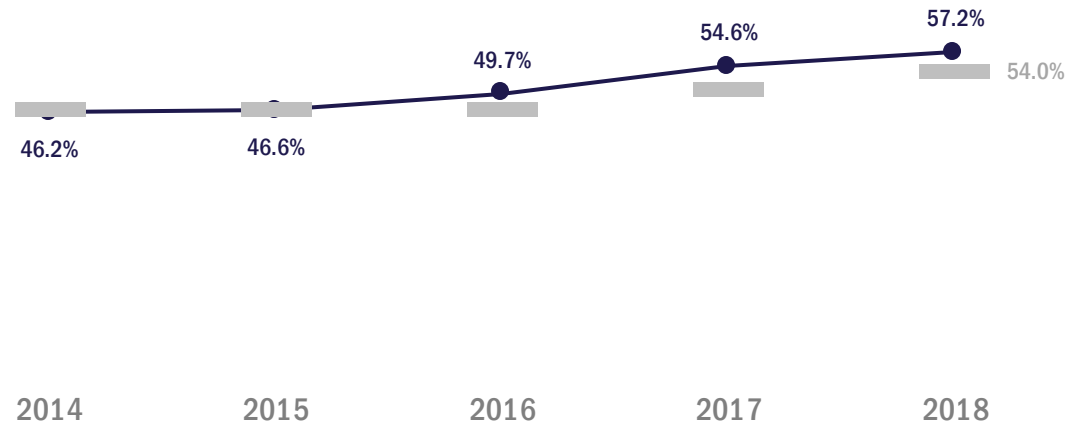
2018 benchmark source:

2016 CCO 90th percentile

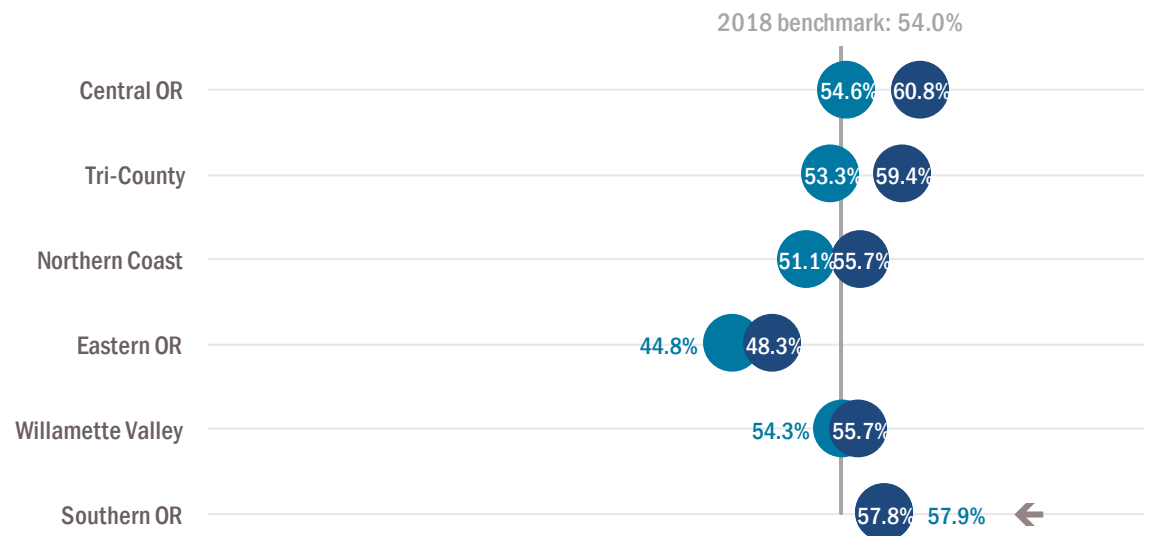
2018 data (N=6,156)

- Statewide change since 2017: **+4.8%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **15**

Statewide



By region



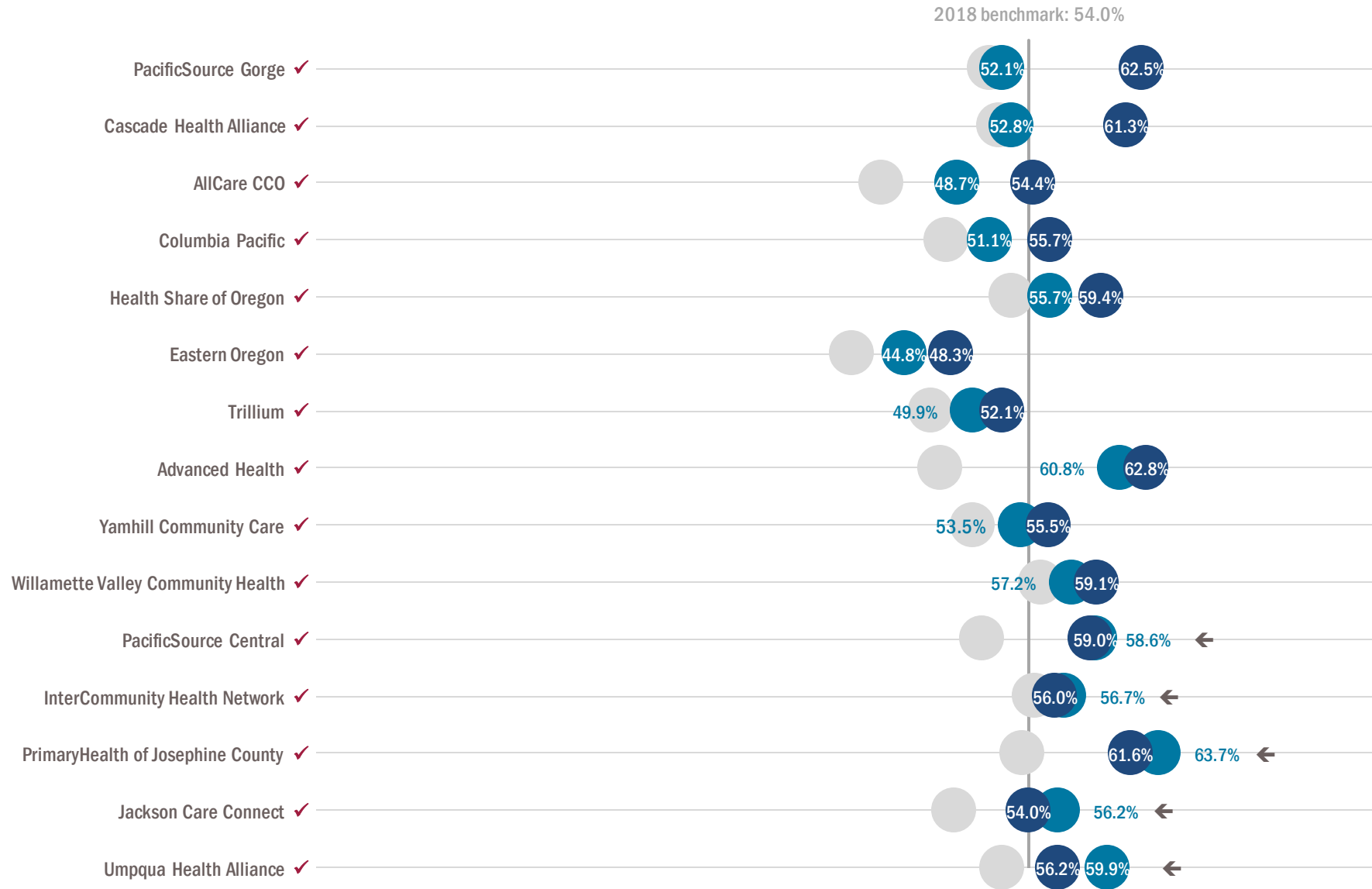
[Back to table of contents.](#)



COLORECTAL CANCER SCREENING

Colorectal cancer screening in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





CONTROLLING HIGH BLOOD PRESSURE

Controlling hypertension

Percentage of adult patients (ages 18–85) with a diagnosis of hypertension (high blood pressure) whose condition was adequately controlled.

Data source:

Electronic Health Records

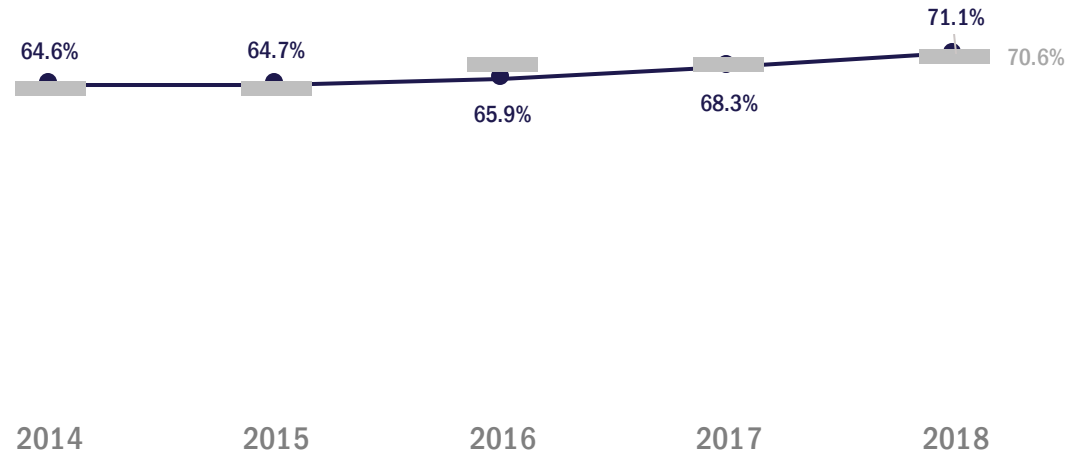
2018 benchmark source:

2016 national Medicaid 90th percentile

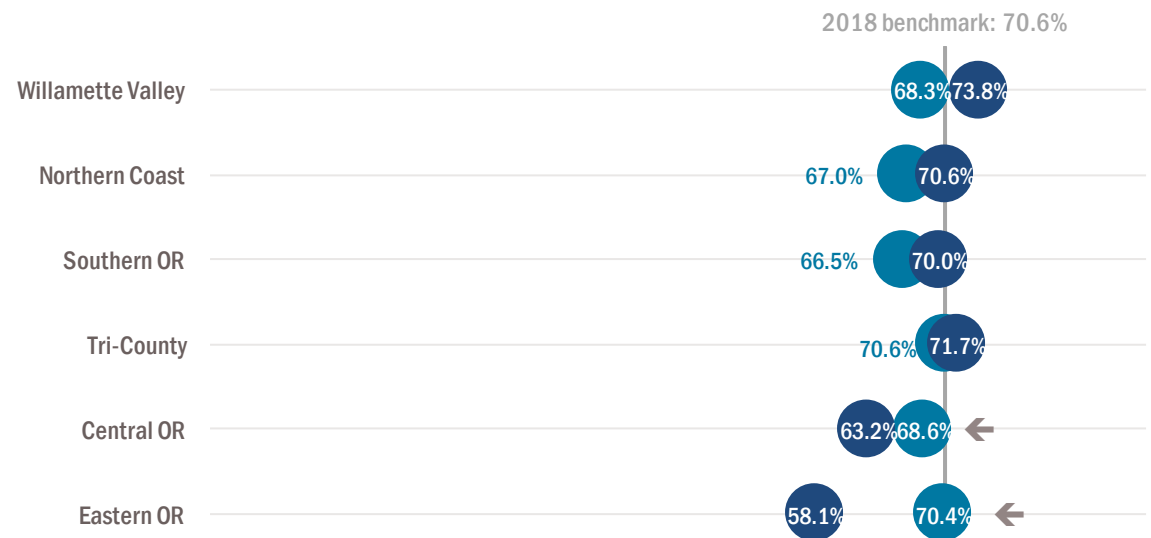
2018 data (N=125,944)

- Statewide change since 2017: **+4.1%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **12**

Statewide



By region



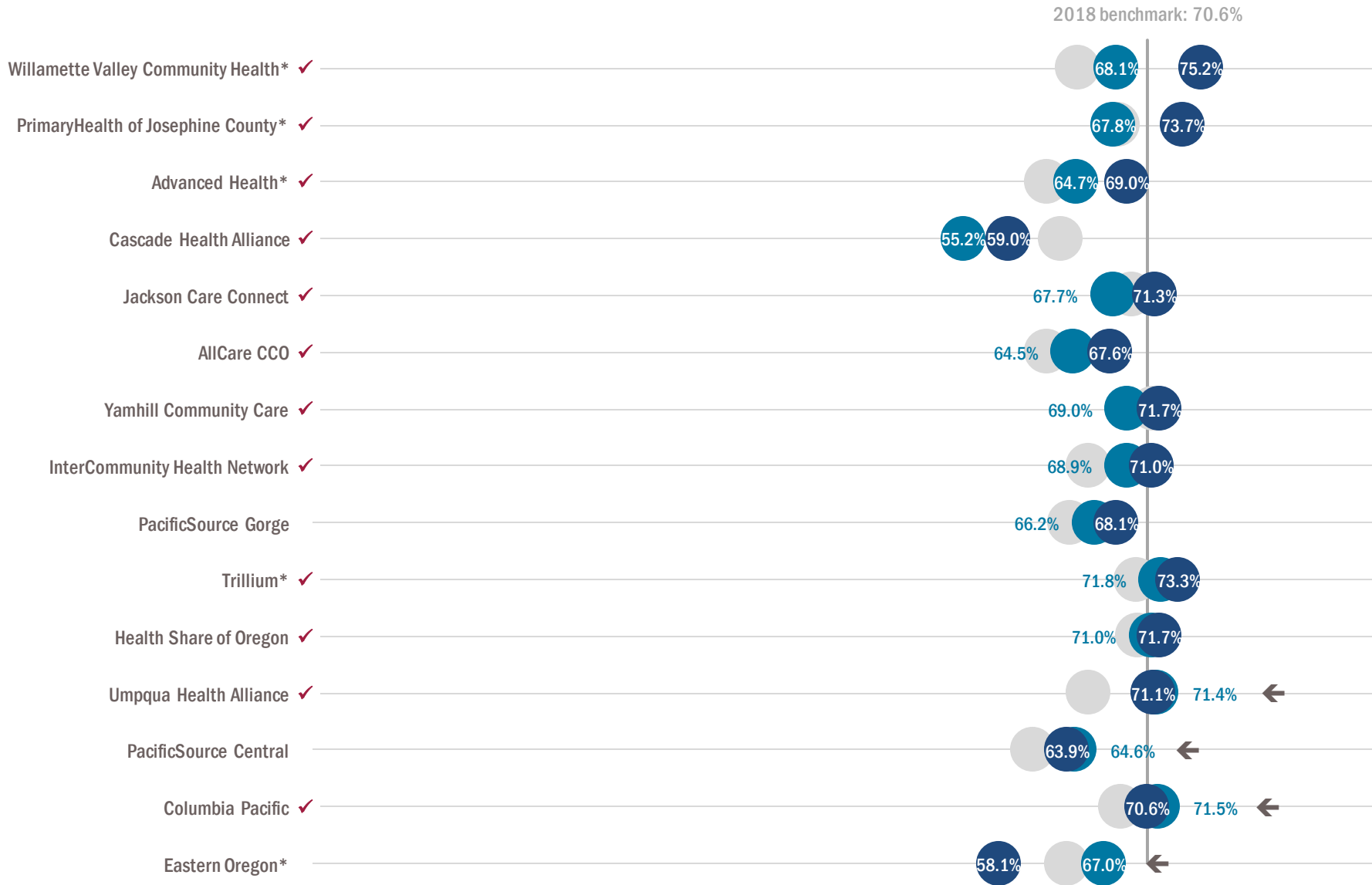
[Back to table of contents.](#)



CONTROLLING HIGH BLOOD PRESSURE

Controlling hypertension in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.



\$ ↗ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants for children (all ages)

Percentage of children ages 6-14 who received a dental sealant during the measurement year.

Data source:

Administrative (billing) claims

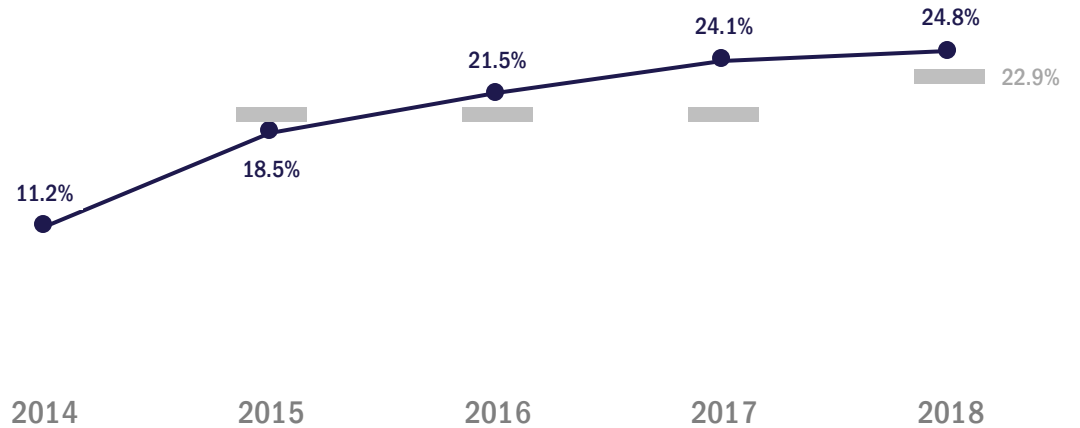
2018 benchmark source:

2016 CCO 75th percentile

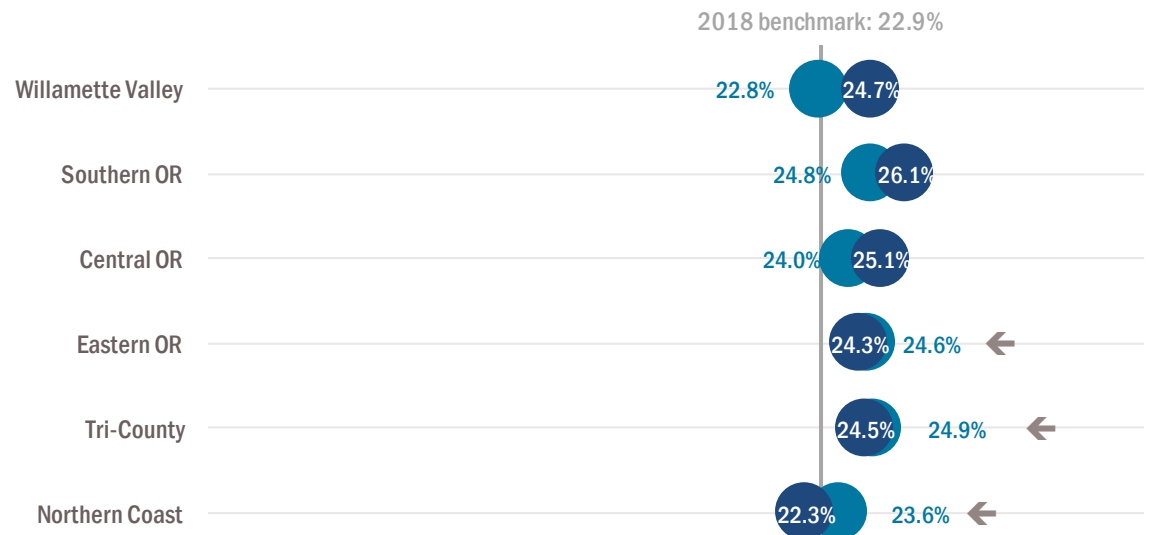
2018 data (N=137,444)

- Statewide change since 2017: **+2.5%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **14**

Statewide



By region

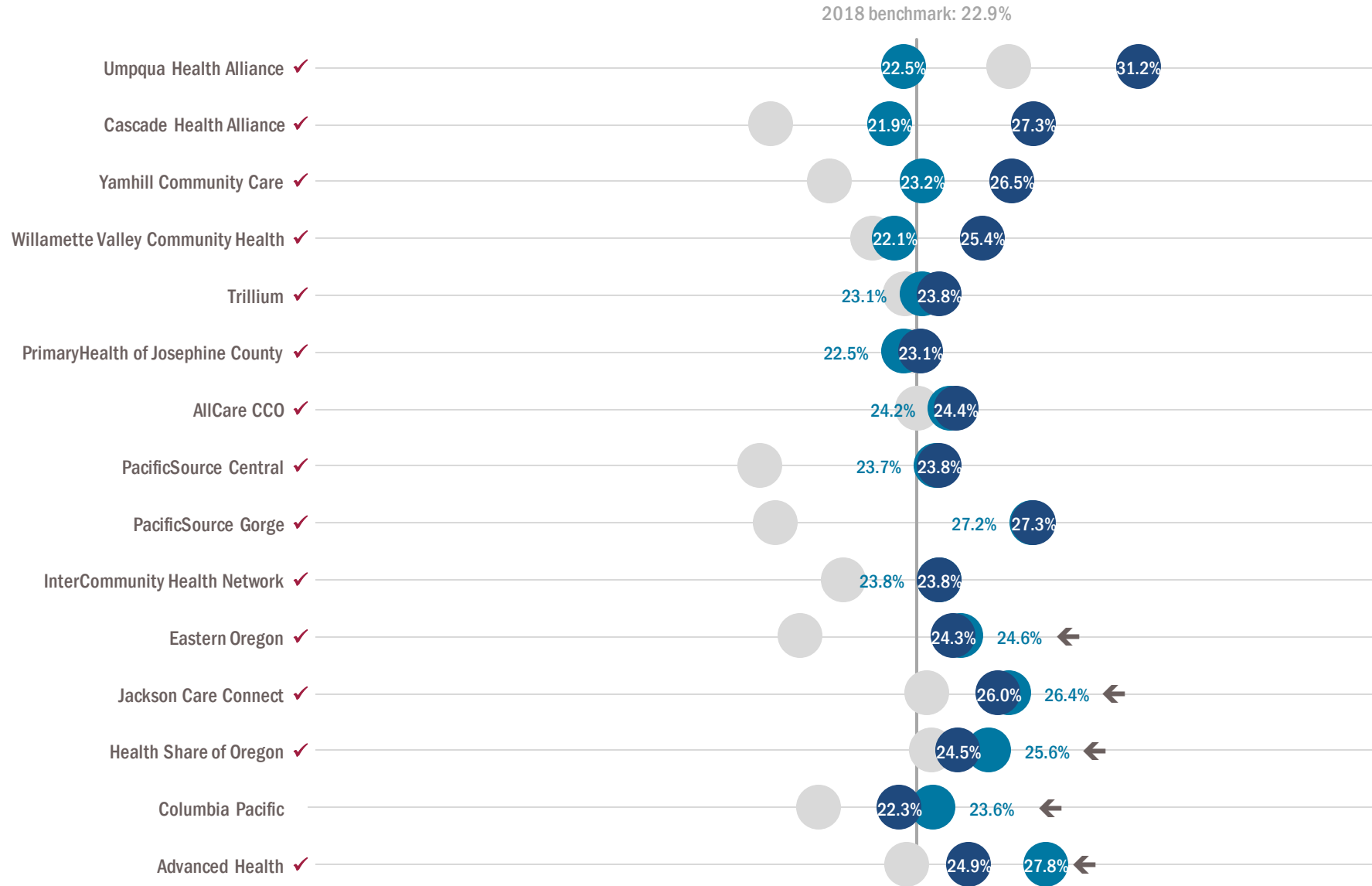


[Back to table of contents.](#)

DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages) 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants for children (ages 6-9)

Percentage of children ages 6-9 who received a dental sealant during the measurement year.

Data source:

Administrative (billing) claims

2018 benchmark source:

2016 CCO 75th percentile

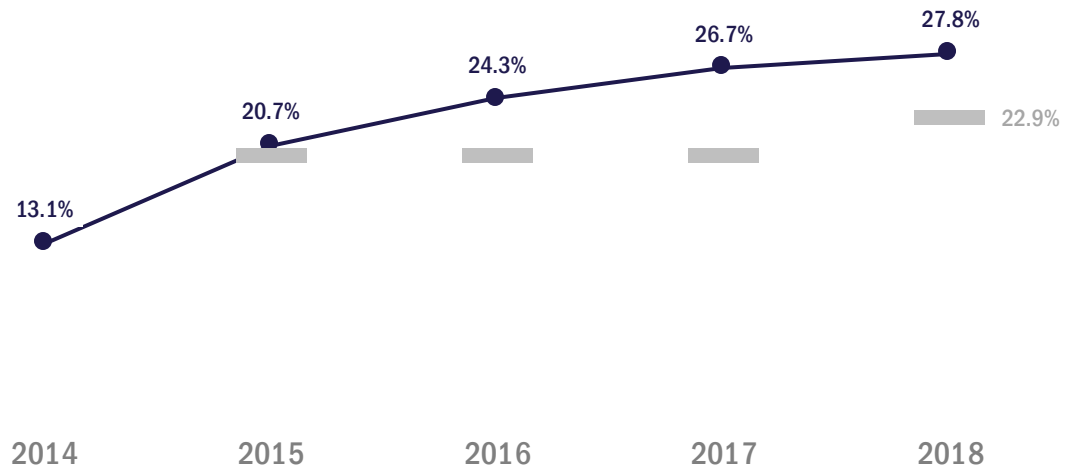
2018 data (N=61,517)

- Statewide change since 2017: **+4.1%**
- Number of CCOs that improved: **10**

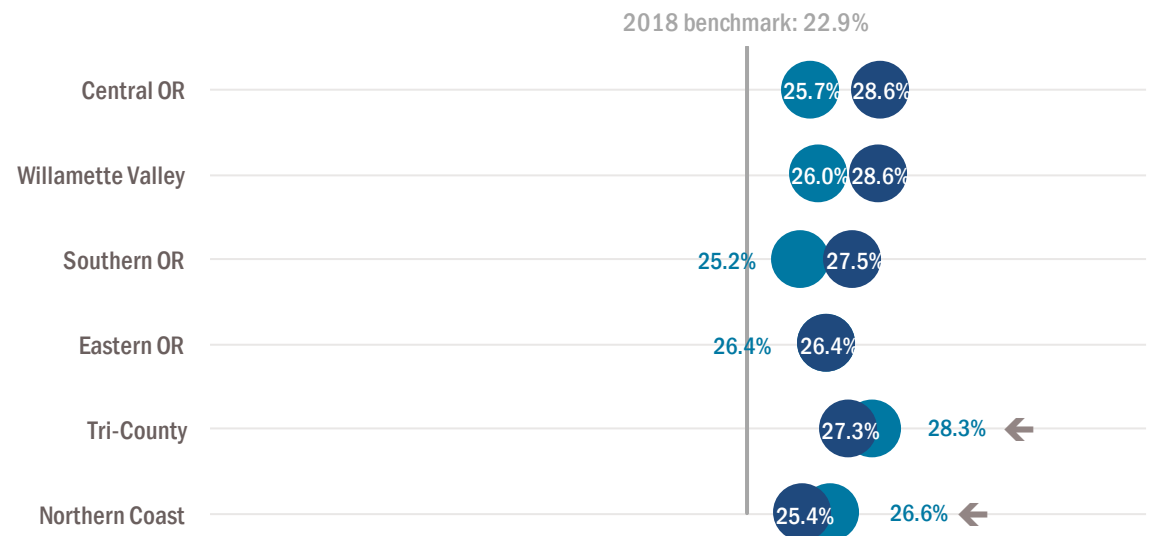
Results are stratified by age group (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

[Back to table of contents.](#)

Statewide

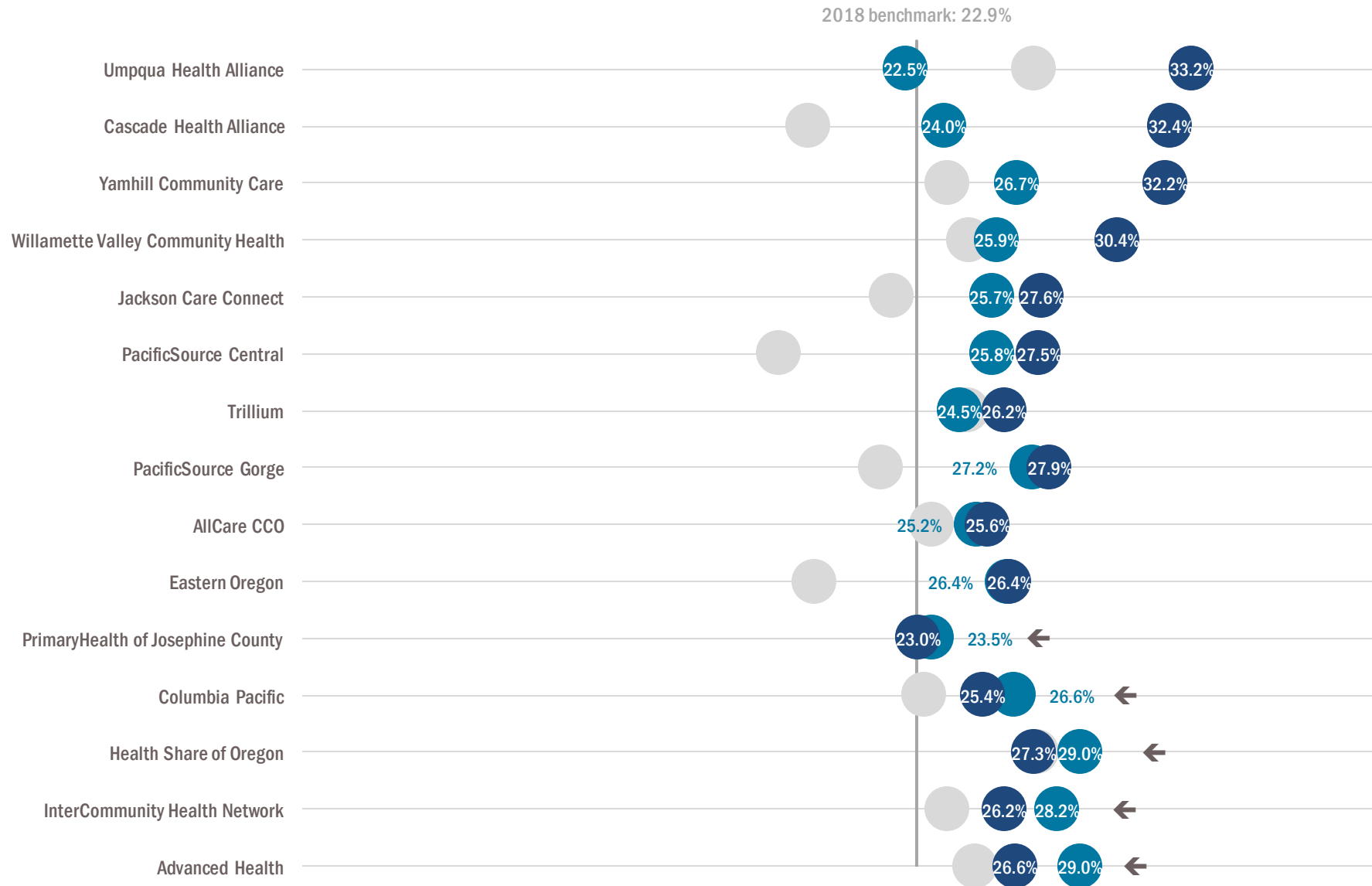


By region



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants on permanent molars for children (ages 6-9) in 2017 and 2018, by CCO.



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants for children (ages 10-14)

Percentage of children ages 10-14 who received a dental sealant during the measurement year.

Data source:

Administrative (billing) claims

2018 benchmark source:

2016 CCO 75th percentile

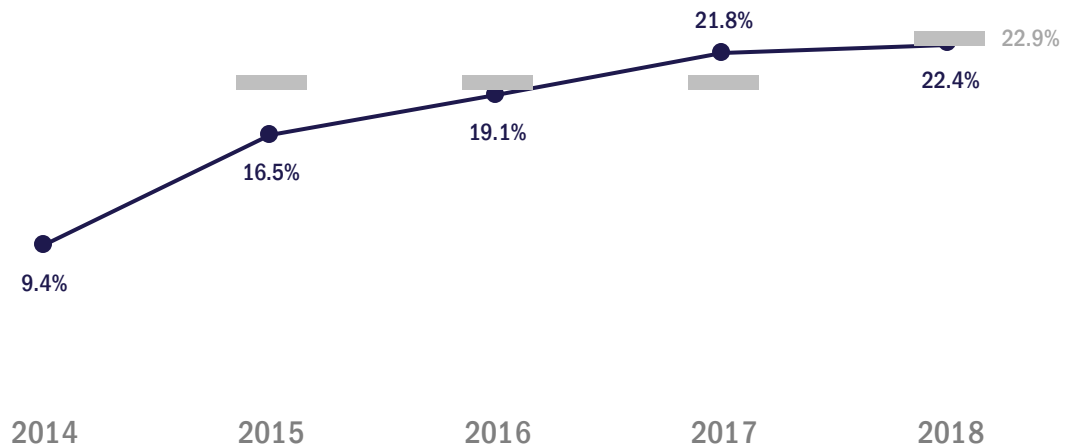
2018 data (N=75,927)

- Statewide change since 2017: **+1.4%**
- Number of CCOs that improved: **6**

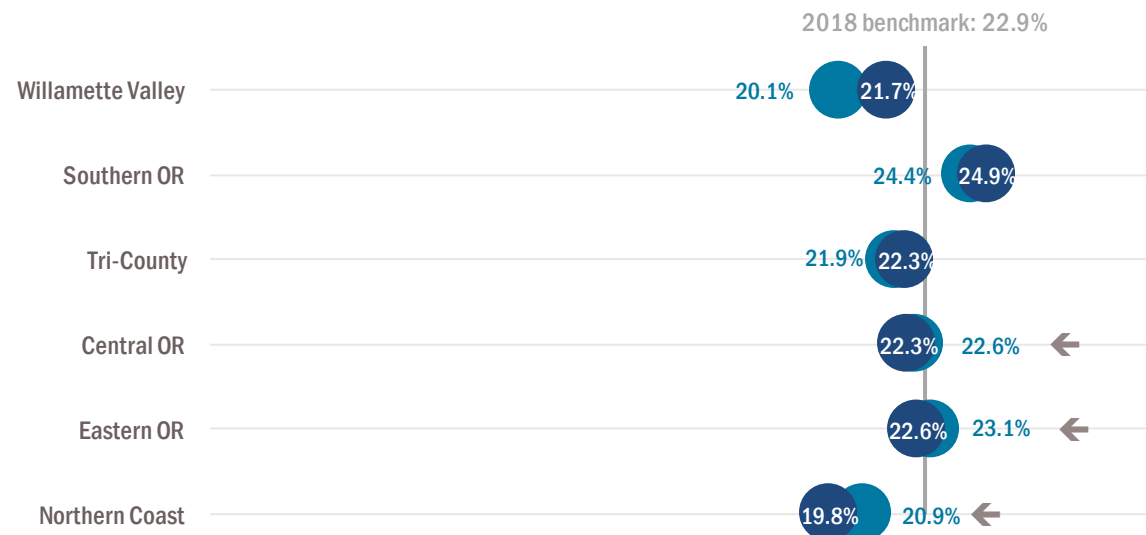
Results are stratified by age group (6-9 and 10-14) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

[Back to table of contents.](#)

Statewide

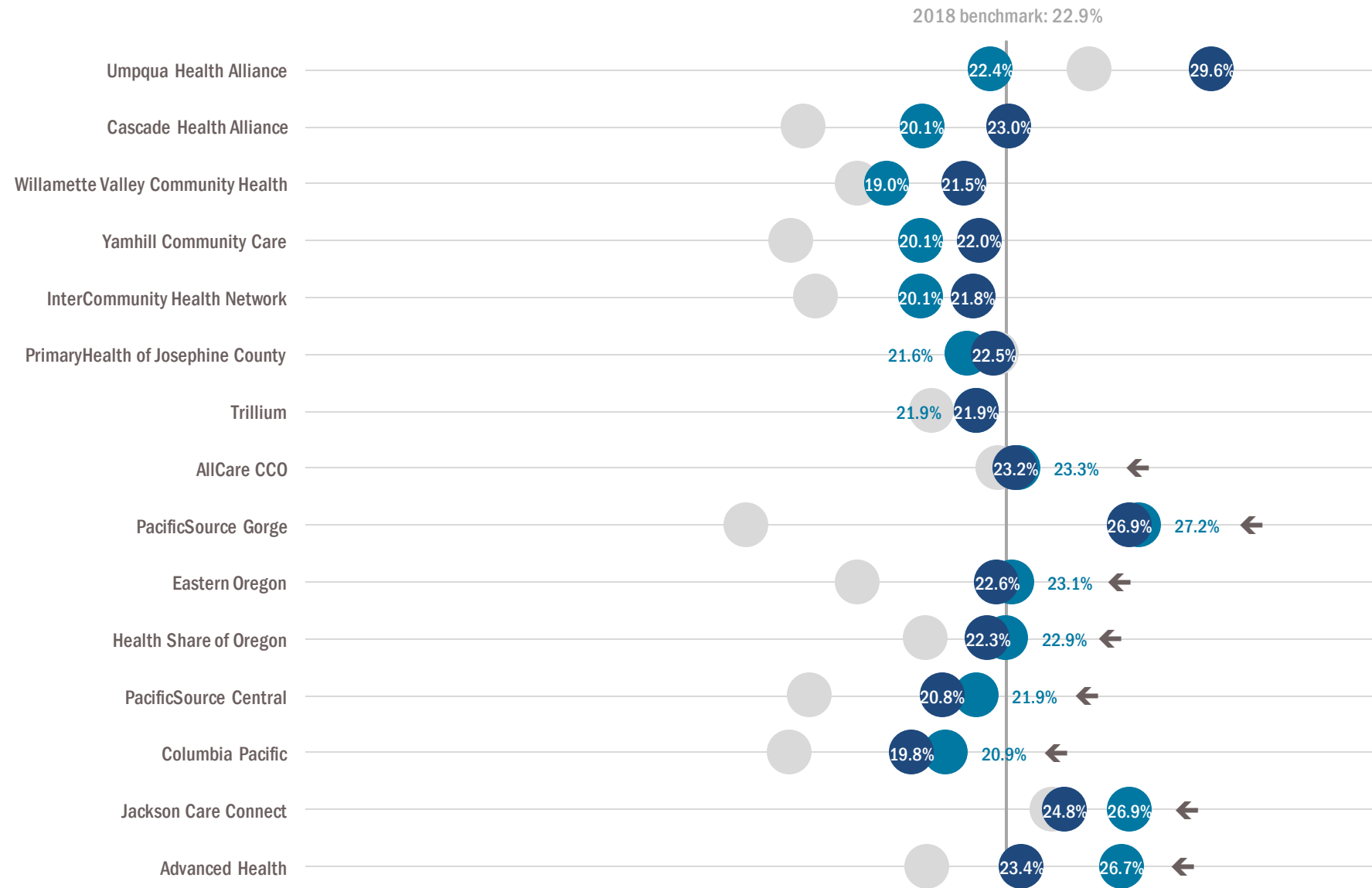


By region



DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14) in 2017 and 2018, by CCO.





DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up

Percentage of adult patients (ages 18 and older) who had appropriate screening and follow-up planning for depression.

Data source:

Electronic Health Records

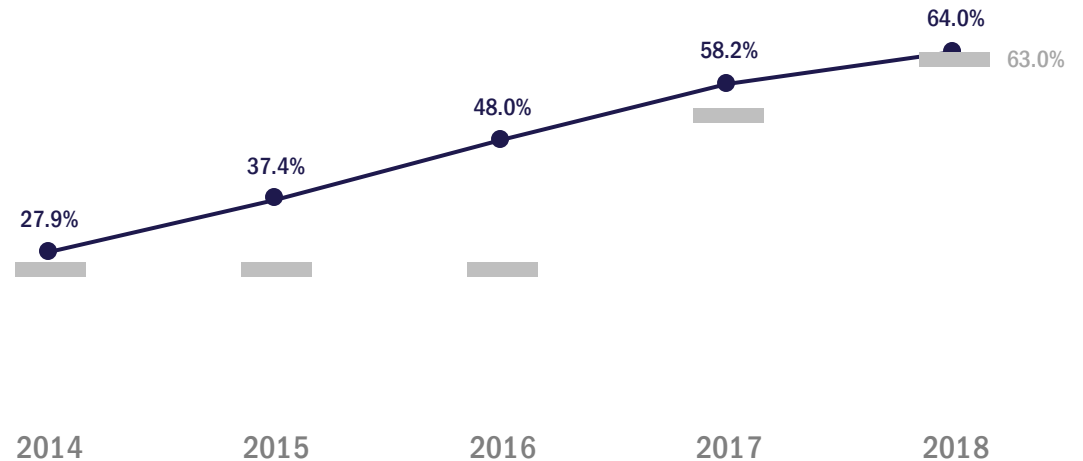
2018 benchmark source:

2016 CCO 90th percentile

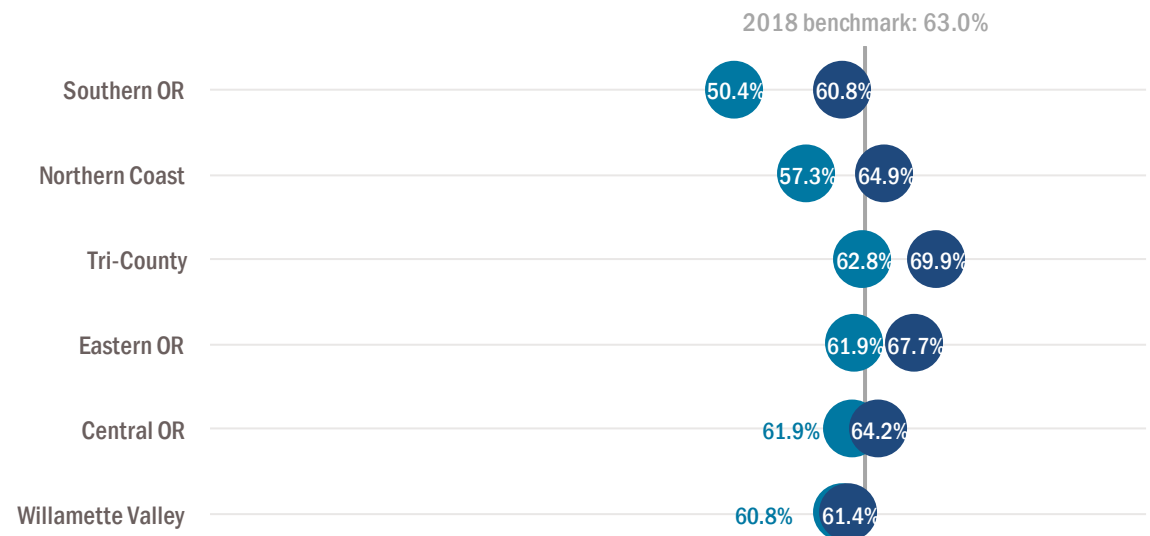
2018 data (N=362,912)

- Statewide change since 2017: **+10.0%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **15**

Statewide



By region



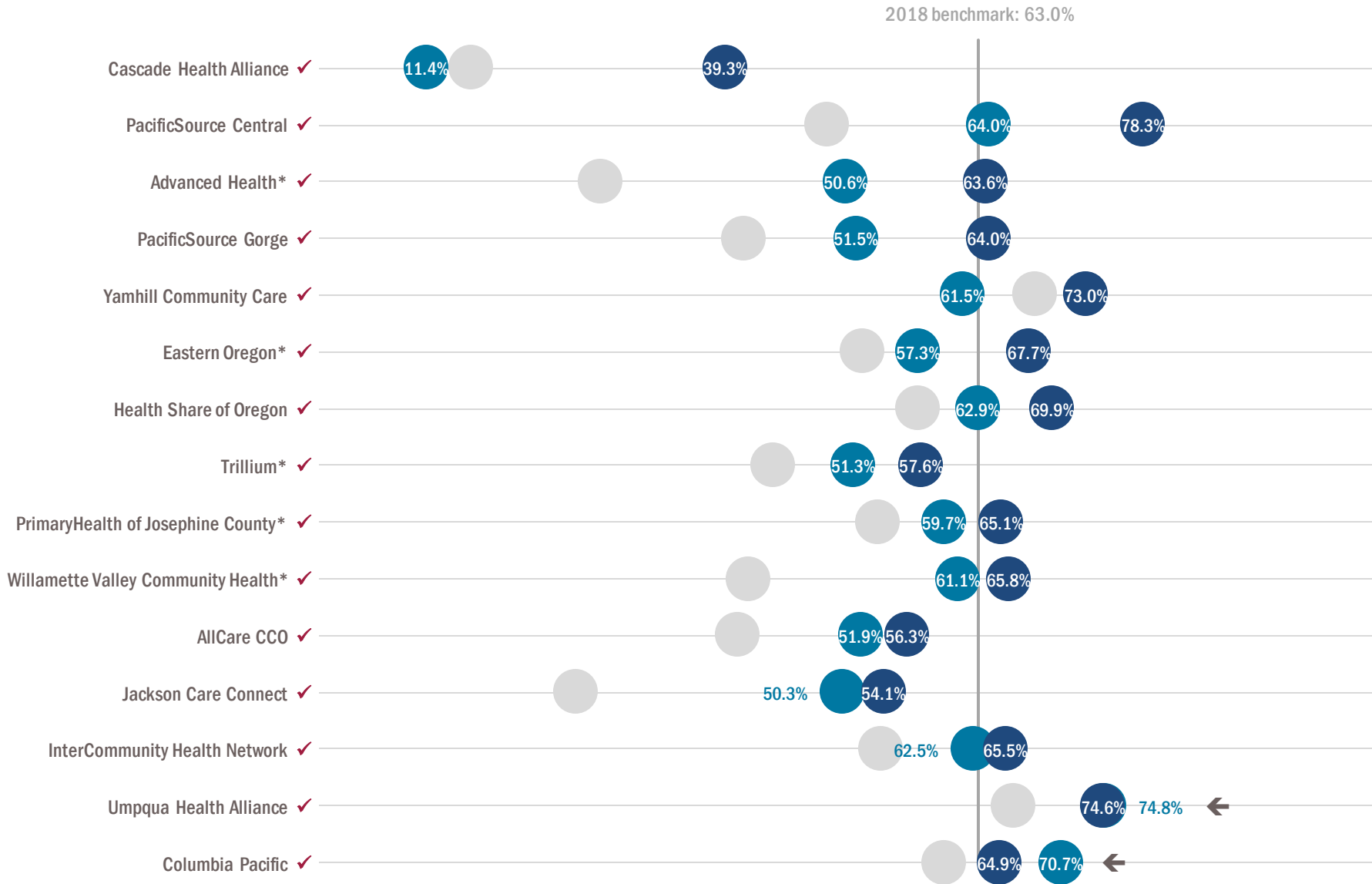
[Back to table of contents.](#)



DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up plan in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings

Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Data source:

Administrative (billing) claims

2018 benchmark source:

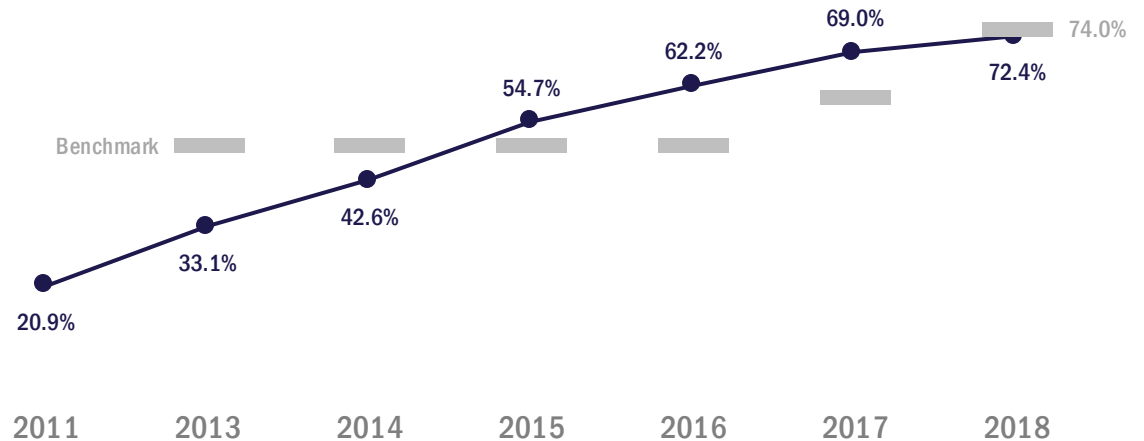
2016 CCO 90th percentile

2018 data (N=41,354)

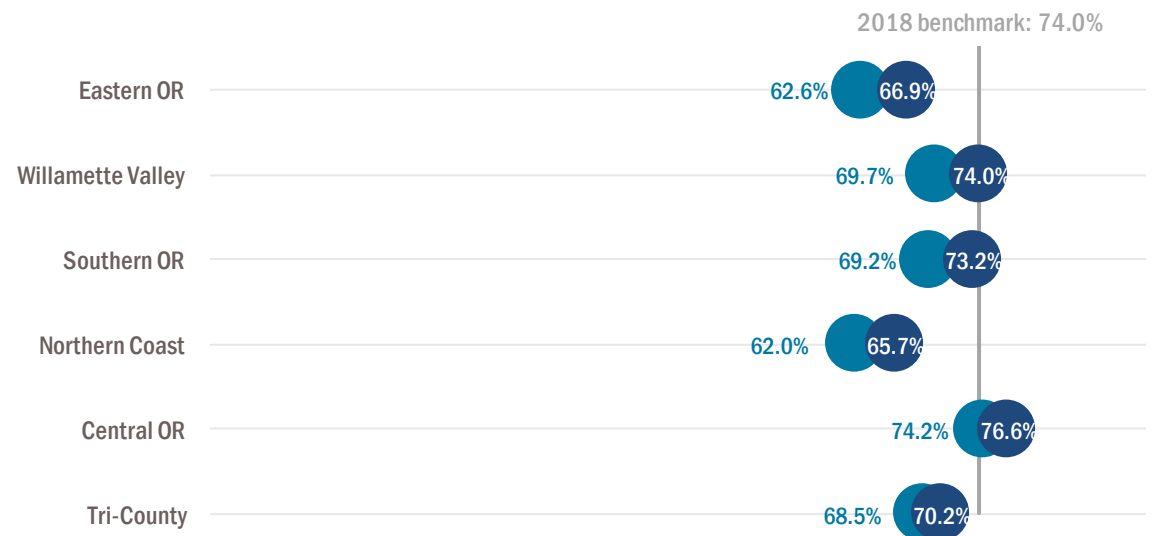
- Statewide change since 2017: **+5.4%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **15**

[Back to table of contents.](#)

Statewide



By region

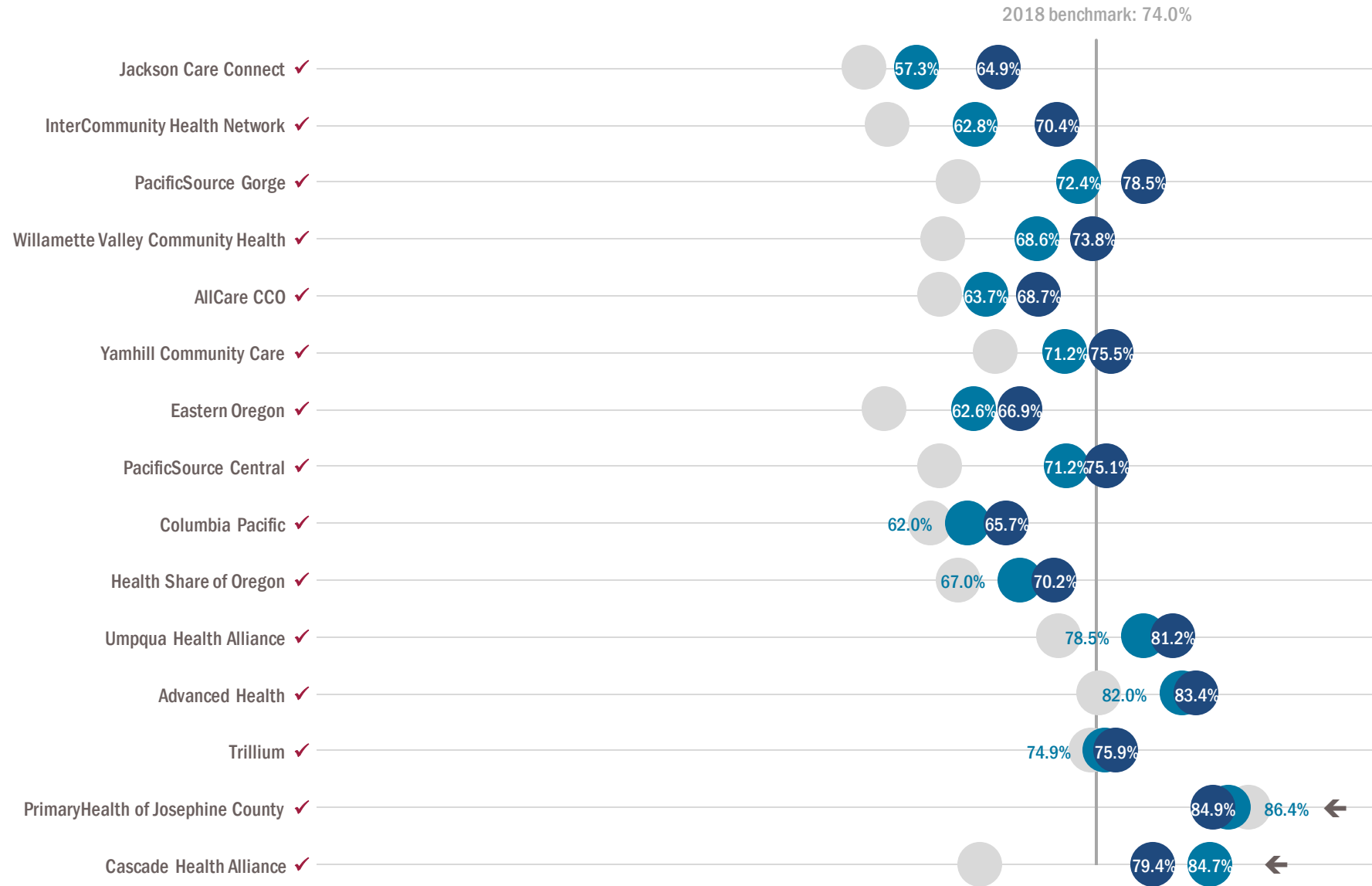




DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





DIABETES CARE: HbA1c POOR CONTROL

Diabetes Care: HbA1c Poor Control

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower score is better.

Data source:

Electronic Health Records

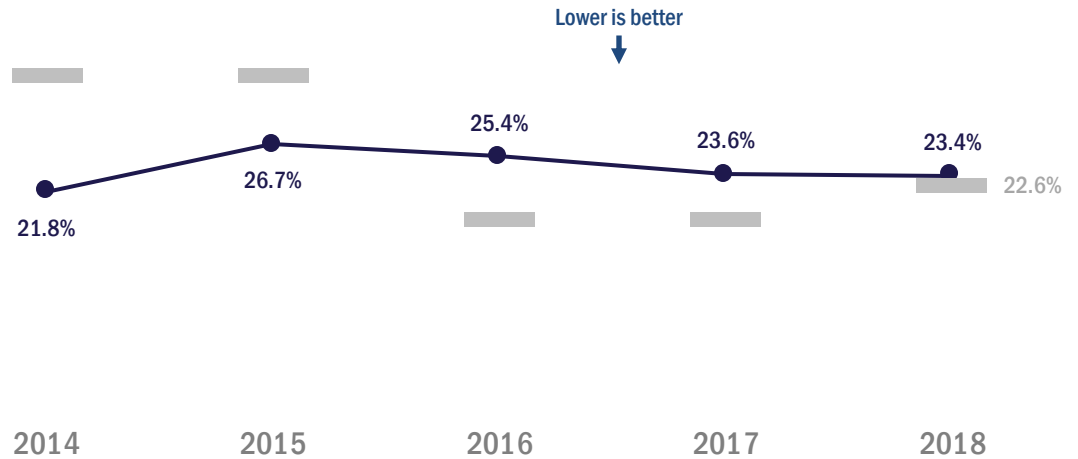
2018 benchmark source:

2016 CCO 90th percentile

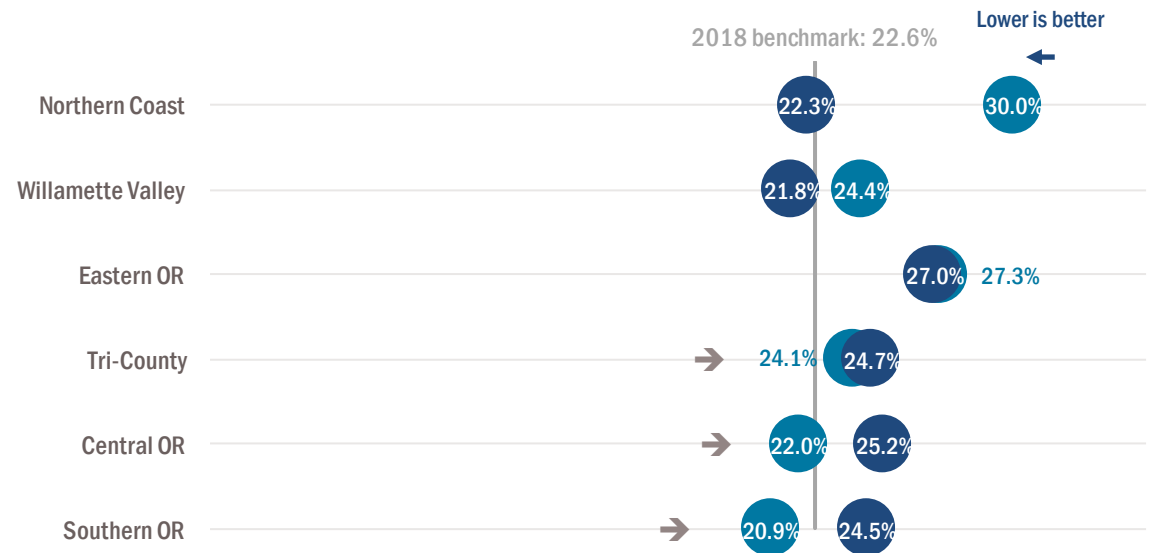
2018 data (N=54,664)

- Statewide change since 2017: **-0.8%**
- Number of CCOs that improved: **6**
- Number of CCOs achieving target: **7**

Statewide



By region



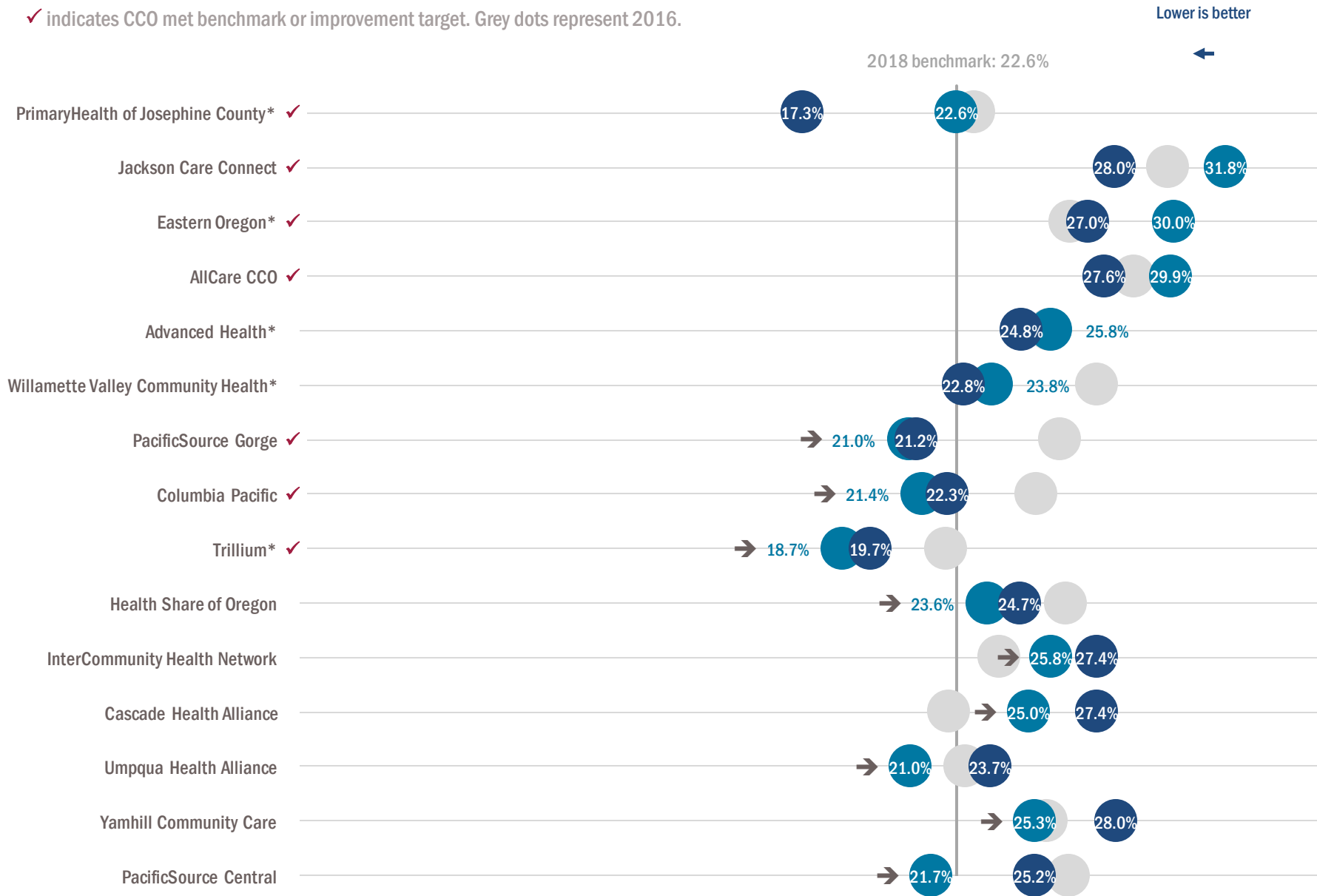
[Back to table of contents.](#)



DIABETES CARE: HbA1c POOR CONTROL

Diabetes care, Hba1c poor control in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.





DISPARITY MEASURE: ED UTILIZATION AMONG MEMBERS WITH MENTAL ILLNESS

Disparity measure

Rate of ambulatory ED utilization for physical health conditions from member who have a history of mental illness.

Data source:

Administrative (billing) claims

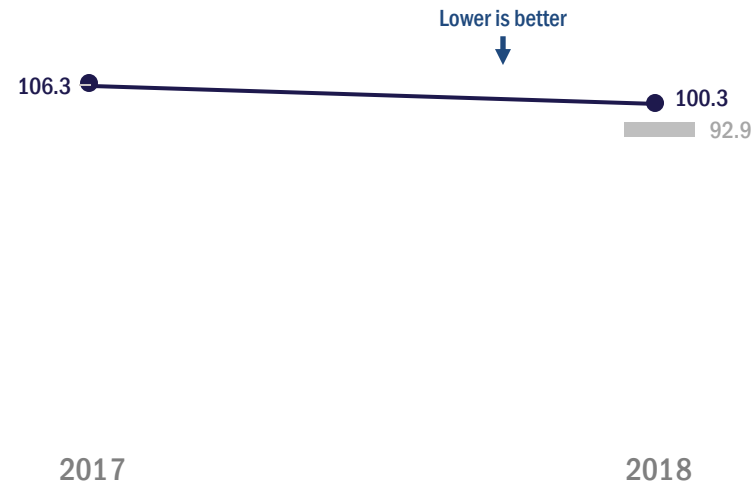
2018 benchmark source:

2016 CCO 90th percentile

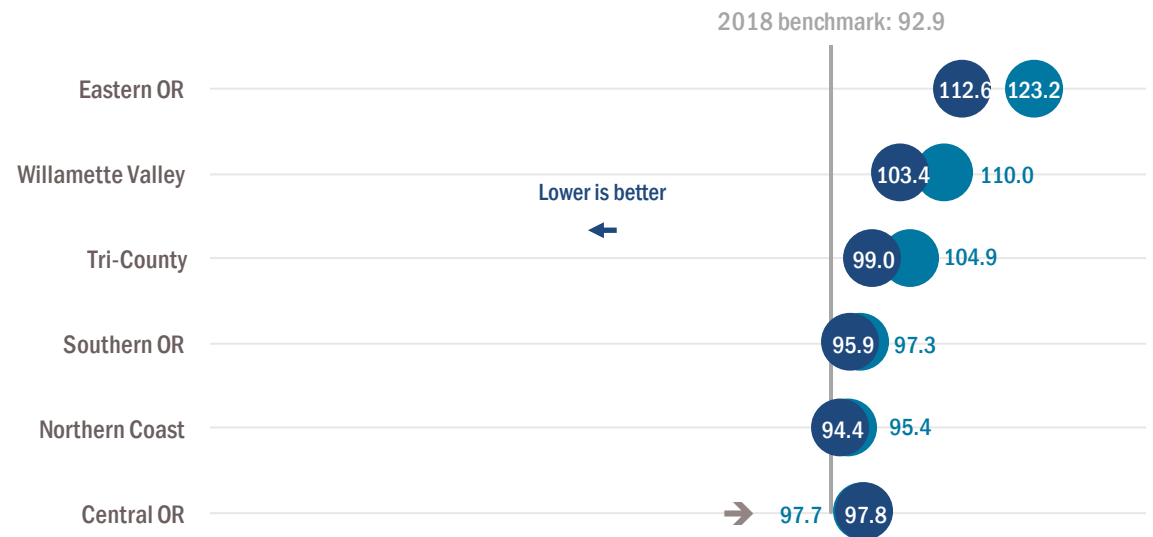
2018 data (N=1,628,332 member months)

- Statewide change since 2017: **-5.6%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **12**

Statewide



By region



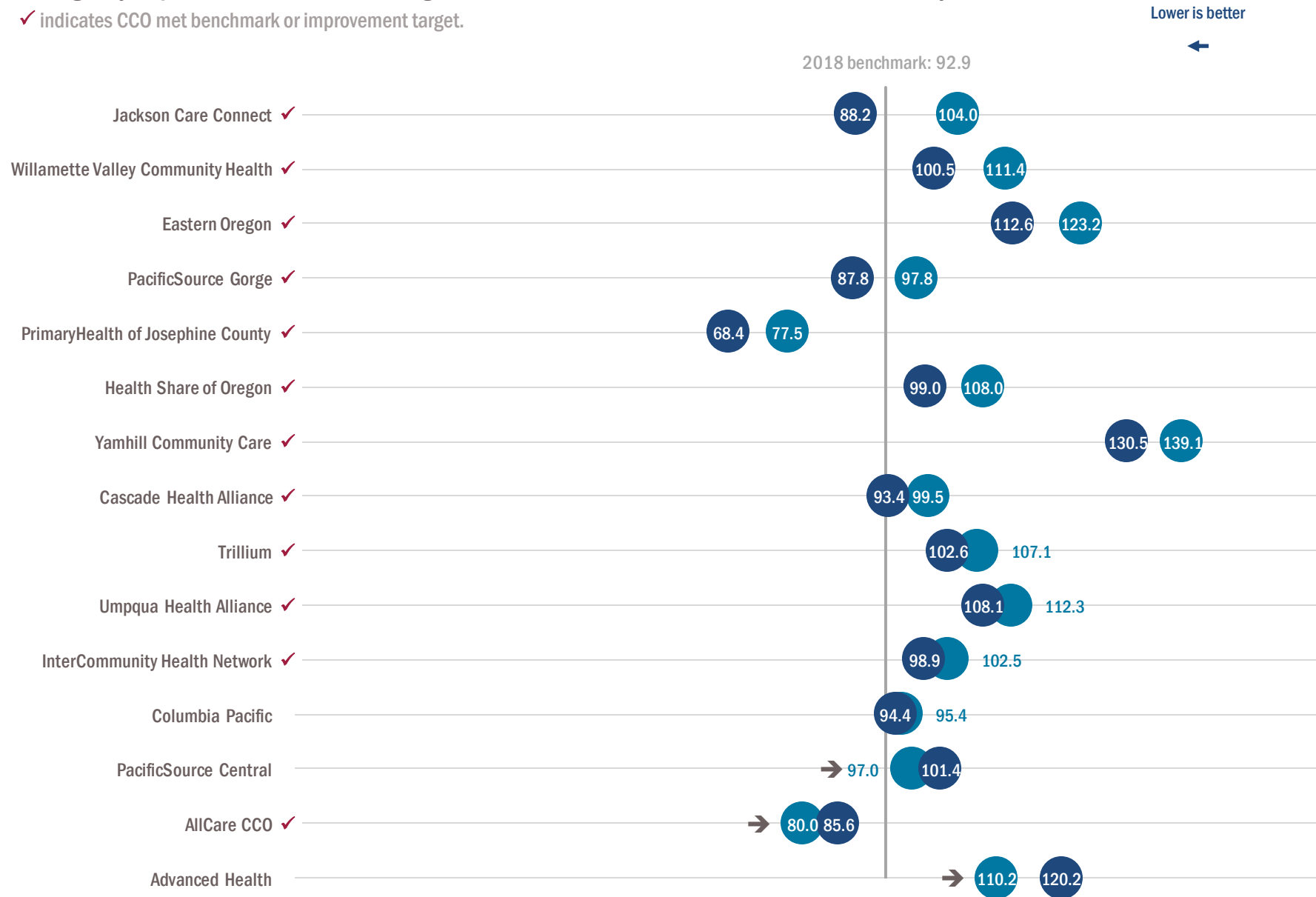
[Back to table of contents.](#)



DISPARITY MEASURE: ED UTILIZATION AMONG MEMBERS WITH MENTAL ILLNESS

Emergency department utilization among members with mental illness in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target.





EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-50)

Effective contraceptive use (15-50)

Percentage of women (ages 15-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Data source:

Administrative (billing) claims

2018 benchmark source:

Committee consensus

2018 data (N=126,455)

- Statewide change since 2017: **-0.9%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **10**

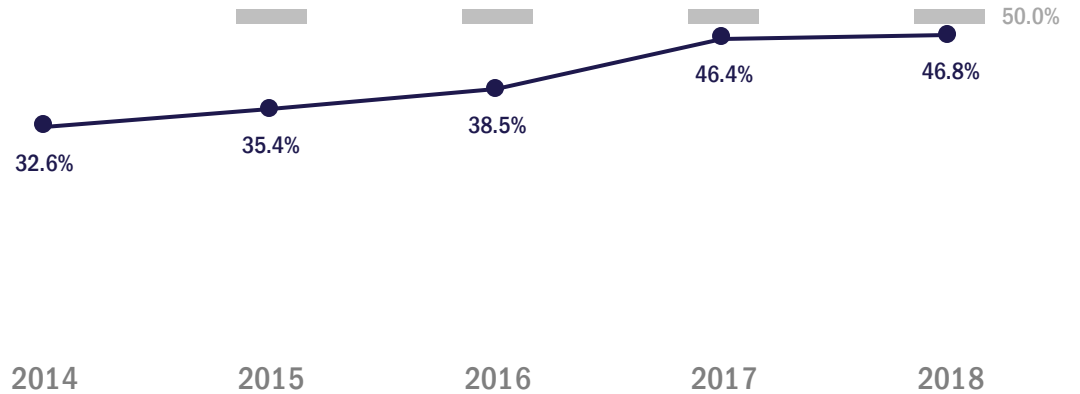
2018 is the first year adolescents ages 15-17 are included in the incentivized measure.

2016 results are not reported at the CCO level due to change in methodology.

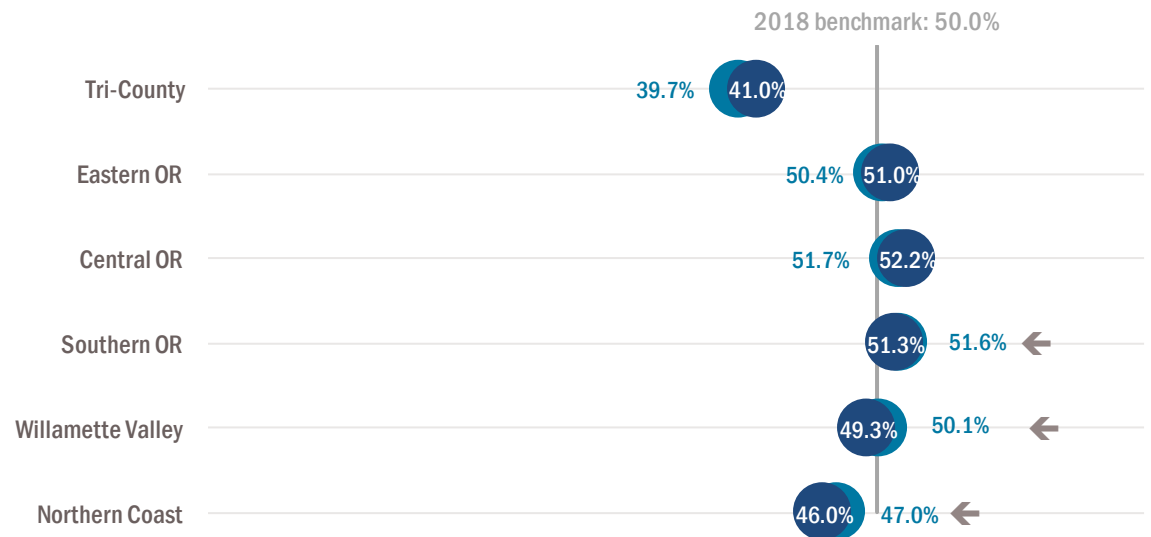
[Back to table of contents.](#)

Statewide

Note: 2017-2018 performance is not directly comparable to earlier years due to change in methodology.



By region

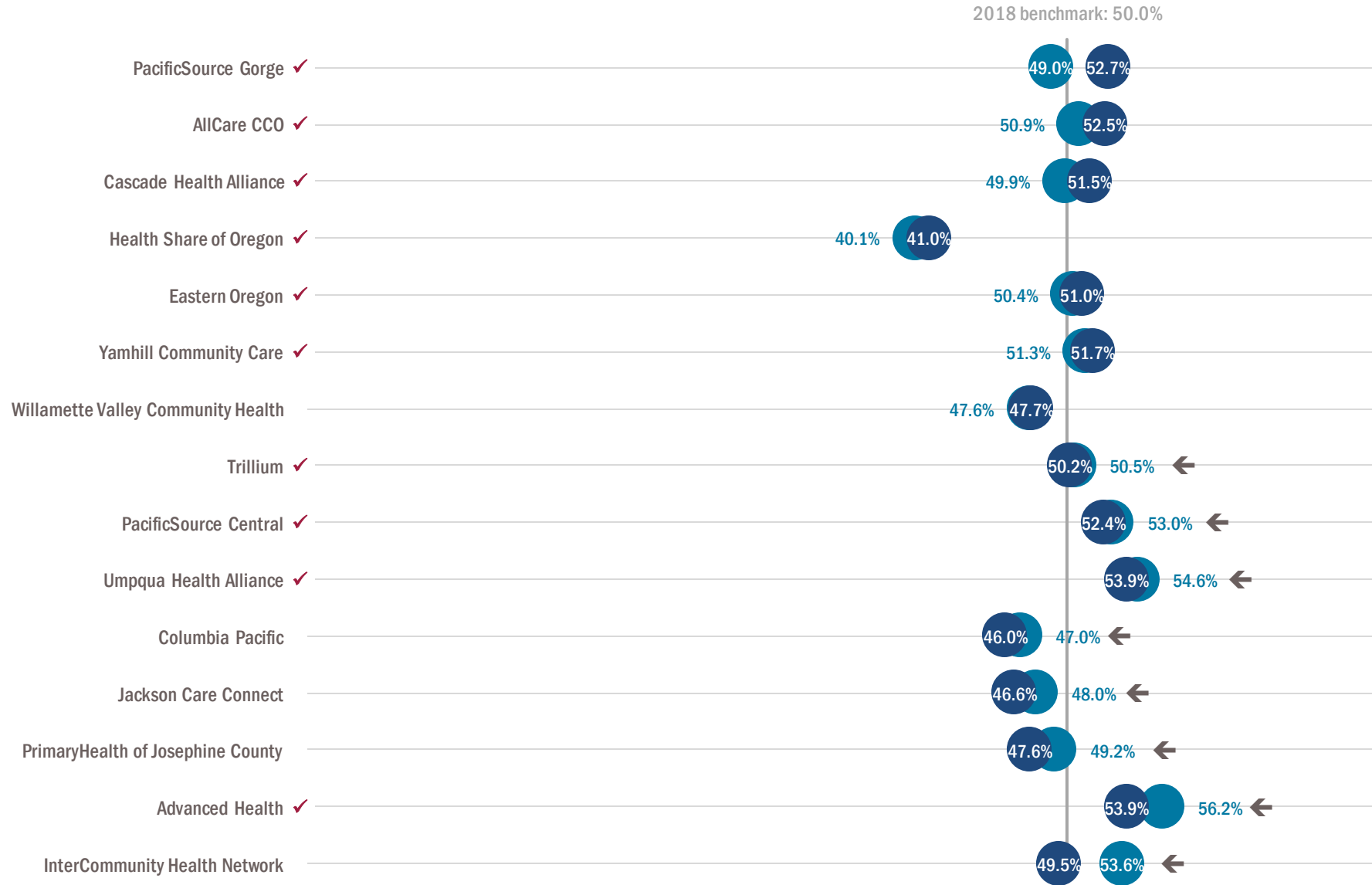




EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-50)

Effective contraceptive use among adult women at risk of unintended pregnancy in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target.



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use (15-17)

Percentage of adolescent women (ages 15-17) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Data source:

Administrative (billing) claims

2018 benchmark source:

Committee consensus

2018 data (N=19,023)

- Statewide change since 2017: **5.9%**
- Number of CCOs that improved: **10**

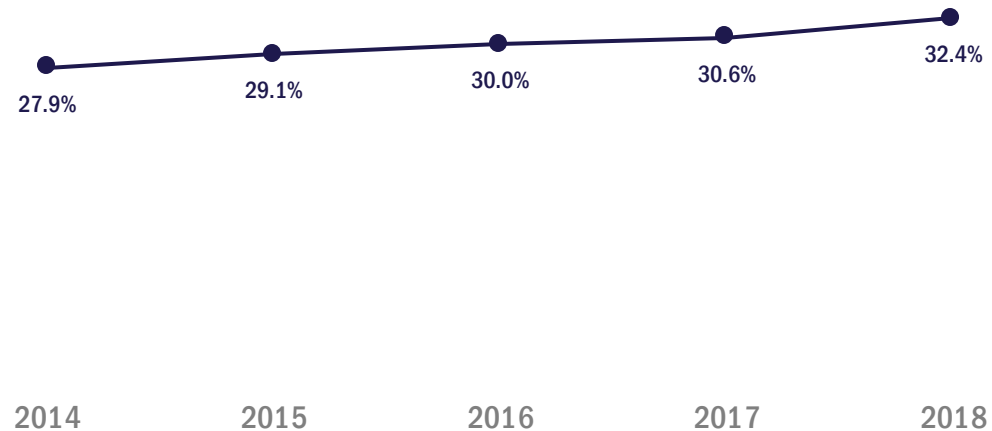
Results are stratified by age group (adolescents and adults) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

2016 results are not reported at the CCO level due to change in methodology.

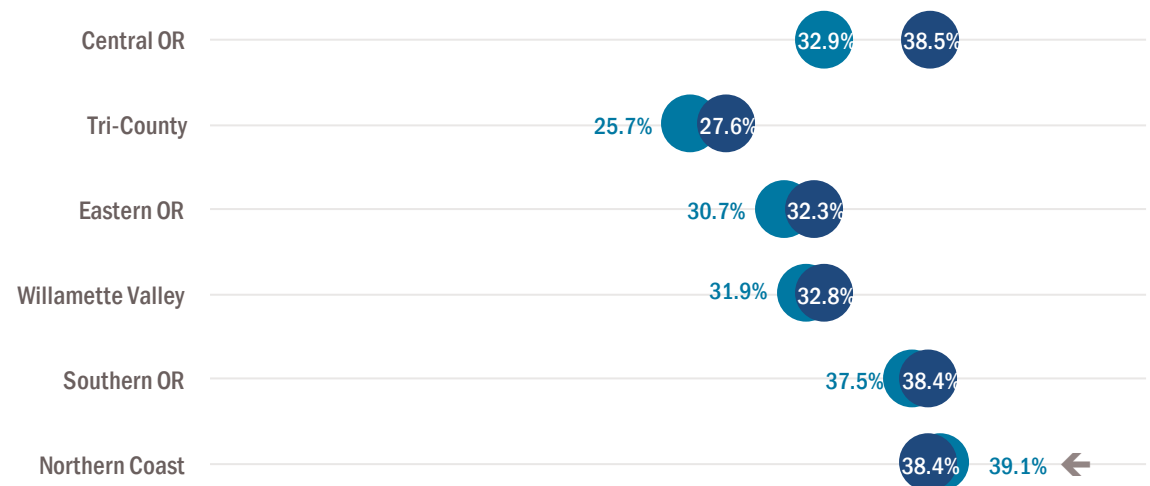
[Back to table of contents.](#)

Statewide

Note: 2017-2018 performance is not directly comparable to earlier years due to change in methodology.

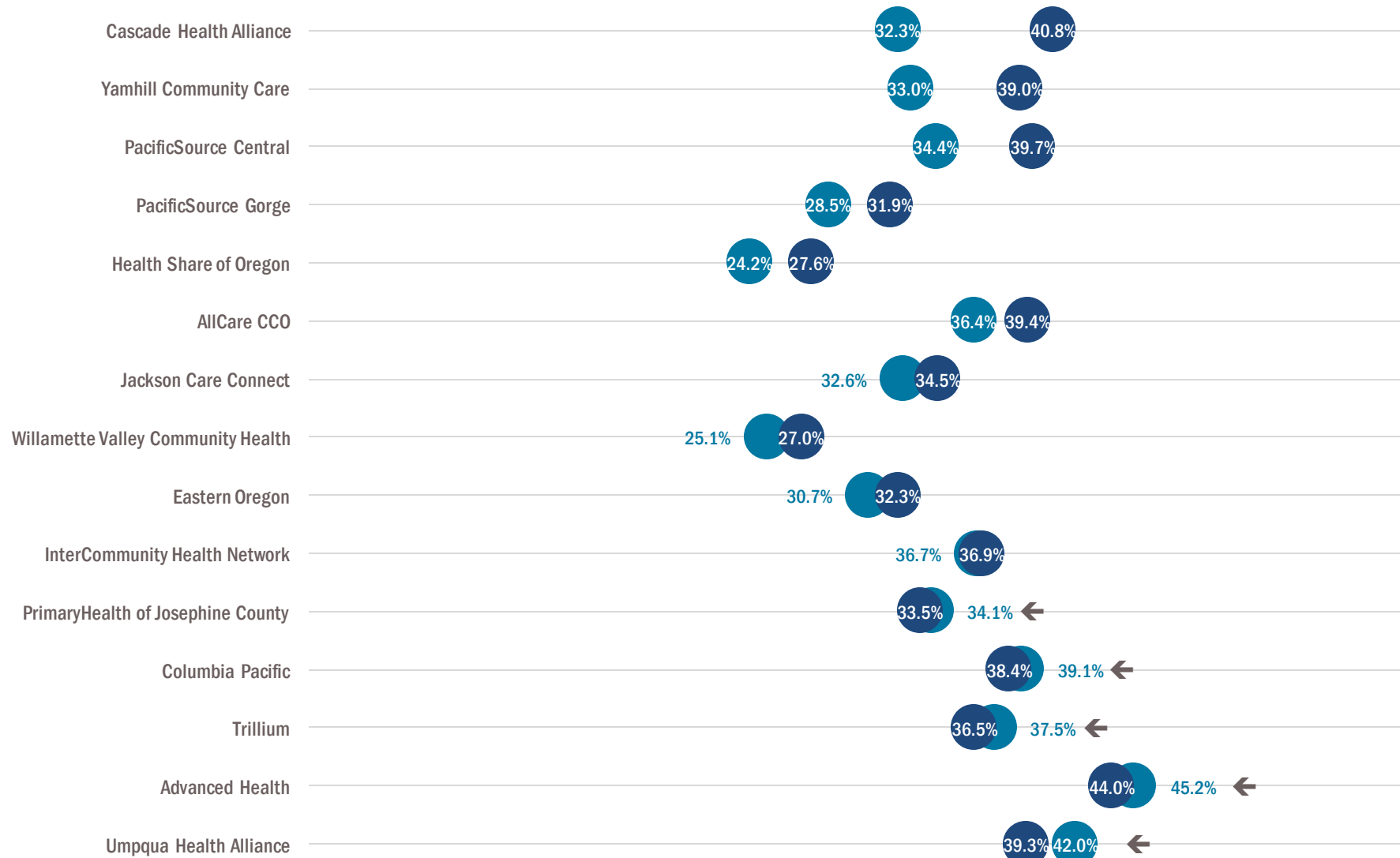


By region



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among adolescent women at risk of unintended pregnancy in 2017 and 2018, by CCO.



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

Data source:

Administrative (billing) claims

2018 benchmark source:

Committee consensus

2018 data (N=107,432)

- Statewide change since 2017: **-0.2%**
- Number of CCOs that improved: **5**

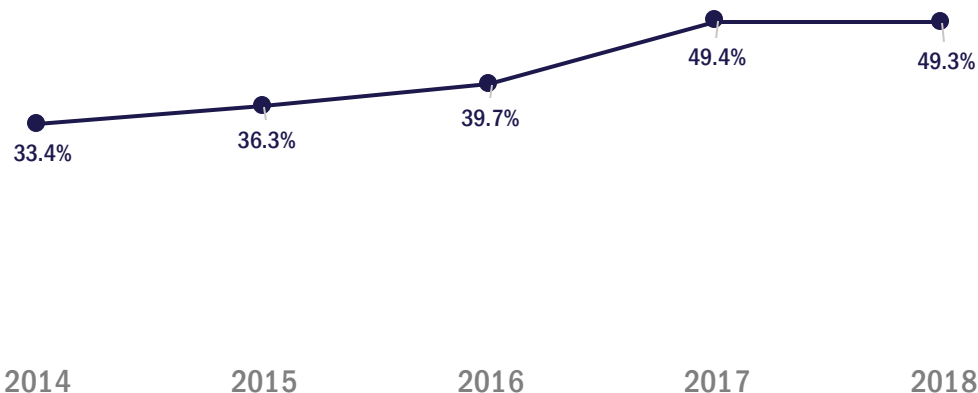
Results are stratified by age group (adolescents and adults) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

2016 results are not reported at the CCO level due to change in methodology.

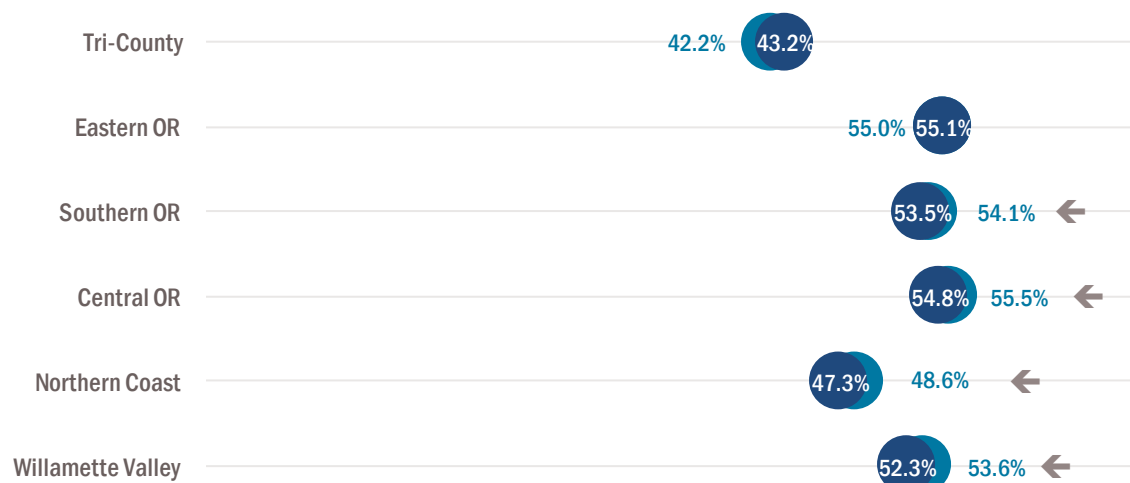
[Back to table of contents.](#)

Statewide

Note: 2017-2018 performance is not directly comparable to earlier years due to change in methodology.

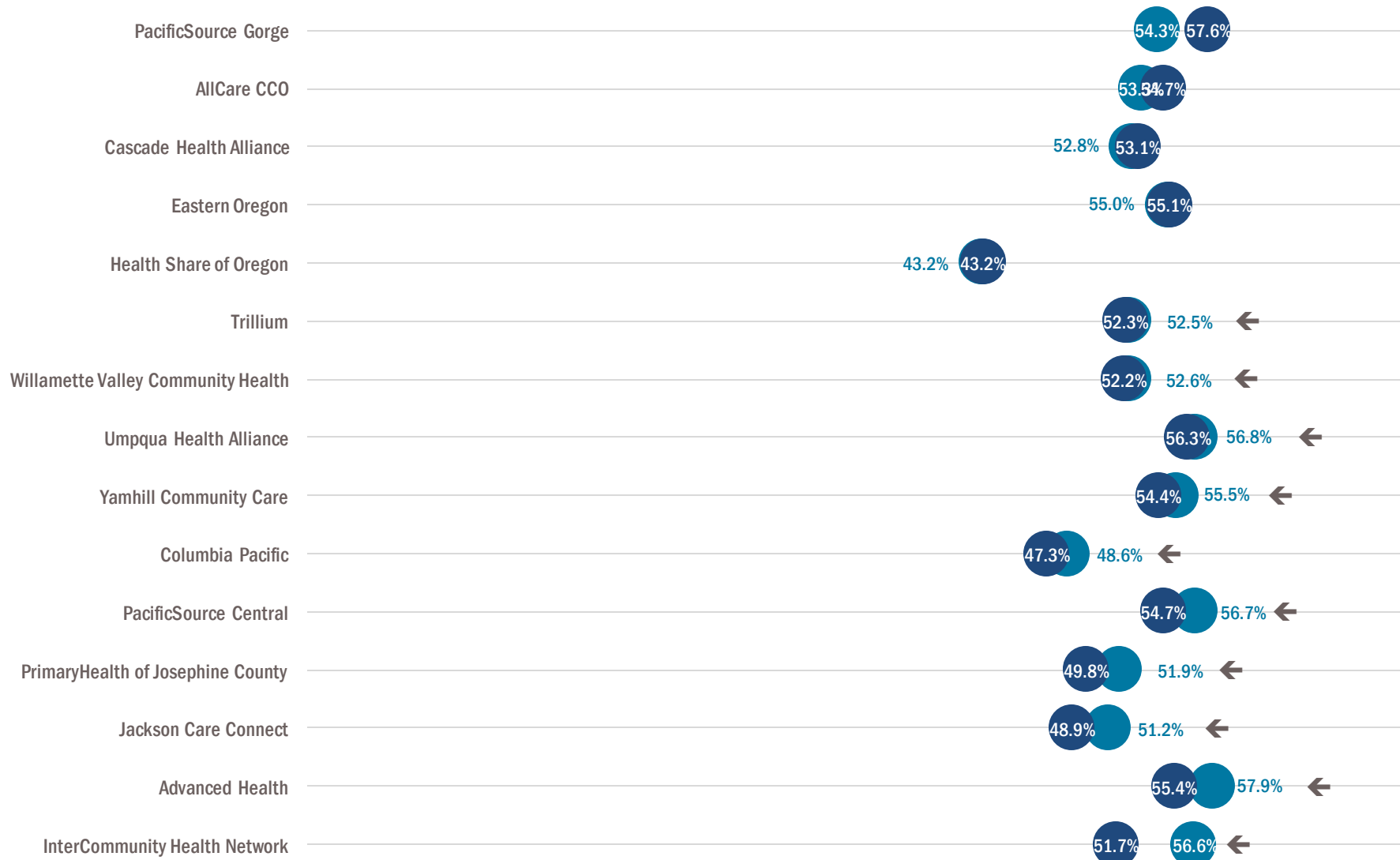


By region



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among women ages 18-50 at risk of unintended pregnancy in 2017 and 2018, by CCO.



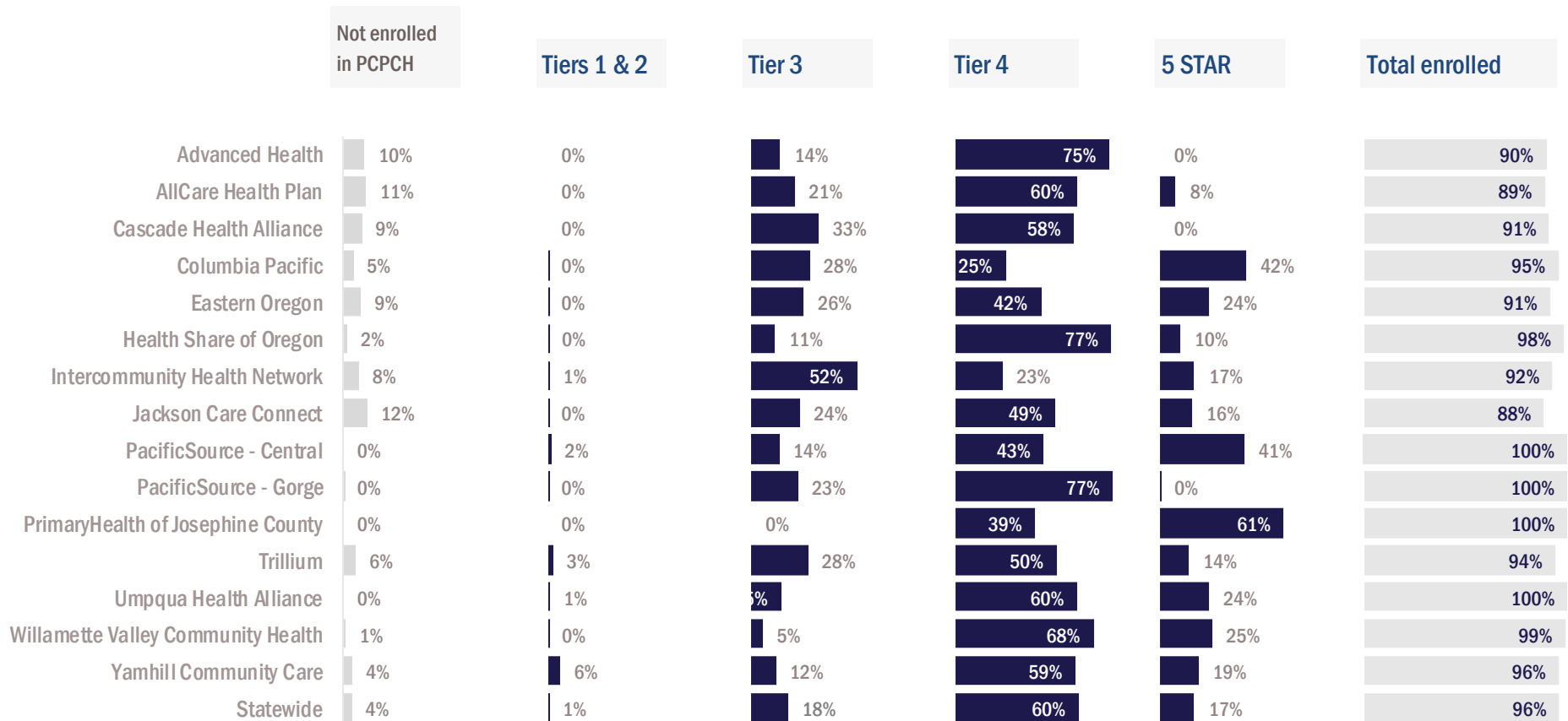


PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Statewide in 2018, 96 percent of CCO members are enrolled in a PCPCH, resulting in a weighted score of 76.2 percent.

The Patient-Centered Primary Care Home (PCPCH) enrollment incentive measure uses a weighted methodology to ensure members are not just enrolled in a PCPCH, but are enrolled in the higher PCPCH tiers.

Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years. The graphs below show member enrollment by CCO across the PCPCH tiers. The next page shows each CCO's PCPCH "score" using the weighted methodology for the incentive measure. A CCO must achieve a score of at least 60 percent to be eligible to earn 100 percent of its quality pool.

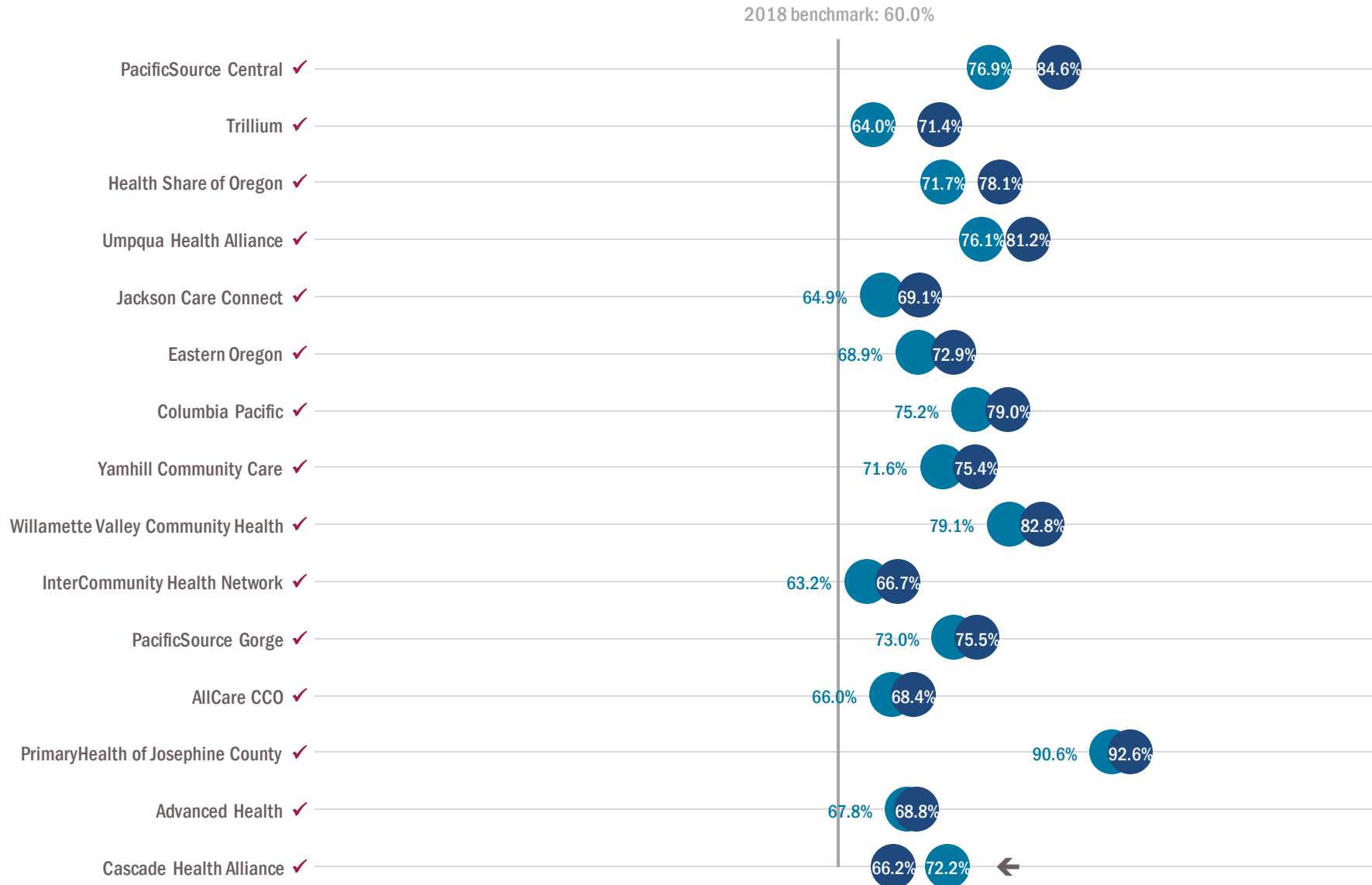




PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-Centered Primary Care Home enrollment score in 2017 and 2018, by CCO.

✓ indicates CCO met 60 percent threshold.





PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

Data source:

Administrative (billing) claims and medical record review

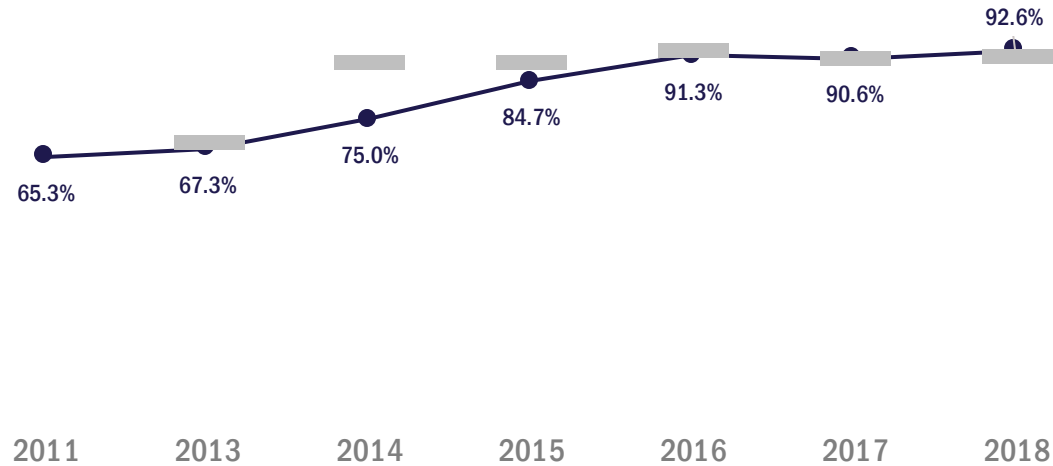
2018 benchmark source:

2017 national Medicaid 90th percentile

2018 data (N=5,235)

- Statewide change since 2017: **+1.6%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **15**

Statewide



By region



[Back to table of contents.](#)

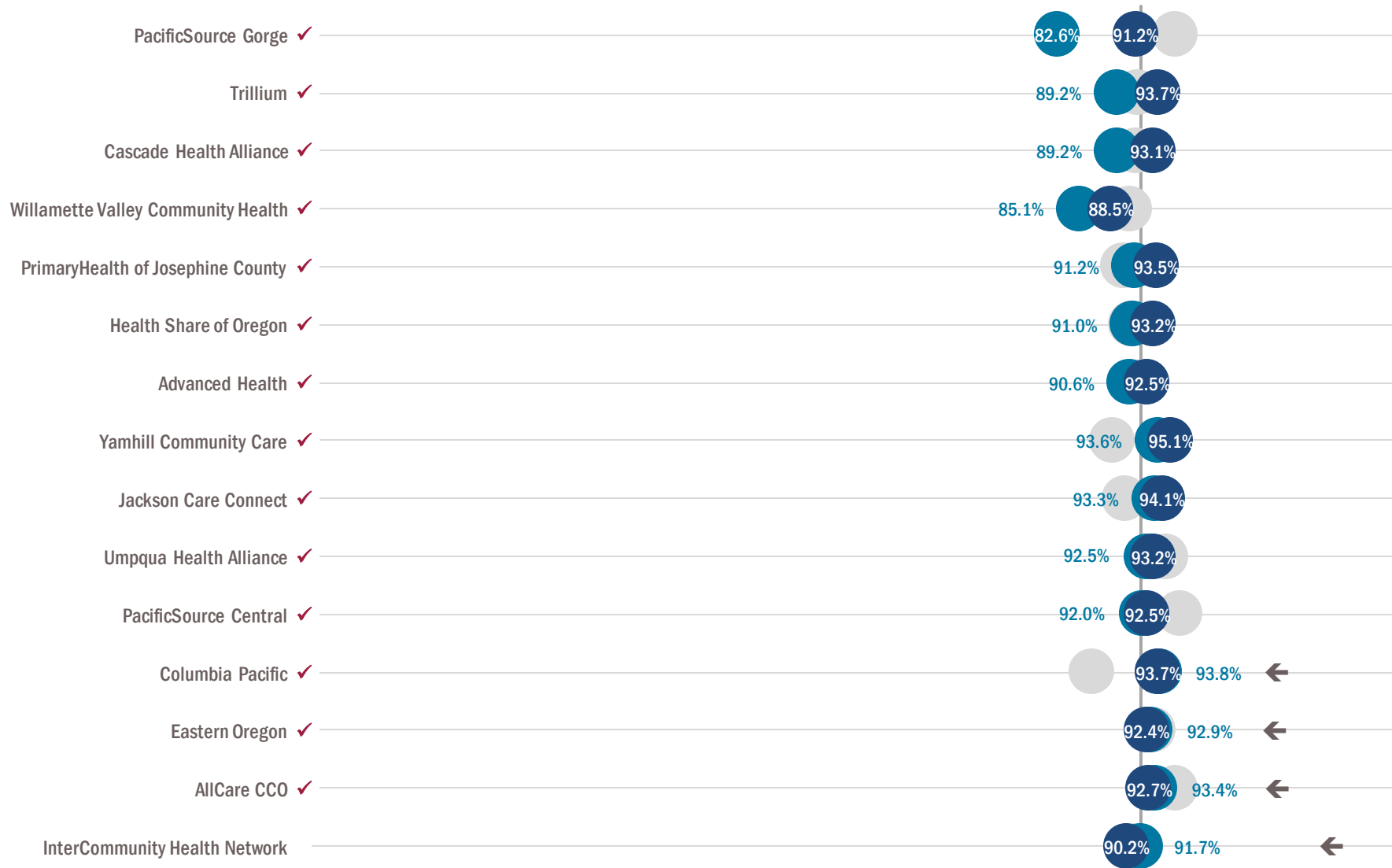


PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care in 2017 and 2018, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2016.

2018 benchmark: 91.7%





Weight assessment and counseling

Percentage of patients 3-17 years of age who had evidence of the following during the measurement period. Three rates are reported and averaged:

- 1) % of patients with height, weight and BMI documentation
- 2) % of patients with counseling for nutrition
- 3) % of patients with counseling for physical activity

Data source:

Electronic Health Records

2018 benchmark source:

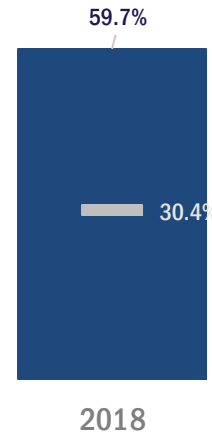
MIPS 2017 benchmarks - 50th percentile

2018 data (N=511,383)

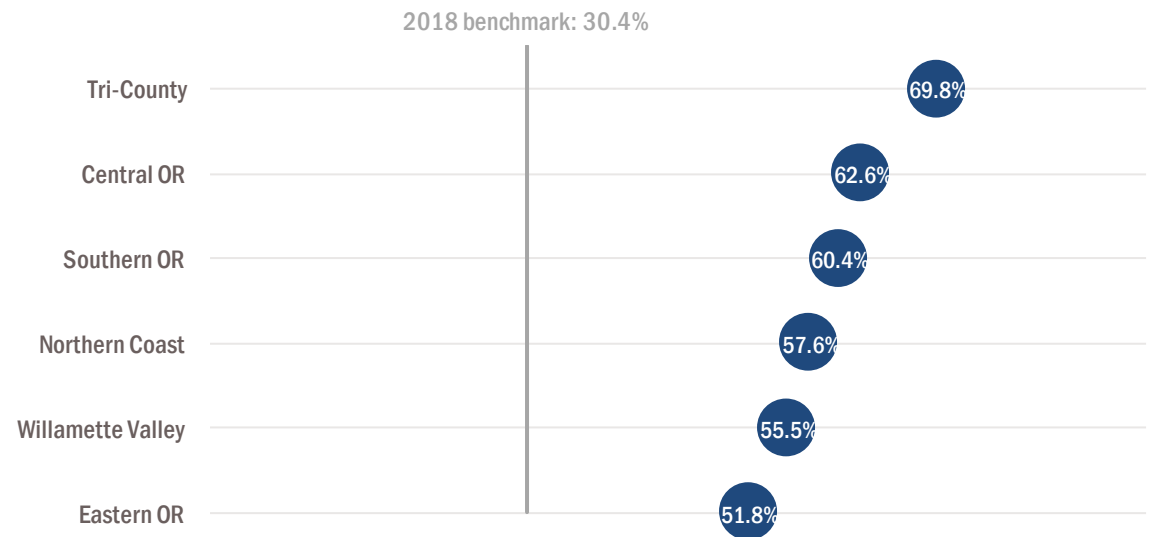
- Statewide change since 2017: *n/a*
- Number of CCOs that improved: *n/a*
- Number of CCOs achieving target: 15

[Back to table of contents.](#)

Statewide



By region

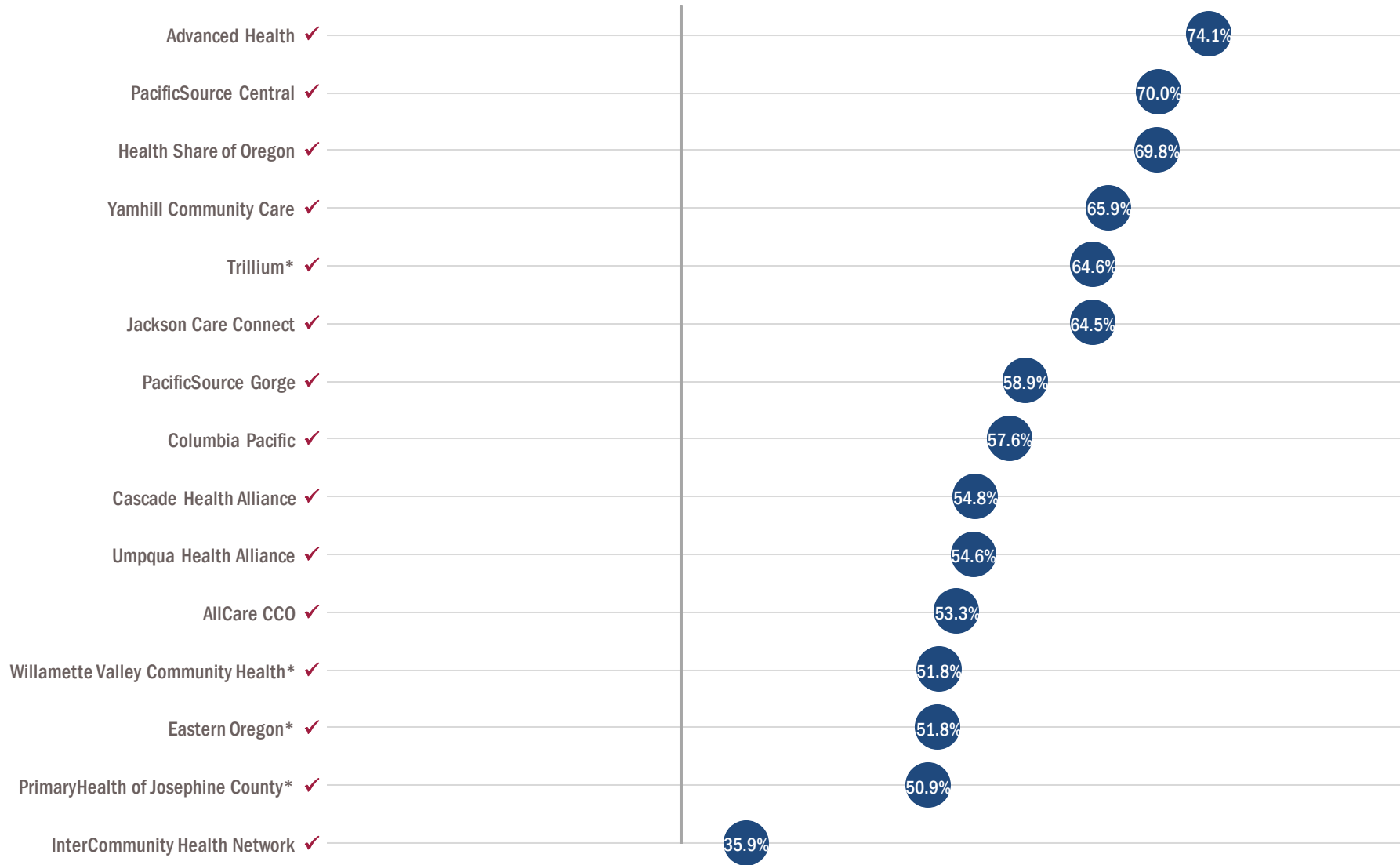




Weight assessment, nutrition, and activity counseling for children and adolescents in 2018, by CCO.

✓ indicates CCO met benchmark. Because 2018 was the first reporting year, no improvement targets were set.

2018 benchmark: 30.4%



Appendix B



State Quality and



CMS Core measures



ALL-CAUSE READMISSIONS

All-cause readmissions

Percentage of adult members (ages 18 and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge. A lower score for this measure is better.

Data source:

Administrative (billing) claims

2018 benchmark source:

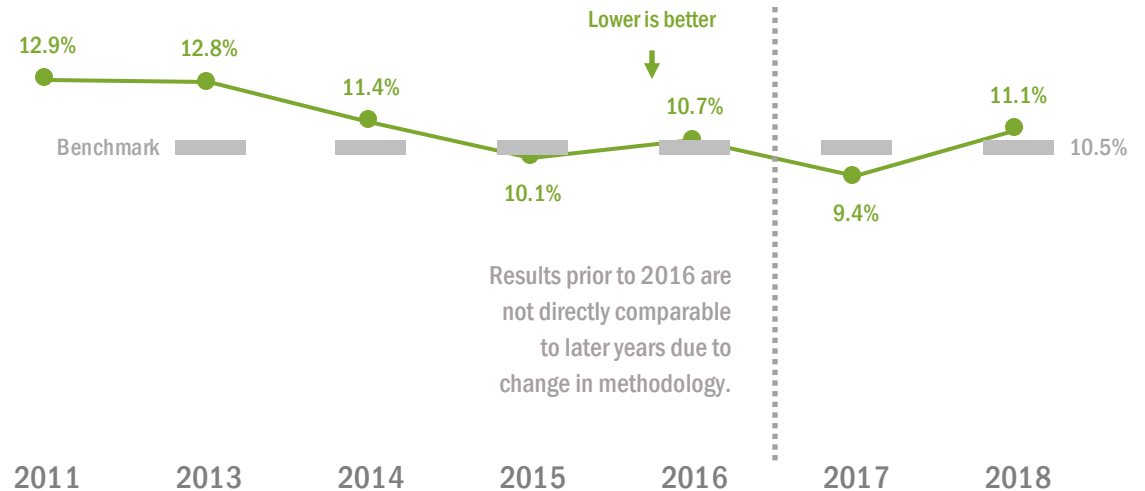
Average of 2013 commercial and Medicare 75th percentiles

2018 data (N=32,008)

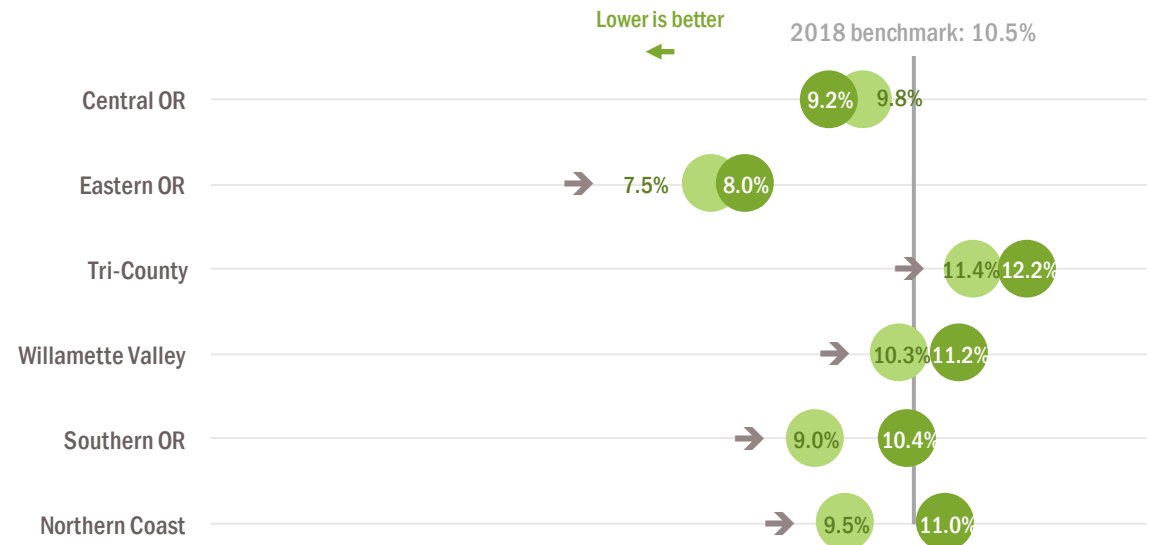
- Statewide change since 2017: **+6.7%**
- Number of CCOs that improved: **2**

[Back to table of contents.](#)

Statewide



By region





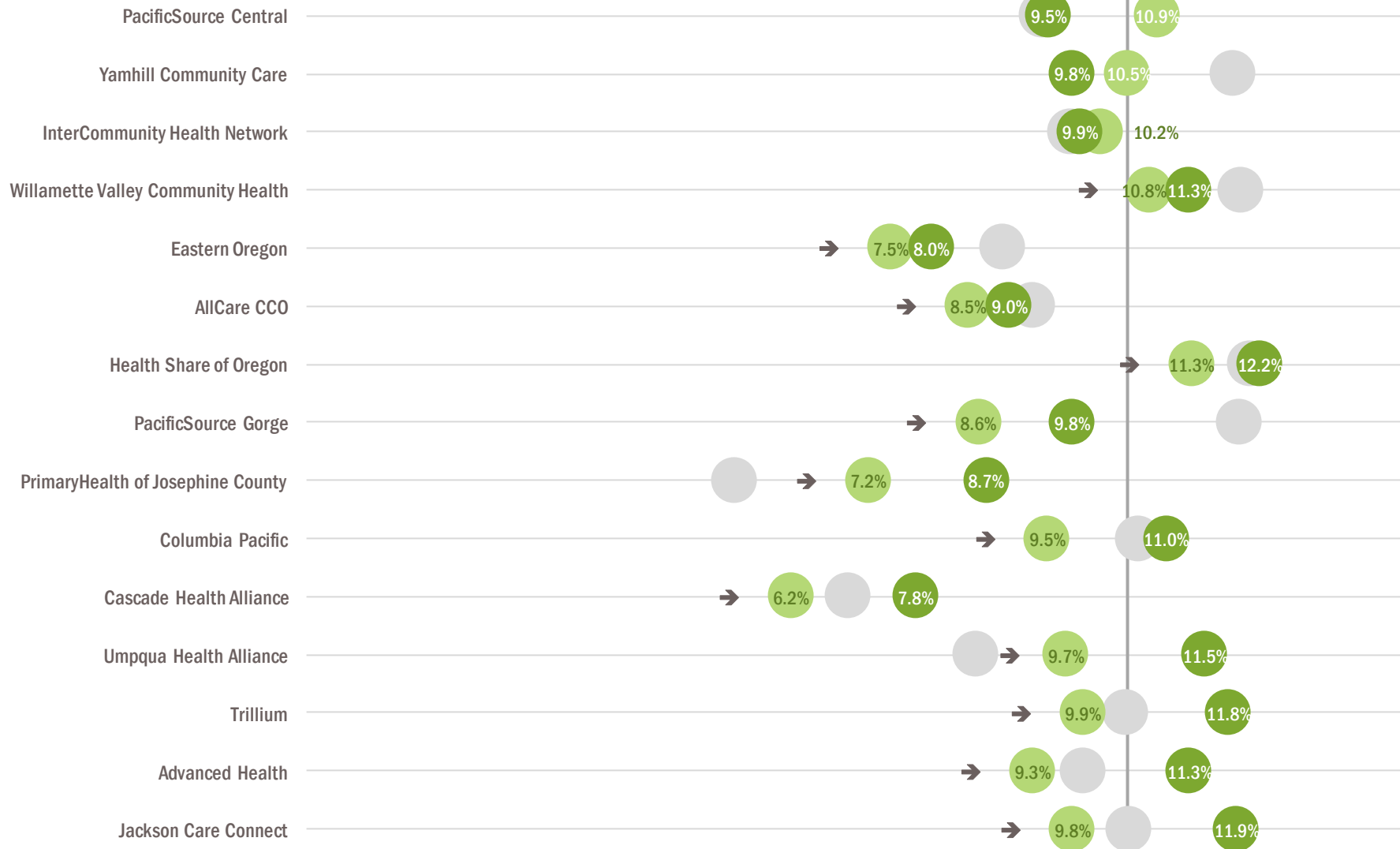
ALL-CAUSE READMISSIONS

Hospital all-cause readmissions in 2017 and 2018, by CCO.

Grey dots represent 2016.

Lower is better ←

2018 benchmark: 10.5%



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable ED utilization

Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.

Rates are derived from the Ambulatory care: emergency department utilization measure and are reported per 1,000 member months. A lower number suggests more appropriate emergency department utilization.

Data source:

Administrative (billing) claims

2018 benchmark source:

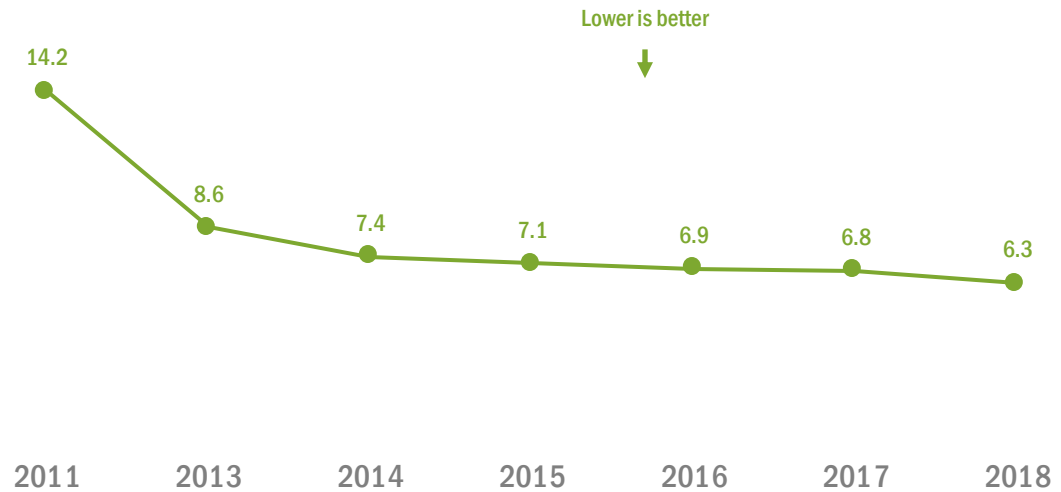
n/a

2018 data (N=9,989,010 member months)

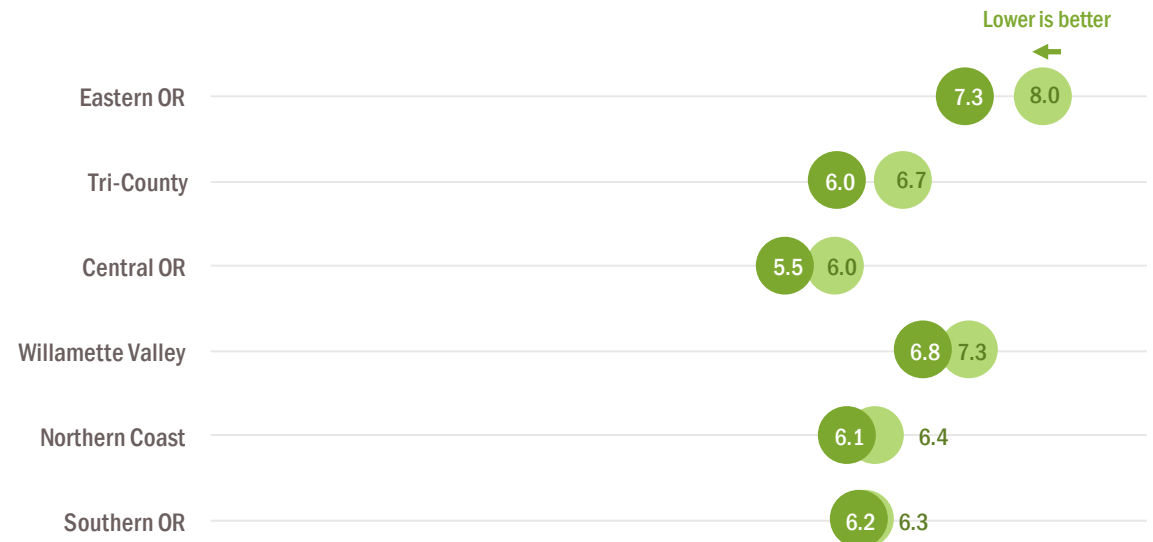
- Statewide change since 2017: **-8.7%**
- Number of CCOs that improved: **11**

[Back to table of contents.](#)

Statewide



By region



AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2017 and 2018, by CCO.

Grey dots represent 2016.





AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization

Rate of outpatient services, such as office visits, home visits, nursing home care, urgent care and counseling or screening services

Data source:

Administrative (billing) claims

2018 benchmark source:

n/a

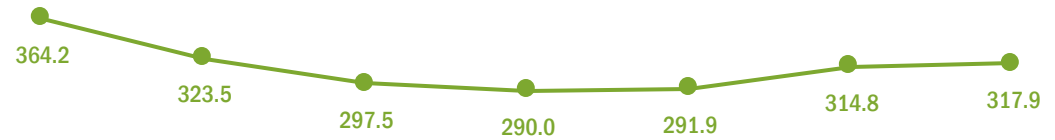
2018 data (N=9,989,010 member months)

- Statewide change since 2017: **-0.1%**

Rates are shown per 1,000 member months, which means that in one month, there are on average X visits occurring per 1,000 CCO members.

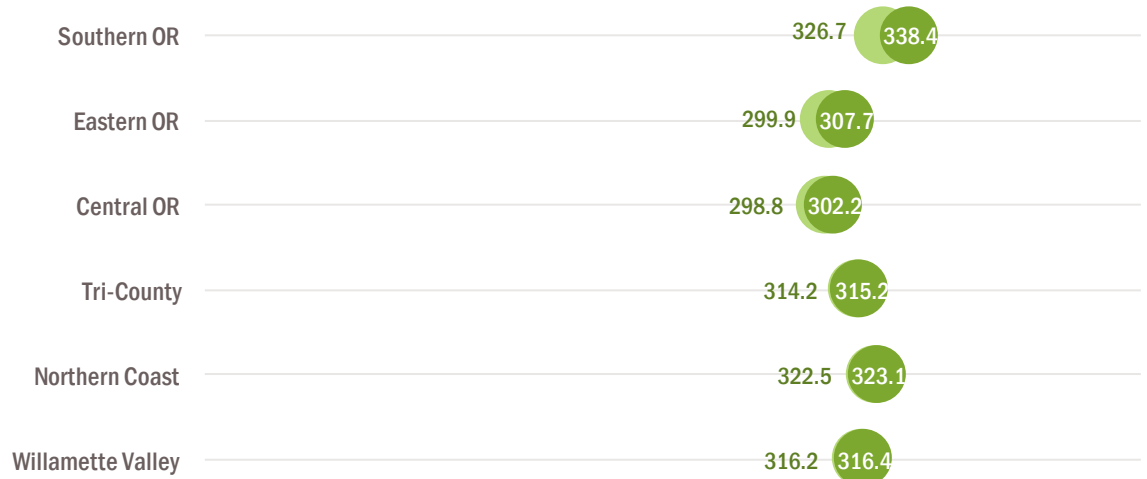
[Back to table of contents.](#)

Statewide



2011 2013 2014 2015 2016 2017 2018

By region

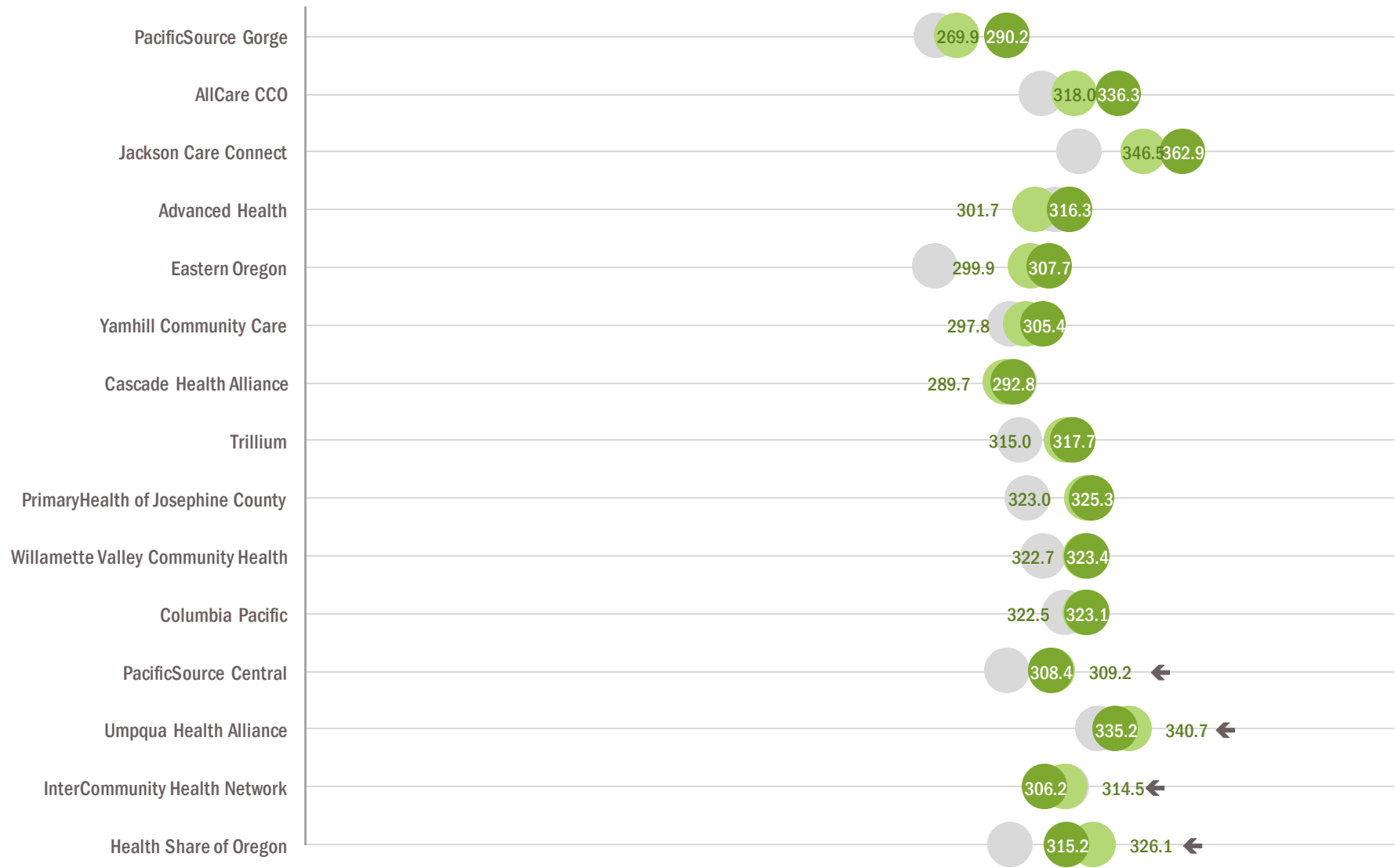




AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2017 and 2018, by CCO.

Grey dots represent 2016.





ANY DENTAL SERVICE

Any Dental Service

Percentage of CCO members (all ages) who received at least one dental or oral health service within the reporting year.

Data source:

Administrative (billing) claims

2018 benchmark source:

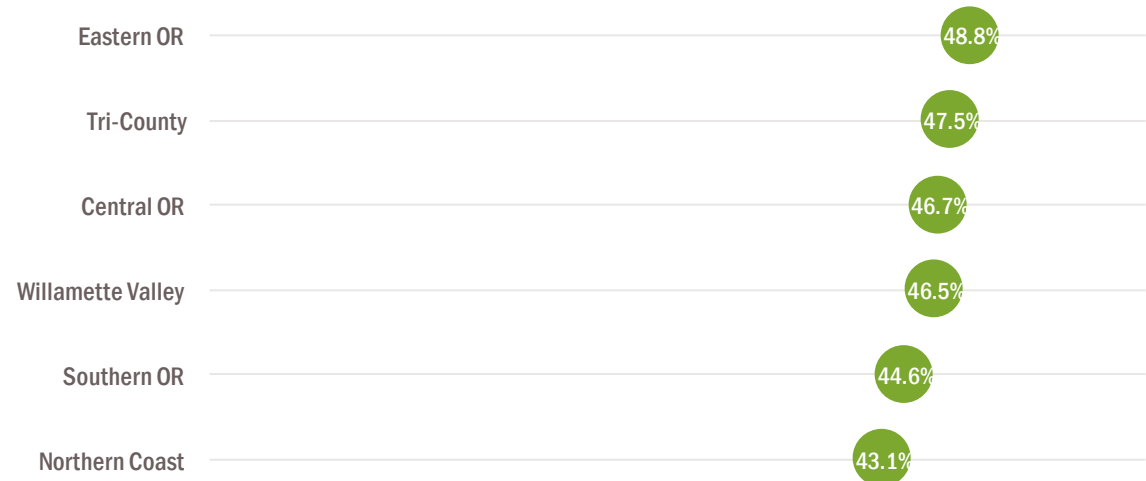
n/a

2018 data (N=732,455)

Statewide



By region

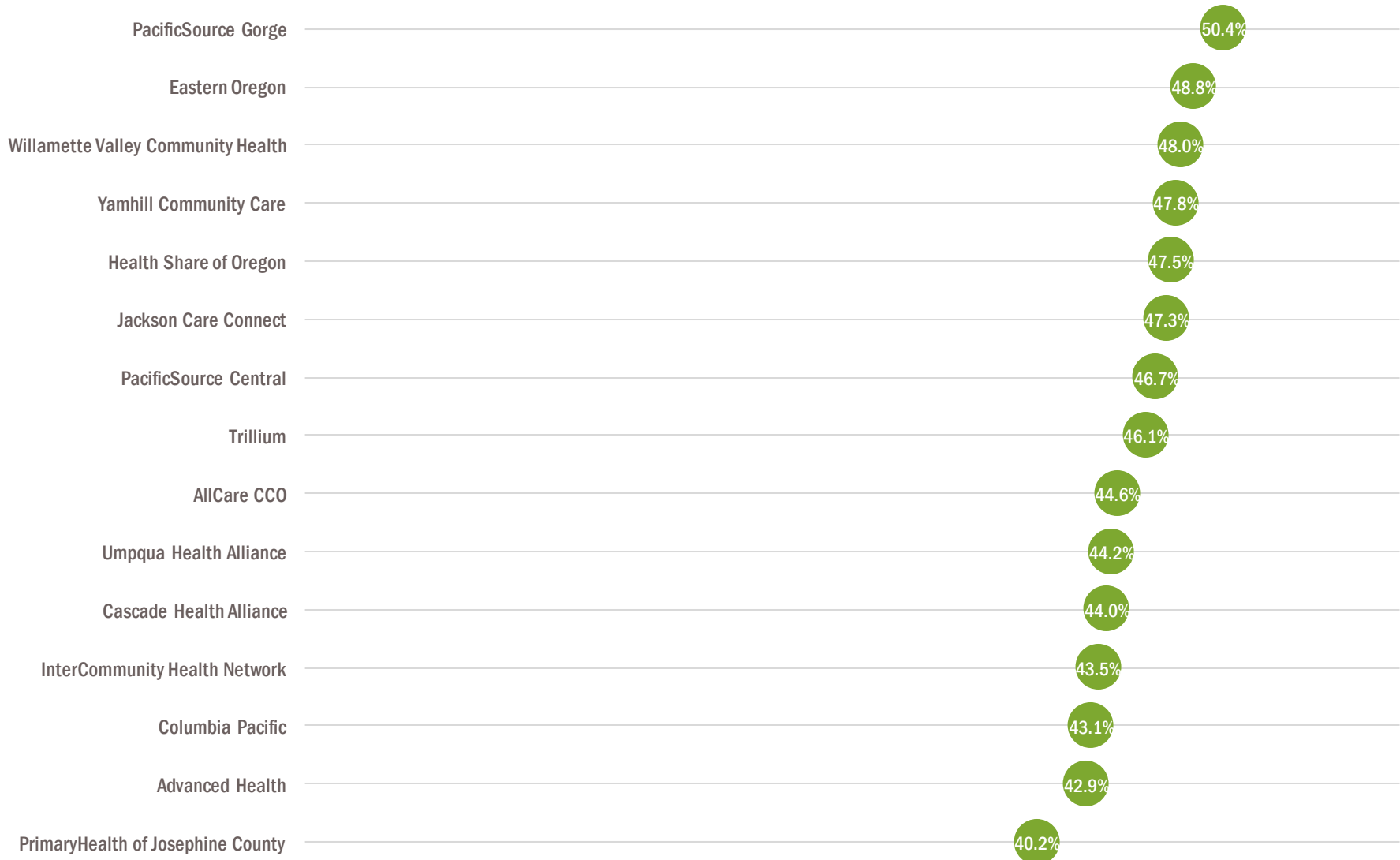


[Back to table of contents.](#)



ANY DENTAL SERVICE

ANY DENTAL SERVICE in 2017 and 2018, by CCO.





CAHPS: ACCESS TO DENTAL CARE—ADULTS

CAHPS: Access to Dental Care—Adults

Percentage of adult members who said they had a regular dentist they would go to for checkups and cleanings or when they have cavity or tooth pain.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

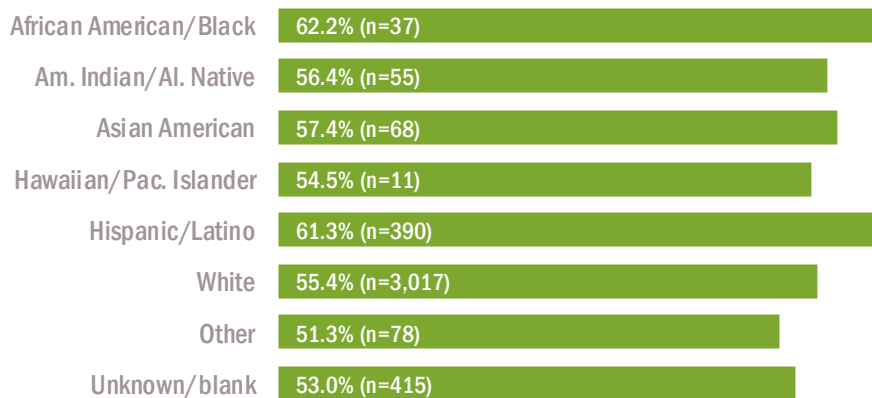
n/a

2018 data (N=4,071)

Statewide



By race/ethnicity



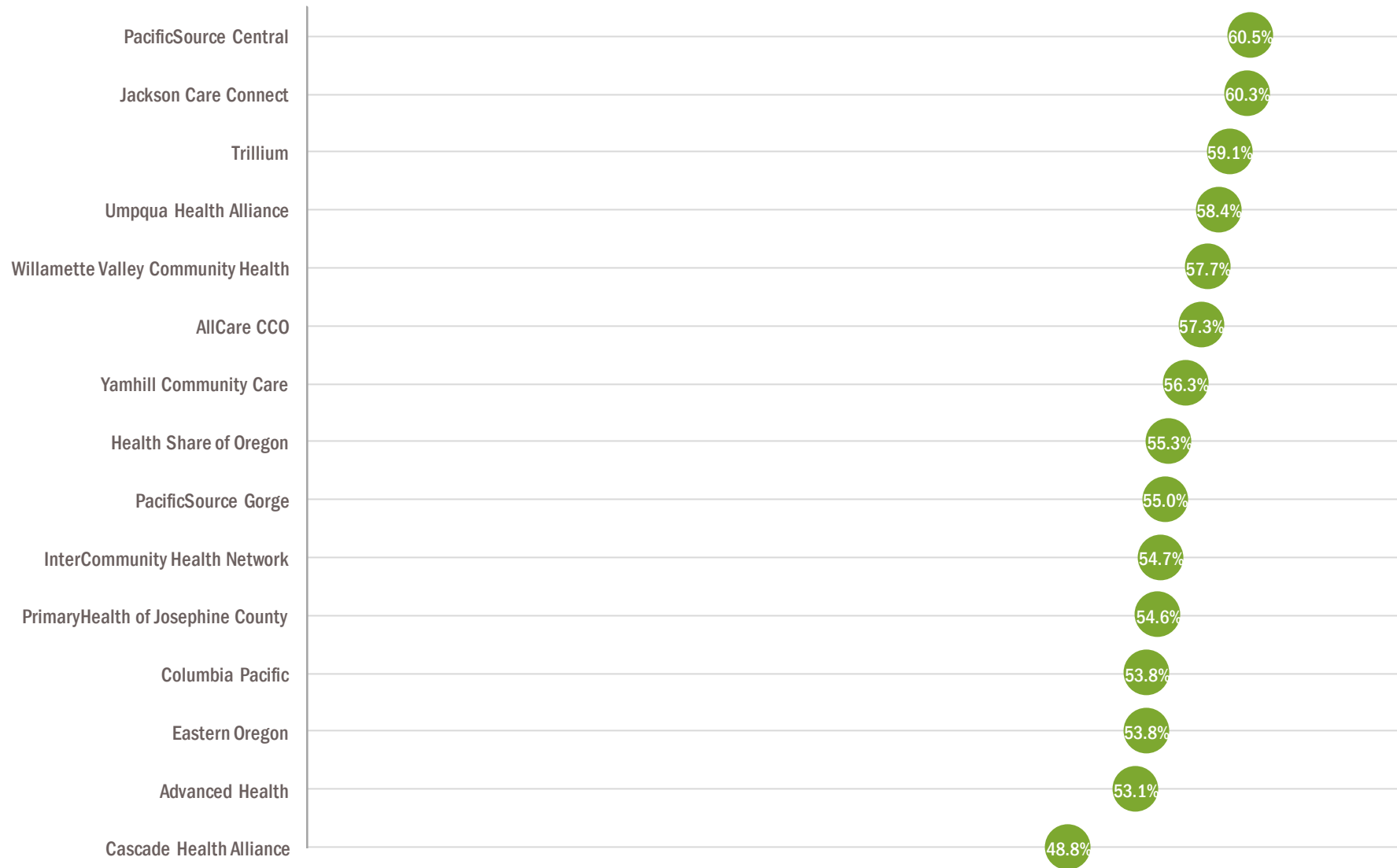
^ data suppressed (n<10)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: ACCESS TO DENTAL CARE—ADULTS

CAHPS: Access to Dental Care—Adults in 2018, by CCO.





CAHPS: ACCESS TO DENTAL CARE—CHILDREN

CAHPS: Access to Dental Care—Children

Percentage of parents who said their children had a regular dentist they would go to for checkups and cleanings or when they have cavity or tooth pain.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

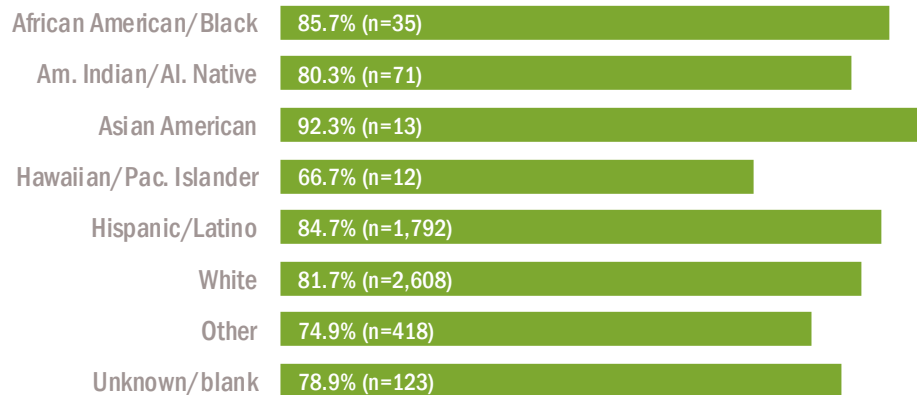
n/a

2018 data (N=5,072)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: ACCESS TO DENTAL CARE—CHILDREN

CAHPS: Access to Dental Care—Children in 2018, by CCO.





CAHPS: GETTING NEEDED CARE—ADULTS

CAHPS: Getting Needed Care—Adults

Percentage of adult members who said it was easy to get the care, tests or treatment they needed and that they could get an appointment to see a specialist as soon as they needed.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

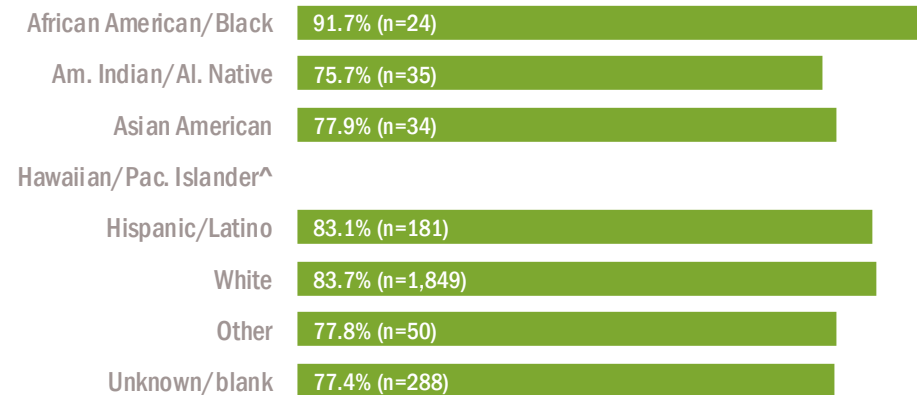
n/a

2018 data (N=2,468)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: GETTING NEEDED CARE—ADULTS

CAHPS: Getting Needed Care—Adults in 2018, by CCO.





CAHPS: GETTING NEEDED CARE—CHILDREN

CAHPS: Getting Needed Care—Children

Percentage of parents who said it was easy to get their children the care, tests or treatment they needed and that they could get an appointment to see a specialist as soon as they needed.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

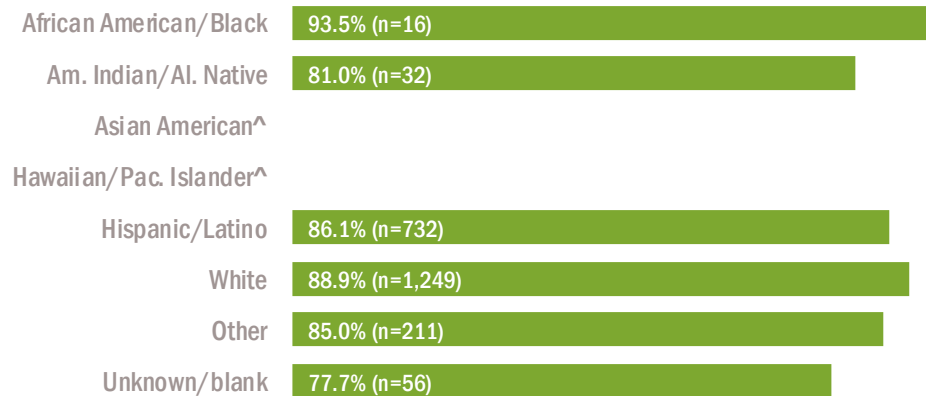
n/a

2018 data (N=2,309)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: GETTING NEEDED CARE—CHILDREN

CAHPS: Getting Needed Care—Children in 2018, by CCO.





CAHPS: HEALTH STATUS—ADULTS

CAHPS: Health Status—Adults

Percentage of adult members who would rate their overall health as good, very good or excellent.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

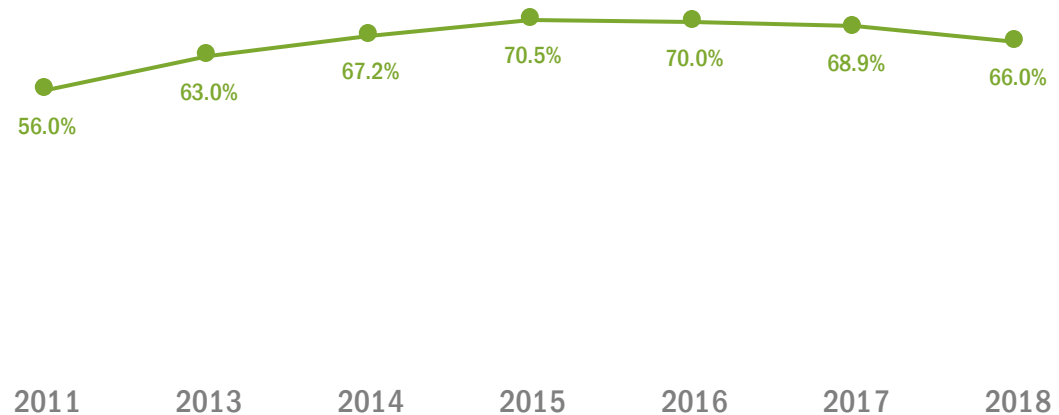
n/a

2018 data (N=4,085)

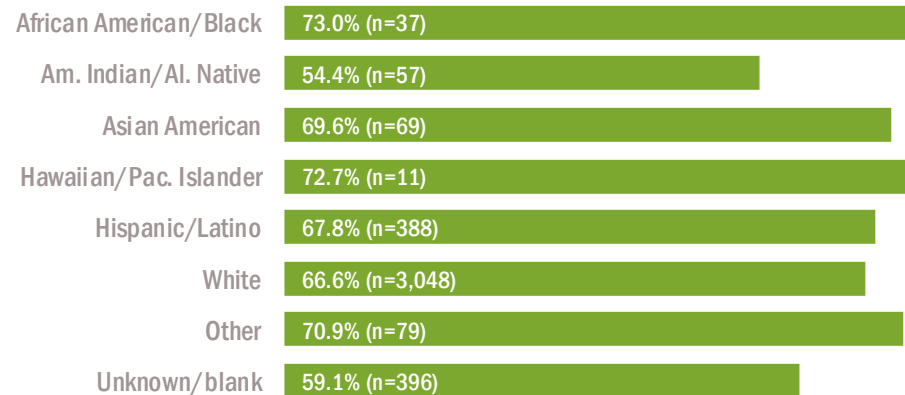
- Statewide change since 2017: **-4.2%**
- Number of CCOs that improved: **6**

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

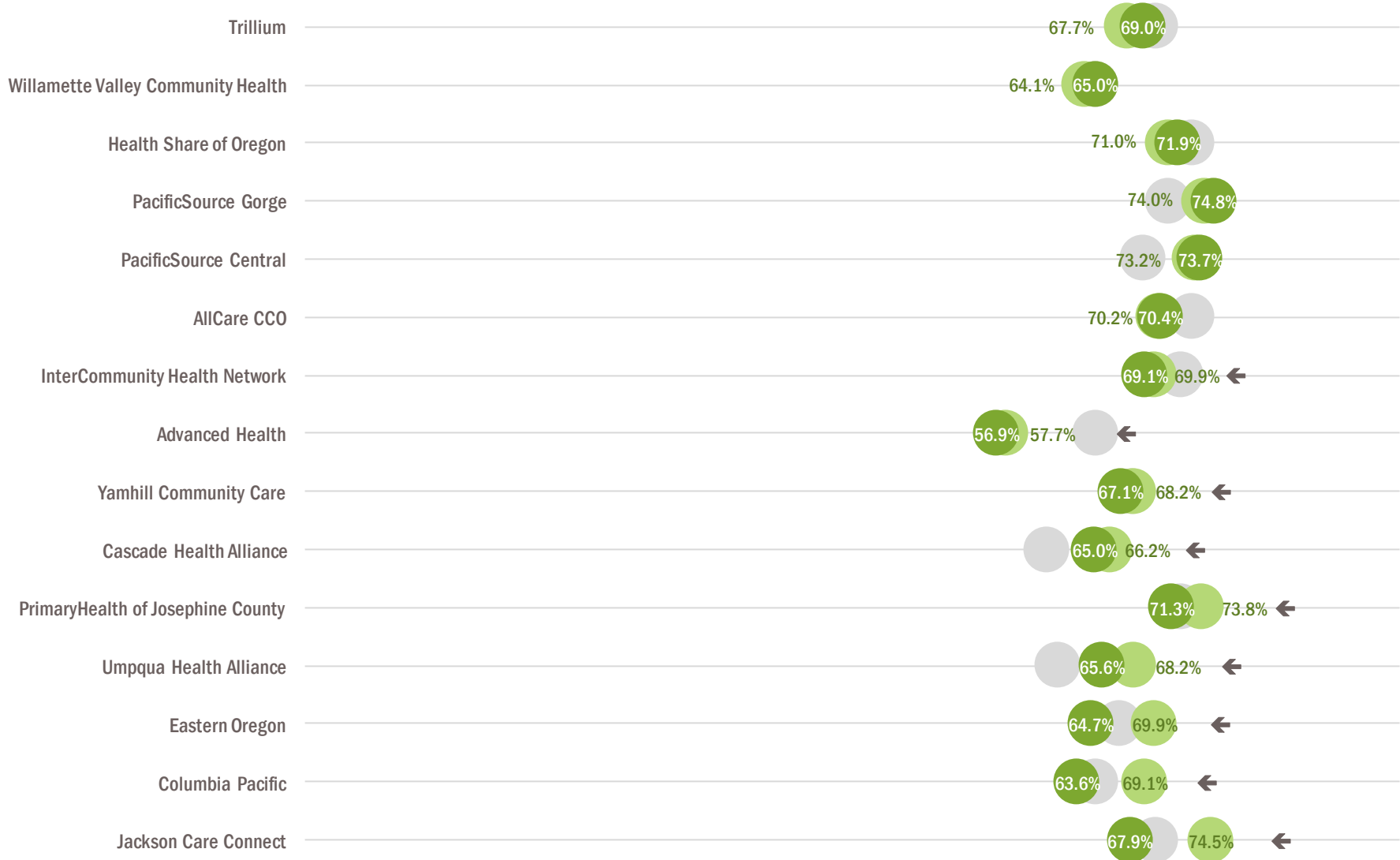
Each race category excludes Hispanic/Latino



CAHPS: HEALTH STATUS—ADULTS

CAHPS: Health Status—Adults in 2017 and 2018, by CCO.

Grey dots represent 2016.





CAHPS: HEALTH STATUS—CHILDREN

CAHPS: Health Status—Children

Percentage of parents who would rate their child's overall health as good, very good or excellent.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

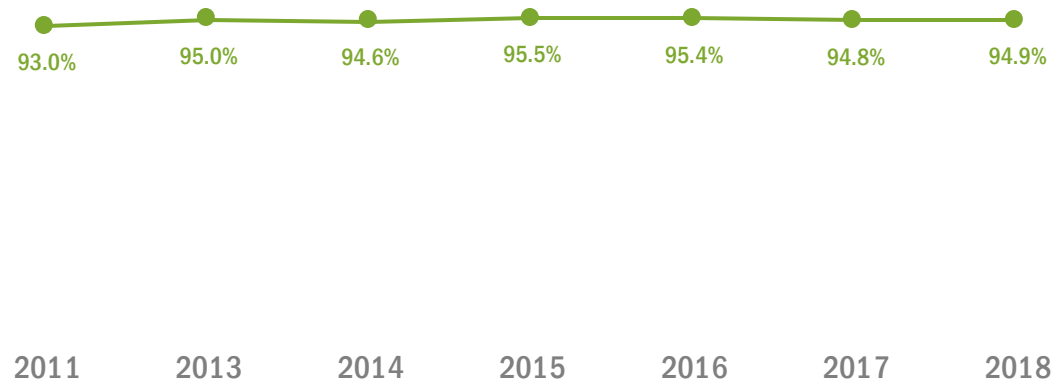
n/a

2018 data (N=5,154)

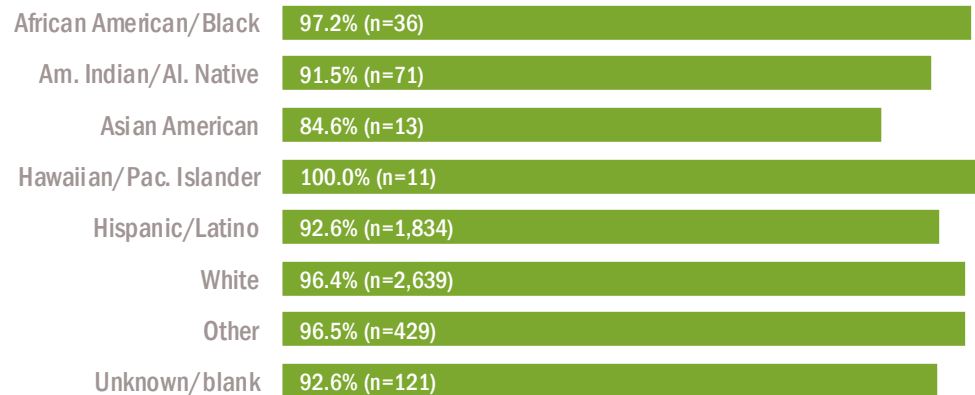
- Statewide change since 2017: **-13.3%**
- Number of CCOs that improved: **9**

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

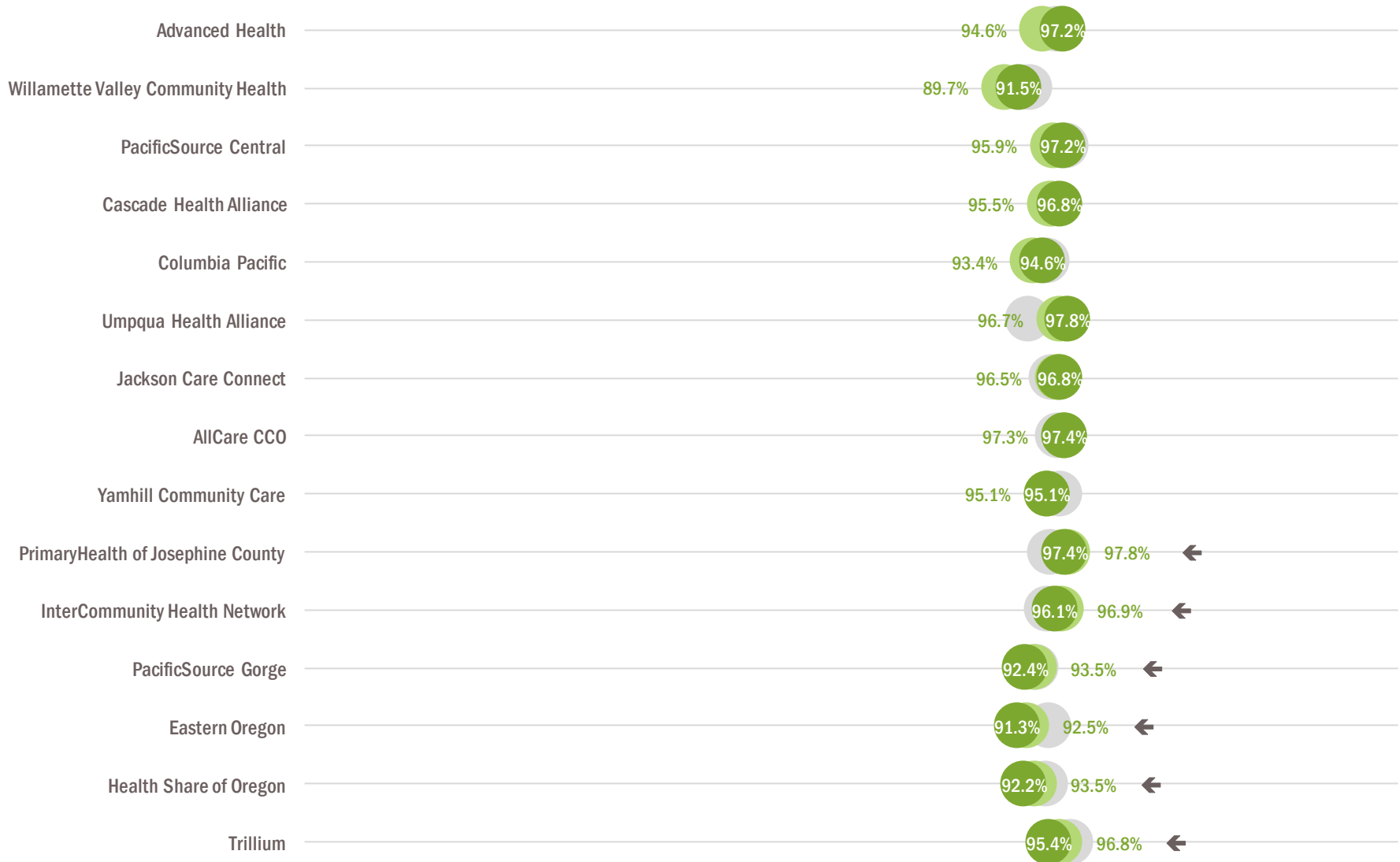
Each race category excludes Hispanic/Latino



CAHPS: HEALTH STATUS—CHILDREN

CAHPS: Health Status—Children in 2017 and 2018, by CCO.

Grey dots represent 2016.





CAHPS: HOW WELL DOCTORS COMMUNICATE—ADULTS

CAHPS: Doctors Communicate—Adults

Percentage of adult members who thought their personal doctor explained things in a way that was easy to understand, listened carefully to them, showed respect for what they had to say, and spent enough time with them.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

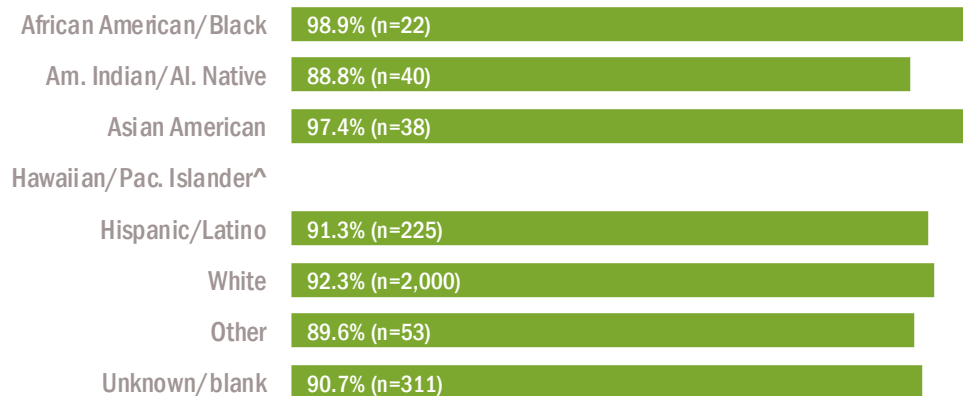
n/a

2018 data (N=2,694)

Statewide



By race/ethnicity



^ data suppressed (n<10)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: HOW WELL DOCTORS COMMUNICATE—ADULTS

CAHPS: How Well Doctors Communicate—Adults in 2018, by CCO.





CAHPS: Doctors Communicate—Children

Percentage of parents who thought their child's personal doctor explained things in a way that was easy to understand, listened carefully to them, showed respect for what they had to say, and spent enough time with them.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

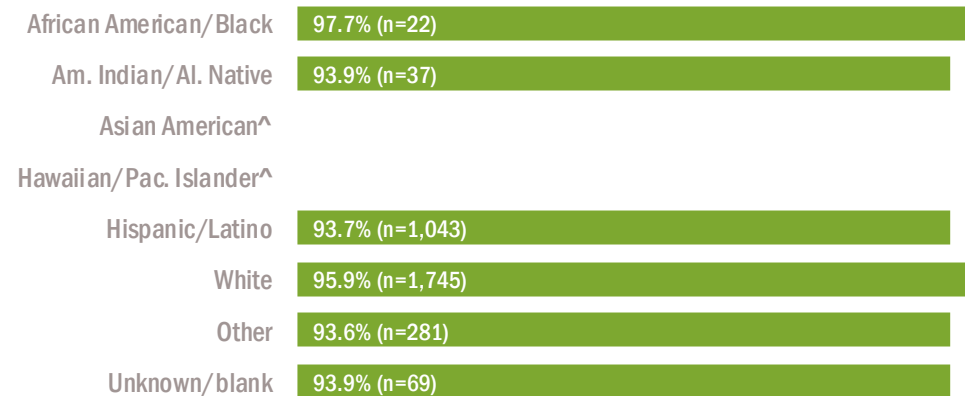
n/a

2018 data (N=3,210)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: How Well Doctors Communicate—Children in 2018, by CCO.





Med Cessation: Advised to Quit

Percentage of adult members who said their doctor or other health provider advised them to quit smoking or using tobacco.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

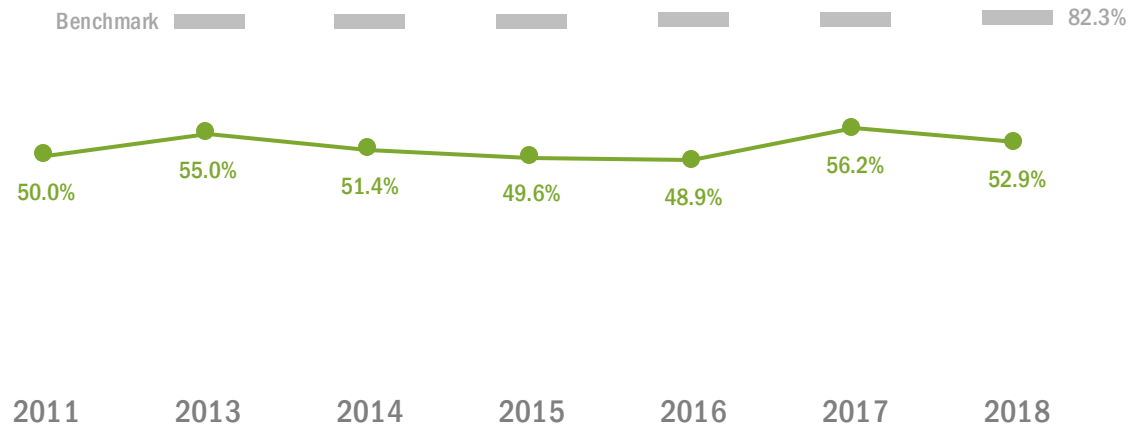
2017 national Medicaid 90th percentile

2018 data (N=1,163)

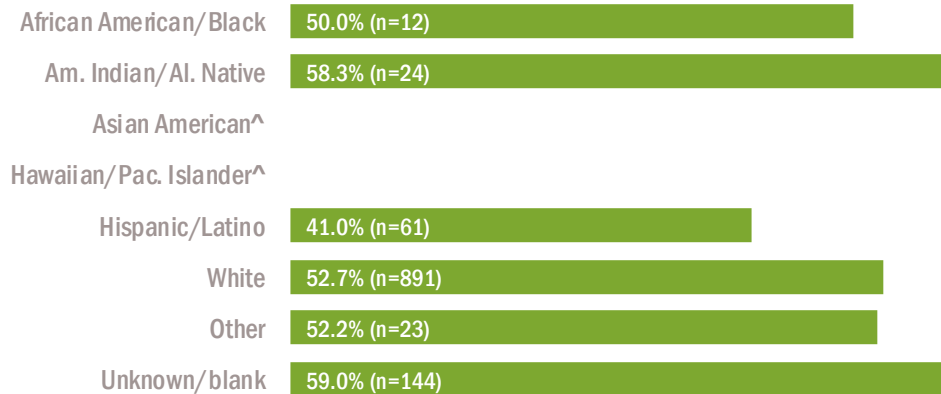
- Statewide change since 2017: **-5.9%**
- Number of CCOs that improved: **6**

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

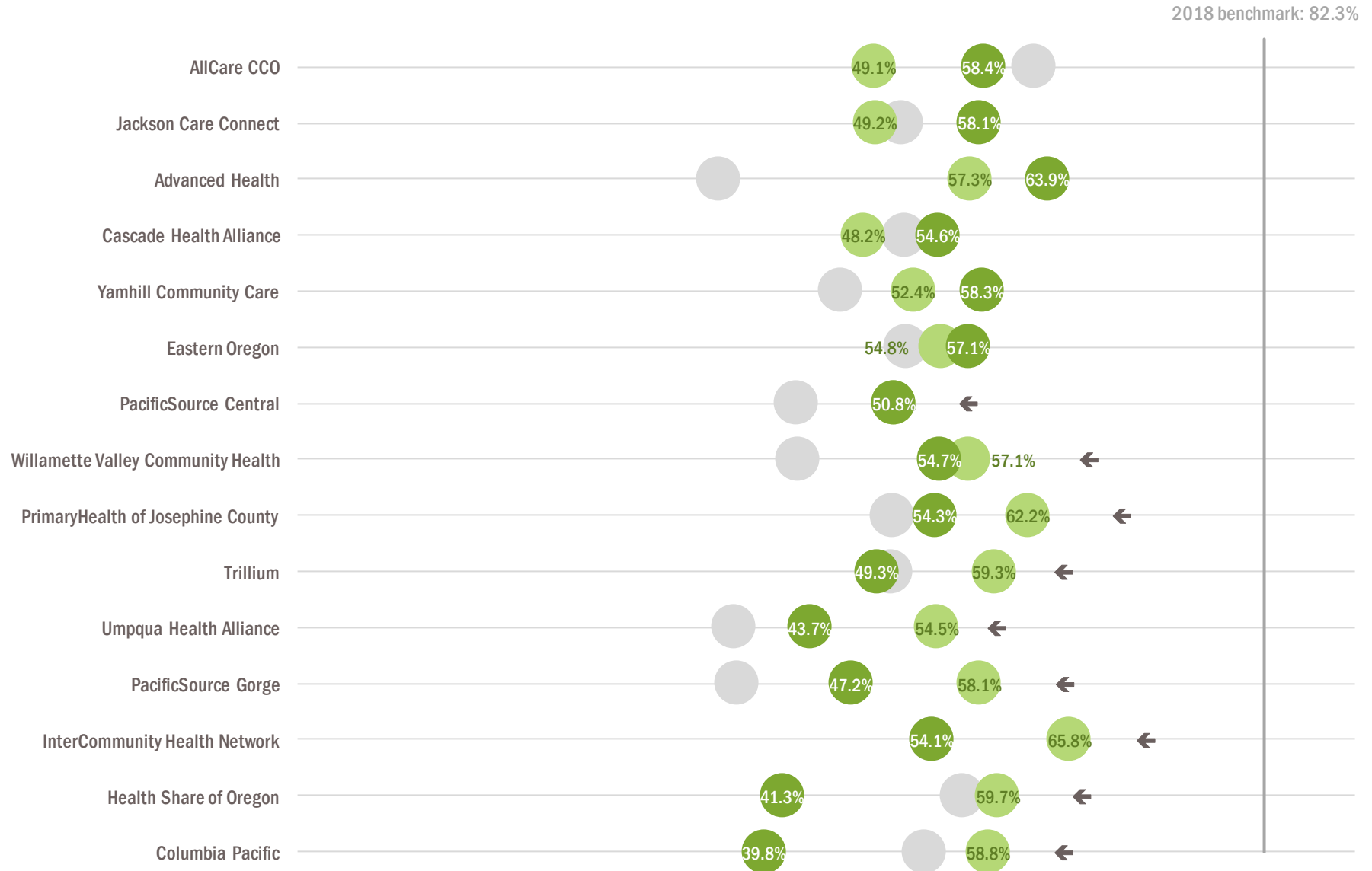
n = subpopulation denominator

Each race category excludes Hispanic/Latino



CAHPS: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED TO QUIT

Med Cessation: Advised to Quit in 2017 and 2018, by CCO.





Med Cessation: Advised Medication

Percentage of adult members who said their doctor or other health provider recommended or discussed medication to assist with quitting smoking or using tobacco.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

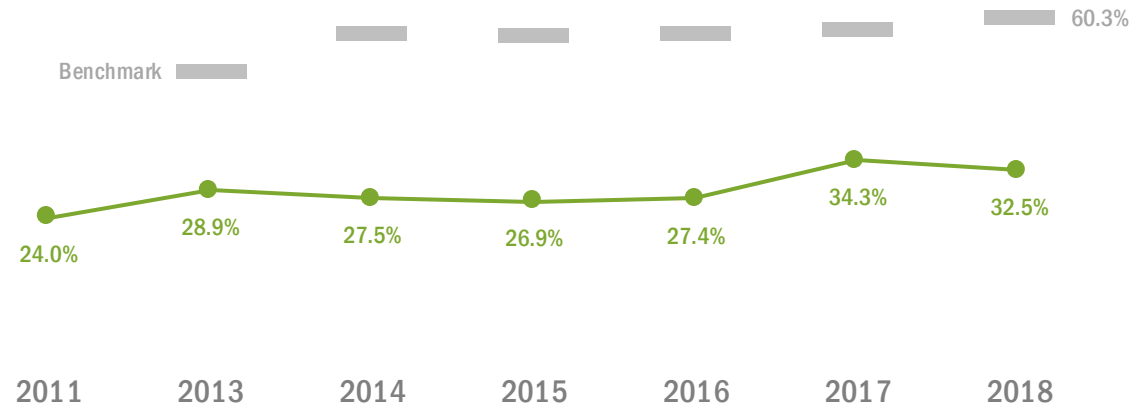
2017 national Medicaid 90th percentile

2018 data (N=1,163)

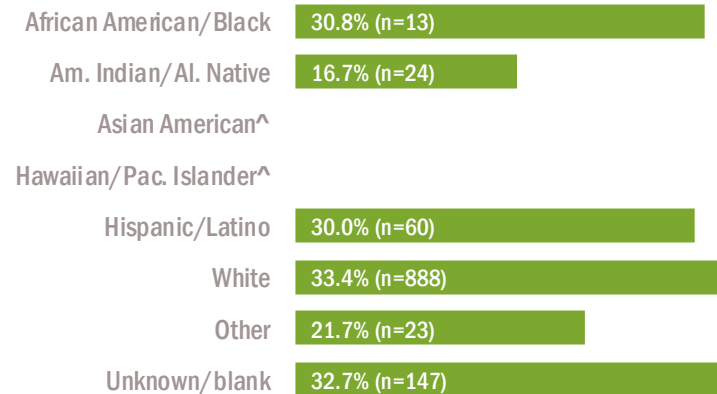
- Statewide change since 2017: **-5.2%**
- Number of CCOs that improved: **7**

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

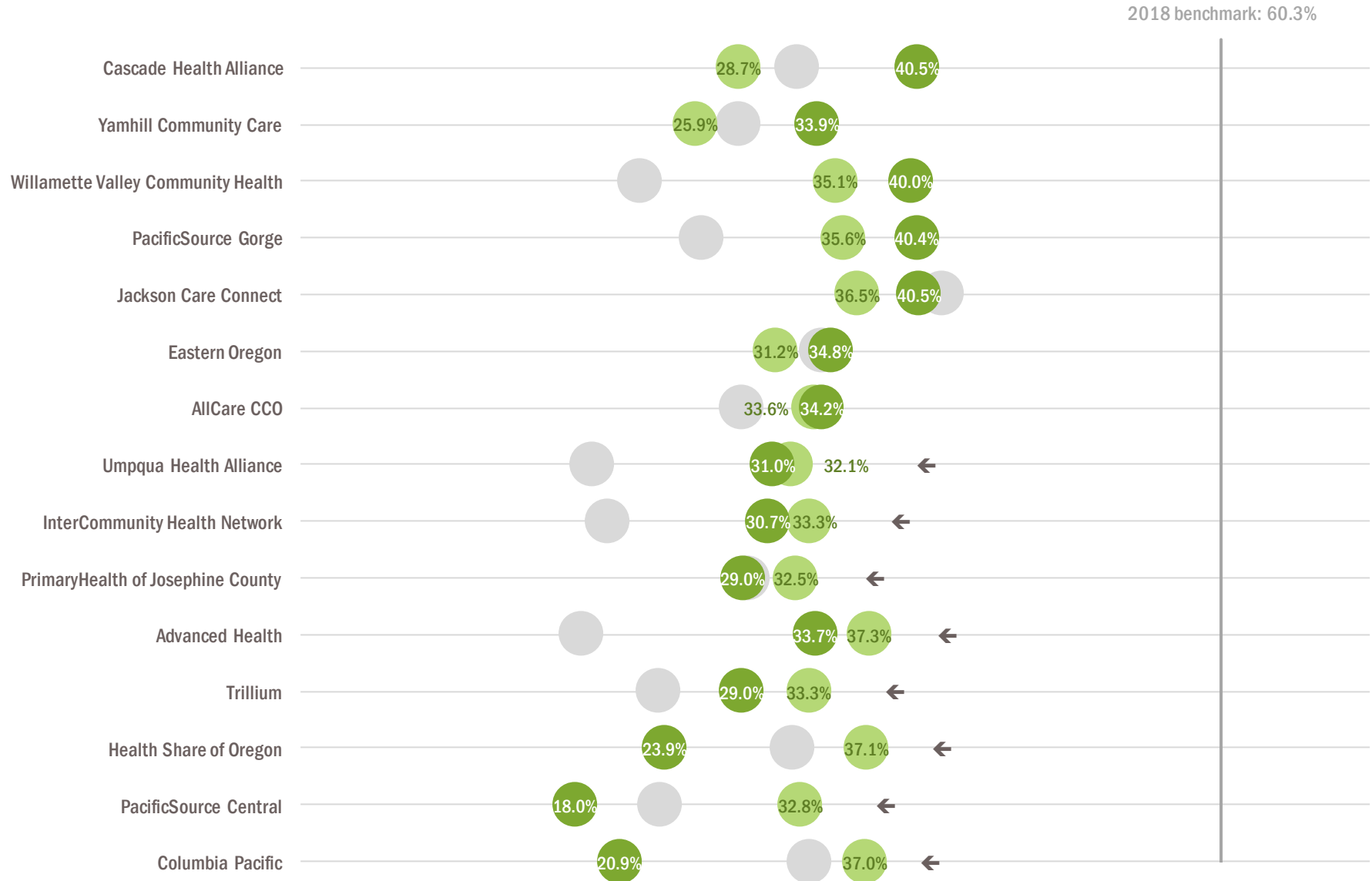
n = subpopulation denominator

Each race category excludes Hispanic/Latino



CAHPS: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED MEDICATION

Med Assistance: Advised Medication in 2017 and 2018, by CCO.





Med Assistance: Advised Strategies

Percentage of adult members who said their doctor or other health provider recommended or discussed strategies other than medication to assist with quitting smoking or using tobacco.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

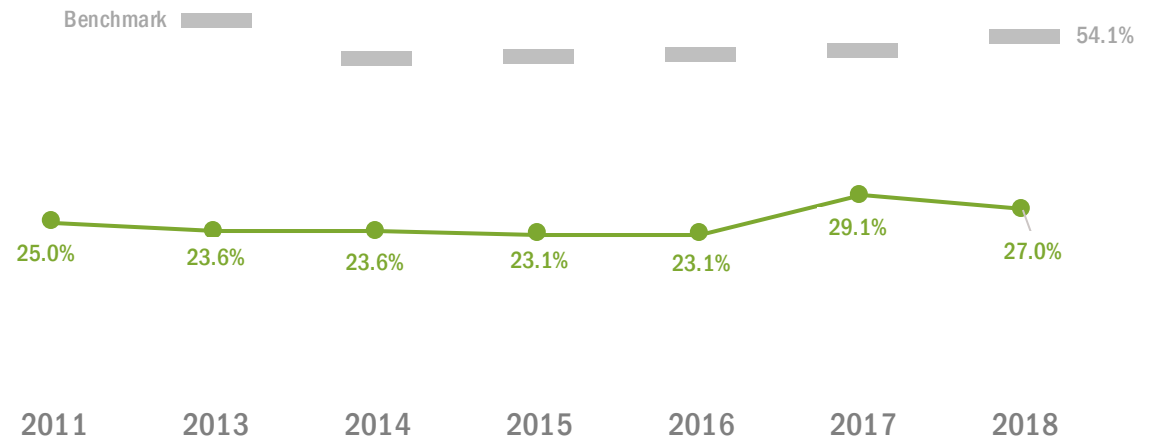
2017 national Medicaid 90th percentile

2018 data (N=1,154)

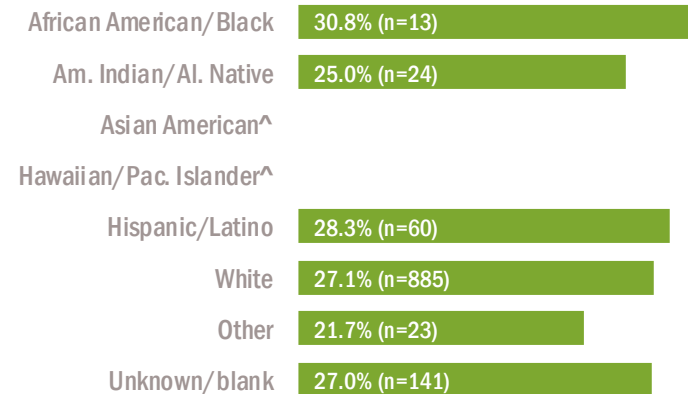
- Statewide change since 2017: **-7.2%**
- Number of CCOs that improved: **6**

[Back to table of contents.](#)

Statewide



By race/ethnicity



^ data suppressed (n<10)

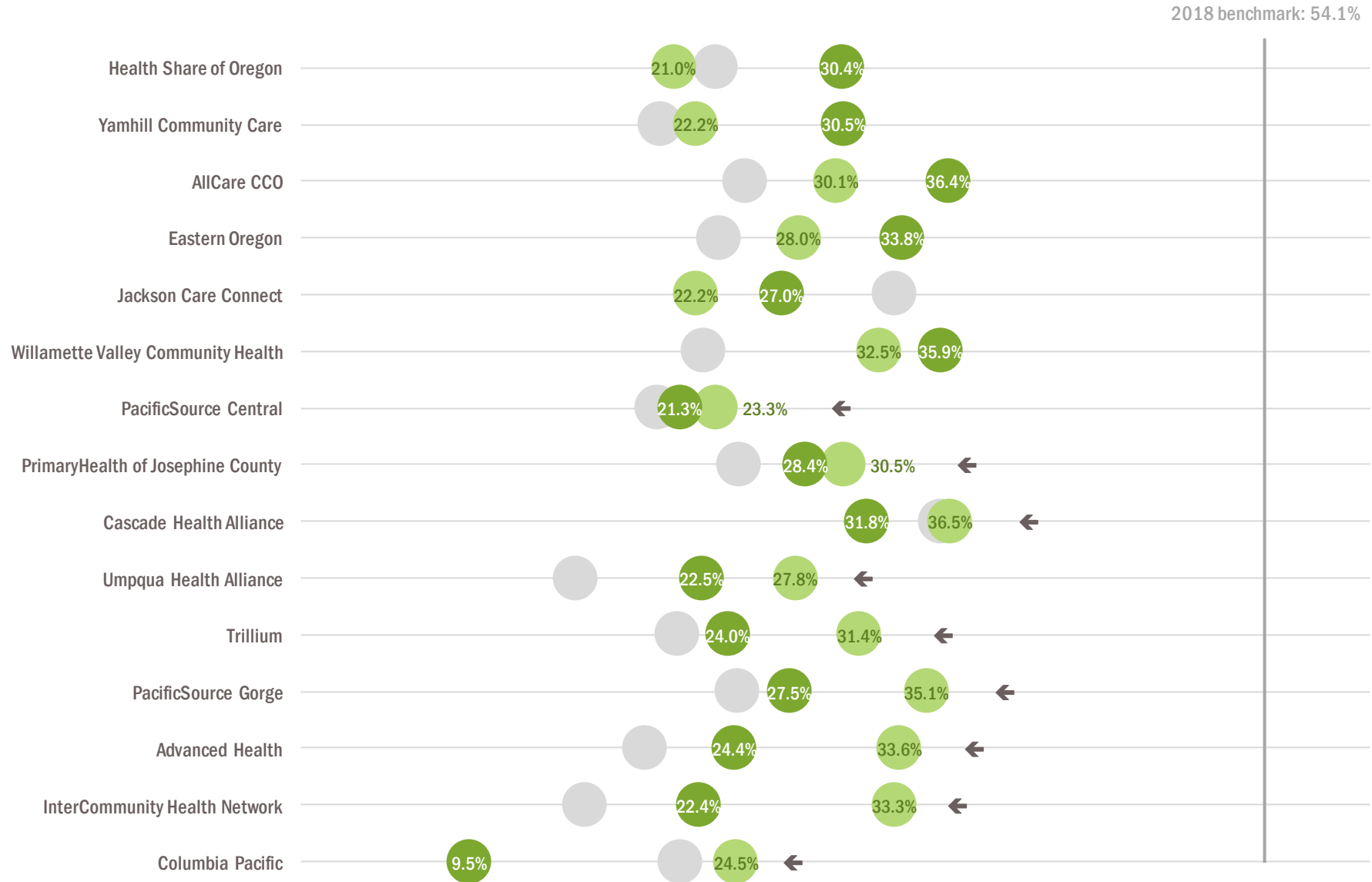
n = subpopulation denominator

Each race category excludes Hispanic/Latino



CAHPS: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED STRATEGIES

Med Assistance: Advised Strategies in 2017 and 2018, by CCO.





CAHPS: OVERALL RATINGS—ADULTS

CAHPS: Overall Ratings—Adults

Percentage of adult members who rated their overall health care as at least 8 out of 10.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

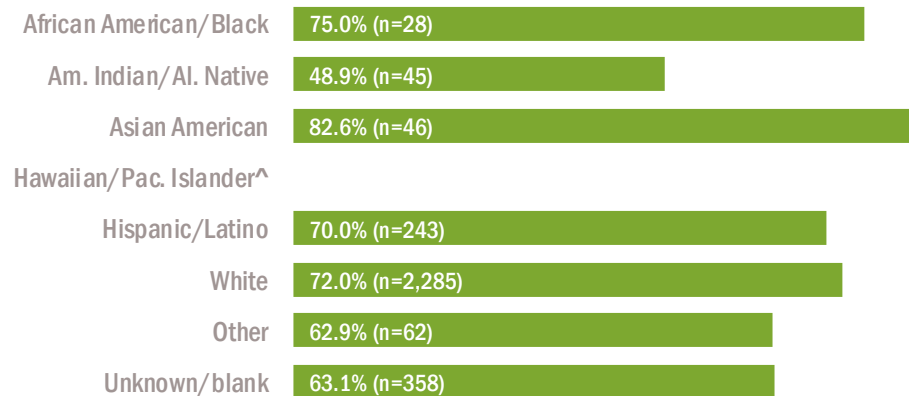
n/a

2018 data (N=3,074)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

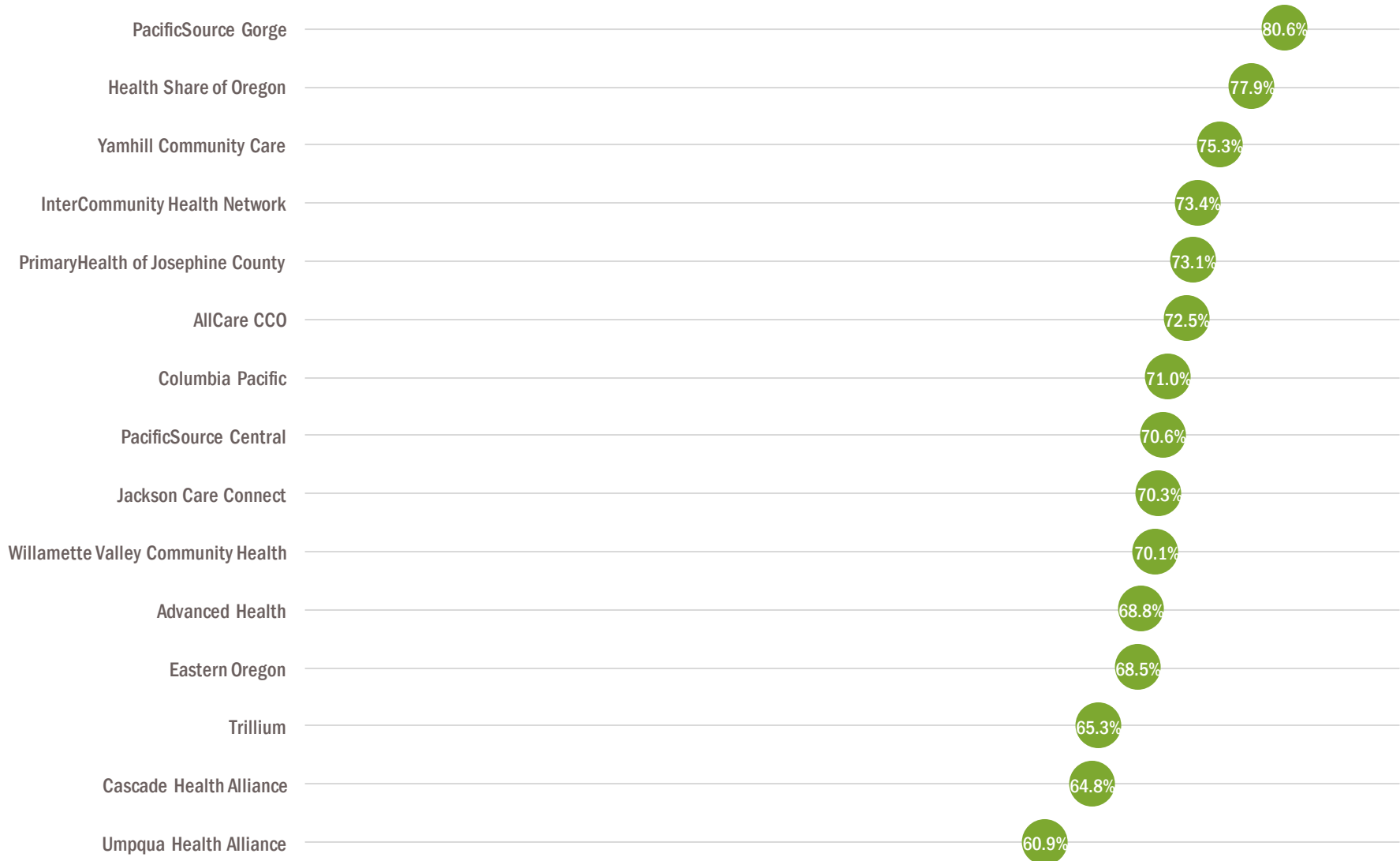
Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: OVERALL RATINGS—ADULTS

CAHPS: Overall Ratings—Adults in 2018, by CCO.





CAHPS: OVERALL RATINGS—CHILDREN

CAHPS: Overall Ratings—Children

Percentage of parents who rated their child’s overall health care as at least 8 out of 10.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

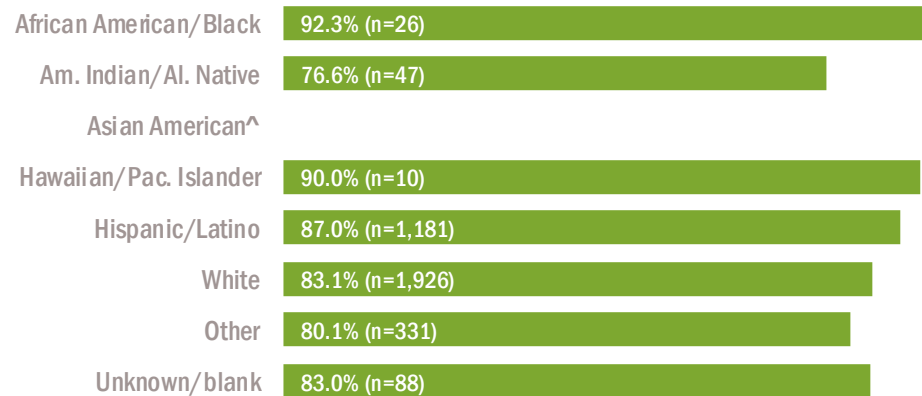
n/a

2018 data (N=3,618)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: OVERALL RATINGS—CHILDREN

CAHPS: Overall Ratings—Children in 2018, by CCO.





CAHPS: SATISFACTION WITH CARE—ADULTS

CAHPS: Satisfaction with care—Adults

Percentage of adult members who received needed information or help and thought they were treated with courtesy and respect by customer service staff.

Data source:

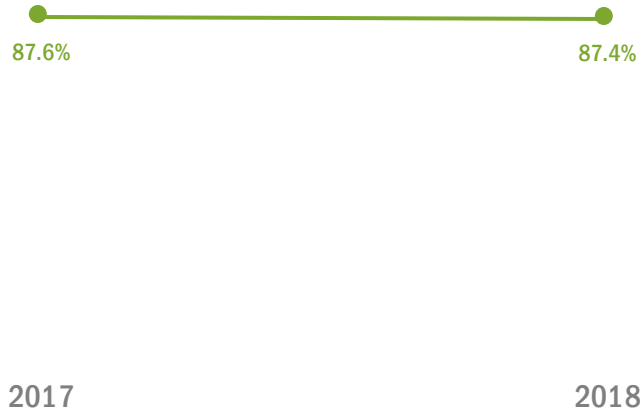
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

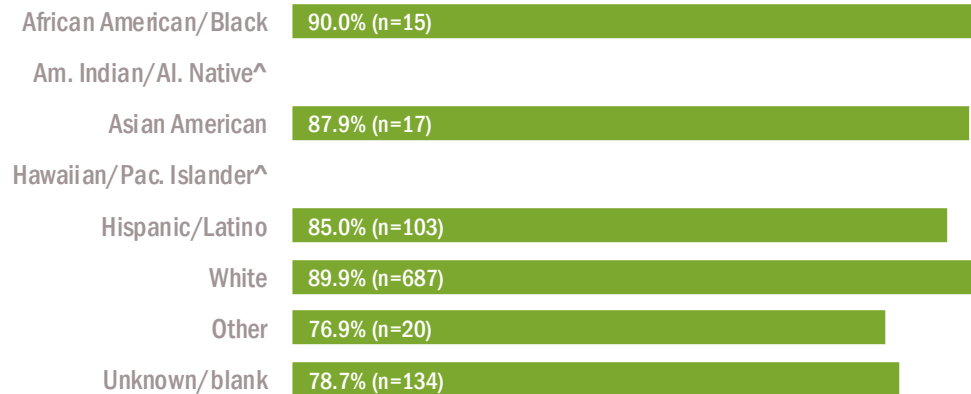
n/a

2018 data (N=991)

Statewide



By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

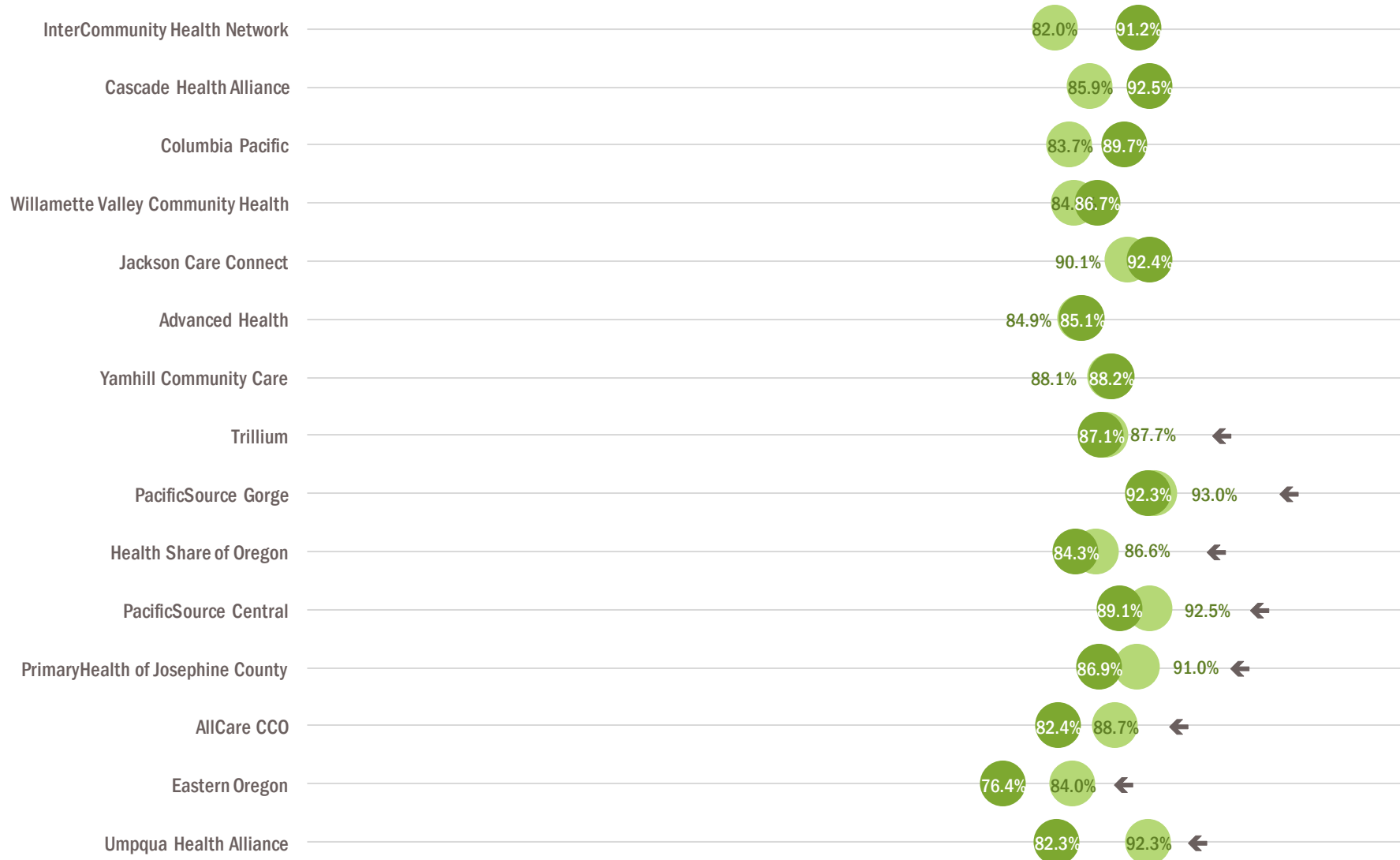
Each race category excludes Hispanic/Latino

[Back to table of contents.](#)



CAHPS: SATISFACTION WITH CARE—ADULTS

CAHPS: Satisfaction with care —Adults in 2017 and 2018, by CCO.





CAHPS: SATISFACTION WITH CARE—CHILDREN

CAHPS: Satisfaction with care—Children

Percentage of parents who said their children received needed information or help and thought they were treated with courtesy and respect by customer service staff.

Data source:

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2018 benchmark source:

n/a

2018 data (N=1,314)

[Back to table of contents.](#)

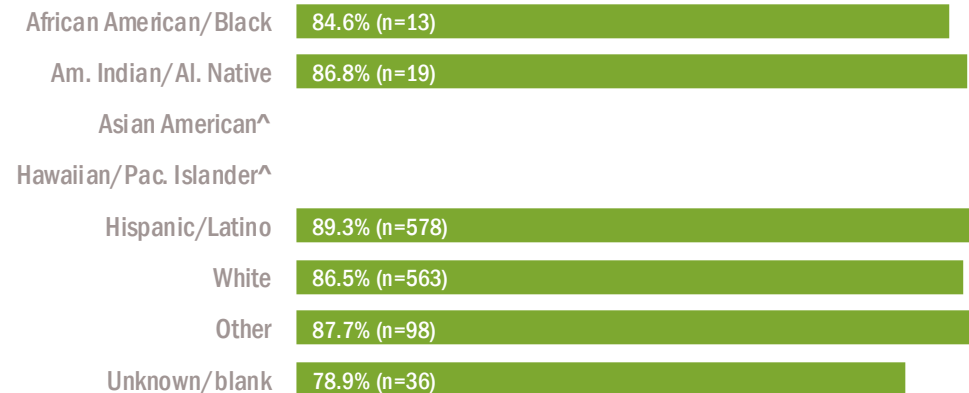
Statewide



2017

2018

By race/ethnicity



^ data suppressed (n<10)

n = subpopulation denominator

Each race category excludes Hispanic/Latino



CAHPS: SATISFACTION WITH CARE—CHILDREN

CAHPS: Satisfaction with care –Children in 2017 and 2018, by CCO.





CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS

Child and adolescent access to PCP

Percentage of children and adolescents (ages 12 months—19 years) who had a visit with a primary care provider.

Data source:

Administrative (billing) claims

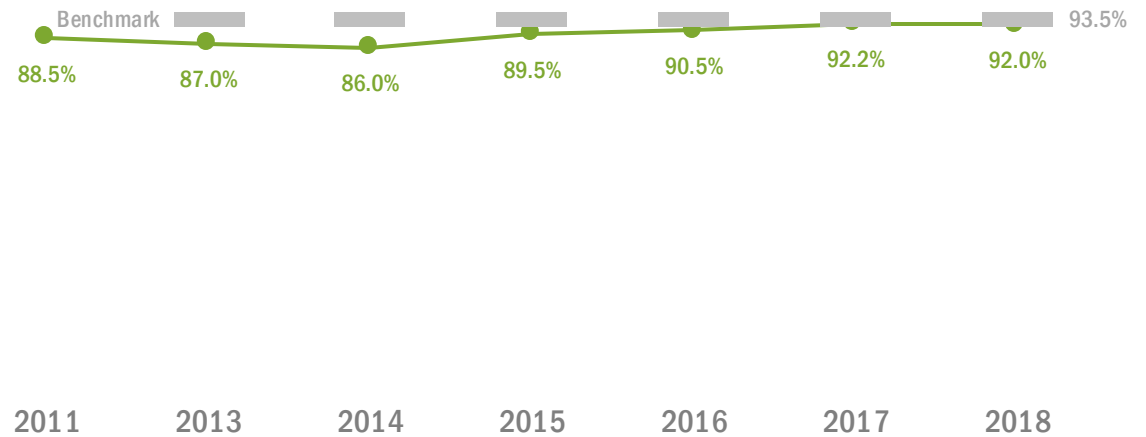
2018 benchmark source:

2017 national Medicaid 75th percentile

2018 data (N=211,704)

- Statewide change since 2017: **+0.1%**
- Number of CCOs that improved: **8**

Statewide



By region



[Back to table of contents.](#)




CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS

Childhood and adolescent access to primary care providers in 2017 and 2018, by CCO.

Grey dots represent 2016.





CHLAMYDIA SCREENING

Chlamydia screening

Percentage of sexually active women (ages 16-24) who had a test for chlamydia infection.

Data source:

Administrative (billing) claims

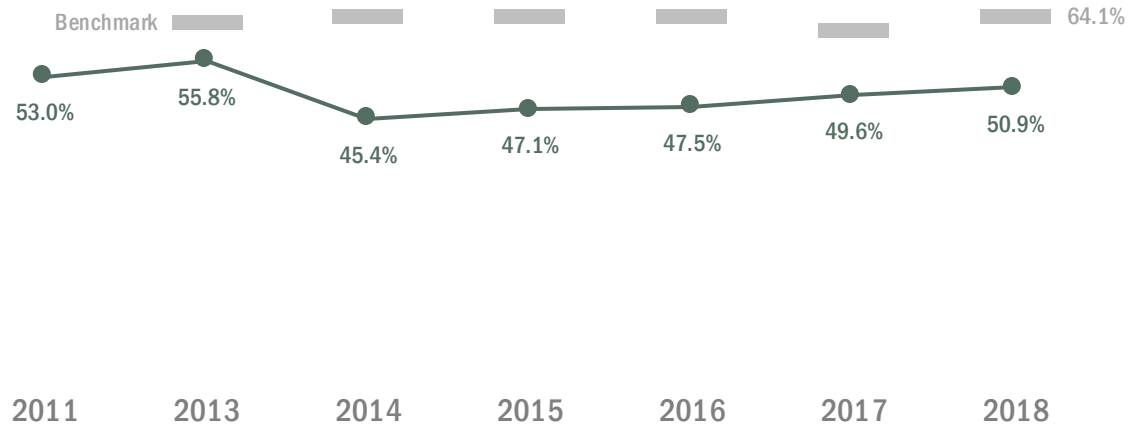
2018 benchmark source:

2017 national Medicaid 75th percentile

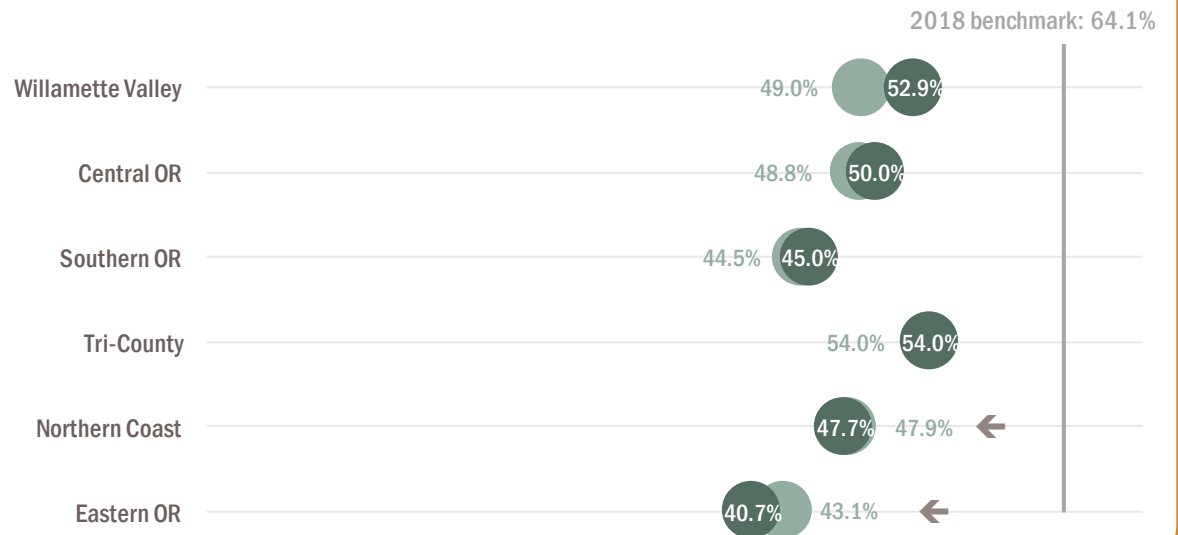
2018 data (N=27,879)

- Statewide change since 2017: **+3.7%**
- Number of CCOs that improved: **9**

Statewide



By region

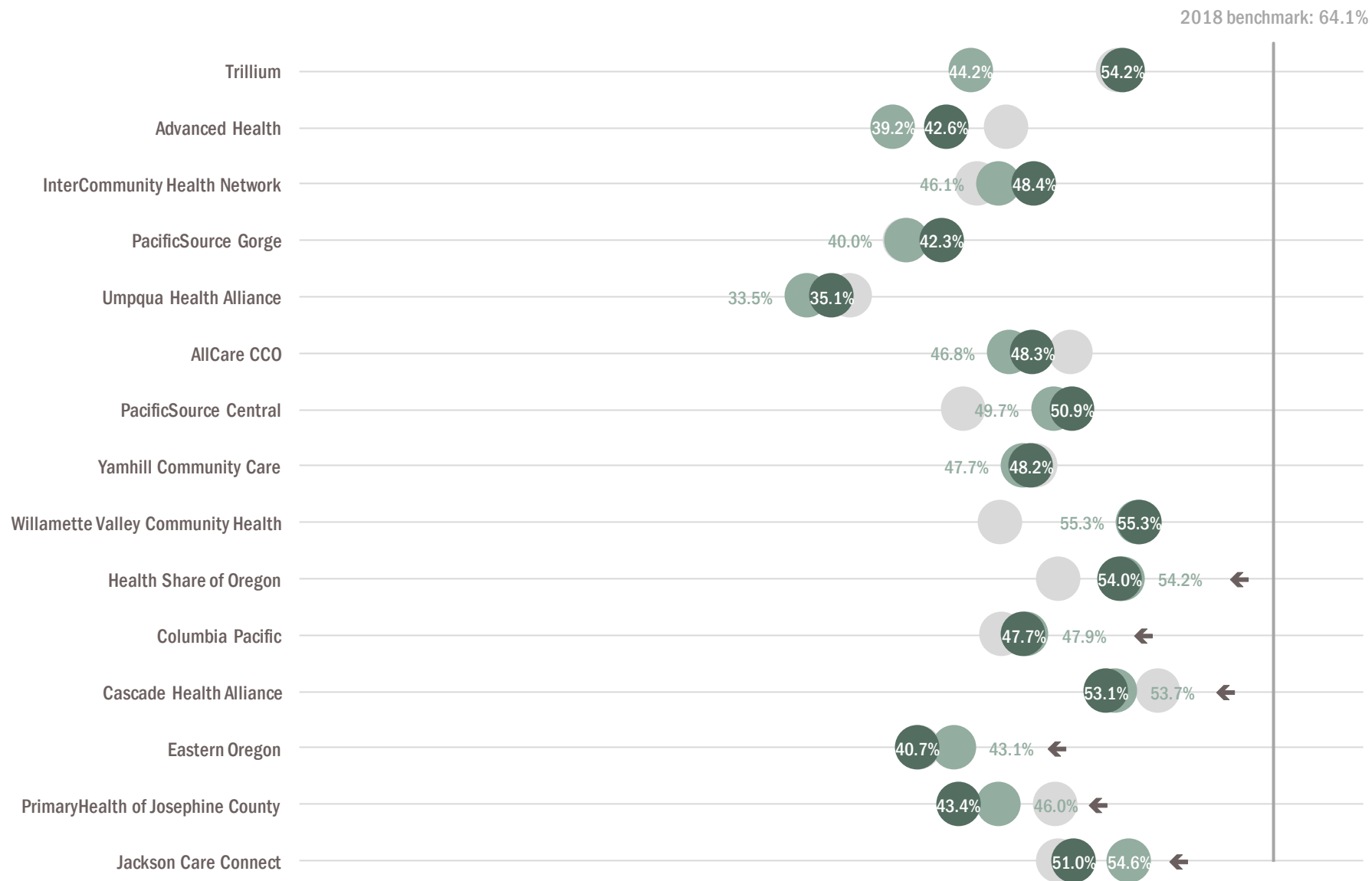


[Back to table of contents.](#)

CHLAMYDIA SCREENING

Chlamydia screening in 2017 and 2018, by CCO.

Grey dots represent 2016.



COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Hba1c testing

Percentage of adult patients (ages 18-75) with diabetes who received at least one A1c blood sugar test.

Data source:

Administrative (billing) claims

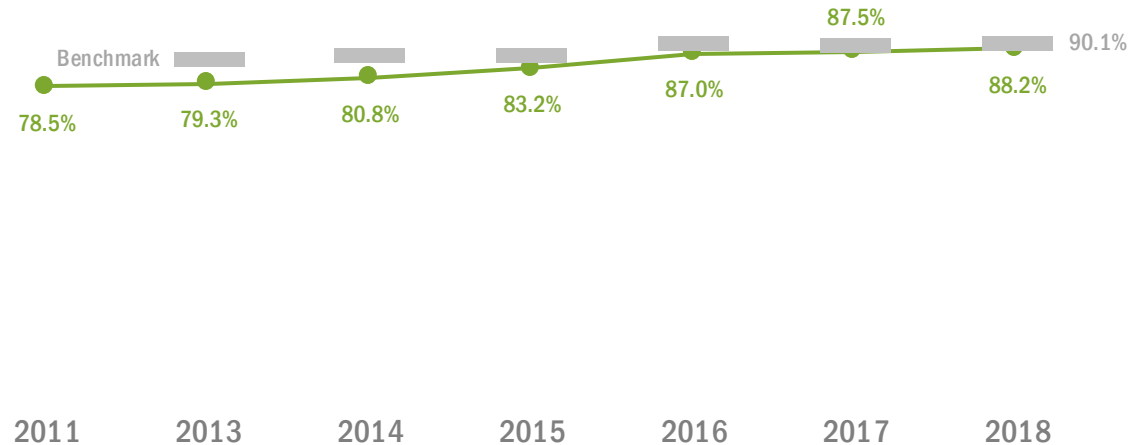
2018 benchmark source:

2017 national Medicaid 75th percentile

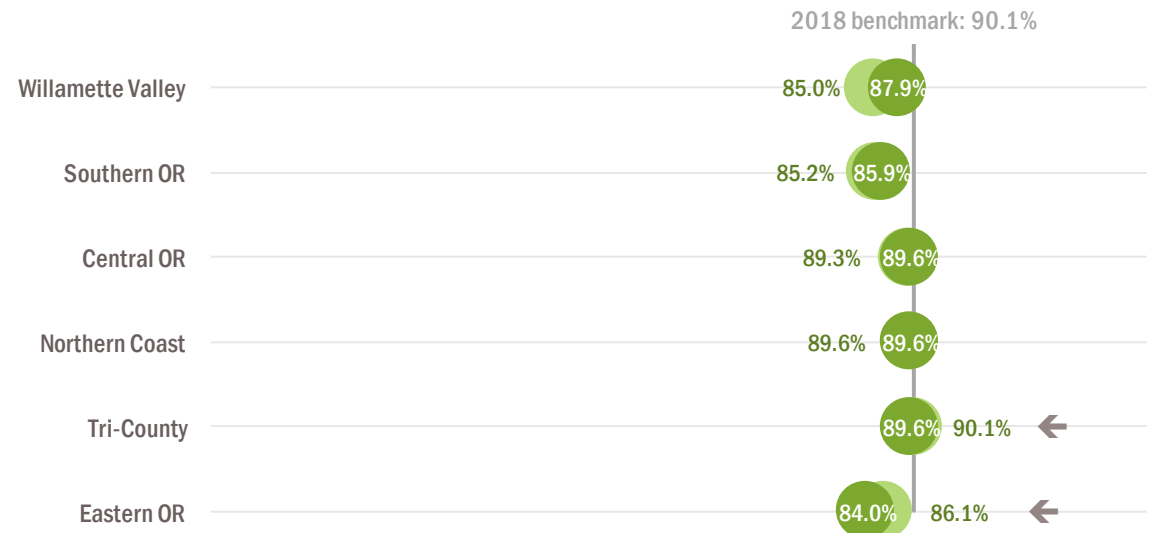
2018 data (N=34,475)

- Statewide change since 2017: **+1.0%**
- Number of CCOs that improved: **9**

Statewide



By region

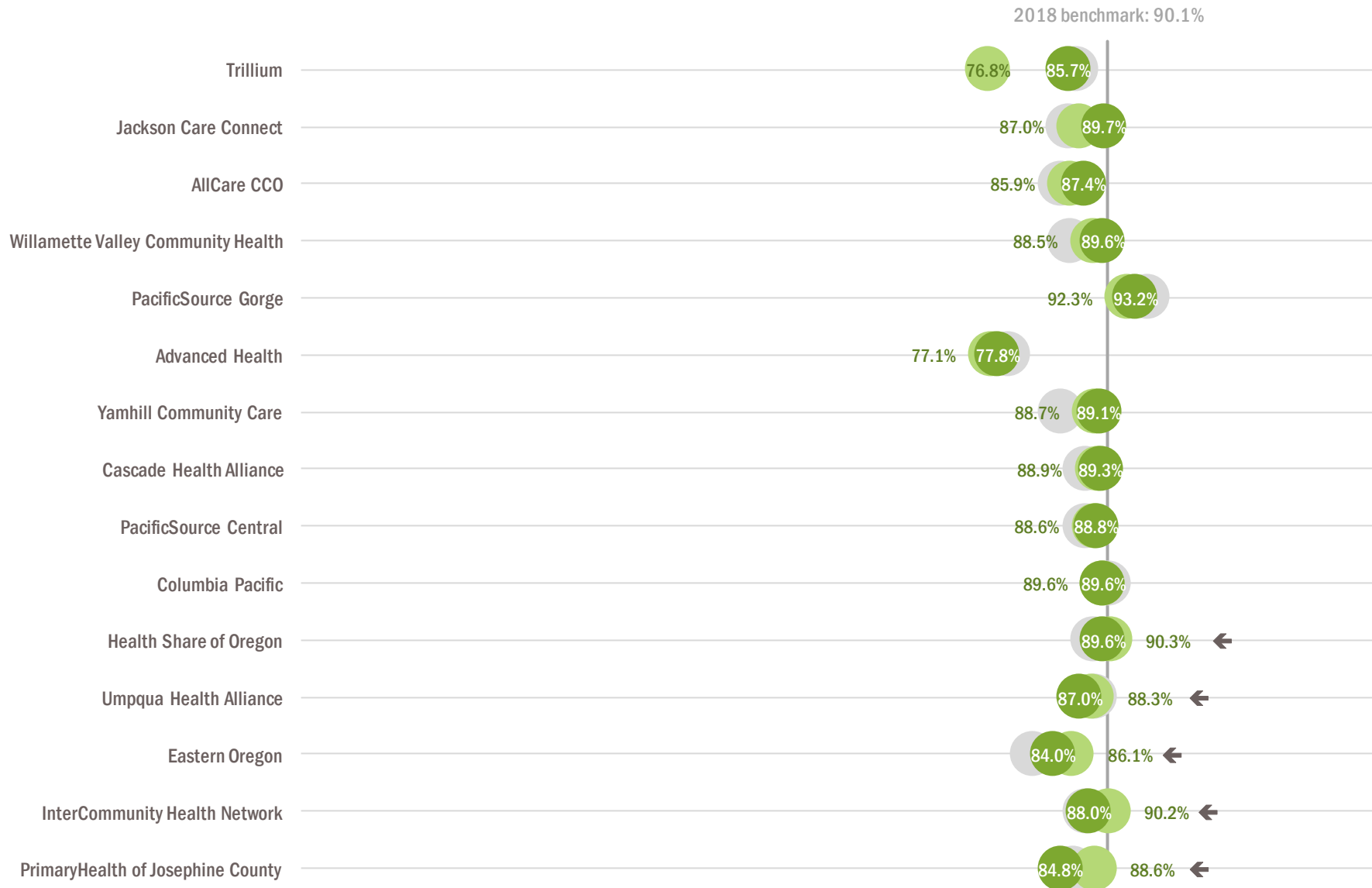


[Back to table of contents.](#)

COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Hba1c testing for members with diabetes in 2017 and 2018, by CCO.

Grey dots represent 2016.





FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (7 DAY)

Follow-up ED Mental Illness

Percentage of emergency department (ED) visits for members age 6 and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days.

Data source:

Administrative (billing) claims

2018 benchmark source:

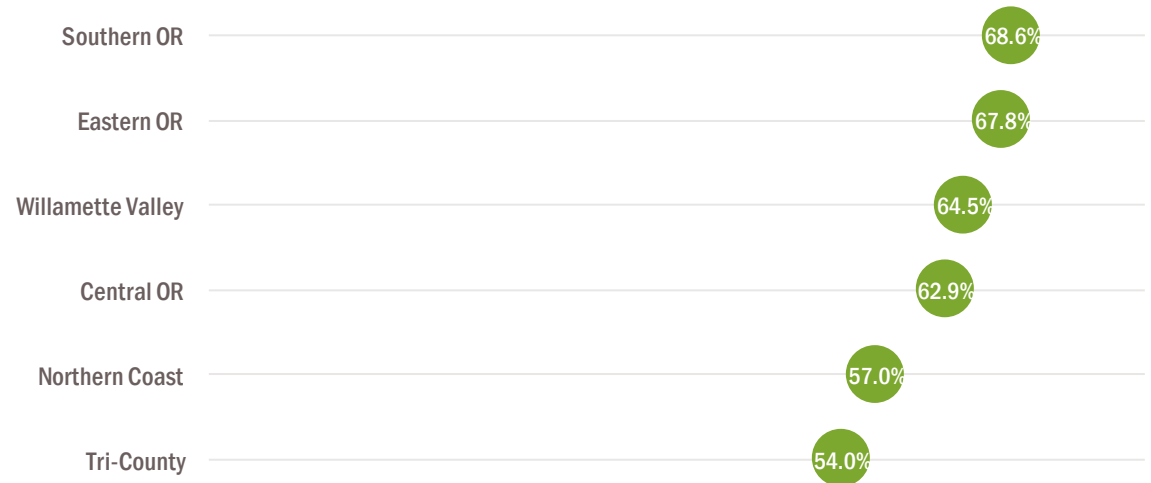
n/a

2018 data (N=4,803)

Statewide



By region

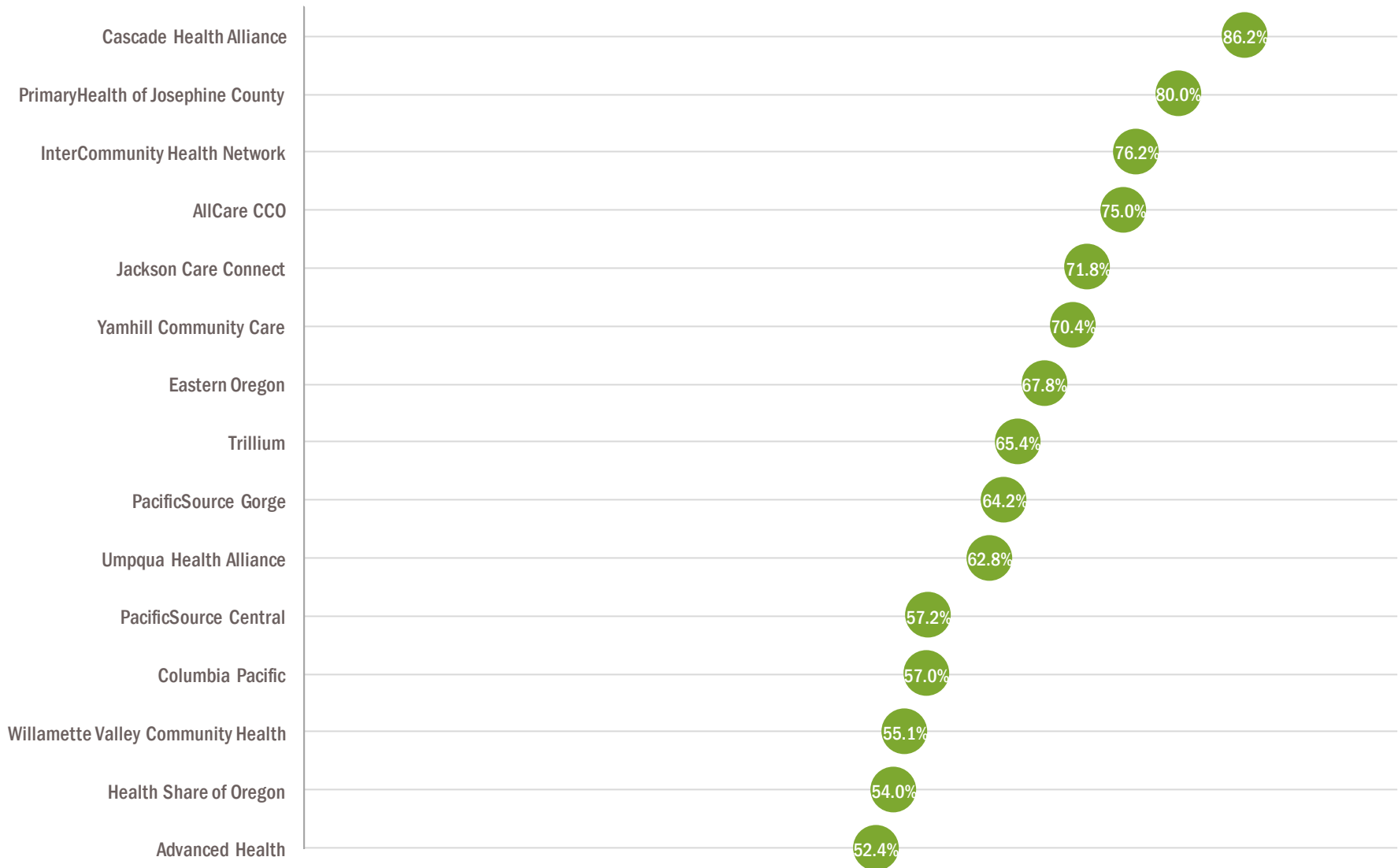


[Back to table of contents.](#)



FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (7 DAY)

7-day Follow-Up After ED for Mental Illness in 2018, by CCO.





FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (30 DAY)

Follow-up ED Mental Illness

Percentage of emergency department (ED) visits for members age 6 and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days.

Data source:

Administrative (billing) claims

2018 benchmark source:

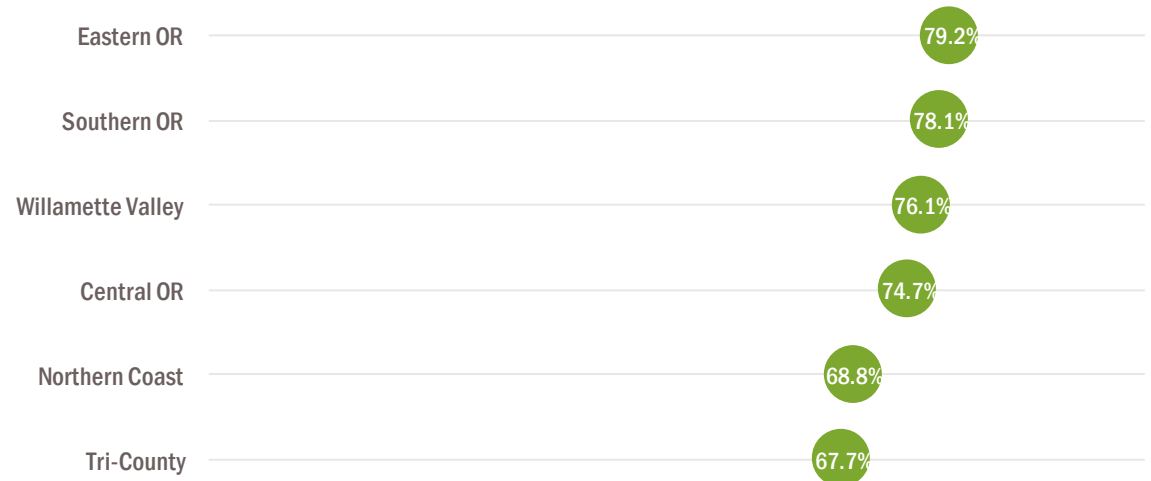
n/a

2018 data (N=4,803)

Statewide



By region

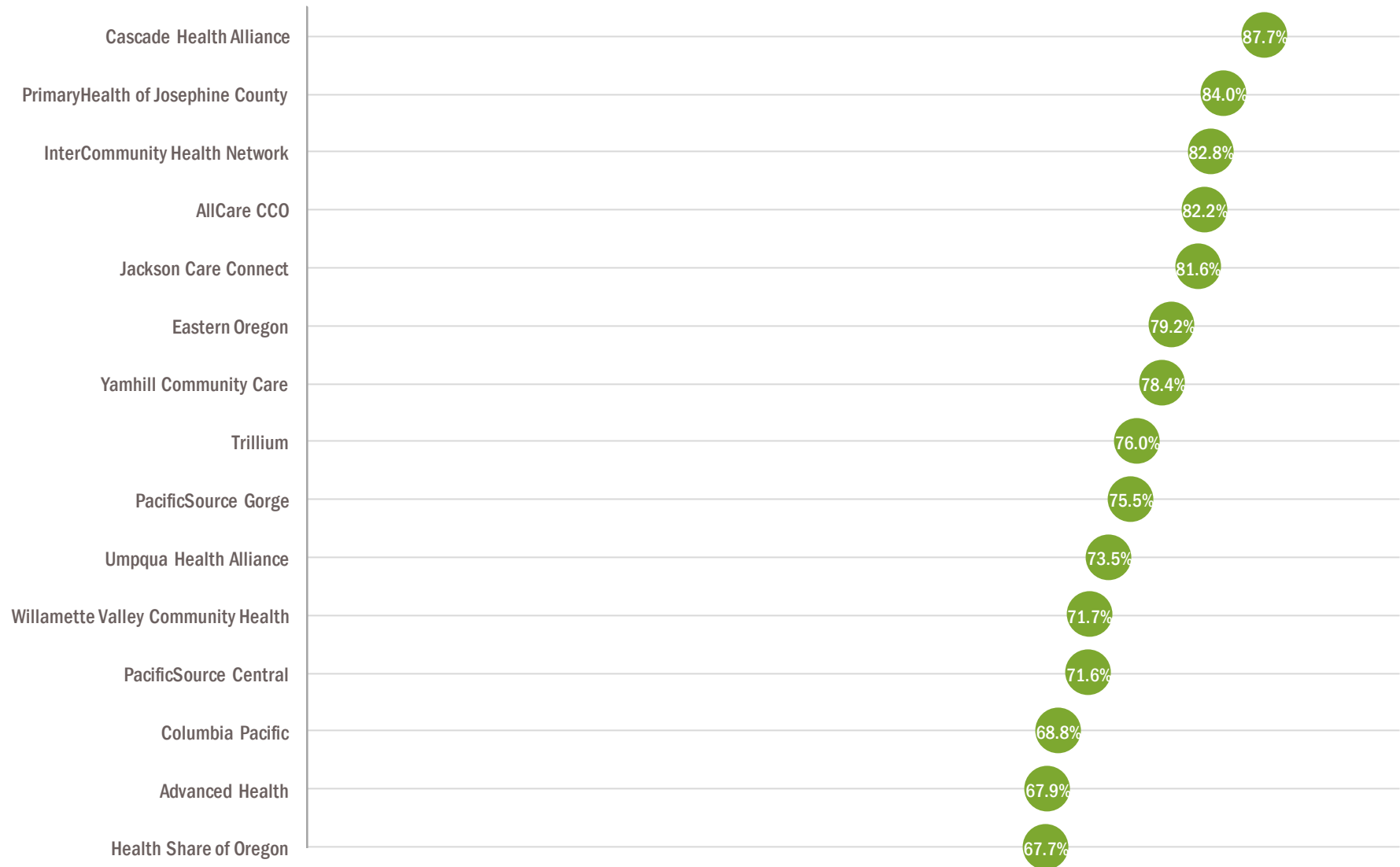


[Back to table of contents.](#)



30-day Follow-Up After ED for Mental Illness in 2018, by CCO.

2018 benchmark: 0.0%





FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (7 DAY)

Follow-up ED Dental

Percentage of dental caries-related emergency department (ED) visits among CCO members (all age) who visited a dental/ oral health provider within 7 days.

Data source:

Administrative (billing) claims

2018 benchmark source:

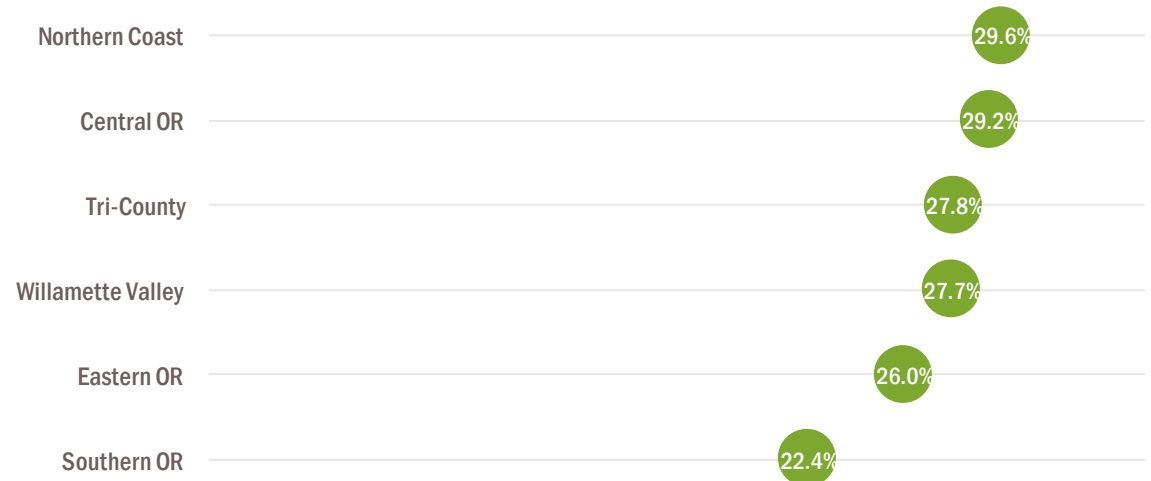
n/a

2018 data (N=2,618)

Statewide



By region

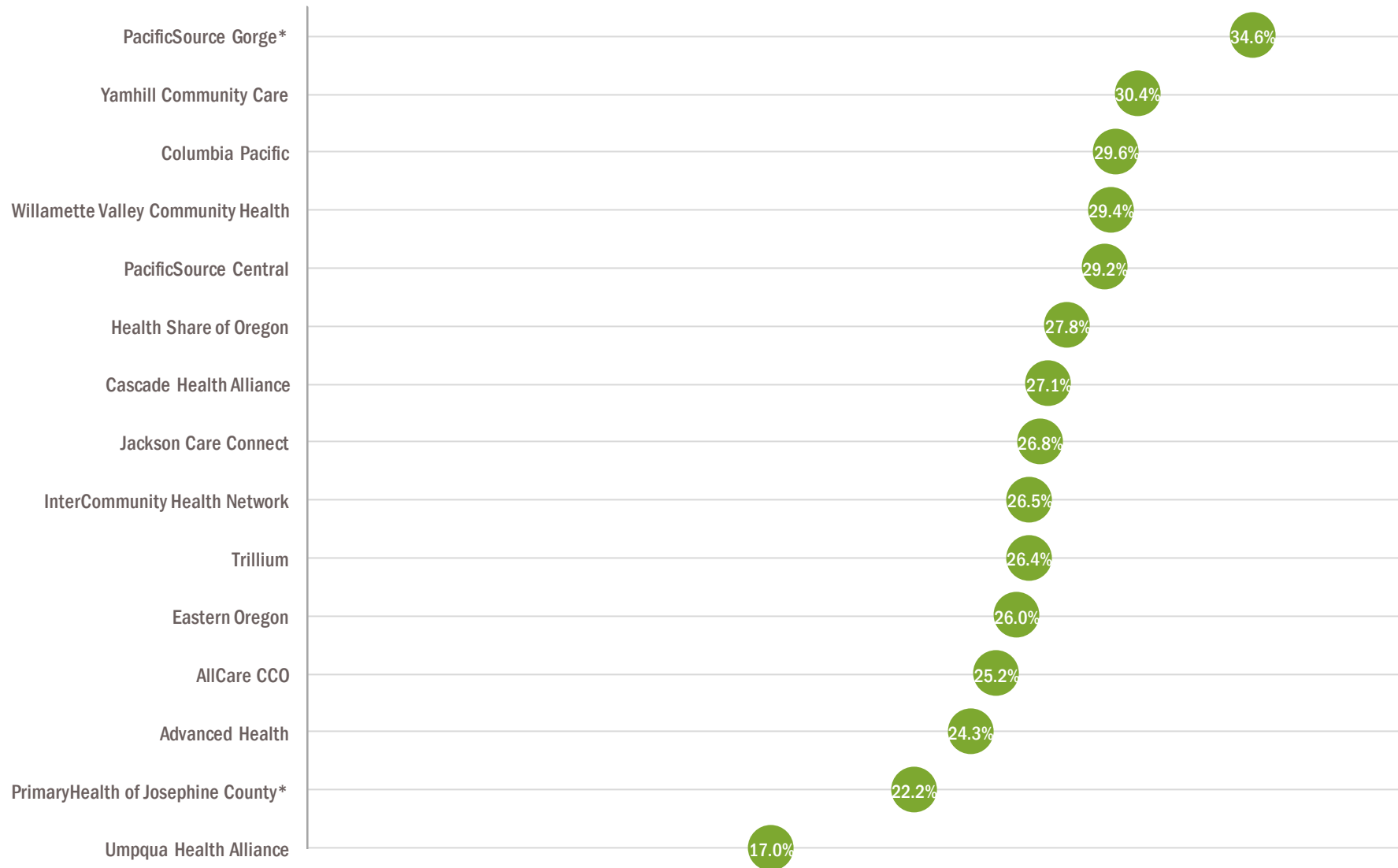


[Back to table of contents.](#)



FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (7 DAY)

7-day Follow-up After ED for Non-traumatic Dental Reasons in 2018, by CCO.





FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (30 DAY)

Follow-up ED Dental

Percentage of dental caries-related emergency department (ED) visits among CCO members (all age) who visited a dental/oral health provider within 30 days.

Data source:

Administrative (billing) claims

2018 benchmark source:

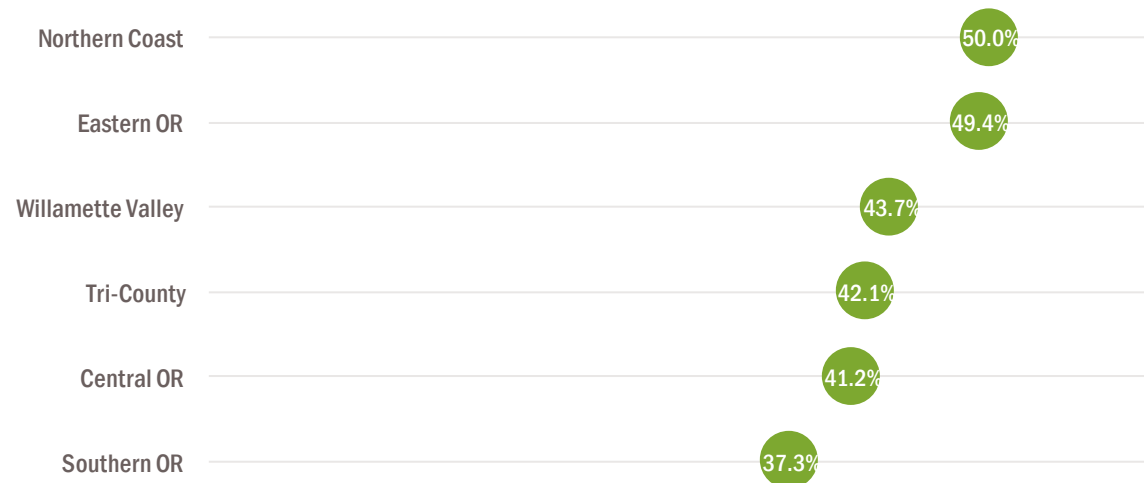
n/a

2018 data (N=2,618)

Statewide



By region

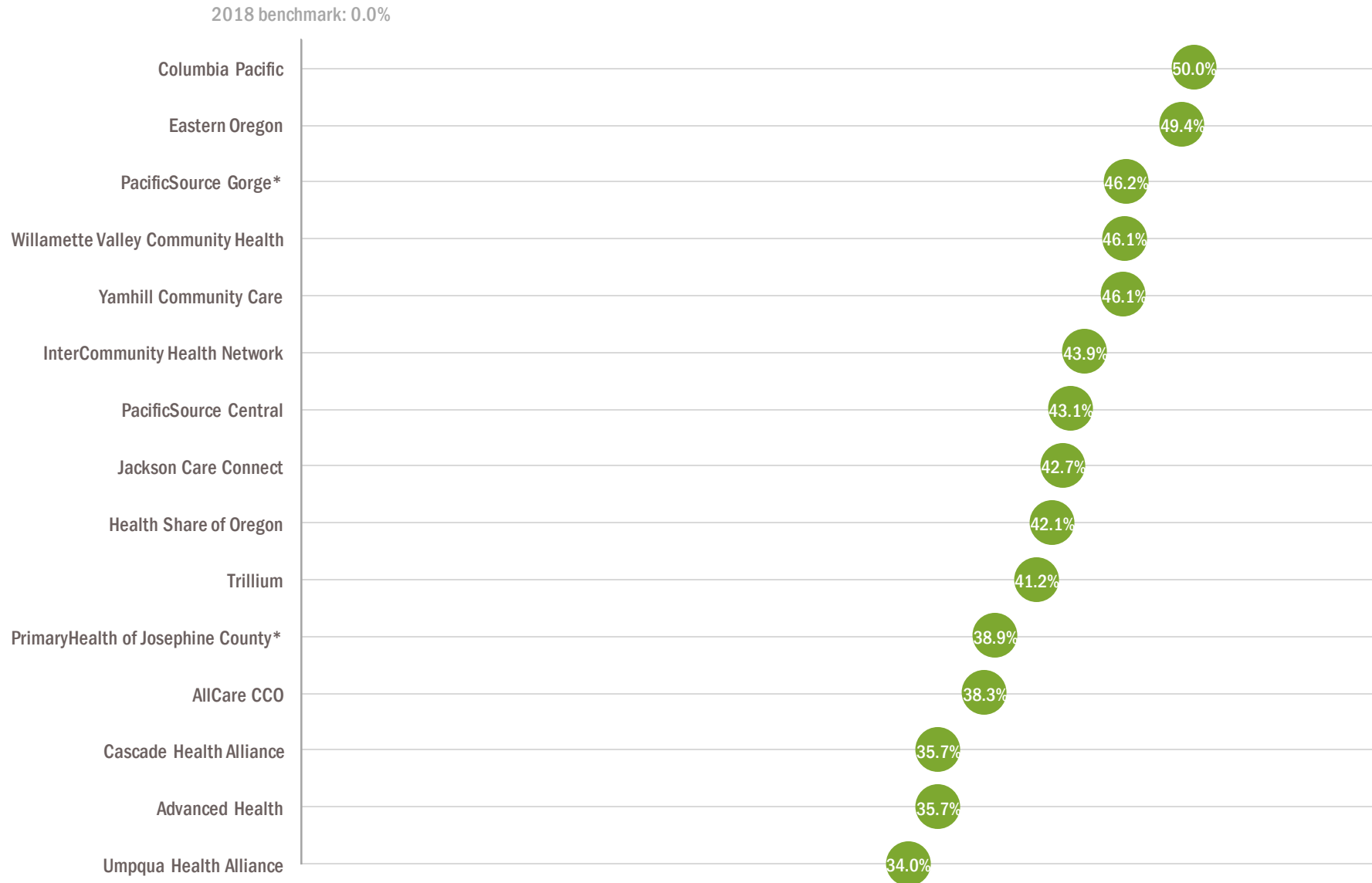


[Back to table of contents.](#)



FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (30 DAY)

30-day Follow-up After ED for Non-traumatic Dental Reasons in 2018, by CCO.





FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-Up Mental Illness

Percentage of members (ages 6 and older) who received a follow-up visit with a health care provider within seven days of being discharged from a mental illness-related hospitalization.

Data source:

Administrative (billing) claims

2018 benchmark source:

2016 CCO 75th percentile

2018 data (N=3,159)

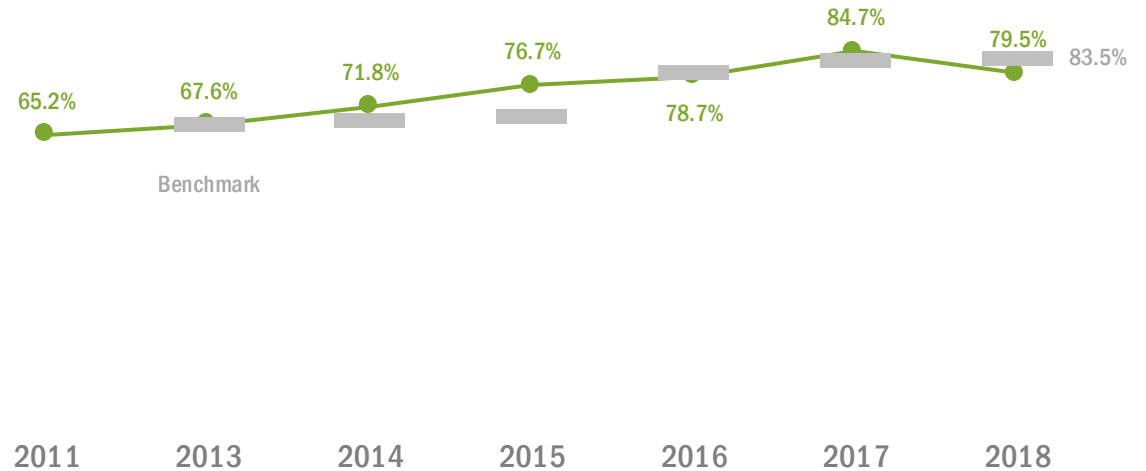
- Statewide change since 2017: **-7.1%**
- Number of CCOs that improved: **5**

Results prior to 2014 are not directly comparable to later years due to change in methodology (same-day follow-up was included in the measure numerator).

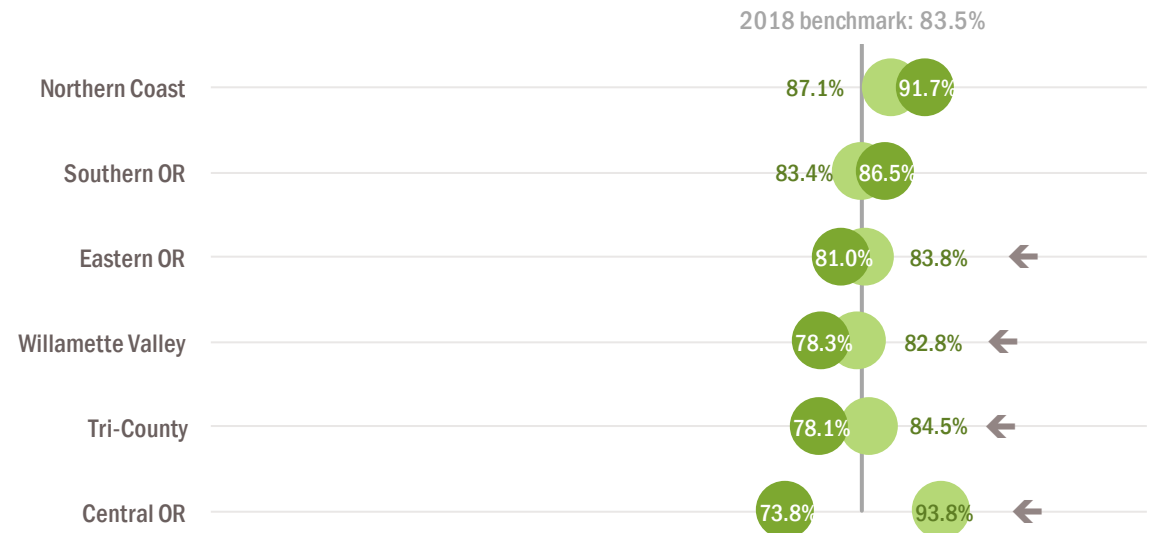
Follow-up after hospitalization for mental illness was a CCO incentive measure from 2013-2017.

[Back to table of contents.](#)

Statewide



By region



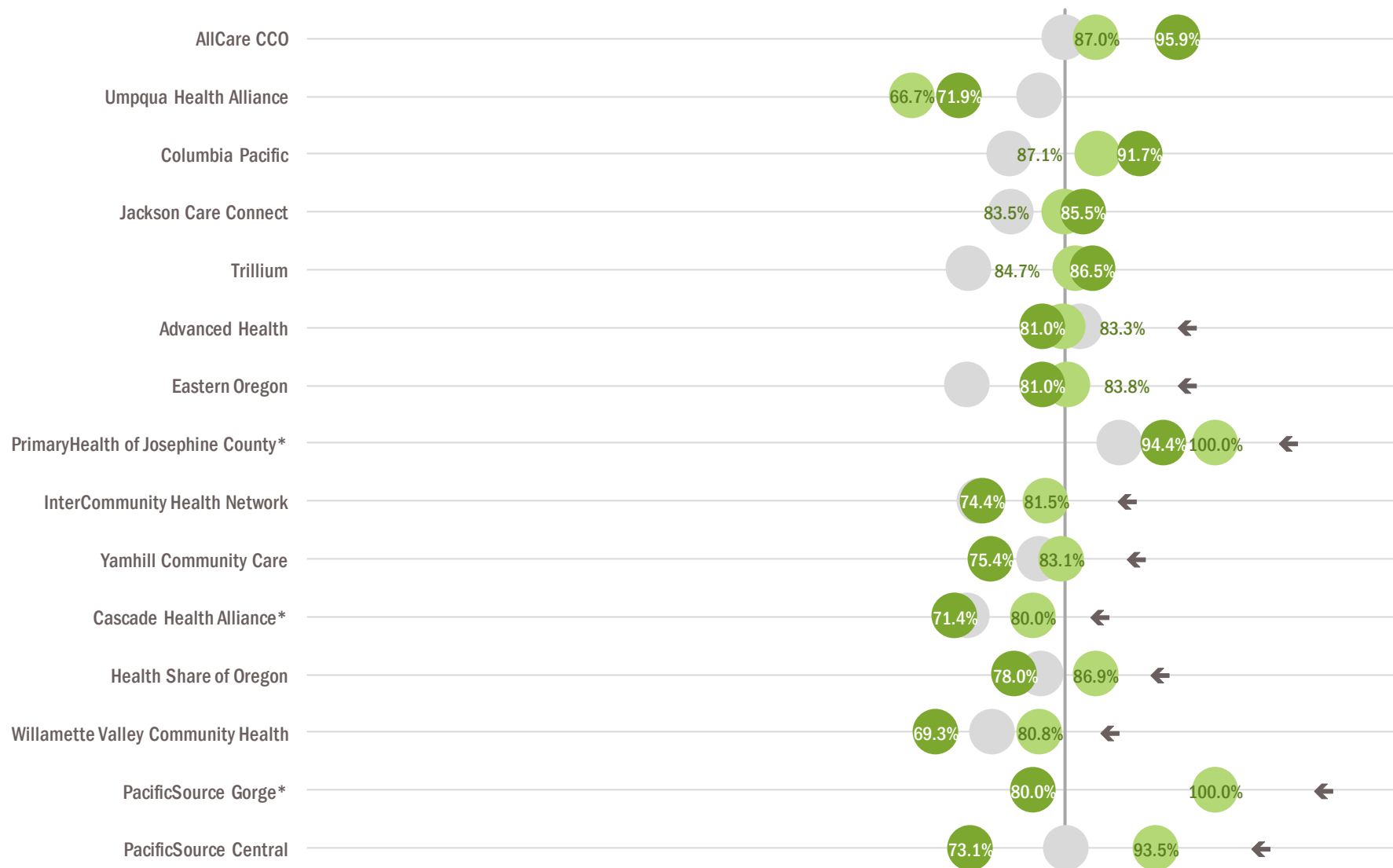


FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up After Hospitalization for Mental Illness in 2017 and 2018, by CCO.

Grey dots represent 2016.

2018 benchmark: 83.5%





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

ADHD (Initiation)

Percentage of children (ages 6-12) who had one follow-up visit with a provider during the 30 days after receiving a new prescription for ADHD medication.

Data source:

Administrative (billing) claims

2018 benchmark source:

2017 national Medicaid 90th percentile

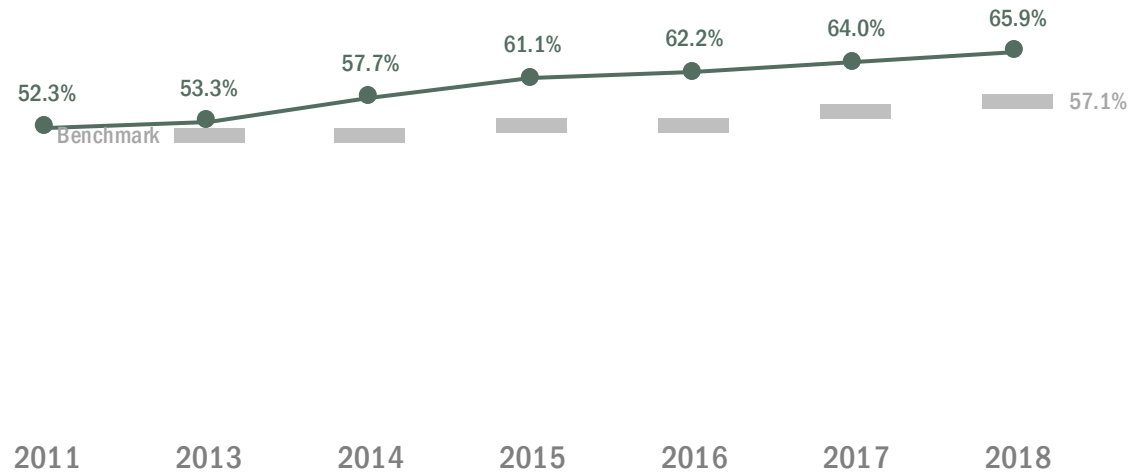
2018 data (N=2,001)

- Statewide change since 2017: **+3.1%**
- Number of CCOs that improved: **10**

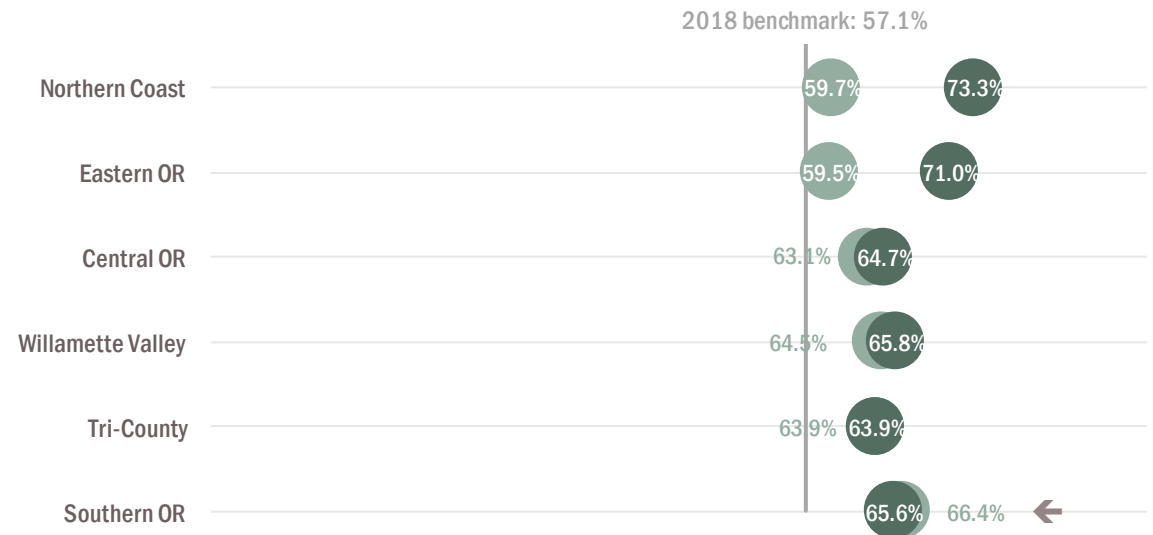
Follow-up care for children prescribed ADHD medication is a former CCO incentive measure; it was retired in 2015.

[Back to table of contents.](#)

Statewide



By region



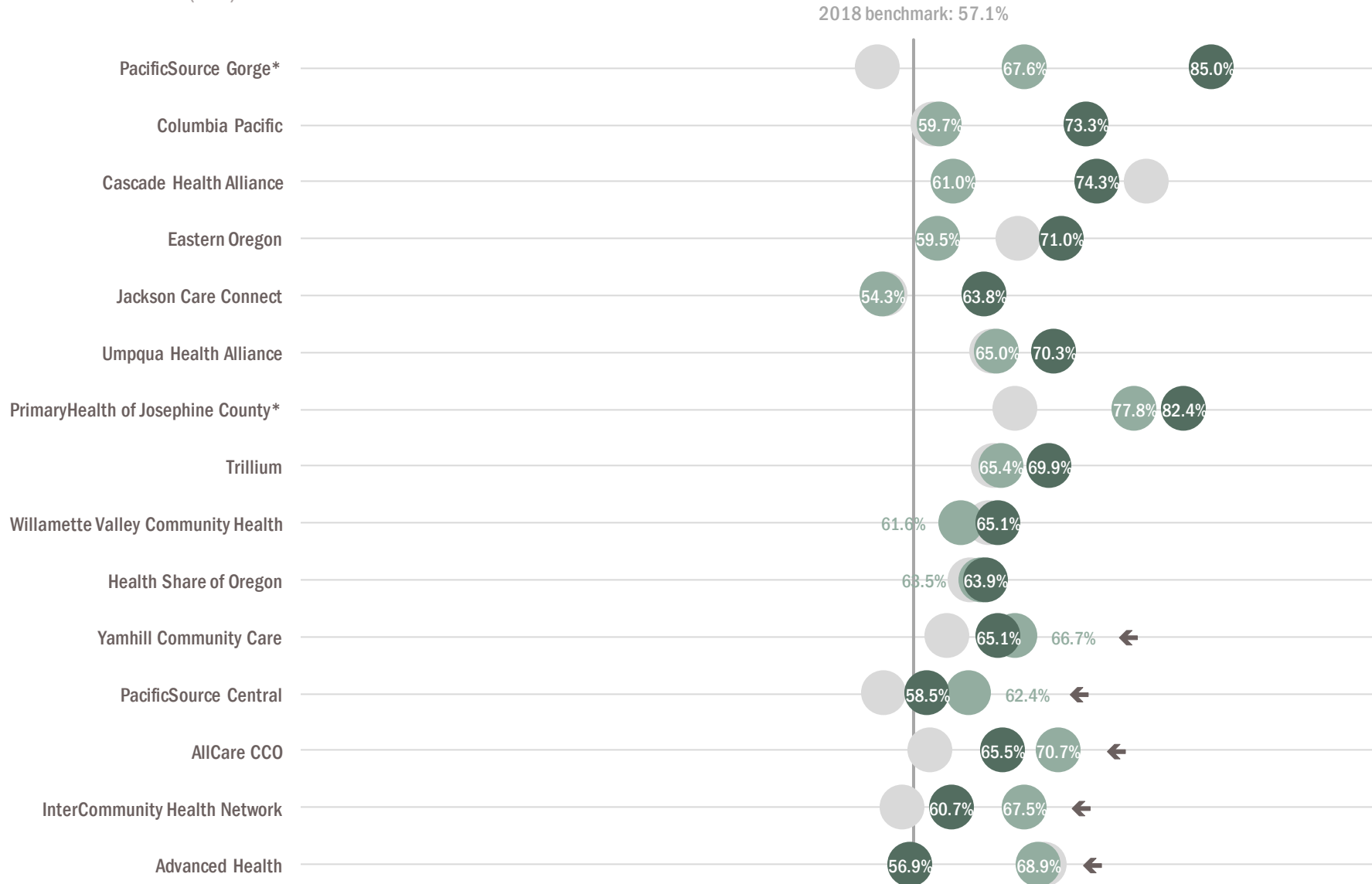


FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication in 2017 and 2018, by CCO.

Grey dots represent 2016.

* note small denominator (n<30)





FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

ADHD (Continuation & Maintenance)

Percentage of children (ages 6-12) who remained on attention deficit hyperactivity disorder (ADHD) medication for 210 days after receiving a new prescription and who had at least two follow-up visits with a provider within 270 days after the initiation phase.

Data source:

Administrative (billing) claims

2018 benchmark source:

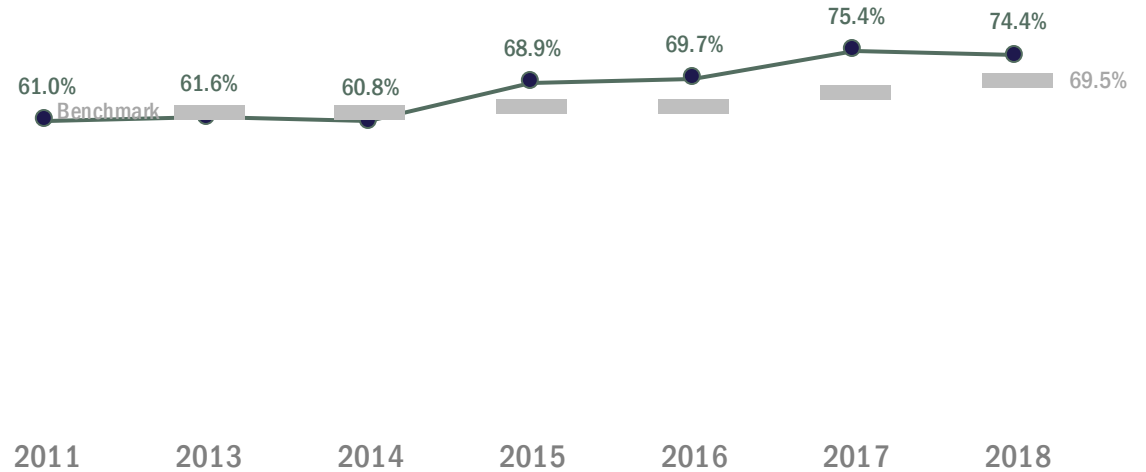
2017 national Medicaid 90th percentile

2018 data (N=661)

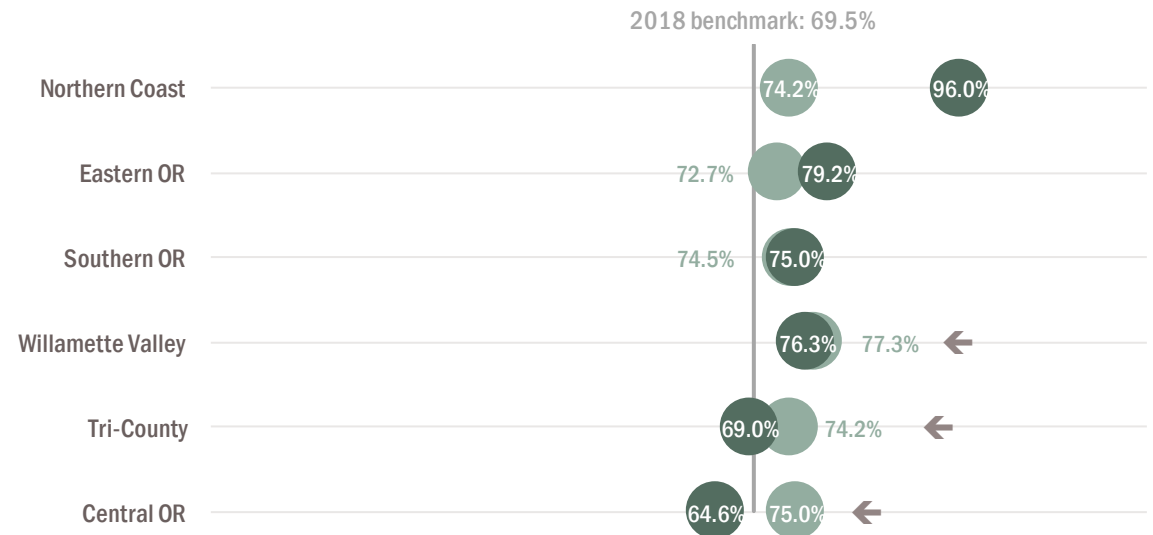
- Statewide change since 2017: **-2.5%**
- Number of CCOs that improved: **8**

[Back to table of contents.](#)

Statewide



By region



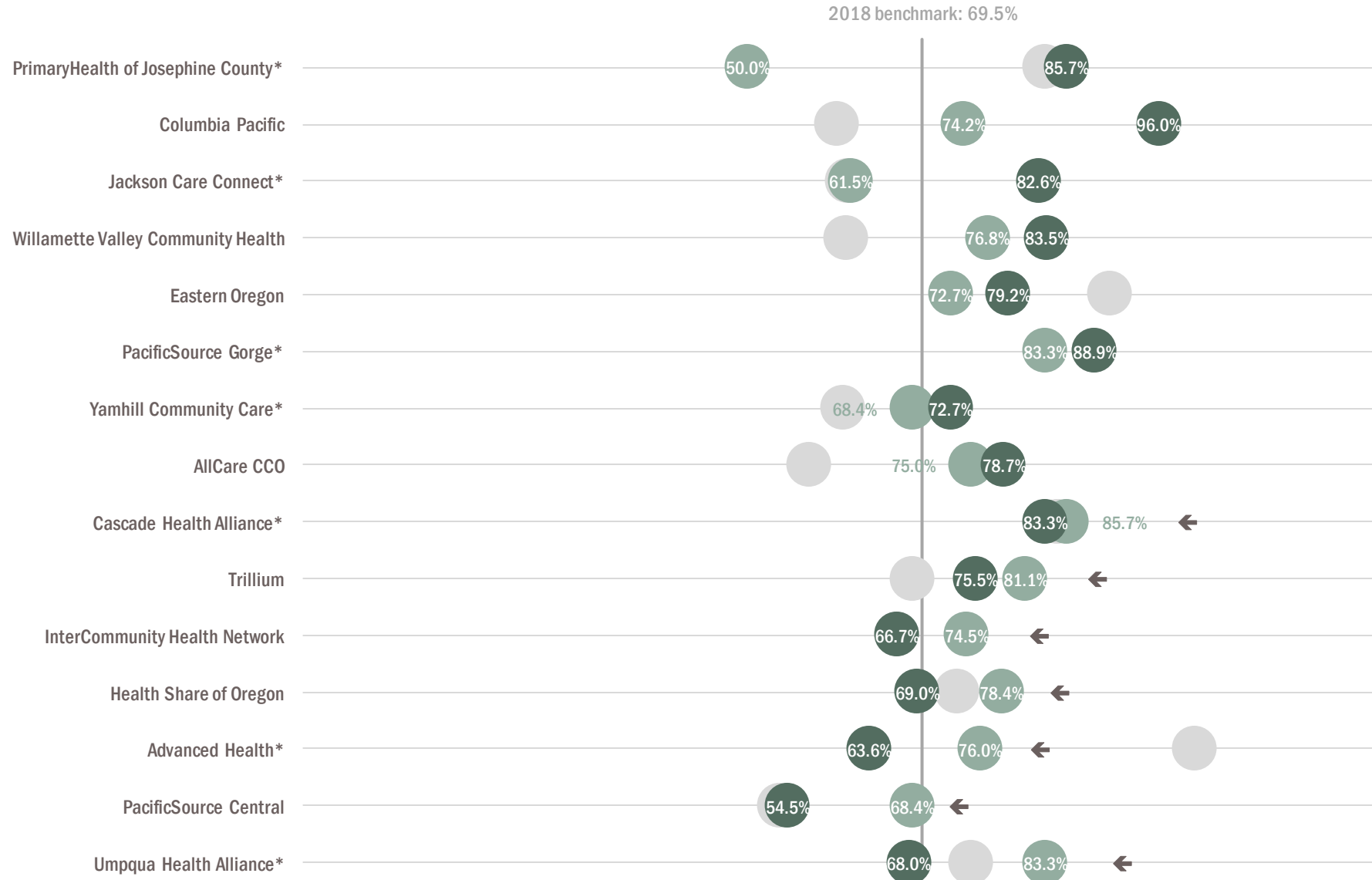


FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Continuing follow-up for children prescribed ADHD medication in 2017 and 2018, by CCO.

Grey dots represent 2016.

^ note small denominator (n<30)





IMMUNIZATIONS FOR ADOLESCENTS—Combo 1

Immunizations for adolescents

Percentage of adolescents who received recommended vaccines (meningococcal and Tdap/TD) before their 13th birthday.

Data source:

Administrative (billing) claims and ALERT immunization data

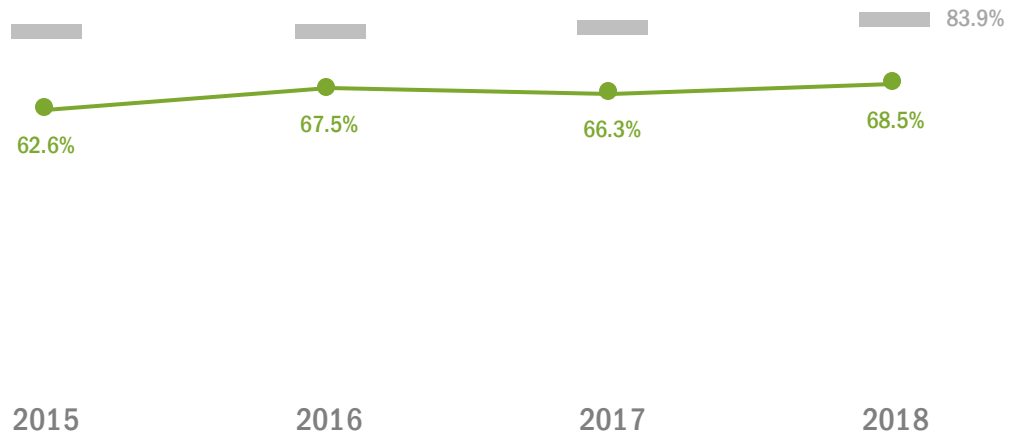
2018 benchmark source:

2017 national Medicaid 75th percentile

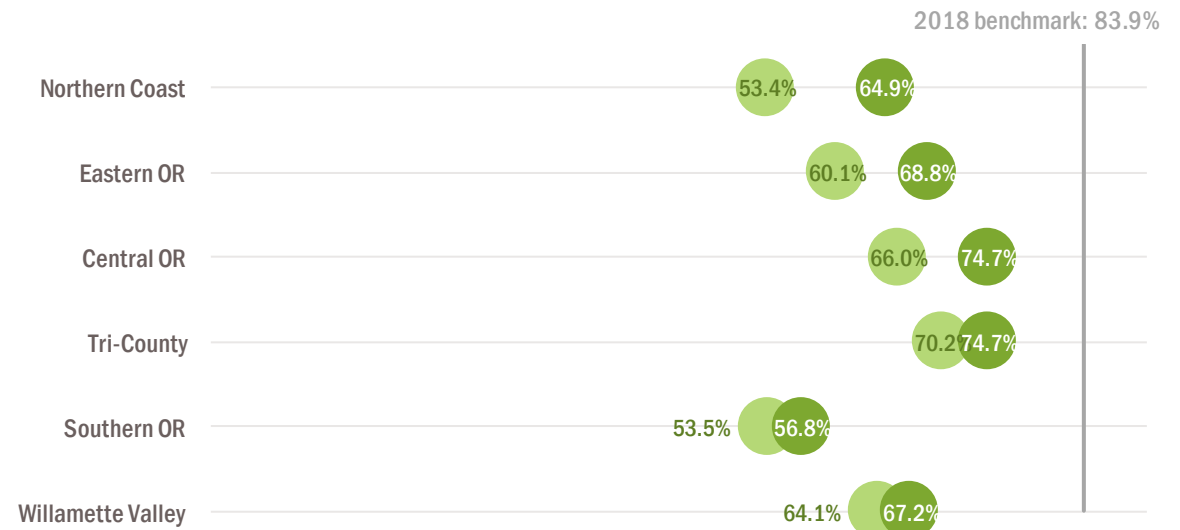
2018 data (N=12,642)

- Statewide change since 2017: **+6.0%**
- Number of CCOs that improved: **13**

Statewide



By region



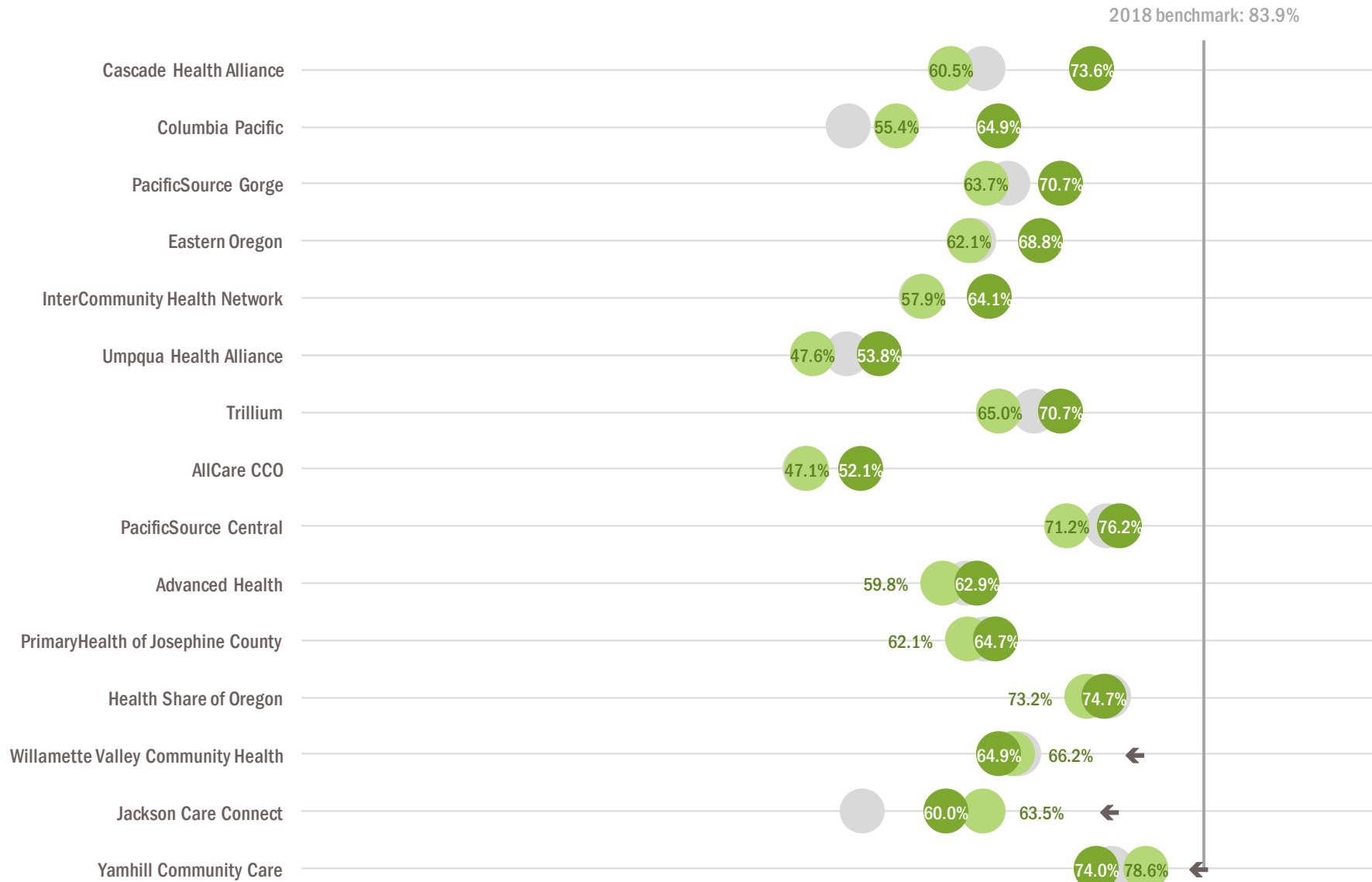
[Back to table of contents.](#)



IMMUNIZATIONS FOR ADOLESCENTS—Combo 1

Immunizations for adolescents in 2017 and 2018, by CCO.

Grey dots represent 2016.





IMMUNIZATIONS FOR ADOLESCENTS—Combo 2

Immunizations for adolescents

Percentage of adolescents who received recommended vaccines (meningococcal, Tdap/TD and HPV) before their 13th birthday.

Data source:

Administrative (billing) claims and ALERT immunization data

2018 benchmark source:

n/a

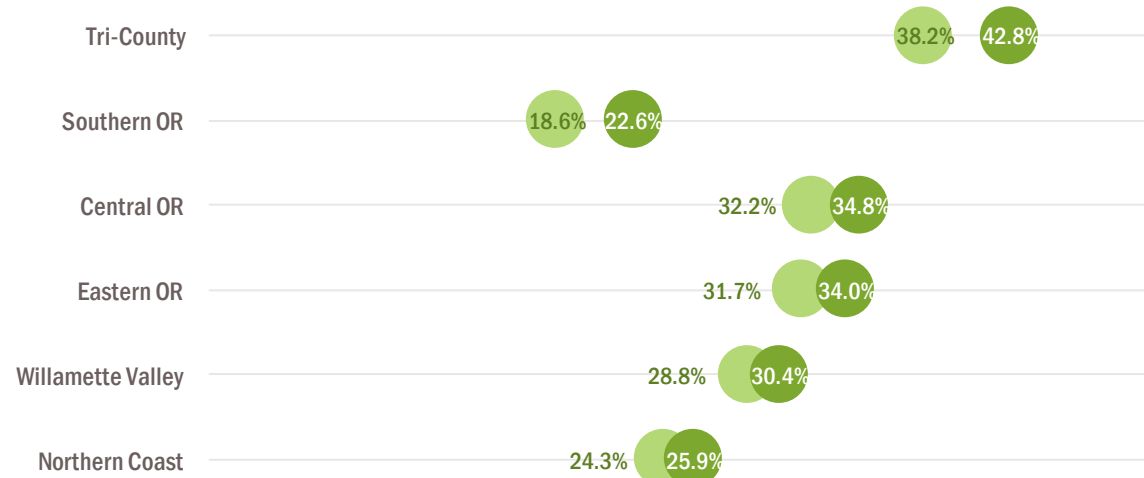
2018 data (N=12,642)

- Statewide change since 2017: **+6.4%**
- Number of CCOs that improved: **11**

Statewide



By region

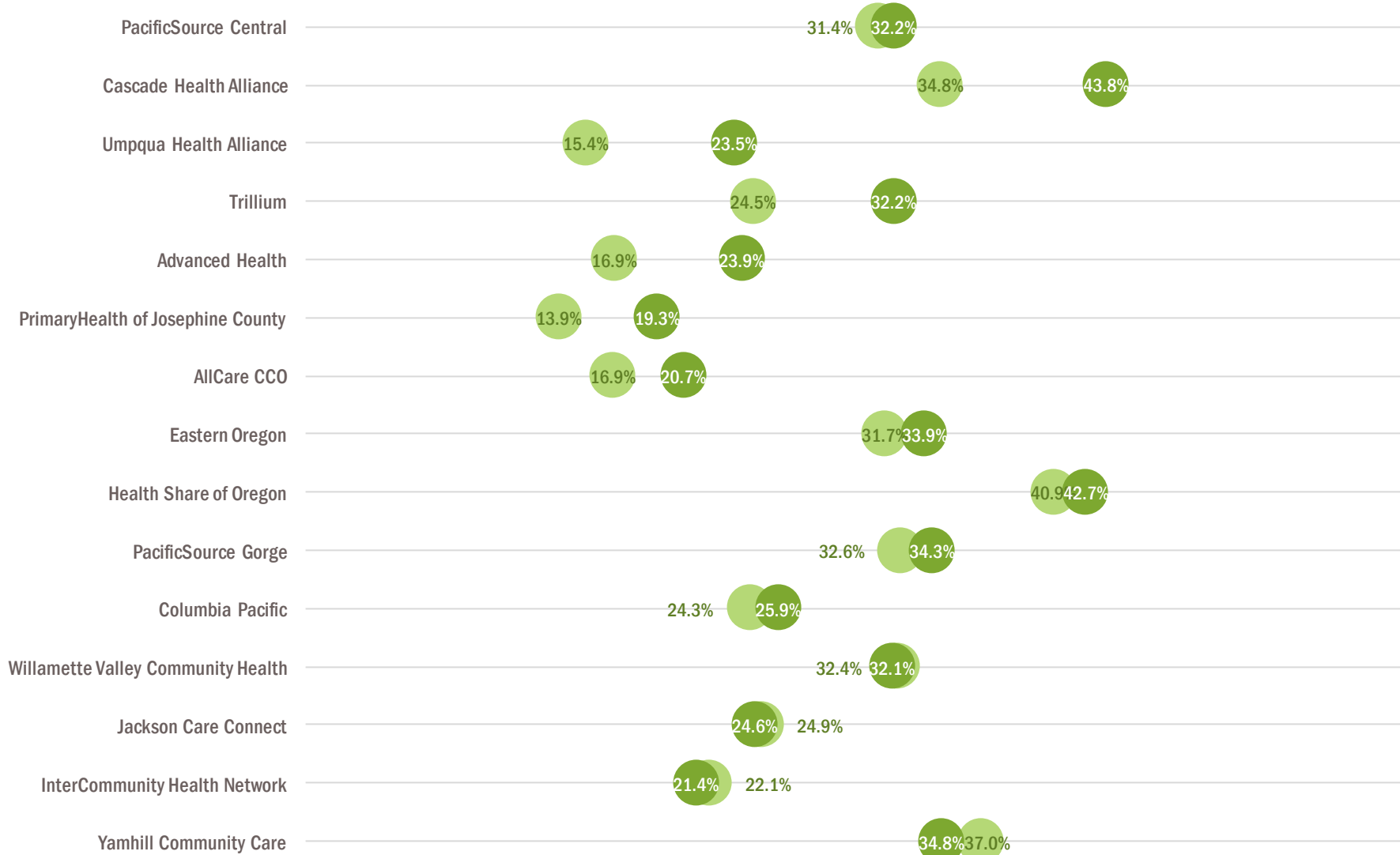


[Back to table of contents.](#)



IMMUNIZATIONS FOR ADOLESCENTS—Combo 2

Immunizations for adolescents in 2017 and 2018, by CCO.





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

IET (Initiation)

Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis.

Data source:

Administrative (billing) claims

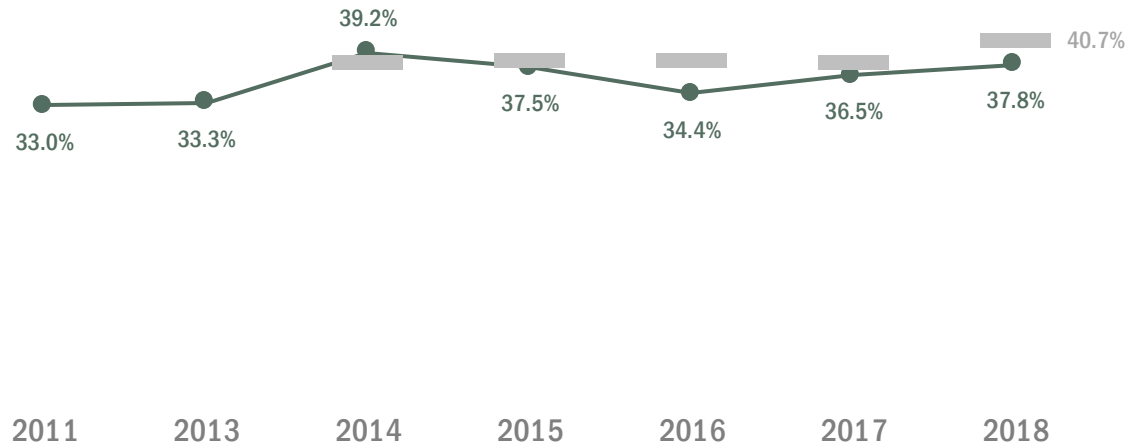
2018 benchmark source:

2017 national Medicaid median

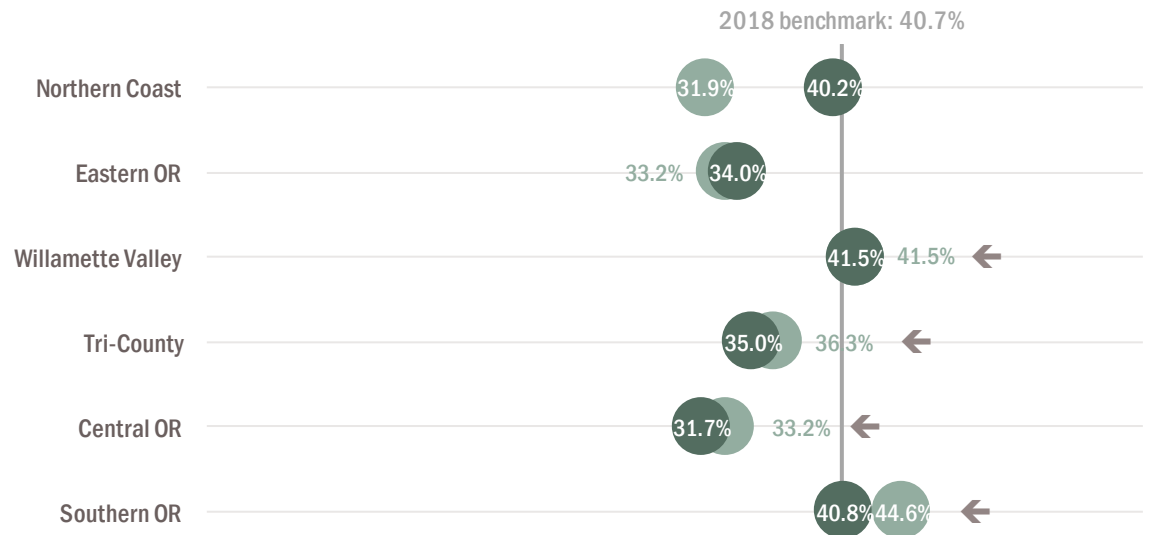
2018 data (N=12,682)

- Statewide change since 2017: **+3.6%**
- Number of CCOs that improved: **7**

Statewide



By region



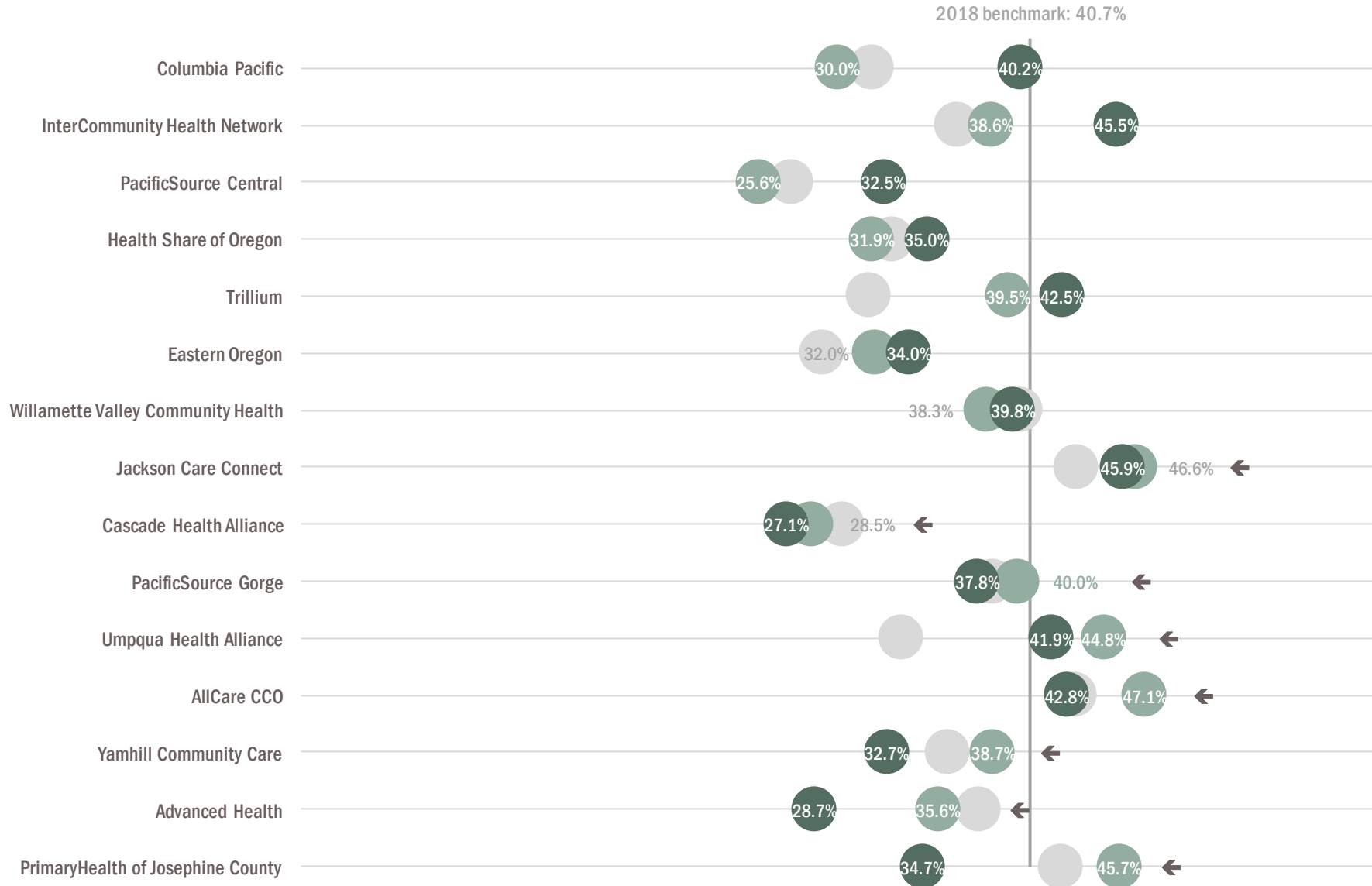
[Back to table of contents.](#)



INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation of treatment for members newly diagnosed with alcohol or drug dependence in 2017 and 2018, by CCO.

Grey dots represent 2016.





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

IET (Engagement)

Percentage of members (ages 13 and older) newly diagnosed with alcohol or other drug dependence who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment.

Data source:

Administrative (billing) claims

2018 benchmark source:

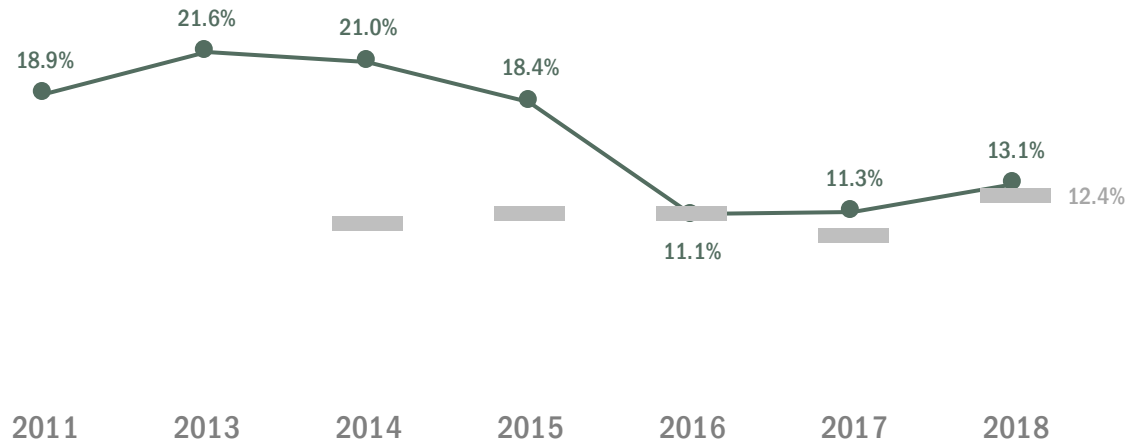
2017 national Medicaid median

2018 data (N=12,682)

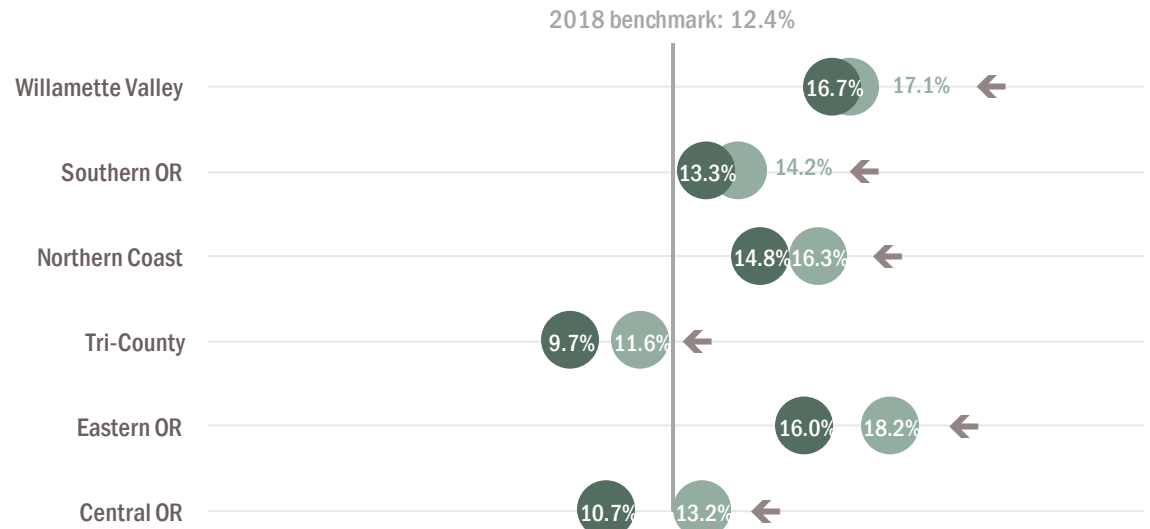
- Statewide change since 2017: **+15.9%**
- Number of CCOs that improved: **8**

[Back to table of contents.](#)

Statewide



By region





INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Continuation of treatment for members with alcohol or other drug dependence in 2017 and 2018, by CCO.

Grey dots represent 2016.



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

PQI 1

Rate of adult members (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease. A lower score is better.

PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Data source:

Administrative (billing) claims

2018 benchmark source:

10 percent reduction from 2017

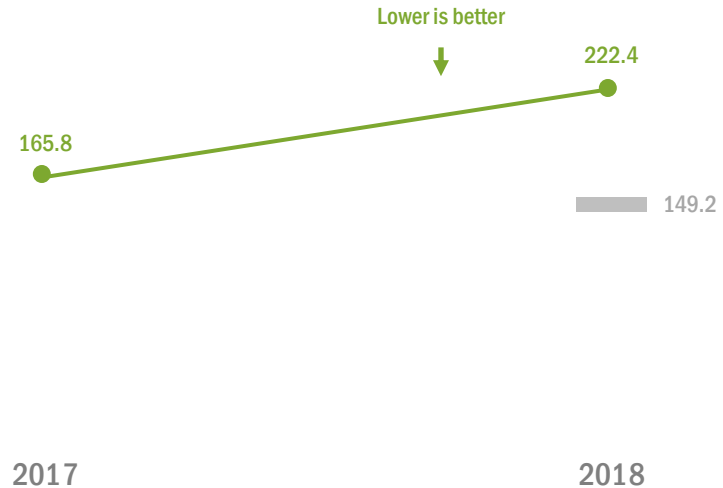
2018 data (N=491,102 member years)

- Statewide change since 2017: **+34.1%**
- Number of CCOs that improved: **3**

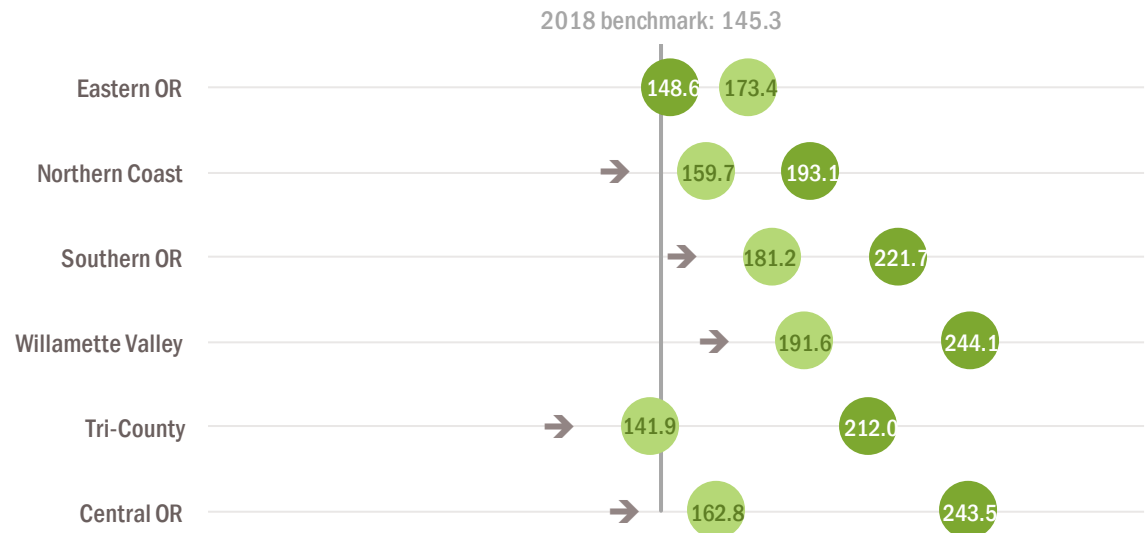
Rates are shown per 100,000 member years which means that in one year, there are on average X visits occurring per 100,000 CCO members.

[Back to table of contents.](#)

Statewide

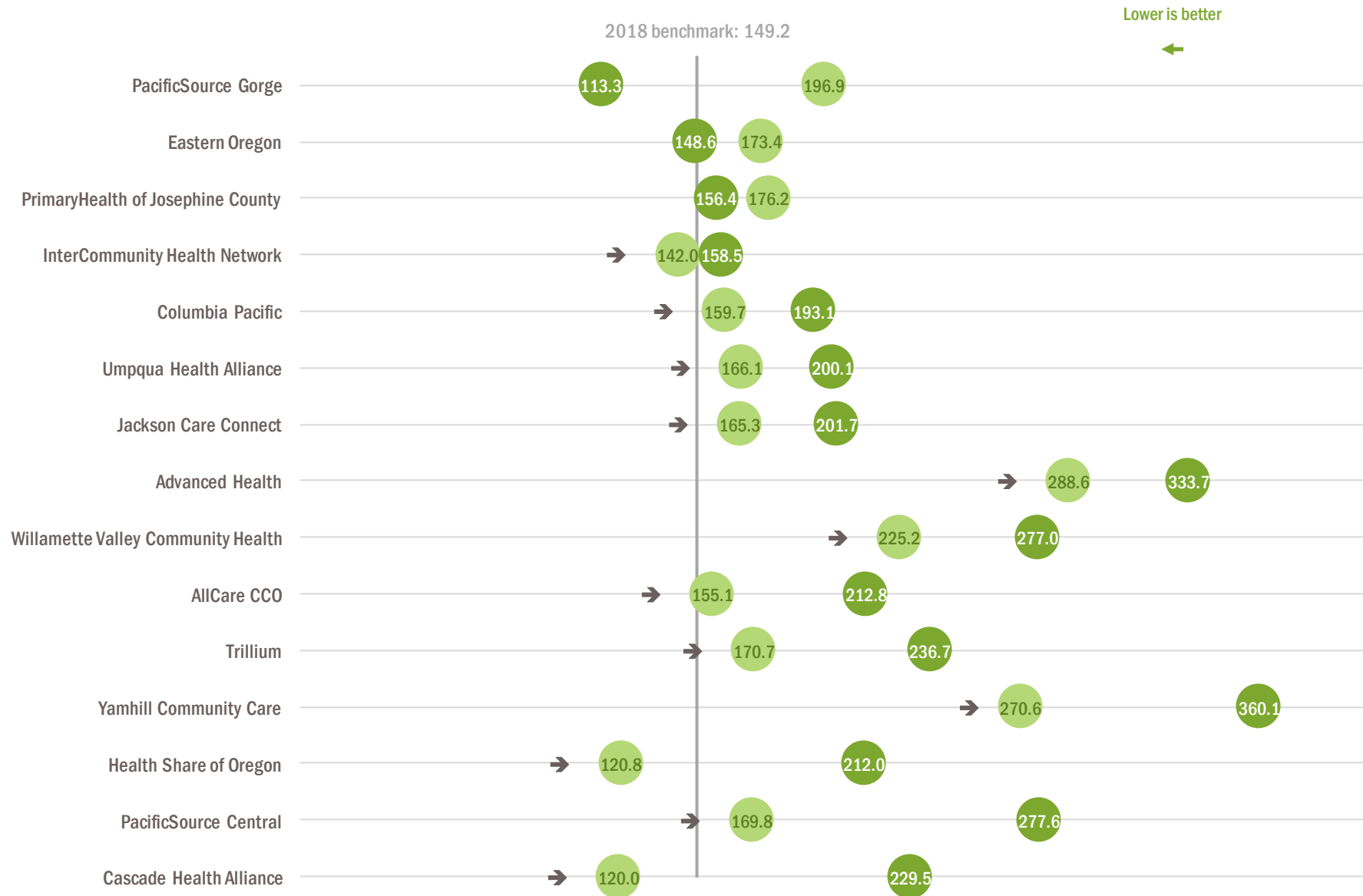


By region



PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Hospital admissions for short-term diabetes complications in 2017 and 2018, by CCO.



PQI 05: COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE

PQI 5

Rate of adult members (ages 40 and older) who had hospital stay because of chronic obstructive pulmonary disease or asthma. A lower score is better.

PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Data source:

Administrative (billing) claims

2018 benchmark source:

10 percent reduction from 2017

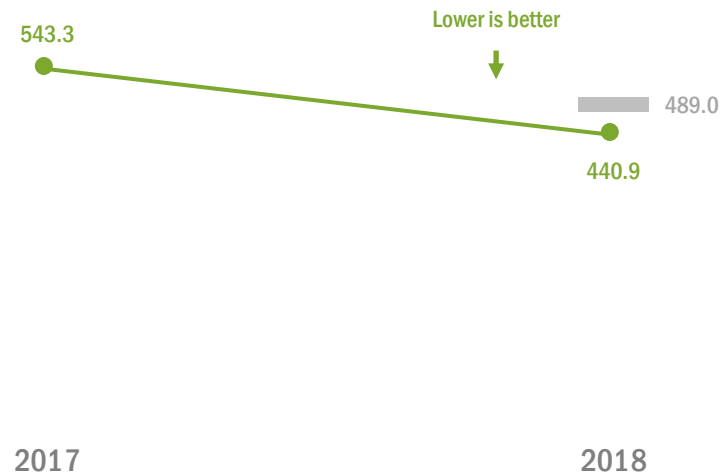
2018 data (N=227,247 member years)

- Statewide change since 2017: **-18.8%**
- Number of CCOs that improved: **14**

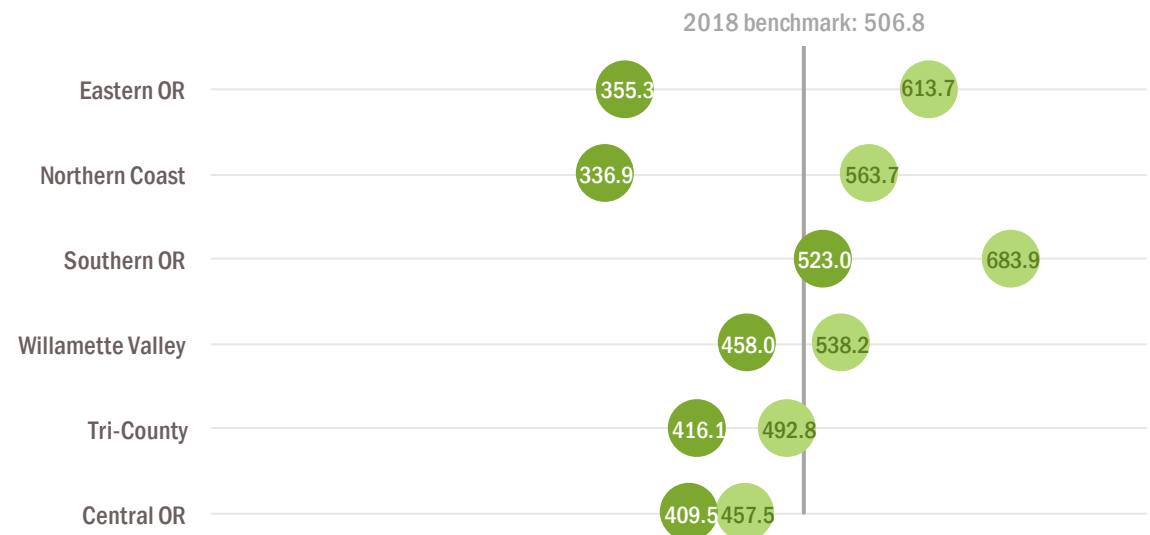
Rates are shown per 100,000 member years which means that in one year, there are on average X visits occurring per 100,000 CCO members.

[Back to table of contents.](#)

Statewide



By region



PQI 05: COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Hospital admissions for COPD or asthma in older adults in 2017 and 2018, by CCO.





PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

PQI 8

Rate of adult members (ages 18 and older) who had a hospital stay because of congestive heart failure. A lower score is better.

PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Data source:

Administrative (billing) claims

2018 benchmark source:

10 percent reduction from 2017

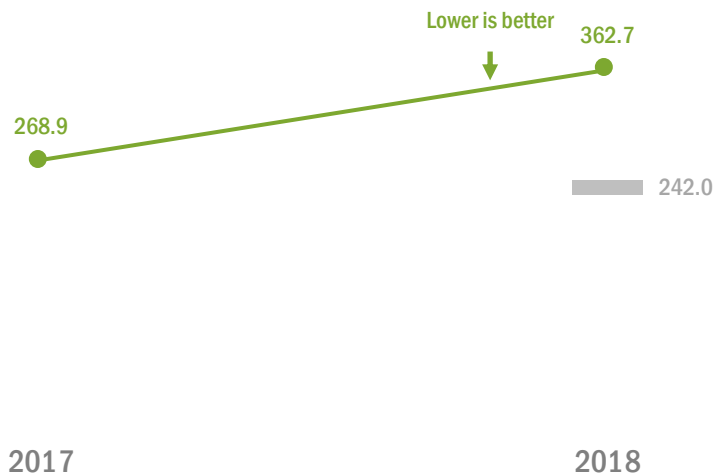
2018 data (N=491,102 member years)

- Statewide change since 2017: **+34.9%**
- Number of CCOs that improved: **1**

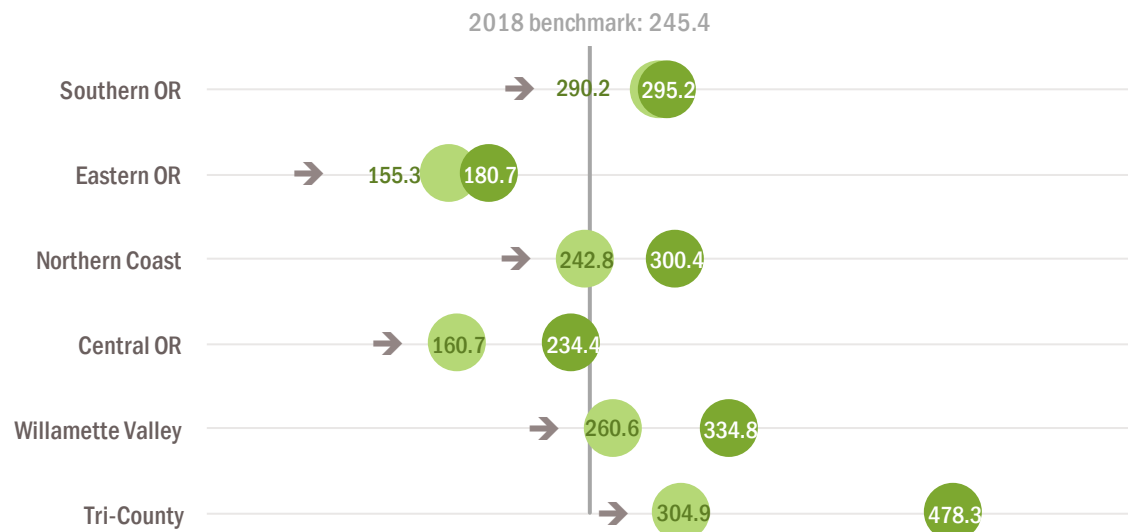
Rates are shown per 100,000 member years which means that in one year, there are on average X visits occurring per 100,000 CCO members.

[Back to table of contents.](#)

Statewide



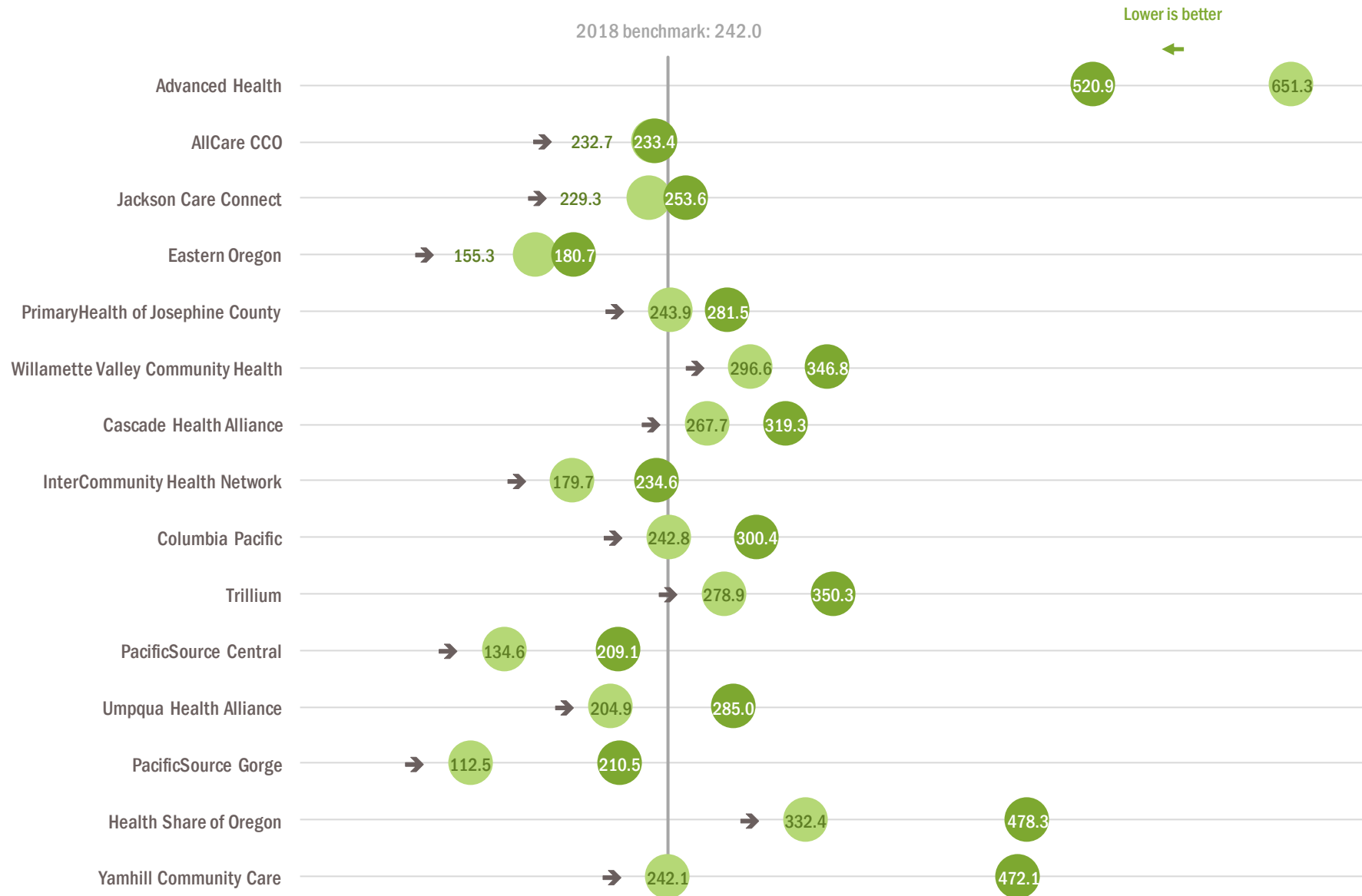
By region





PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Hospital admissions for congestive heart failure in 2017 and 2018, by CCO.





PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

PQI 15

Rate of adult members (ages 18-39) who had a hospital stay because of asthma. A lower score is better.

PQI stands for Prevention Quality Indicator, which is a set of indicators developed by the Agency for Healthcare Research and Quality to track avoidable hospitalizations.

Data source:

Administrative (billing) claims

2018 benchmark source:

10 percent reduction from 2017

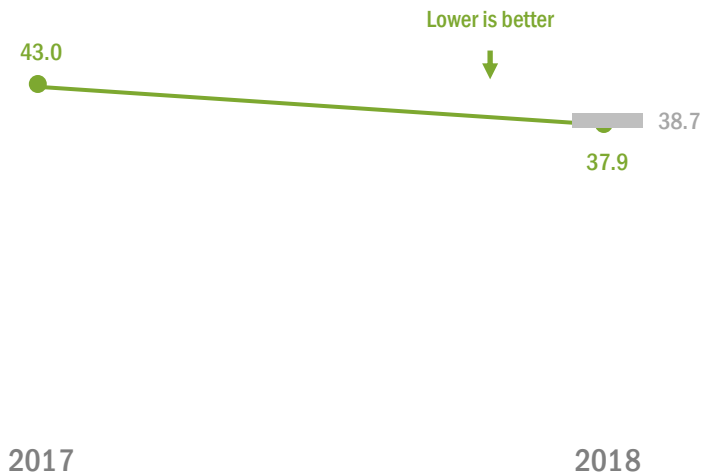
2018 data (N=263,850 member years)

- Statewide change since 2017: **-11.9%**
- Number of CCOs that improved: **9**

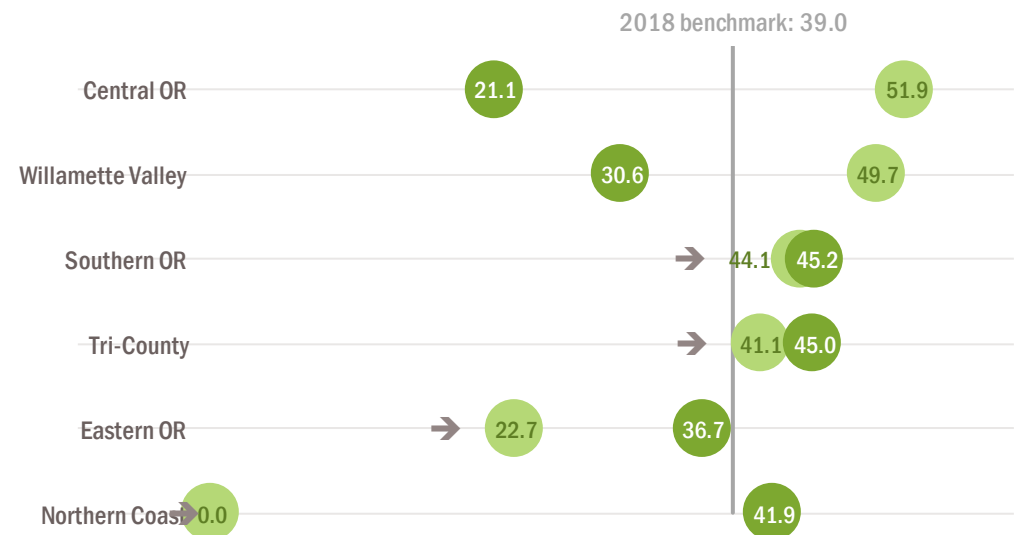
Rates are shown per 100,000 member years which means that in one year, there are on average X visits occurring per 100,000 CCO members.

[Back to table of contents.](#)

Statewide



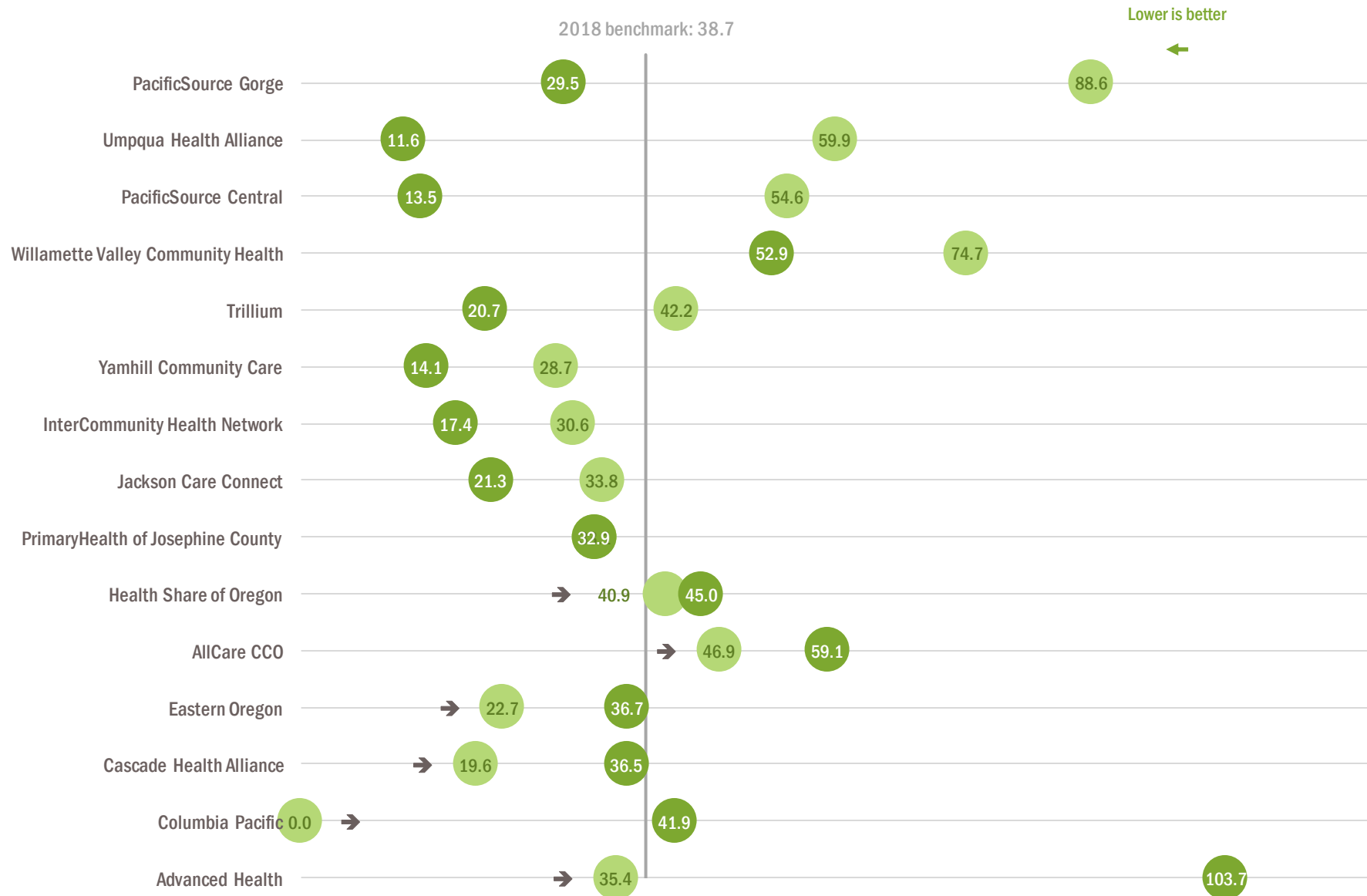
By region





PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Hospital admissions for asthma in younger adults in 2017 and 2018, by CCO.





PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Postpartum care rate

Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery

Data source:

Administrative (billing) claims and medical record review

2018 benchmark source:

2017 national Medicaid 75th percentile

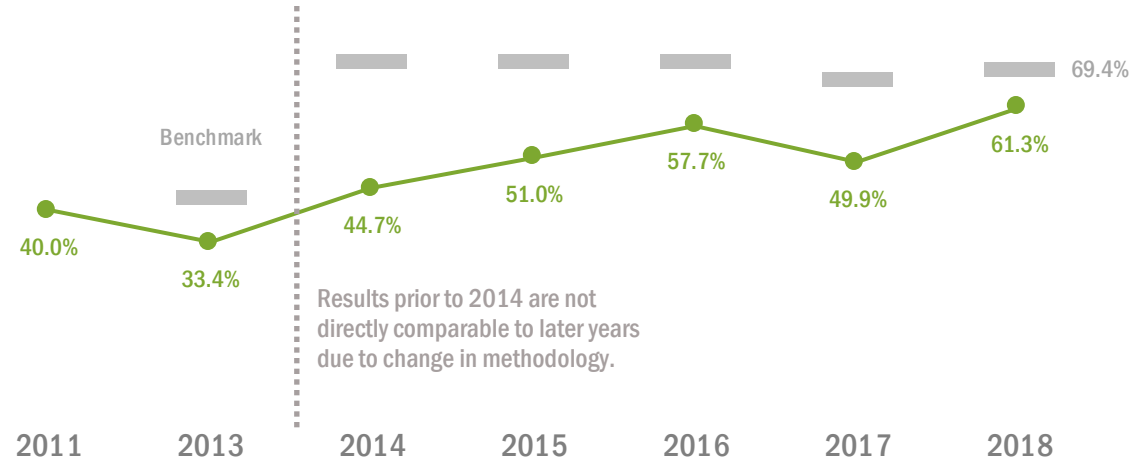
2018 data (N=5,235)

- Statewide change since 2017: **+22.4%**
- Number of CCOs that improved: **12**

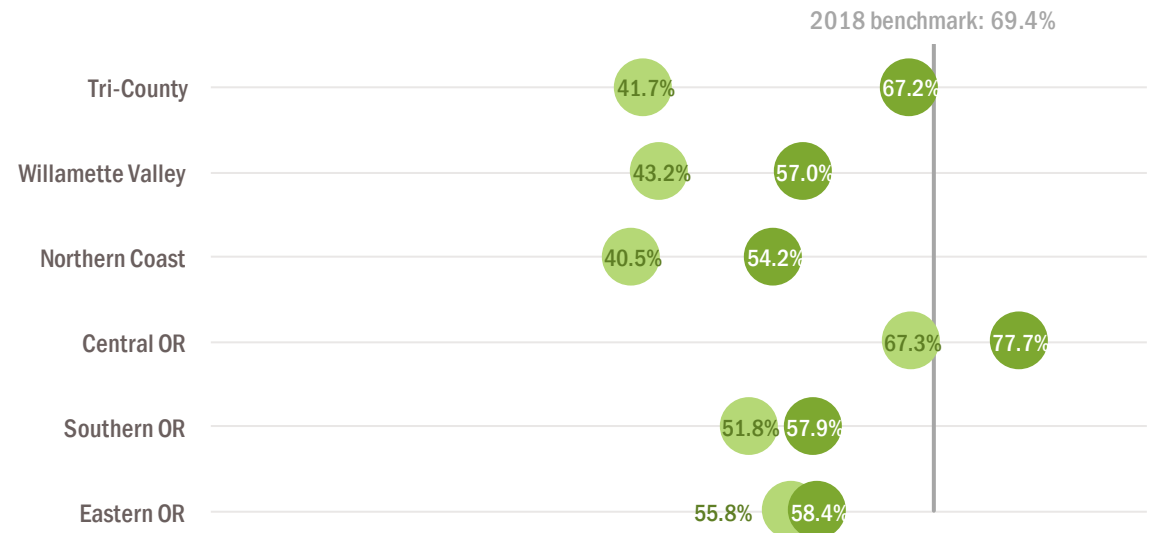
Beginning in 2014, measure specifications were modified to include medical record review. Results prior to 2014 are not directly comparable to later years

[Back to table of contents.](#)

Statewide



By region





PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Percentage of women receiving postpartum care in 2017 and 2018, by CCO.

Grey dots represent 2016.





TOPICAL FLUORIDE VARNISH

Topical Fluoride Varnish

Percentage of CCO members age 1-20 at elevated risk of dental caries who received at least 2 topical fluoride applications within the reporting year.

Data source:

Administrative (billing) claims

2018 benchmark source:

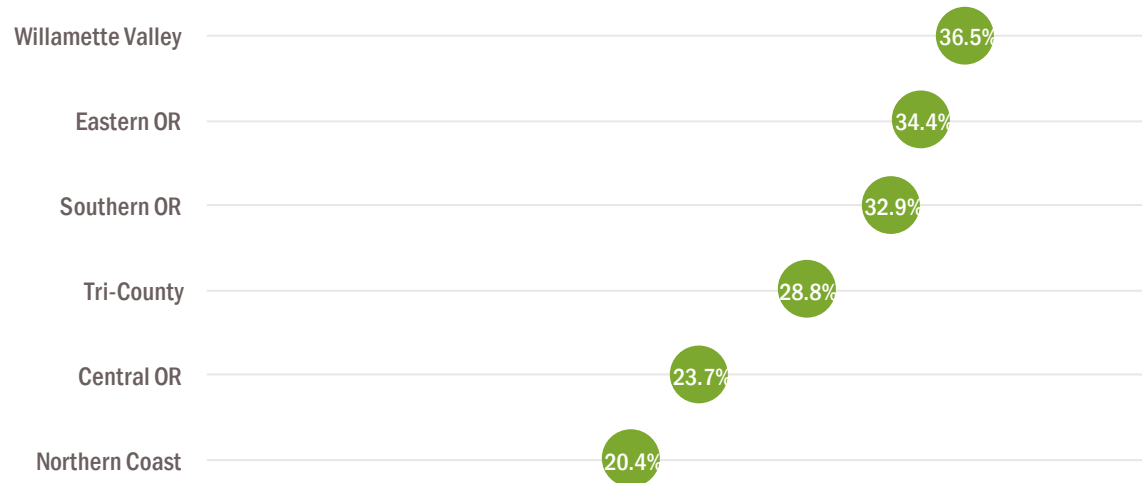
n/a

2018 data (N=111,151)

Statewide



By region

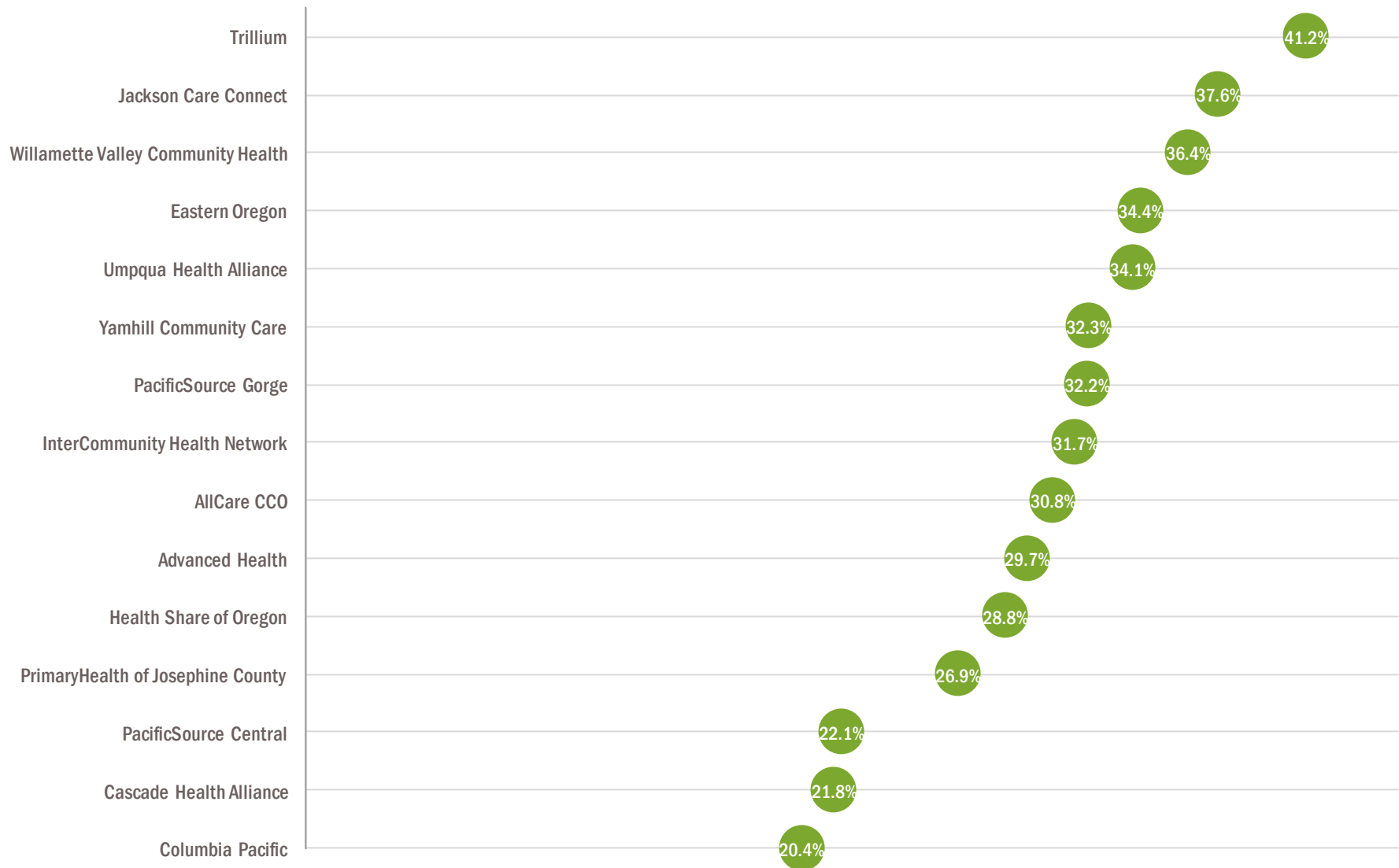


[Back to table of contents.](#)



TOPICAL FLUORIDE VARNISH

Topical Fluoride Varnish in 2018, by CCO.





WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits

Percentage of children who had six visits with their health care provider prior to reaching 15 months of age.

Data source:

Administrative (billing) claims

2018 benchmark source:

2017 National Medicaid 90th percentile

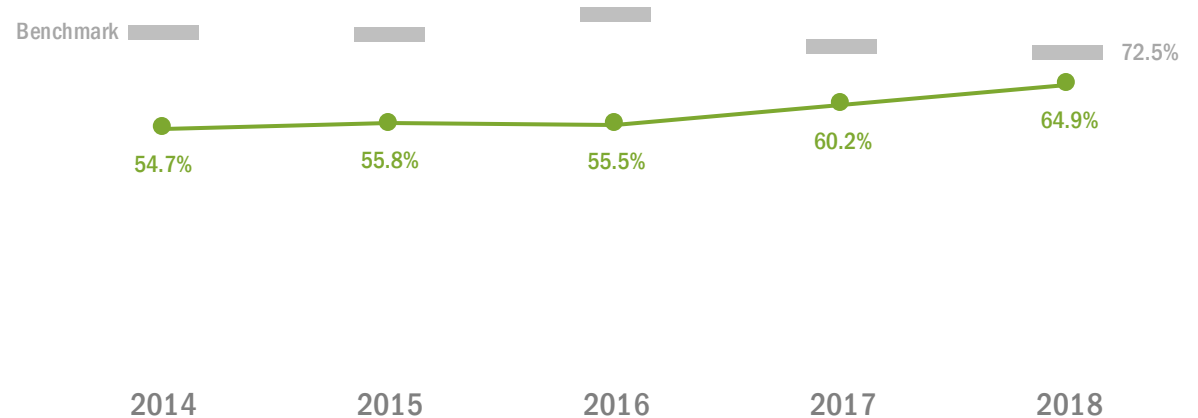
2018 data (N=13,210)

- Statewide change since 2017: **+7.8%**
- Number of CCOs that improved: **15**

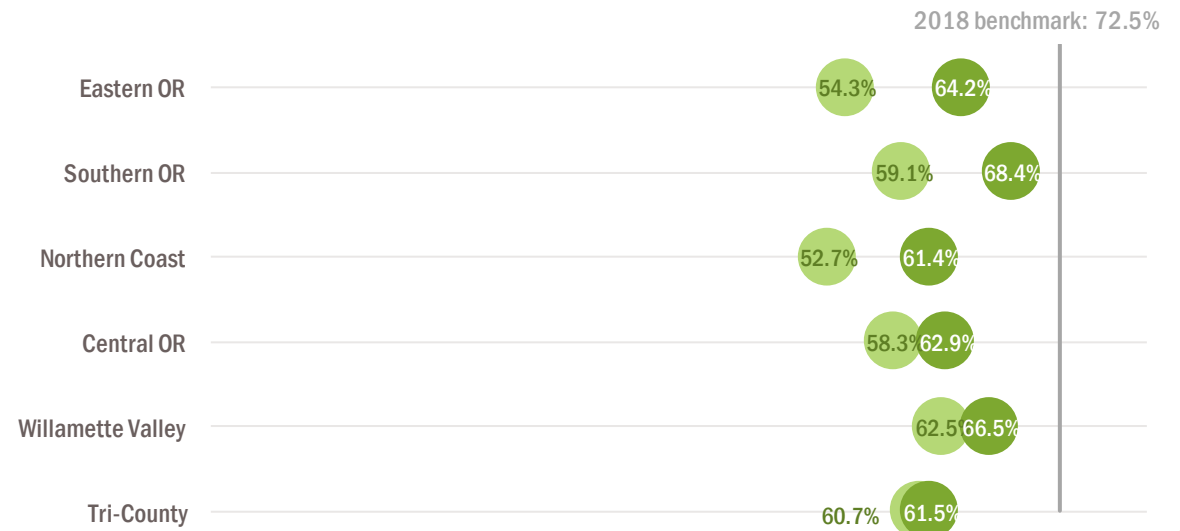
2011 and 2013 statewide data are not available for this measure. Results published in earlier reports for these years cannot be directly compared due to changes in methodology.

[Back to table of contents.](#)

Statewide



By region

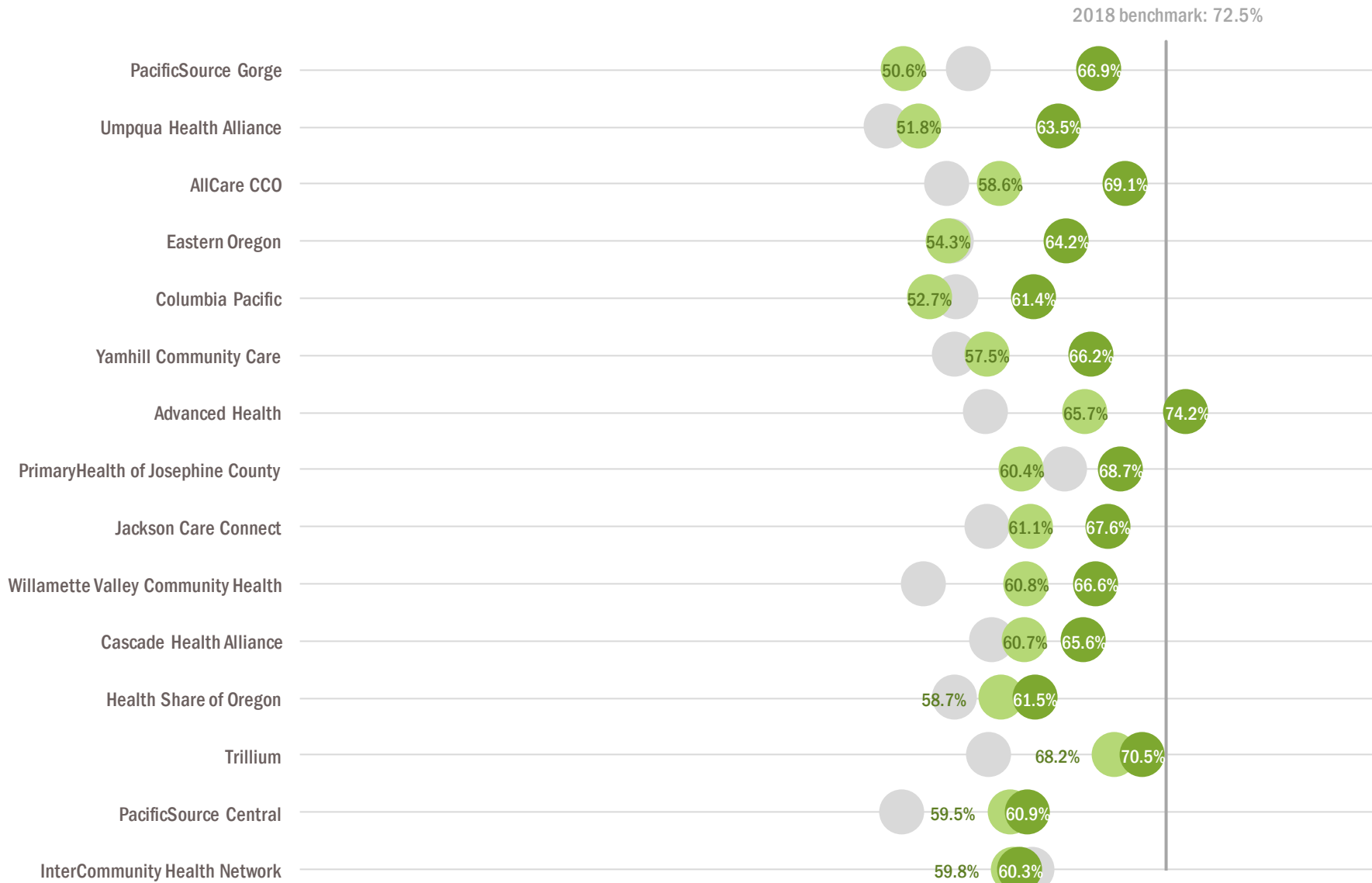




WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits in the first 15 months of life in 2017 and 2018, by CCO.

Grey dots represent 2016.





You can get this document in other languages, large print, braille, or a format your prefer. Contact the Oregon Health Authority Director's Office at 503-947-2340 or OHADirectorsOffice@state.or.us.