Oregon Health System Transformation

CCO Metrics 2019 Final Report

September 2020

Oregon Health Authority

MEASUREMENT PERIOD:
Calendar year 2019
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EXECUTIVE SUMMARY

This report describes the progress of Oregon's coordinated care organizations (CCOs) on quality measures for 2019. Measuring quality and access to care, and holding CCOs accountable to key metrics, is a cornerstone of Oregon's health system transformation. In fact, an independent third-party evaluator, Center for Health Systems Effectiveness at Oregon Health and Sciences University, found incentive measures to be one of the most important tools for CCO quality improvement. (Demonstration Waiver Summative Report).

Oregon is a leader in the nation for working to provide a better health care system. The incentive program rewards CCOs for practices that yield higher quality service delivery to Medicaid members. A report released by OHA and Oregon Health Leadership Council in Summer 2020 showed that Medicaid members experienced the lowest cost and least "low value services" when compared to Commercial and Medicare insured members.

The next important focus of the Medicaid Program will be transforming health care delivery to help eliminate health inequities among the state's most underserved citizens. Toward this goal, OHA plans to release new measures that focus on the health disparities made more apparent during the COVID-19 crisis. Measures will focus on nutrition and physical activity, language access to culturally appropriate care, kindergarten readiness, and social determinants of health, while continuing to emphasize integration of physical health with dental and behavioral health services. Clinical quality will continue to improve to the extent that health equity is achieved in the Medicaid program.

How does Oregon Health Authority help CCOs in quality improvement activities?

OHA works with CCOs throughout the measurement year to look for patterns in performance and to use quality performance data. For example:

- During the measurement year, OHA provides every CCO a summarized monthly metrics dashboard with information that can be parsed at the member level to better understand service use. Because this dashboard is updated monthly with claims-based metric information, CCOs and OHA are able to work together throughout the year to validate measure results. Any discrepancies in reporting can be quickly identified and corrected with smaller lag times. In addition, CCOs can use the ongoing data to target quality improvement efforts.

- The CCO Metrics Technical Advisory Group meets on a bimonthly cycle to identify, discuss and resolve metric questions and challenges at the operational level. These meetings are coordinated with the OHA Transformation Center, which provides practical support directly to CCO staff. For example, technical assistance was offered to help CCOs improve performance on metrics including Diabetes HbA1c Poor Control, Oral Evaluation for Adults with Diabetes, and Emergency Department Visits Among Members Experiencing Mental Illness. Resources from earlier technical assistance, such as childhood immunizations, also remain available to CCOs through recorded webinars and other resources. In addition, OHA supports Innovator Agents to serve as liaisons between CCOs and OHA. The Transformation Center and Innovator Agents help remove communication barriers and ensure OHA remains in touch with each CCO's community.

EXECUTIVE SUMMARY

- At the conclusion of every measurement year, OHA offers a month-long validation period. During this phase of the program, CCOs can ask for clarification about the rules or calculations for any metric and provide additional documentation for the measures as appropriate.

CCOs made large strides on selected quality measures in the first several years of the program; as a result sustained quality improvement efforts are now needed to achieve the aspirational benchmarks based on the most exceptional national performance. The results in this report demonstrate that as the incentive program continues, the targets and benchmarks become even harder to meet or exceed as more difficult change processes become necessary. This ongoing challenge ensures that CCOs continue to focus on quality improvement and work toward making the changes needed for better experiences and outcomes for Oregon Health Plan members.

2019 CCO quality pool earnings

In 2019, the total quality pool was $166 million. The amount each CCO can earn from the quality pool is based on a percentage of their capitated payments each year. The quality pool is disbursed entirely each year through two phases: In Phase One, each CCO can earn up to 100% of their quality pool by meeting certain criteria. In 2019, each CCO earned at least 60% of their quality pool dollars in Stage 1 (specifically, four CCOs earned 60%; six CCOs earned 80%, and five CCOs earned 100%). Any funds left over from this first phase are used to fund Phase Two, the "Challenge Pool." In 2019, the Challenge Pool was worth almost $46 million. Because several large CCOs did not earn 100% in Phase One of the quality pool distribution, the Challenge Pool was substantially larger than in previous years (for example, in 2018 it was just under $11 million). See page 14 for more detail on the 2019 quality pool distribution.

Impacts of the COVID-19 pandemic on quality pool payments

A global pandemic hit Oregon during March 2020. In response to the emergency, OHA evaluated sources of funding that could be released quickly to support CCOs as they prepared for a potential surge in patients needing care. Toward this end, a portion of the 2019 quality pool dollars (60 percent) was distributed to CCOs in April. Normally, the full quality pool for a measurement year is disbursed to CCOs the following June. But, for the 2019 measurement year, only the earned portion of the remaining 40% balance was released to CCOs in June based on the quality performance shown in this report. (Payments are shown on page 15).

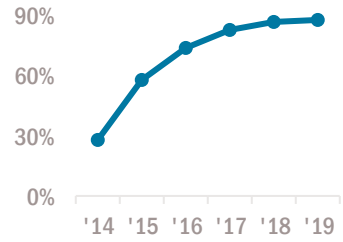
Report highlights

This report shows CCO performance across three categories of measures: CCO incentive metrics, state quality metrics, and CMS core metrics (see page 12 for additional background and more information on the different categories of measures). Key findings are detailed on the following pages.

EXECUTIVE SUMMARY

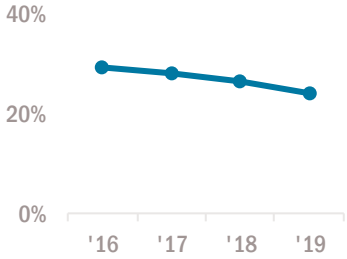
Assessments for Children in DHS Custody: The percentage of children in foster care who received mental, physical and health assessments continues to increase, but at a slower rate than in previous years. Since the metric was first incentivized in 2014, CCOs have improved more than 200%, from 27.9% to 87.8% in 2019. Recently, a work group was established to improve communication around enrollment of children into foster care. These efforts are expected to yield further performance gains in 2021.

Assessments for children in DHS custody



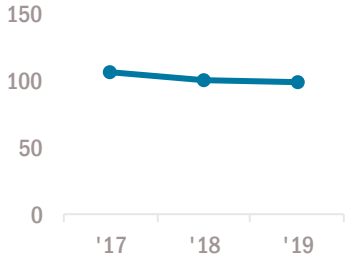
Cigarette Smoking Prevalence: Cigarette smoking prevalence declined among 13 of 15 CCOs in 2019, with three CCOs demonstrating substantial improvement. The overall smoking prevalence in the state decreased by almost nine percent. This is particularly notable because the prevalence of smoking among Medicaid members is significantly higher than among people not on Medicaid.

Cigarette smoking prevalence



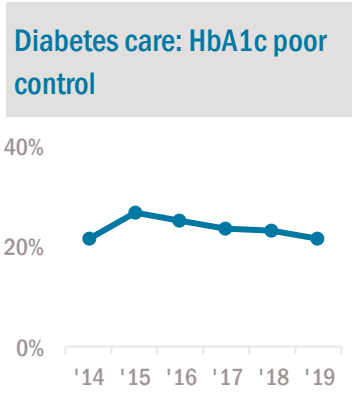
Emergency Department Utilization among Members with Mental Illness: In 2018—the first year ED utilization among members with mental illness was included in the Quality Incentive Program—CCOs showed somewhat flat performance on this measure. However, in 2019, nine of 15 CCOs improved and seven achieved their improvement target. Overall, the state performance showed a modest 1.1% improvement from the prior year on this measure.

ED utilization for members with mental illness

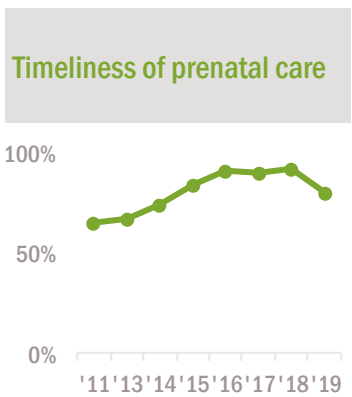


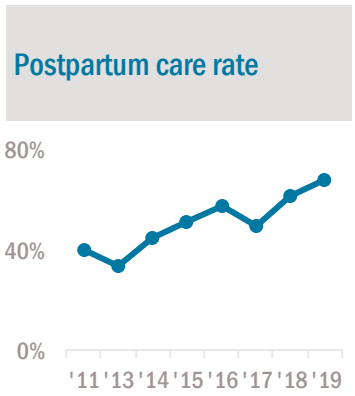
EXECUTIVE SUMMARY

Diabetes Care: HbA1c Poor Control: The percentage of CCO members with diabetes who had poor hemoglobin A1c control in 2019 decreased slightly at the statewide level (a lower score is better on this measure) and seven of 15 CCOs achieved their target.

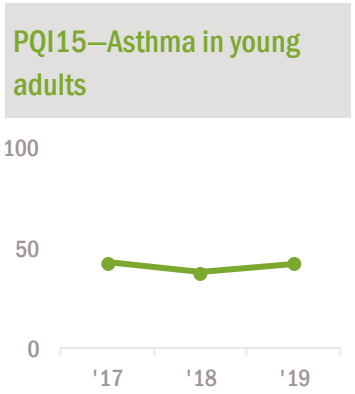


Prenatal and Postpartum Care: 2019 is the first year Postpartum Care is included in the quality incentive pool. All but two CCOs achieved the benchmark or improvement target, and the statewide rate of 68.2% nearly reached the benchmark. Meanwhile, 2019 is the first year the counterpart measure Timeliness of Prenatal Care is no longer incentivized (though it is still being monitored as a state quality metric). Statewide performance on this measure dropped from 92.6% to 80.6%, and no CCOs demonstrated improvements in the rate of women who received a prenatal care visit in the first trimester or within 42 days of enrollment.





Asthma in Young Adults (PQI 15): Notably, asthma as a cause of hospital stay increased almost 12% at the statewide level in 2019, from 37.9 to 42.2 hospital admissions per 100,000 member years (lower numbers reflect better performance). CCO performance varied from 13.7 to 115.8.



EXECUTIVE SUMMARY

New in this report

This report includes four measures which are being reported for the first time:

Oral Evaluation for Adults with Diabetes is a new CCO incentive measure and is crucial due to comorbid conditions that can develop in people with decreased gum health, which is common among those who have diabetes. CCO performance on this measure ranged between 22.7% and 34.6% with a benchmark set at 27.1%. There were no improvement targets set in this year because it is the measure's first appearance on the incentivized list.

Preventive Dental Services among Children Ages 1-5 and 6-14. These measures (reported for each age group) will be added to the CCO Quality Incentive Program beginning in 2020 and are being reported for the first time here. In 2019, a majority of CCOs demonstrated improvement on both measures.

Well-Child Visits 3-6 Years will also be new to the Quality Incentive Program in 2020 and is being reported for the first time here. On this measure, the overall state improvement was three percent, and 11 of 15 CCOs improved on their performance with a final rate of 68.5 percent.

Dual Eligible Supplemental Report

In addition to quality metrics reporting, a new supplemental section describes the quality of services delivered to members who are dual-covered by both Medicaid and Medicare health plans. This group often includes enrollees with the greatest health burdens, including service needs for memory care or other physical and behavioral disabilities.

Findings by Race and Ethnicity Groups

Last year self-reported race and ethnicity data was provided in the annual report for those measures for which it was available from consumer survey responses. This year's report follows the same model. OHA is currently developing a methodology that overcomes the large proportion of missing and indeterminate race information for claims-based measures. This new methodology will enable OHA to report race and ethnicity data for more measures in the future, including in a separate metrics report to be released in 2021.

BACKGROUND / CONTEXT

Medicaid waiver

Medicaid (health coverage for people earning less than 138% of the federal poverty 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 2019, 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 eliminate health inequities. 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 populations 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%, 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 metrics to the Centers for Medicare & Medicaid Services (CMS) as part of the 1115 Medicaid waiver.

CMS core metrics

Core quality measures identified by the Centers for Medicare and & Medicaid Services (CMS), together with commercial plans, managed care plans, physicians, consumers, and others 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 https://www.oregon.gov/OHA/HPA/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.

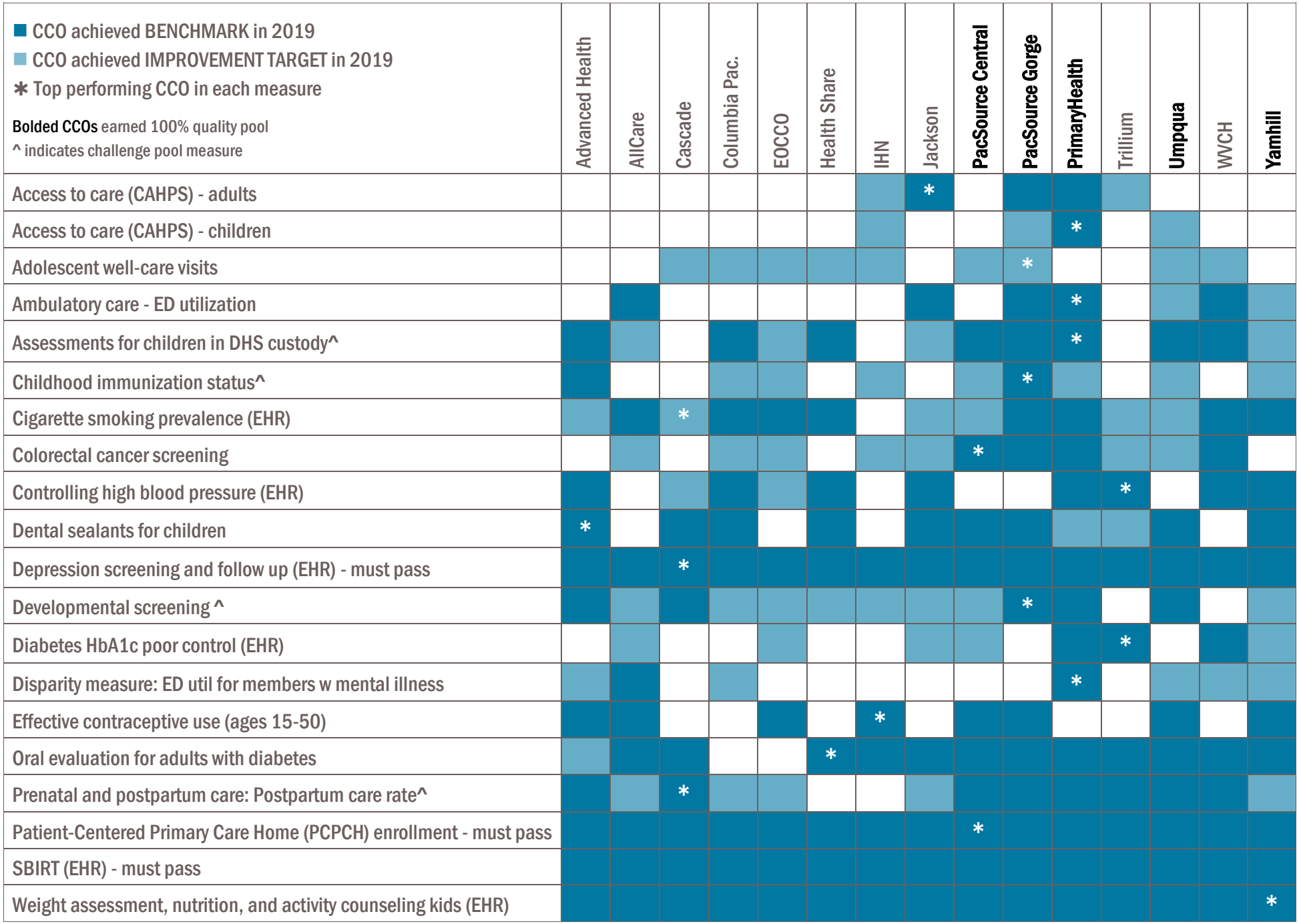
NEW

Additionally, measures that are brand new to this report are 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

2019 INCENTIVE METRIC PERFORMANCE OVERVIEW



2019 QUALITY POOL DISTRIBUTION

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

The 2019 quality pool is more than $166 million. This represents 3.5 percent of the total amount all CCOs were paid in 2019. The quality pool is divided among all CCOs based on their number of members (see page 17 for CCO enrollment numbers) and their performance on the 19 incentive metrics.

Quality Pool: Phase One Distribution

CCOs can earn 100% of their quality pool in the first phase of distribution by:

- Meeting the benchmark or improvement target on 12 of 16 measures; and
- Reporting data for minimum population thresholds for both the SBIRT and Depression screening measures; and
- Achieving a score of 68 or higher for the patient-centered primary care home measure (PCPCH).

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

Challenge Pool: Phase Two Distribution

The challenge pool includes funds remaining after quality pool funds are distributed in phase one. The 2019 challenge pool was more than $45 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. Postpartum care rate

Impact of COVID-19

The COVID-19 global pandemic hit Oregon in March 2020. Sixty percent of the quality pool dollars were released earlier than normal by Oregon Health Authority to infuse money into the medical system, as many clinics faced closure during the shutdown. Normally, the full quality pool is disbursed to CCOs in June of every report-out year that follows the measurement year. But, for 2019 measurement year—because 60% of the available quality pool was paid out early on April 1, 2020—only the remaining 40% balance was released in June. The second disbursement was distributed such that the total amount paid to each CCO was based on incentives for the quality performance shown in this report. A summary of each CCO's early release spending plan can be found here. Values for both payments are reported on the following page.

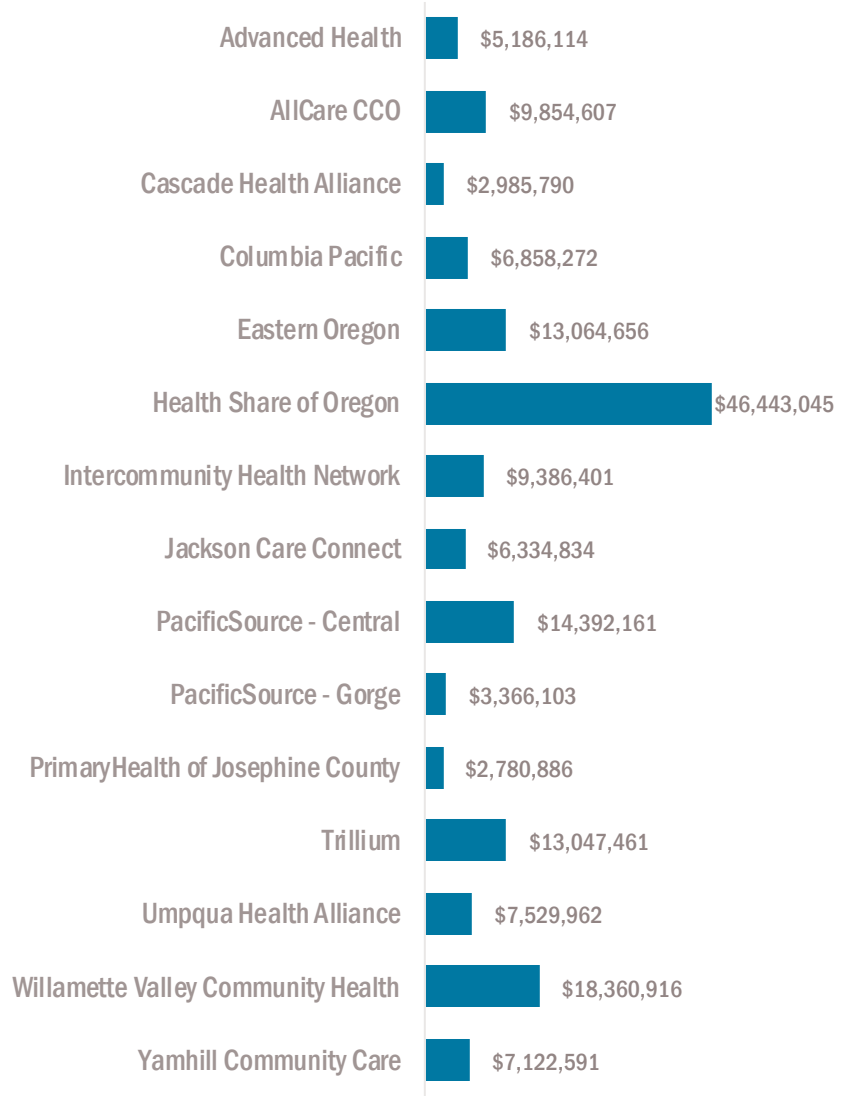
2019 QUALITY POOL DISTRIBUTION

CCO	Phase 1 Distribution				Challenge Pool		Total	
	# Measures met (of 19 possible)	Early distribution (April 2020), 60% of available quality pool	Total 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	$ 2,467,110	$ 3,224,354	80%	4	$ 1,858,037	$ 5,186,114	126%
AllCare Health Plan	14	$ 5,130,021	$ 6,702,564	80%	3	$ 2,954,951	$ 9,854,607	115%
Cascade Health Alliance	11	$ 2,158,805	$ 2,118,524	60%	2	$ 807,550	$ 2,985,790	83%
Columbia Pacific	14	$ 3,359,730	$ 4,391,338	80%	4	$ 2,329,769	$ 6,858,272	122%
Eastern Oregon	14	$ 6,271,365	$ 8,195,384	80%	4	$ 4,607,979	$ 13,064,656	125%
Health Share of Oregon	11	$ 35,210,323	$ 34,504,781	60%	2	$ 11,009,403	$ 46,443,045	79%
Intercommunity Health Network	11	$ 6,545,549	$ 6,414,383	60%	2	$ 2,784,290	$ 9,386,401	86%
Jackson Care Connect	14	$ 3,308,094	$ 4,322,769	80%	3	$ 1,885,368	$ 6,334,834	115%
PacificSource – Central Oregon	15	$ 5,938,535	$ 9,697,879	100%	4	$ 4,406,439	$ 14,392,161	145%
PacificSource – Gorge	16	$ 1,349,245	$ 2,203,725	100%	4	$ 1,095,056	$ 3,366,103	150%
PrimaryHealth of Josephine County	17	$ 1,091,029	$ 1,781,824	100%	4	$ 943,444	$ 2,780,886	153%
Trillium	11	$ 10,732,163	$ 10,515,418	60%	1	$ 2,271,094	$ 13,047,461	73%
Umpqua Health Alliance	16	$ 3,006,890	$ 4,912,276	100%	4	$ 2,467,088	$ 7,529,962	150%
Willamette Valley Community Health	14	$ 10,573,756	$ 13,815,506	80%	2	$ 4,178,192	$ 18,360,916	104%
Yamhill Community Care	16	$ 2,866,386	$ 4,713,749	100%	4	$ 2,266,390	$ 7,122,591	148%
Total		$ 100,029,001	$ 117,514,473			$ 45,865,050	$ 166,713,799	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 17 for CCO enrollment.

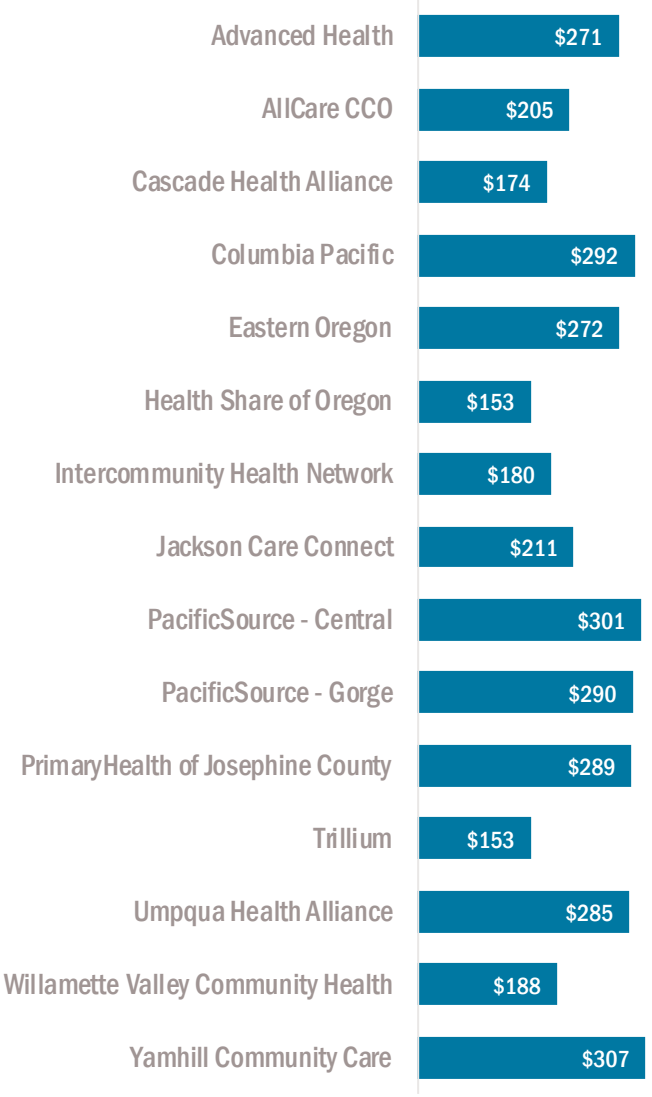
2019 QUALITY POOL DISTRIBUTION

Total quality pool dollars earned, by CCO

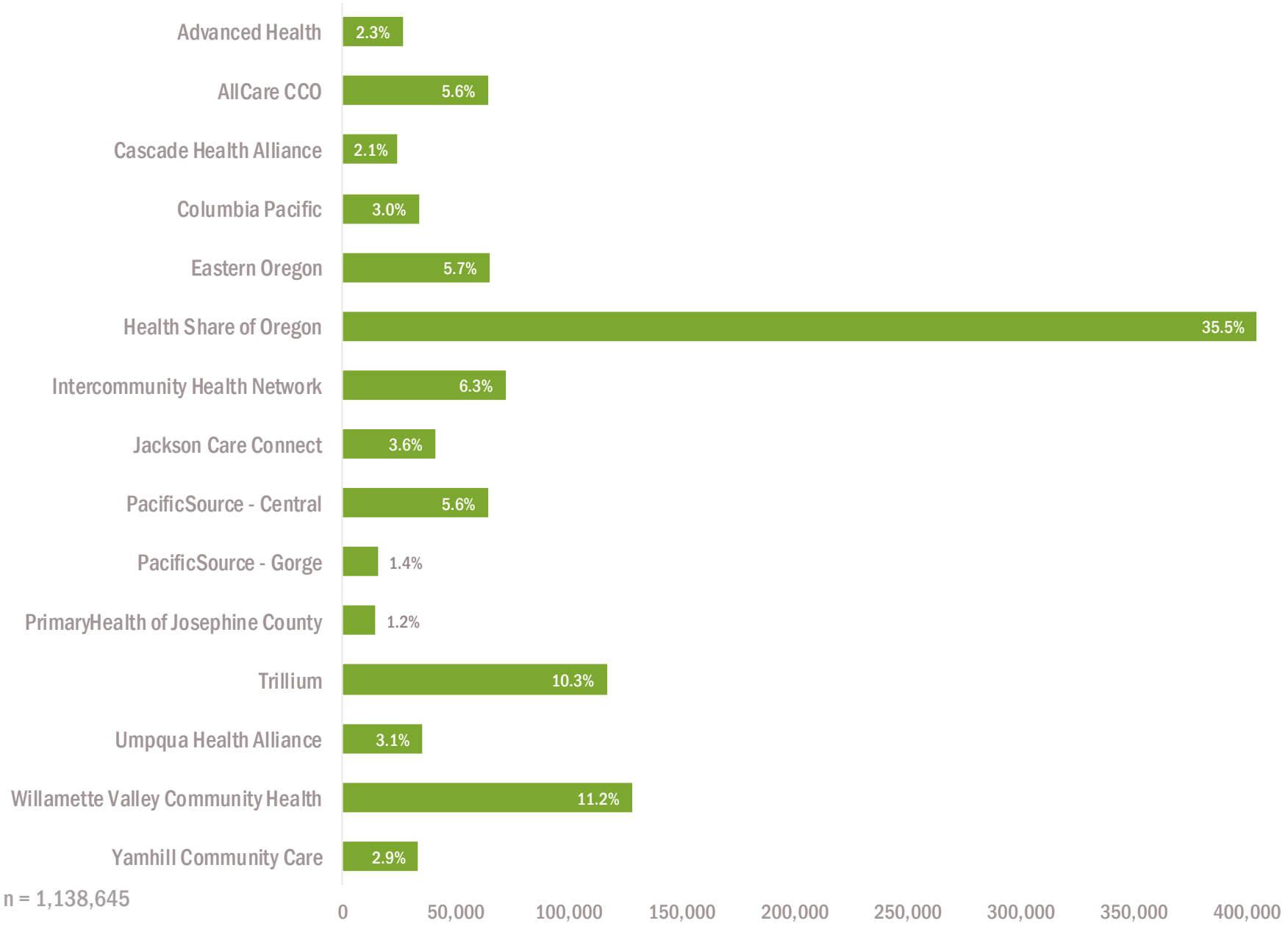


Quality pool earned per member

(December 2019 enrollment)



TOTAL CCO ENROLLMENT (December 2019)



Supplemental Summary:

Dual-Eligible Members of Medicaid and Medicare

DUAL-ELIGIBLE MEMBER PERFORMANCE

In the 2019 CCO performance report, we are highlighting Medicaid members who are dually eligible. Members are dually eligible for both Medicare and Medicaid because of a disability and/or their age. Eligibility in both programs happens when members are younger than 65 years old with a disability, or, when they are over 65 years old with a need for services such as long-term care. "Dual-eligible" members are among the most economically disadvantaged and ill of all Medicaid beneficiaries. Often this group incurs the highest expenses for the health care system and may require a great deal of case management.

Only members who are both enrolled in a CCO and covered by Medicaid and Medicare are shown in these analyses. The quality metric bar charts on the following pages illustrate differences between Medicaid-only members and dual-eligible members. Where possible, the dual-eligible members are broken out by disability and age groups. Age stratification is not possible for some metrics.

Validation of metrics were performed on these quality measures. Validation of the dual-eligible metrics was performed by an independent analyst to confirm these findings. Such validation ensures that Medicaid data extraction logic and code capture is consistently applied.

The dual-eligible members are generally in much poorer health due to either disability or age. The metrics reported for this group show more case management may be needed for certain targeted chronic conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease. Greater case management could also help lower rates of avoidable emergency department use, which is higher among dual-eligible members. Though groups with mental illness and asthma showed slightly higher hospital utilization rates in dual-eligible members, diabetes care did differ from the Medicaid-only group. These metrics are used for quality improvement purposes for members enrolled in CCOs. In the future, dual-eligible members might also be compared between members assigned to CCOs and members in Medicaid Fee-For-Service Open Card.

For more information:

Feng, Z. Vadnais, A. Vreeland, E Haber, S. Wiener, J & Baker B. Analysis of Pathways to Dual Eligible Status: Final Report. U.S. Department of Health and Human Services, 2019. https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report (accessed January, 2020)

Center for Health Care Strategies, Inc. Supporting Integrated Care for Dual Eligibles, 2009. https://www.chcs.org/media/Integrated_Care_Policy_Brief.pdf (accessed January, 2020)

Kim, H. Charlesworth, C. Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon. OHSU Center for Health System Effectiveness, 2016. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Assessing%20the%20Effects%20of%20CCO%20Dual%20Eligibles.pdf (accessed January, 2020)

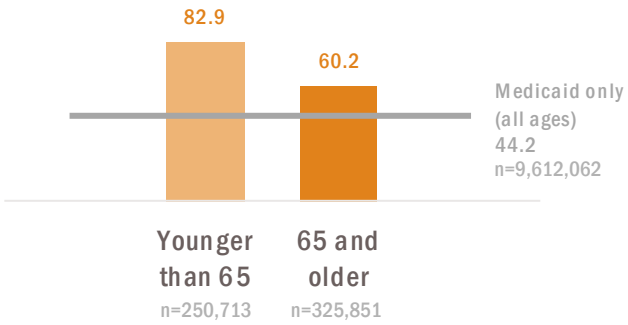
DUAL-ELIGIBLE MEMBERS

Emergency department utilization

The rate of emergency department visits is higher among dual eligible members in both age categories than among Medicaid-only members.

Lower is better

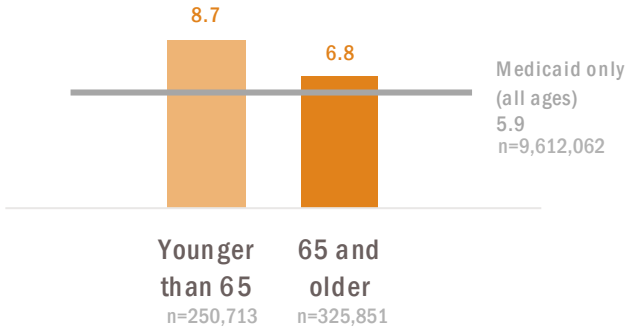
Rates are per 1,000 member months



Avoidable emergency department utilization

The rate of ED visits for conditions that could be more appropriately managed in a different way is higher among dual eligible members in both age categories than among Medicaid-only members.

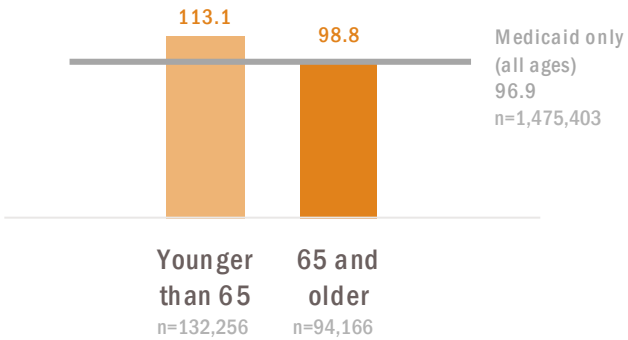
Lower is better



ED utilization among members with mental illness

The rate of emergency department visits for physical health conditions among members with mental illness is higher among dual eligible members in both age categories than among Medicaid-only members.

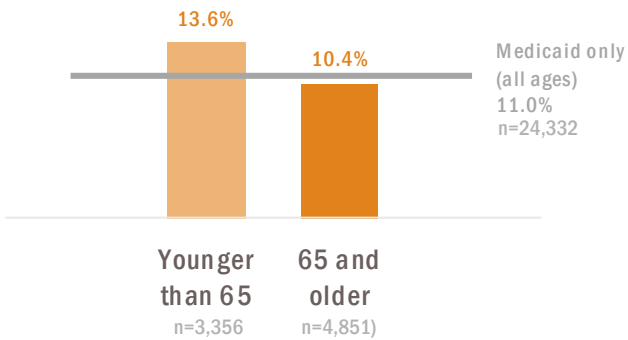
Lower is better



All-cause readmissions

The percentage of members who were readmitted to the hospital for any reason within 30 days of discharge is higher among dual eligible members younger than 65 than among Medicaid-only members.

Lower is better



Measurement period for this special section is July 2018 - June 2019

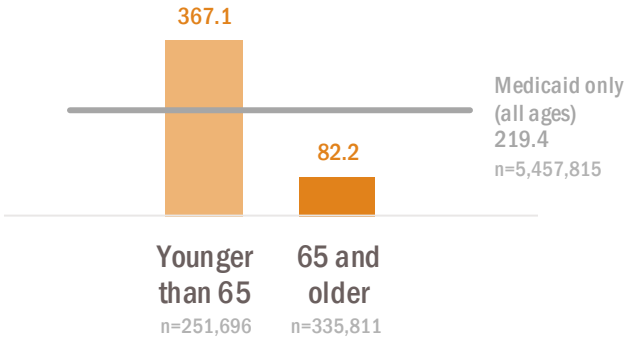
DUAL-ELIGIBLE MEMBERS

PQI 1: Diabetes short-term complications admission rate

The rate of hospital admissions for diabetes complications is higher among younger dual eligible members, but lower among older dual eligible members.

Lower is better

Rates are per 100,000 member years

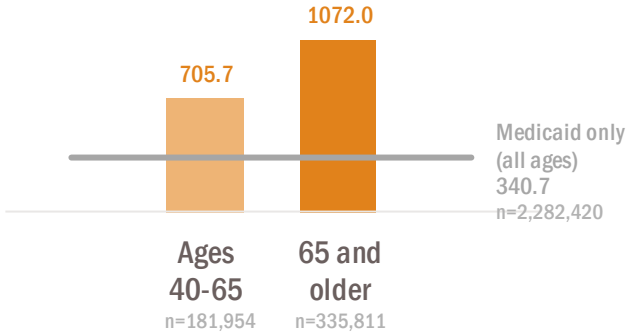


PQI 5: COPD or asthma in older adults admission rate

The rate of hospital admissions for COPD or asthma is higher among dual eligible members in both age categories than among Medicaid-only members.

Lower is better

Rates are per 100,000 member years

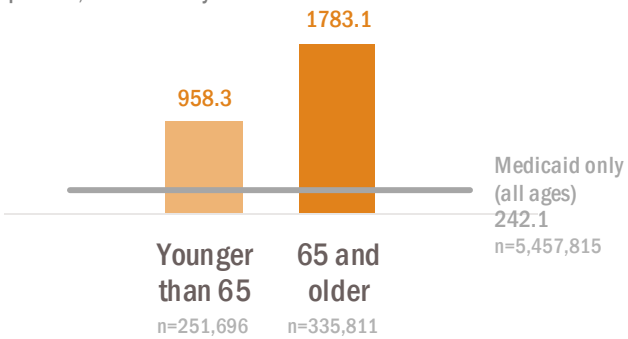


PQI 8: Congestive heart failure admission rate

The rate of hospital admissions for congestive heart failure is higher among dual eligible members in both age categories than among Medicaid-only members.

Lower is better

Rates are per 100,000 member years

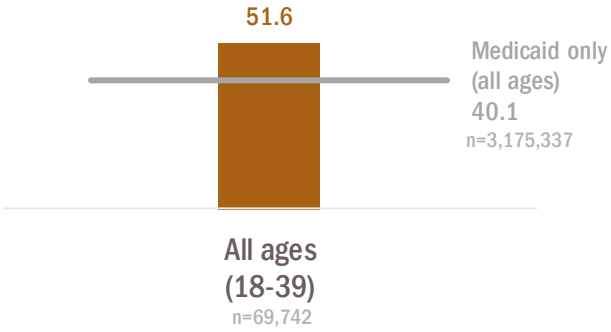


PQI 15: Asthma in younger adults admission rate

The rate of hospital admissions for asthma in younger adults is higher among dual eligible members among Medicaid-only members.

Lower is better

Rates are per 100,000 member years

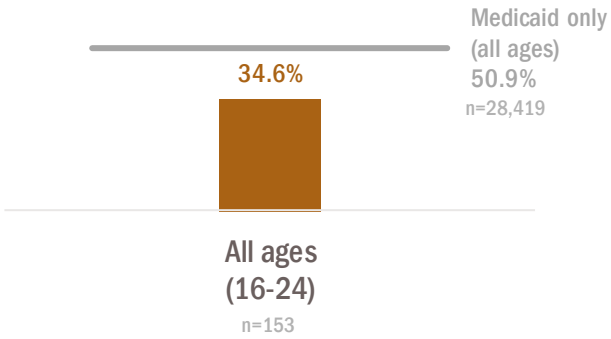


Measurement period for this special section is July 2018 - June 2019

DUAL-ELIGIBLE MEMBERS

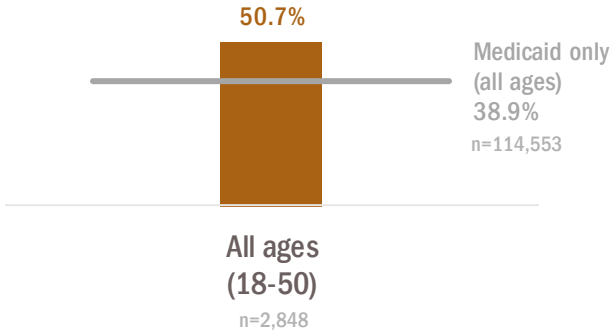
Chlamydia screening

The percentage of sexually active women (ages 16-24) who received a chlamydia screening is lower among dual eligible members than among Medicaid-only members.



Effective contraceptive use

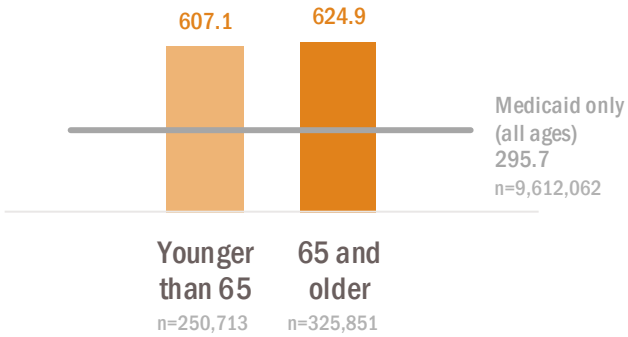
The percentage of women (ages 18-50) at risk of unintended pregnancy who used effective contraceptives is higher among dual eligible members than among Medicaid-only members.



Outpatient utilization

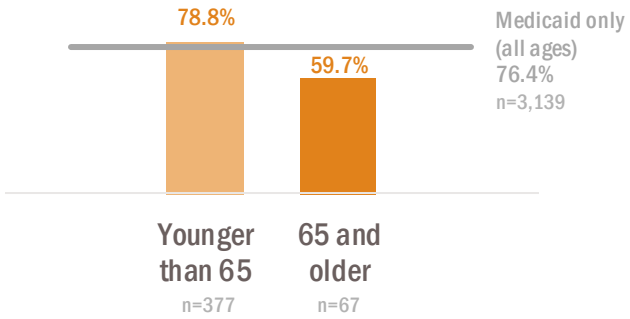
The rate of outpatient utilization is higher among dual eligible members in both age categories than among Medicaid-only members.

Rates are per 1,000 member months



Follow up after hospitalization for mental illness

The percentage of members who received a follow-up visit after a mental illness-related hospitalization is similar among dual eligible members younger than 65, and lower among dual eligible members older than 65, than among Medicaid-only members.

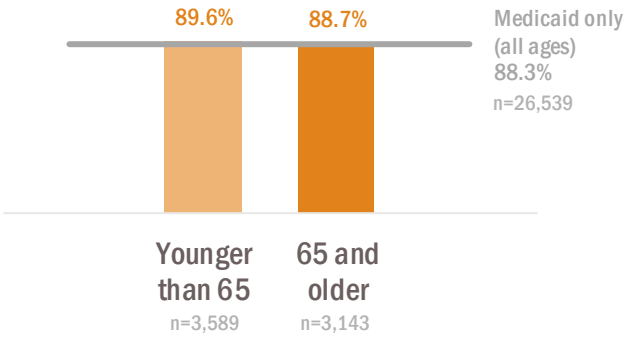


Measurement period for this special section is July 2018 - June 2019

DUAL-ELIGIBLE MEMBERS

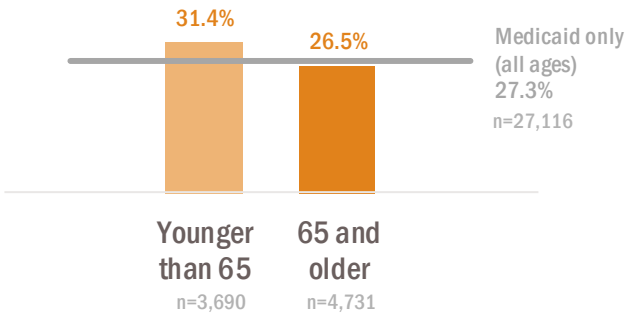
Comprehensive diabetes care

The percentage of members with diabetes who received comprehensive diabetes care is similar among dual eligible members in both age categories than among Medicaid-only members.



Oral evaluation for diabetes

The percentage of members with diabetes who received any dental service is slightly higher among dual eligible members younger than 65 than among Medicaid-only members.



Measurement period for this special section is July 2018 - June 2019

Appendix A

CCO Incentive Measures

ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

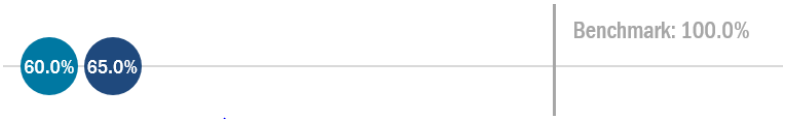
Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. That is, CCOs are not expected to meet the benchmark each year, but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) 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 **2018** (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 2019**. Their **improvement target** is [baseline + 4%] = [60% + 4%] = **64%***

*CCO A's performance in **2019** is 65%; they **achieved their improvement target and will receive quality pool payment** on Measure 1.*



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

ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

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

Data source:
Administrative (billing) claims

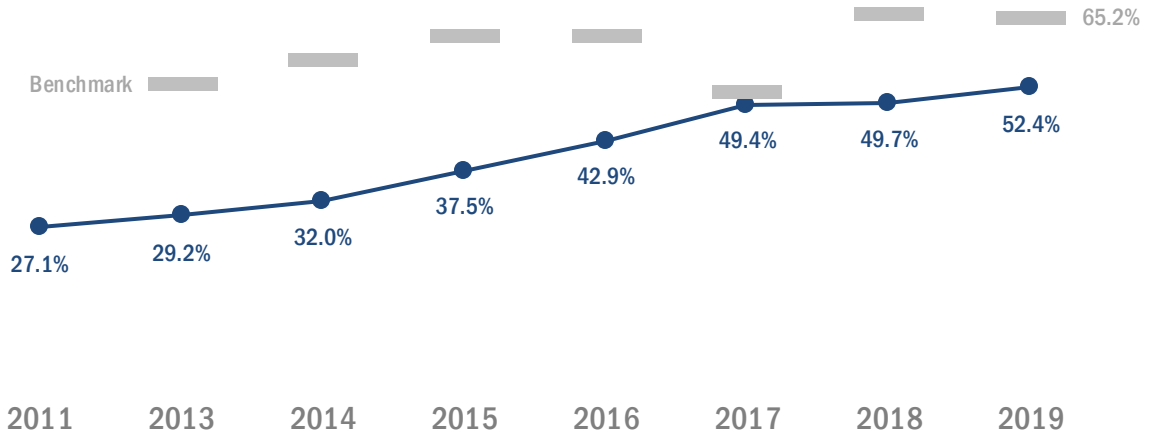
2019 benchmark source:
2018 national Medicaid 75th percentile

2019 data (n=128,836)

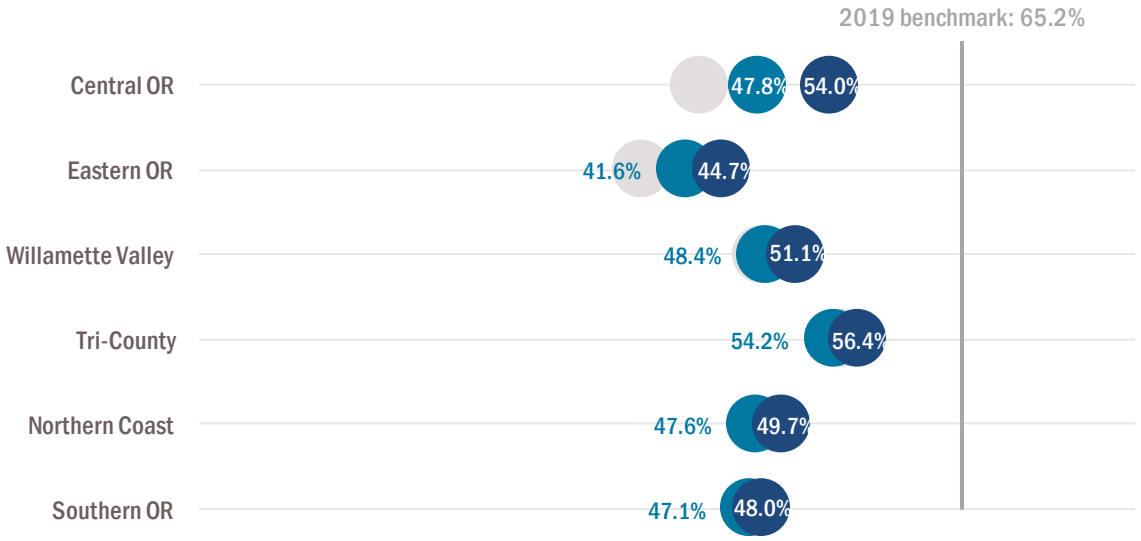
- Statewide change since 2018: **+5.4%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **9**

This measure will no longer be incentivized beginning in 2020.

Statewide



By region



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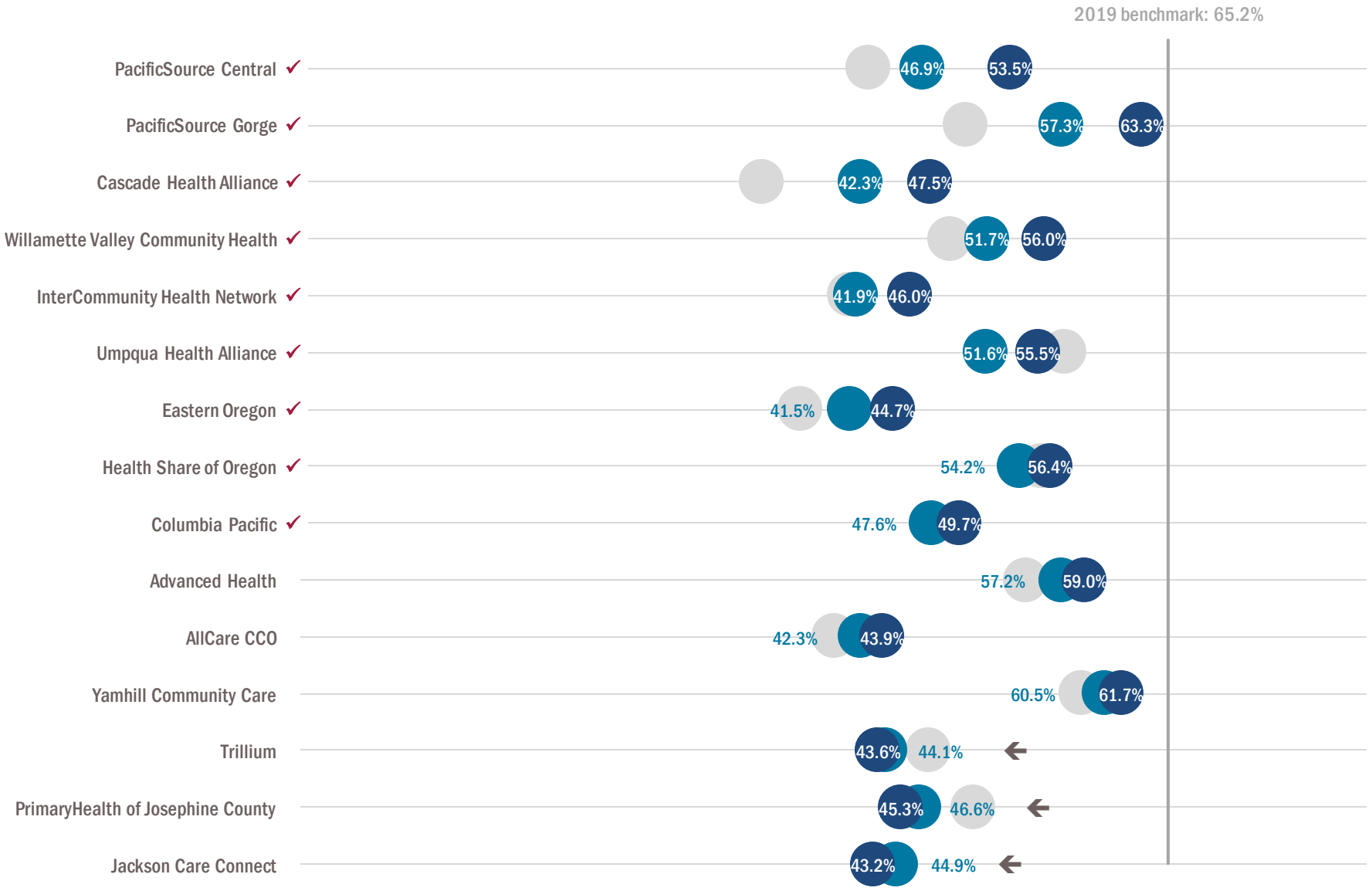
ADOLESCENT WELL-CARE VISITS



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

2019 benchmark source:
2018 national Medicaid 90th percentile

2019 data

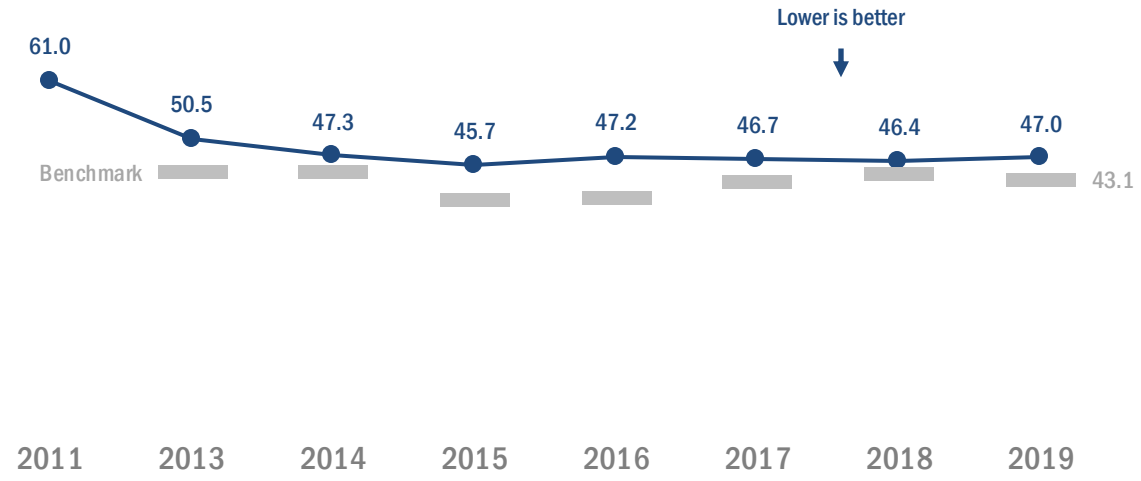
(n=10,440,181 member months)

- Statewide change since 2018: **+1.3%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **7**

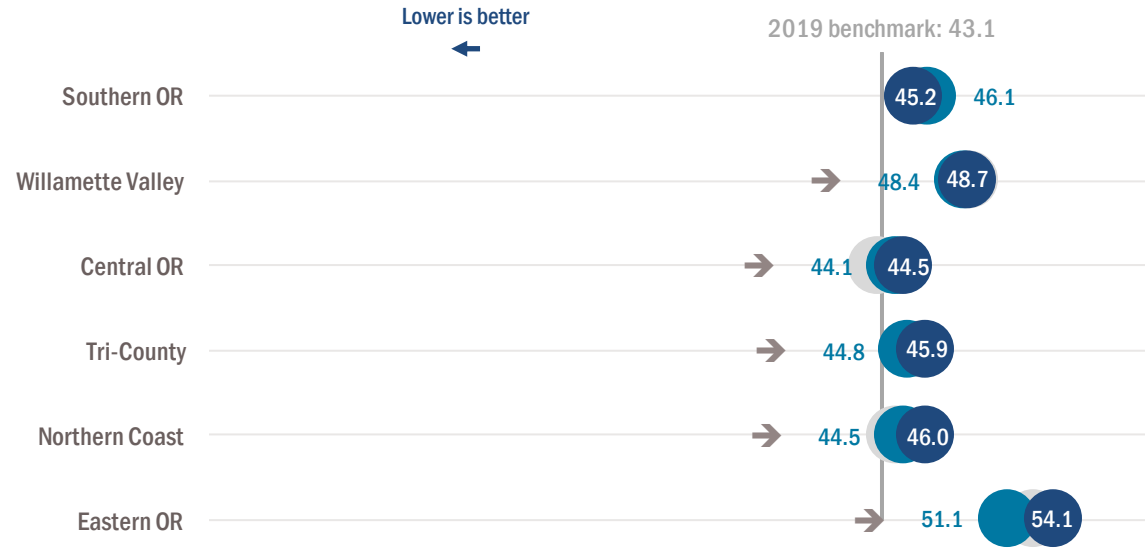
Rates are shown per 1,000 member months, which means that in one month, there are on average 47 visits occurring per 1,000 CCO members.

This measure will no longer be incentivized beginning in 2020.

Statewide



By region



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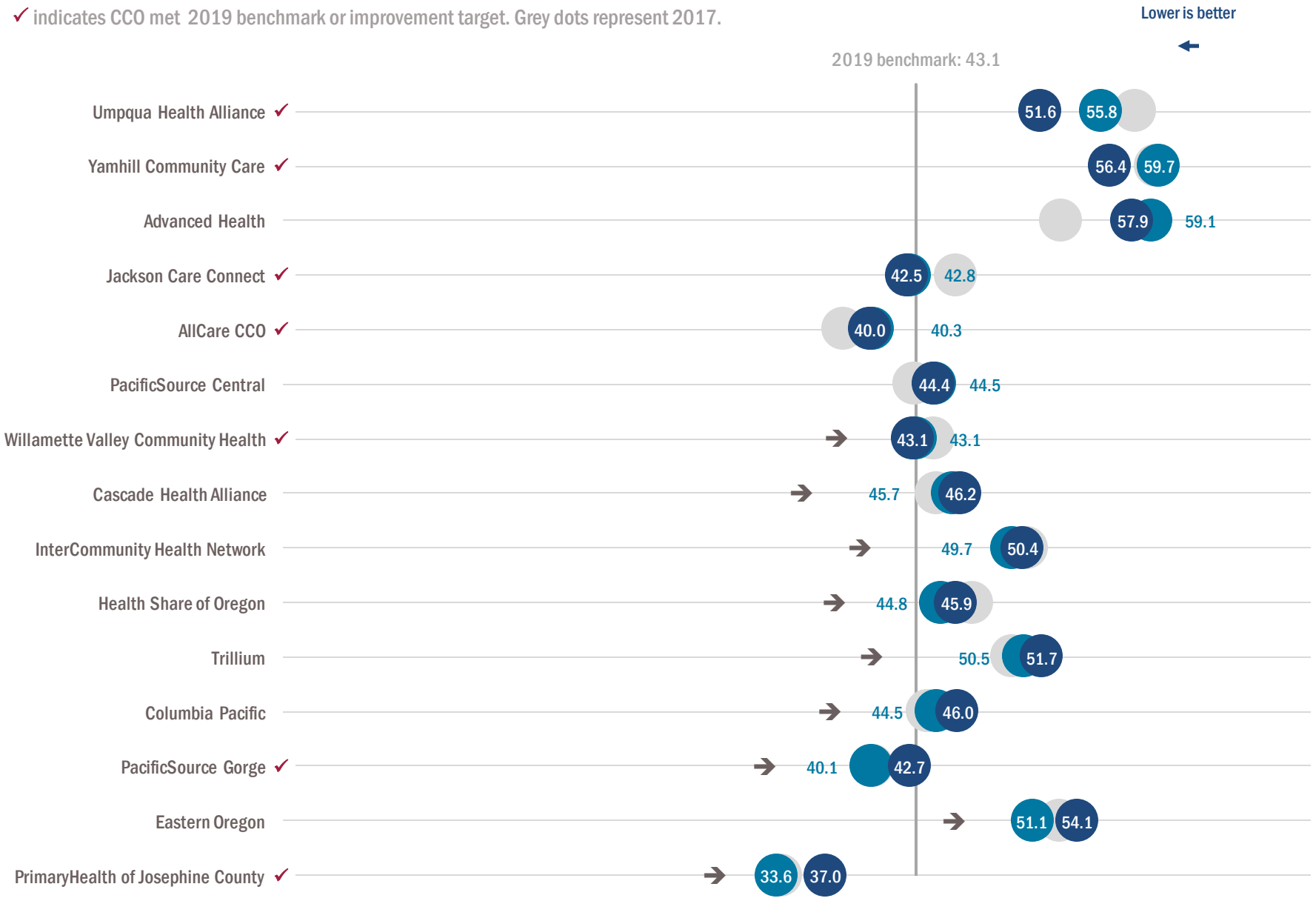
AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody

Percentage of children 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)

2019 benchmark source:

Committee consensus

2019 data (n=1,368)

- Statewide change since 2018: **+1.3%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **12**

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

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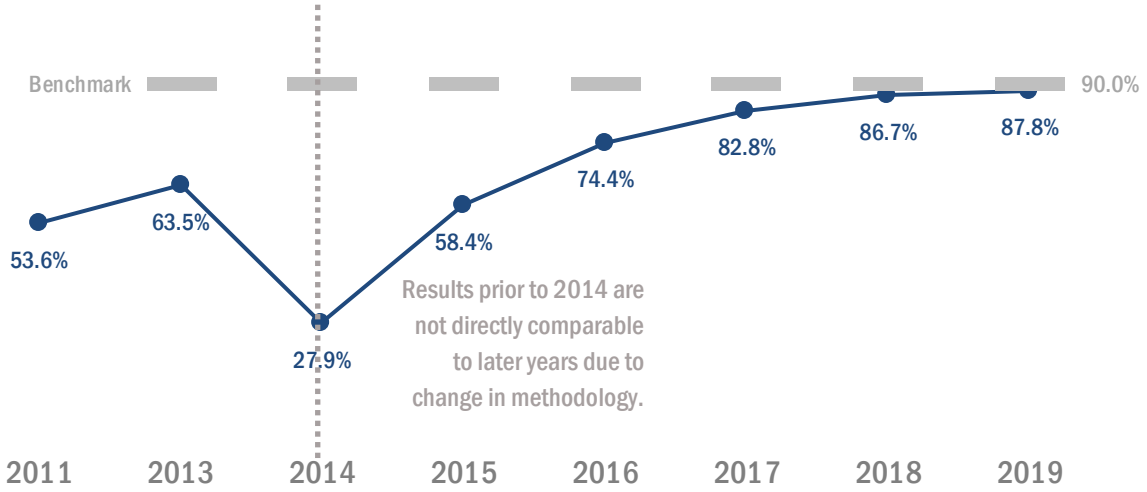
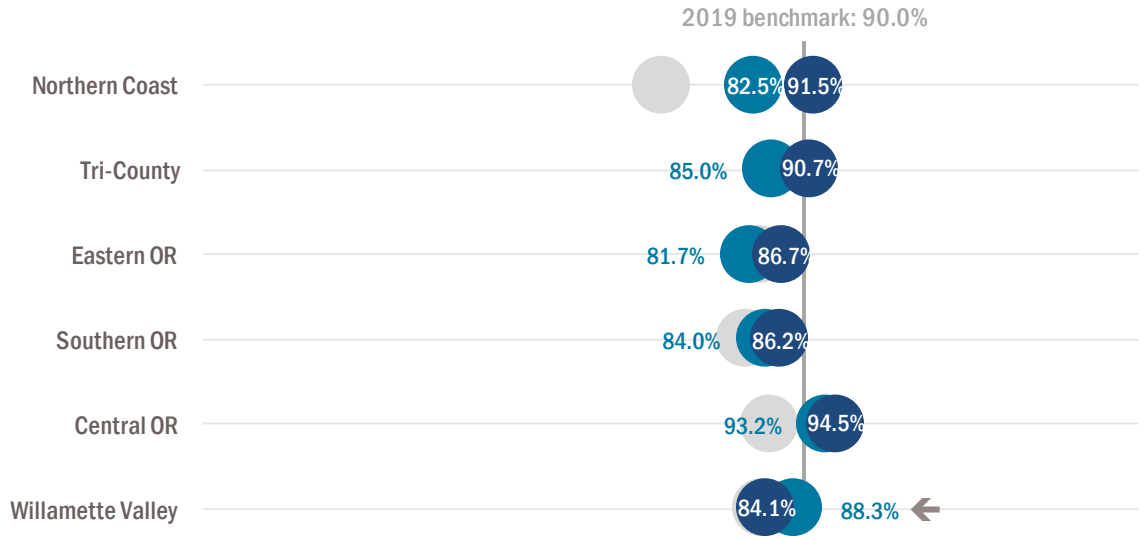
Statewide



By region

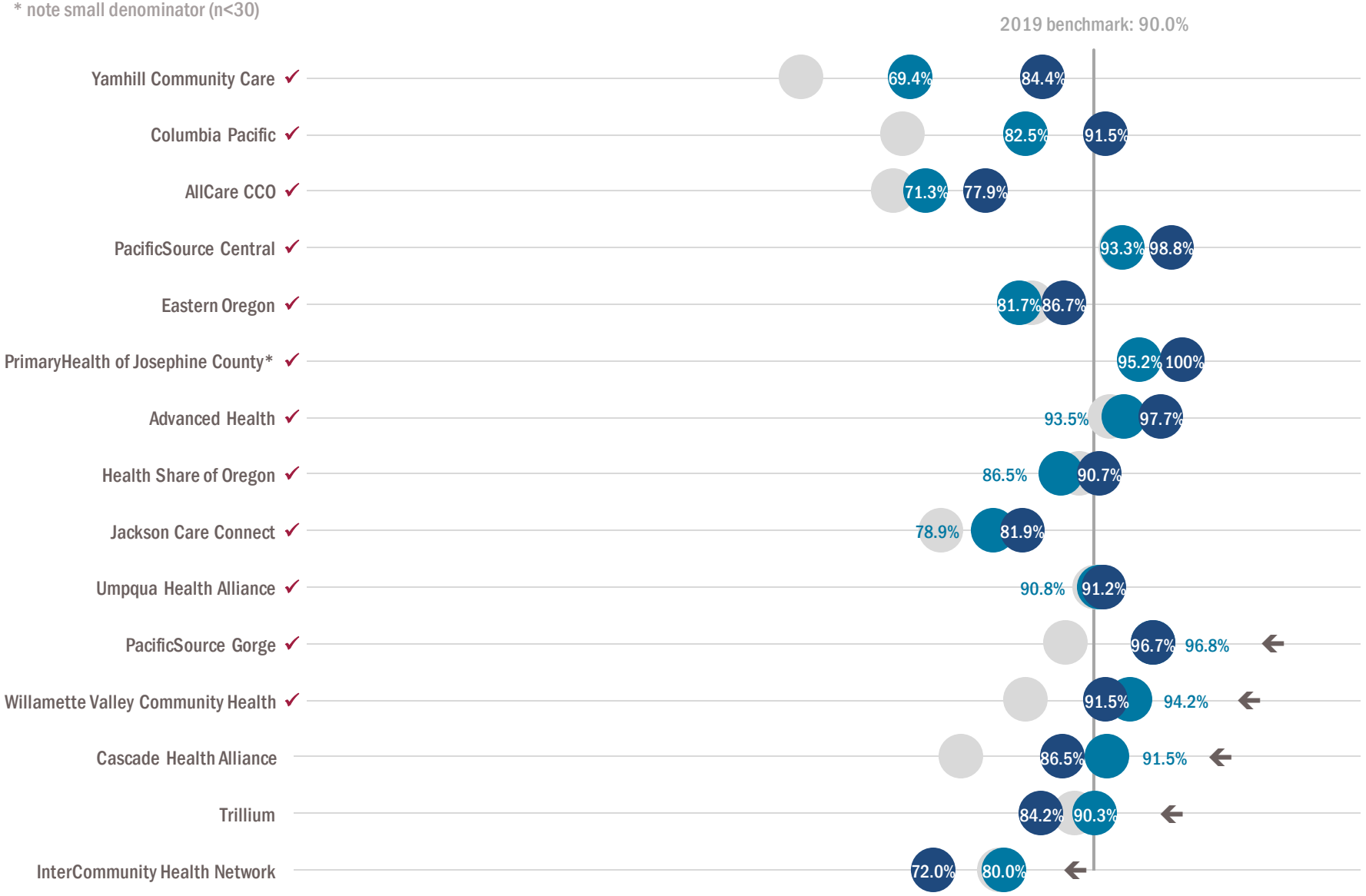


ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.

* note small denominator (n<30)



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

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 communication skills of providers and ease of access to health care services.

2019 benchmark source:

2018 national Medicaid 75th percentile

2019 data (n=4,352)

- Statewide change since 2018: **-1.2%**
- Number of CCOs that improved: **4**
- Number of CCOs achieving target: **5**

This measure will no longer be incentivized beginning in 2020.

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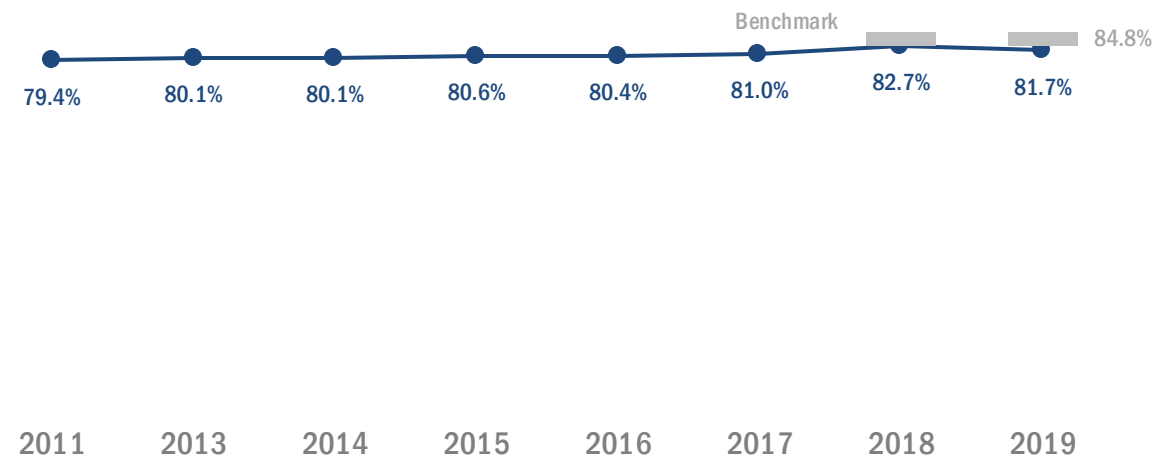
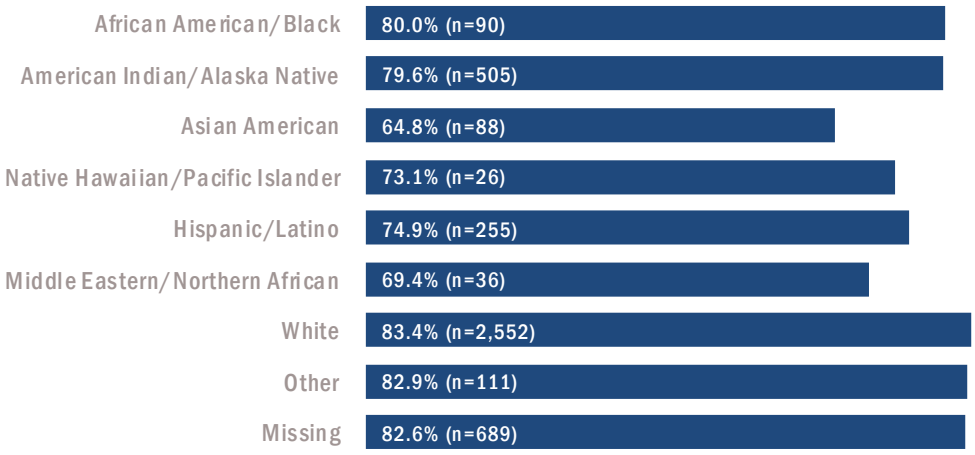
Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

ACCESS TO CARE (CAHPS SURVEY) - ADULTS

Access to care among adults in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.

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

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

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 communication skills of providers and ease of access to health care services.

2019 benchmark source:

2018 national Medicaid 75th percentile

2019 data (n=5,317)

- Statewide change since 2018: **+0.1%**
- Number of CCOs that improved: **8**
- Number of CCOs achieving target: **4**

This measure will no longer be incentivized beginning in 2020.

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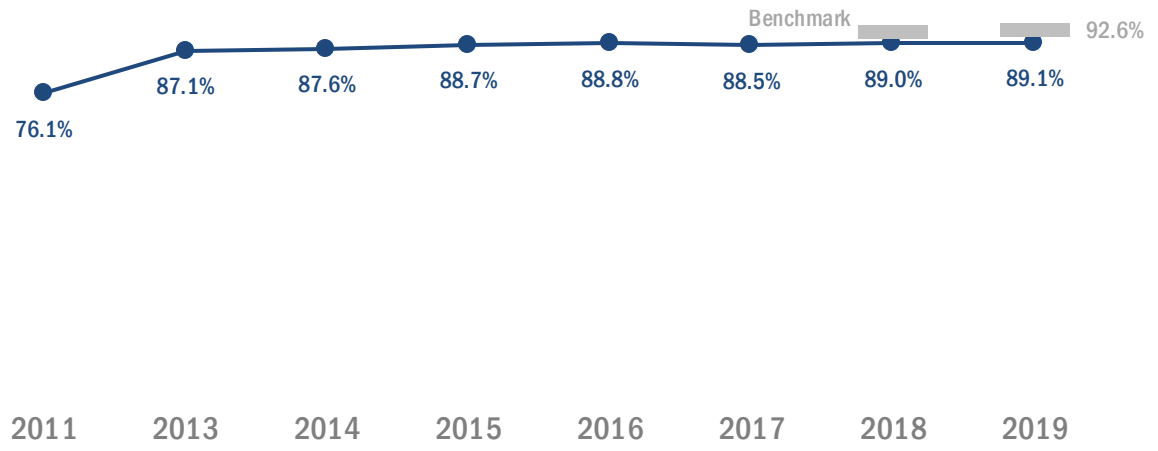
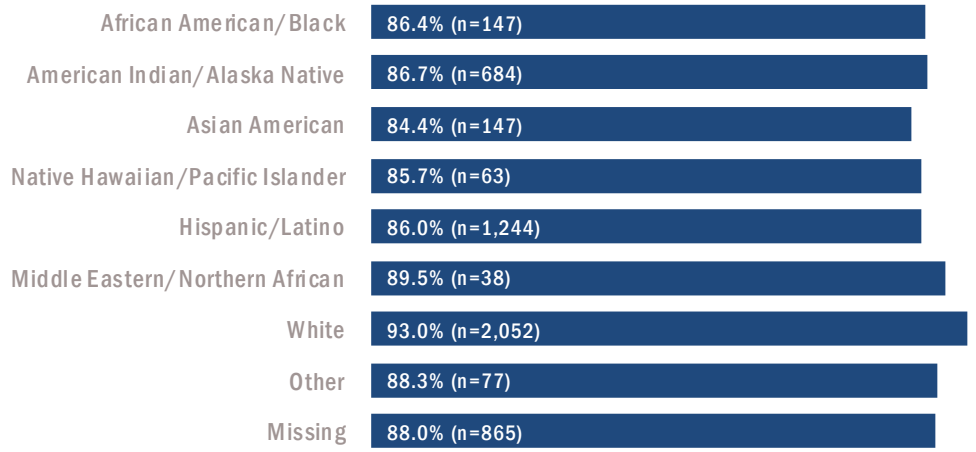
Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

ACCESS TO CARE (CAHPS SURVEY) - CHILDREN

Access to care among children in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.

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

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

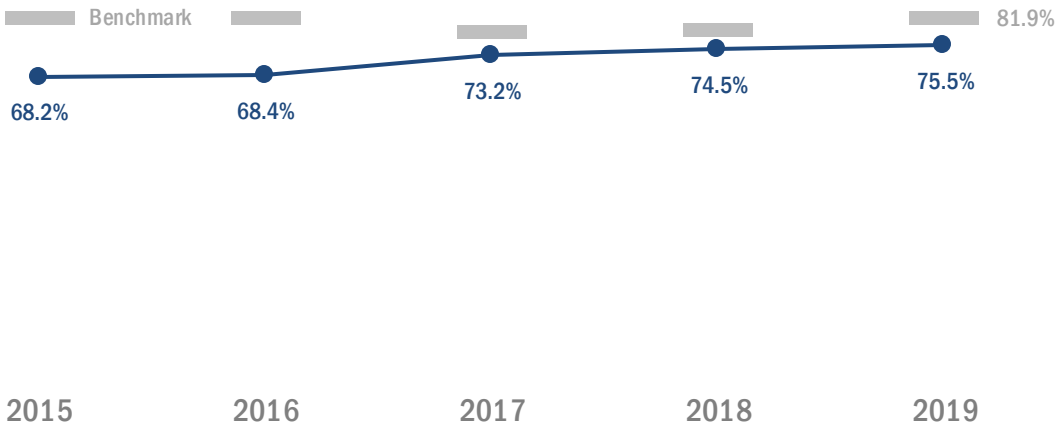
2019 benchmark source:

2018 national Medicaid 90th percentile

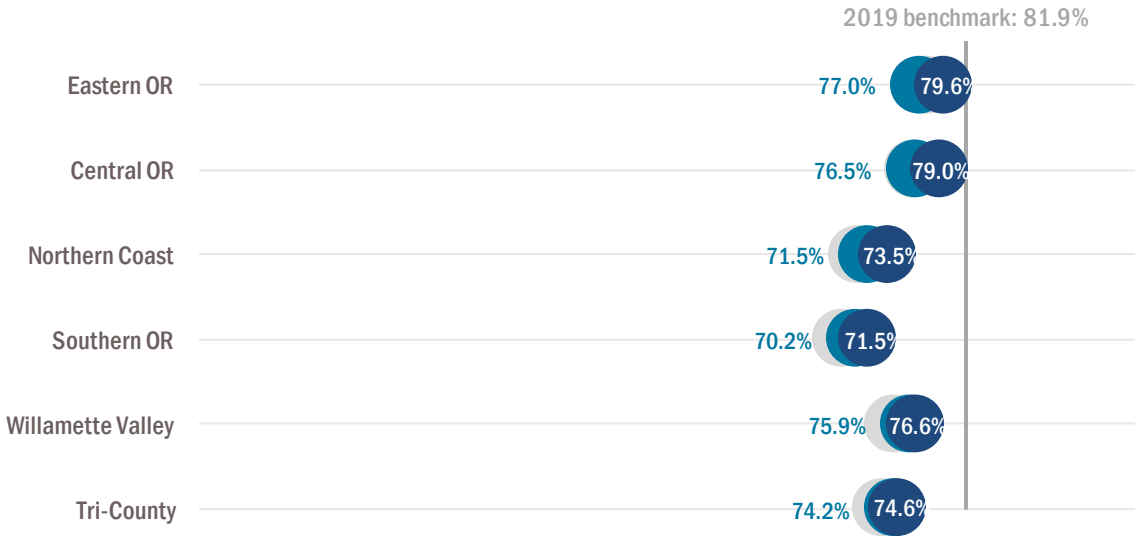
2019 data (n=13,285)

- Statewide change since 2018: **+1.3%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **9**

Statewide



By region



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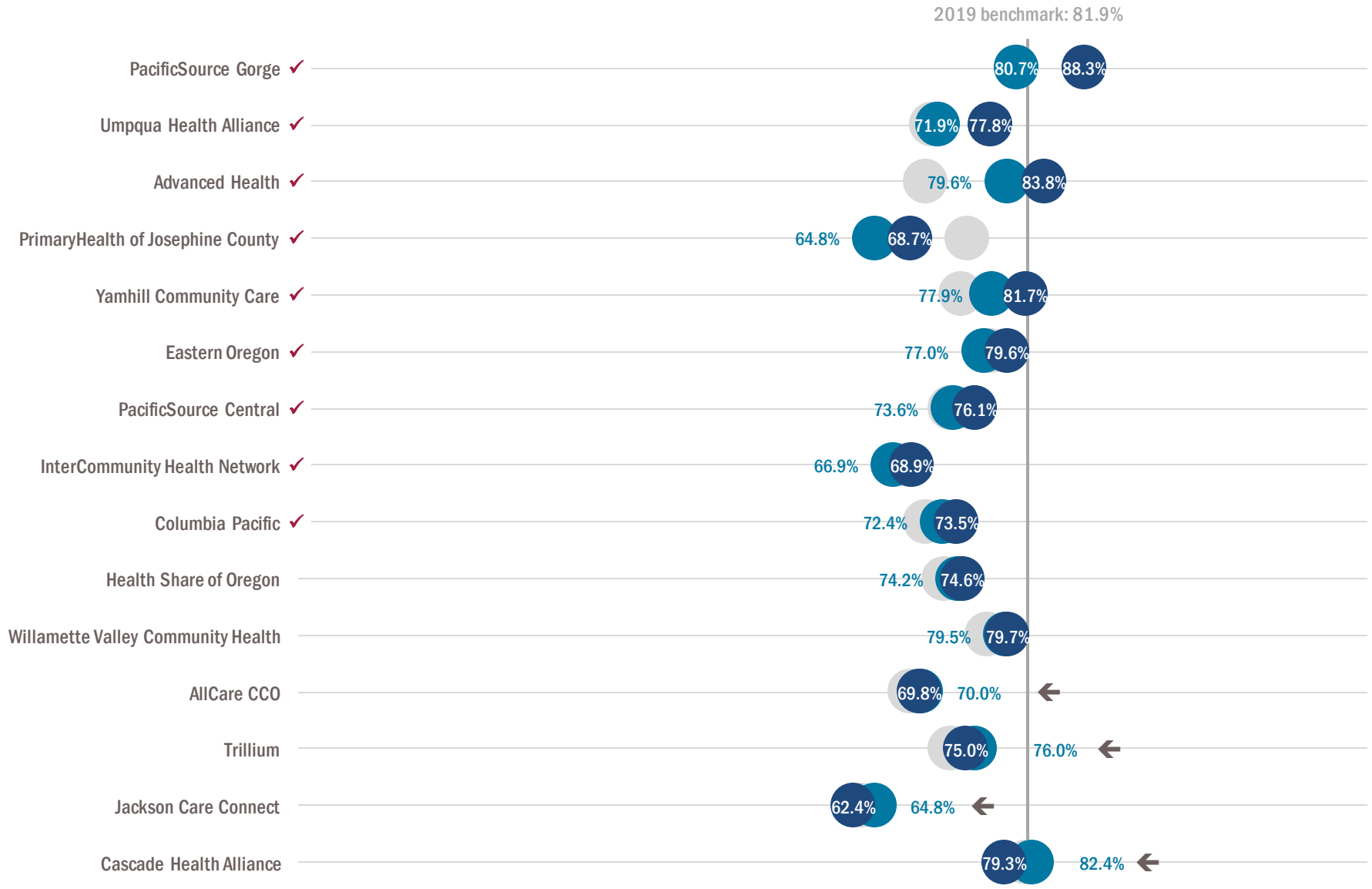
CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



CIGARETTE SMOKING PREVALENCE

Cigarette smoking prevalence

Percentage of Medicaid members age 13 years and older who were screened for smoking status and identified as current smokers.

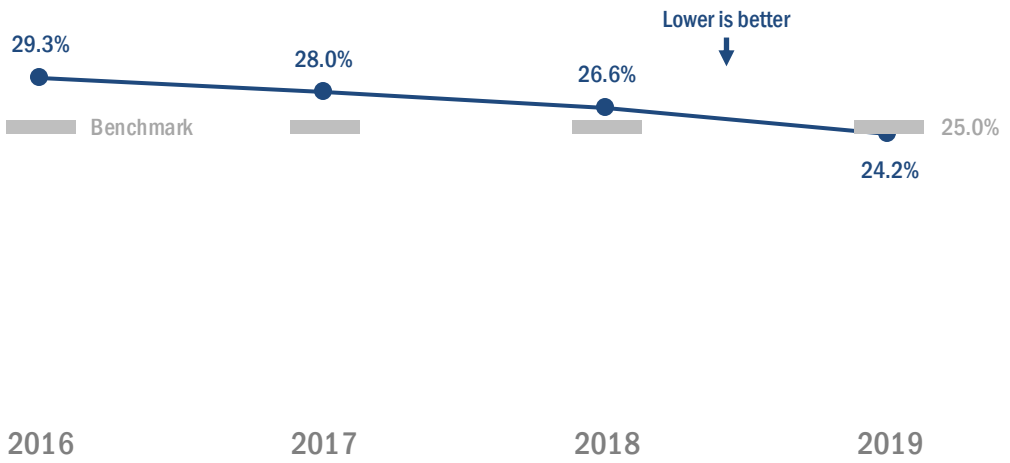
Data source:
Electronic Health Records

2019 benchmark source:
Committee consensus and alignment with 1115 demonstration waiver goals

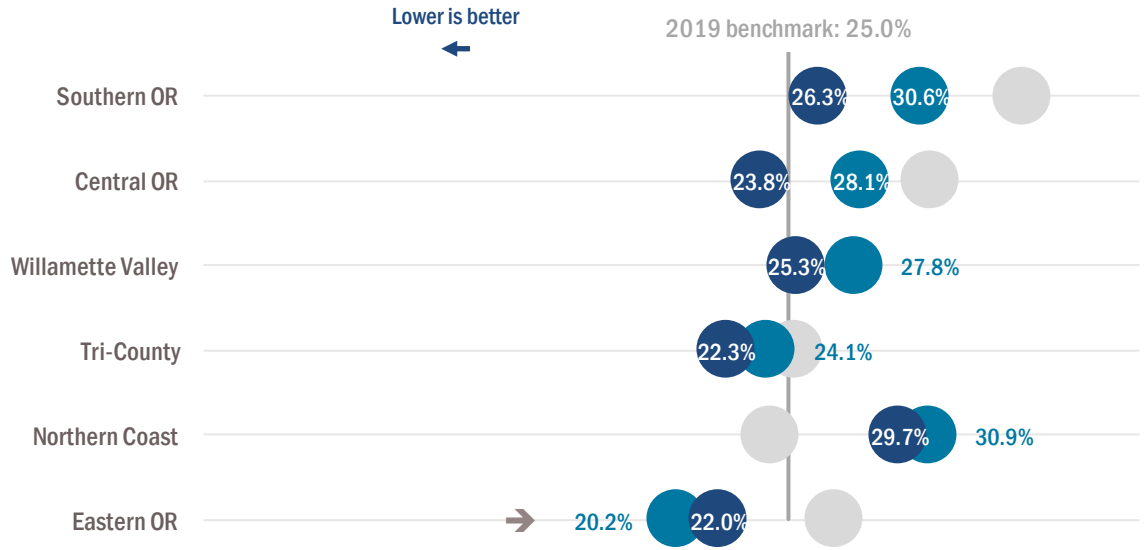
2019 data (n=286,038)

- Statewide change since 2018: **-8.9%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **14**

Statewide



By region



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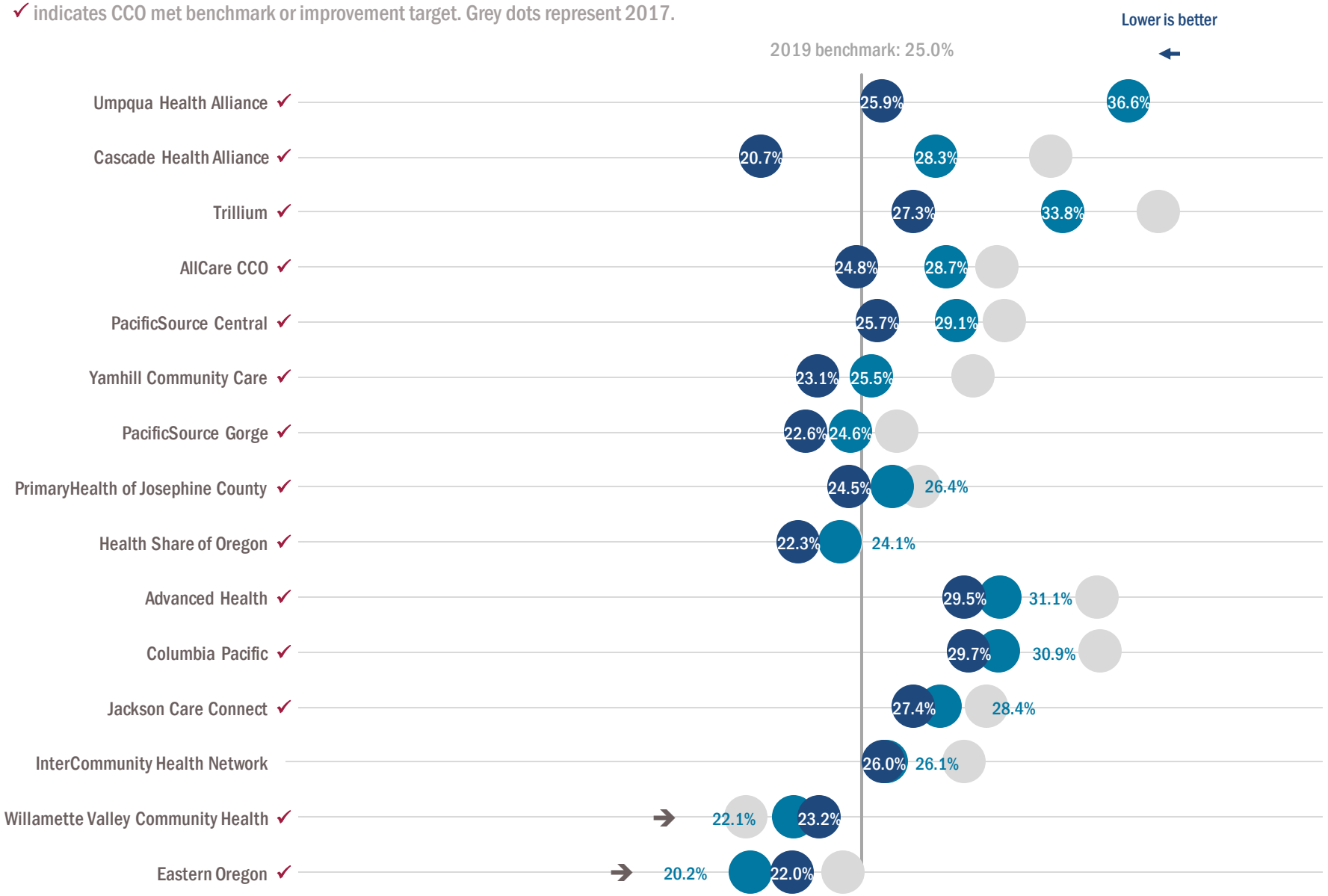
CIGARETTE SMOKING PREVALENCE

Cigarette smoking prevalence in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.



COLORECTAL CANCER SCREENING

Colorectal cancer screening

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

Data source:

Administrative (billing) claims and medical record review

2019 benchmark source:

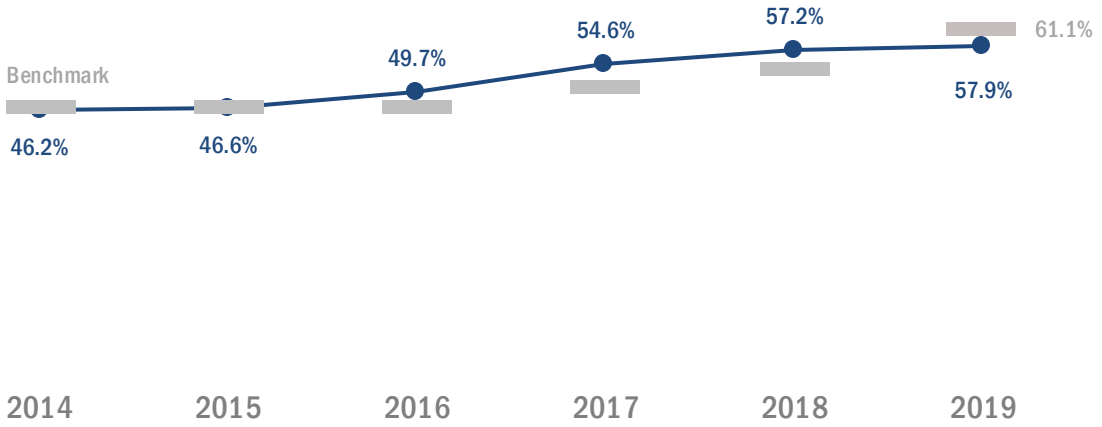
2018 national Commercial 50th percentile

2019 data (n=6,156)

- Statewide change since 2018: **+1.2%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **11**

This measure will no longer be incentivized beginning in 2020.

Statewide



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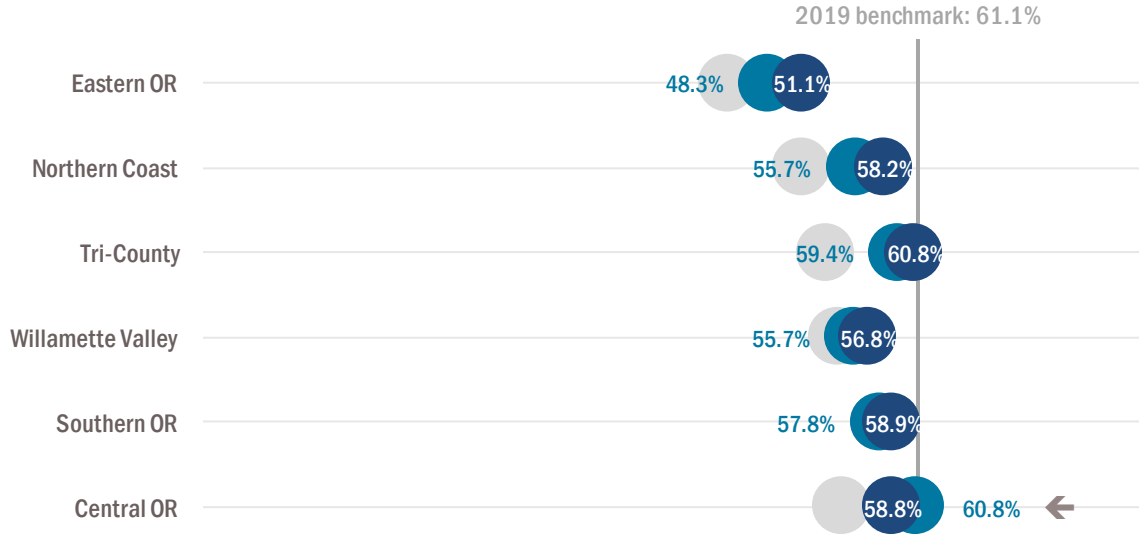

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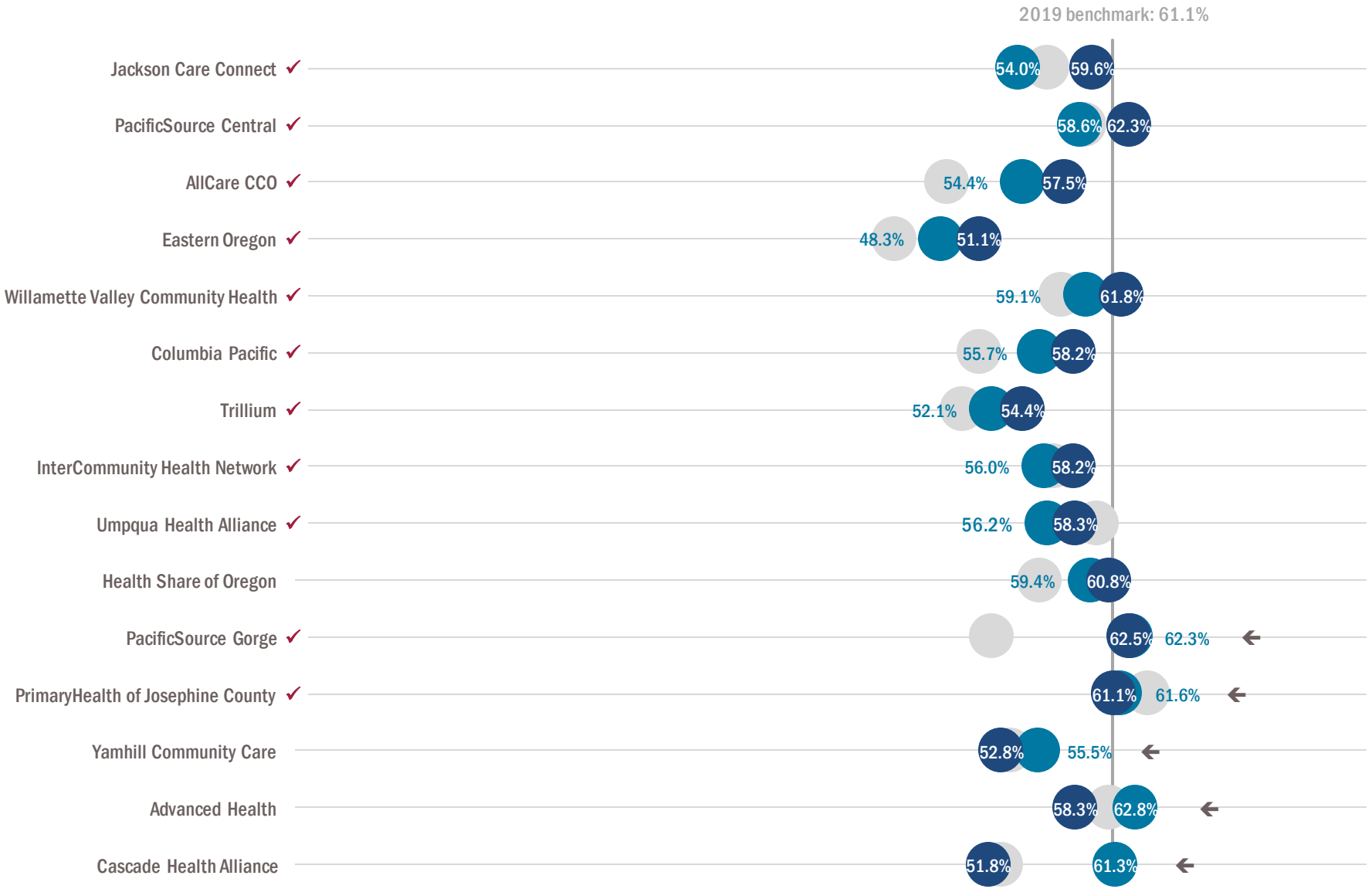
COLORECTAL CANCER SCREENING

Colorectal cancer screening in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.



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

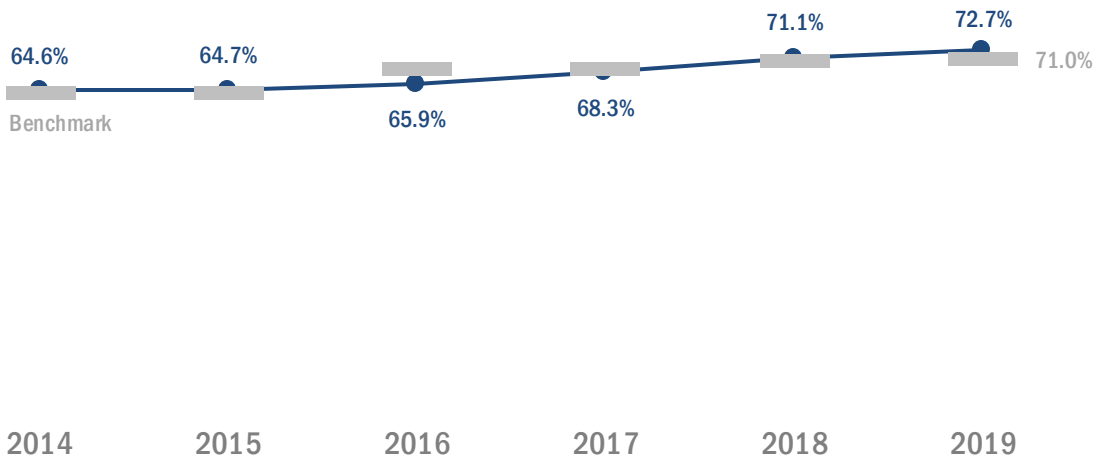
2019 benchmark source:
2018 national Medicaid 90th percentile

2019 data (n=139,002)

- Statewide change since 2018: **+2.3%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **10**

This measure will no longer be incentivized beginning in 2020.

Statewide



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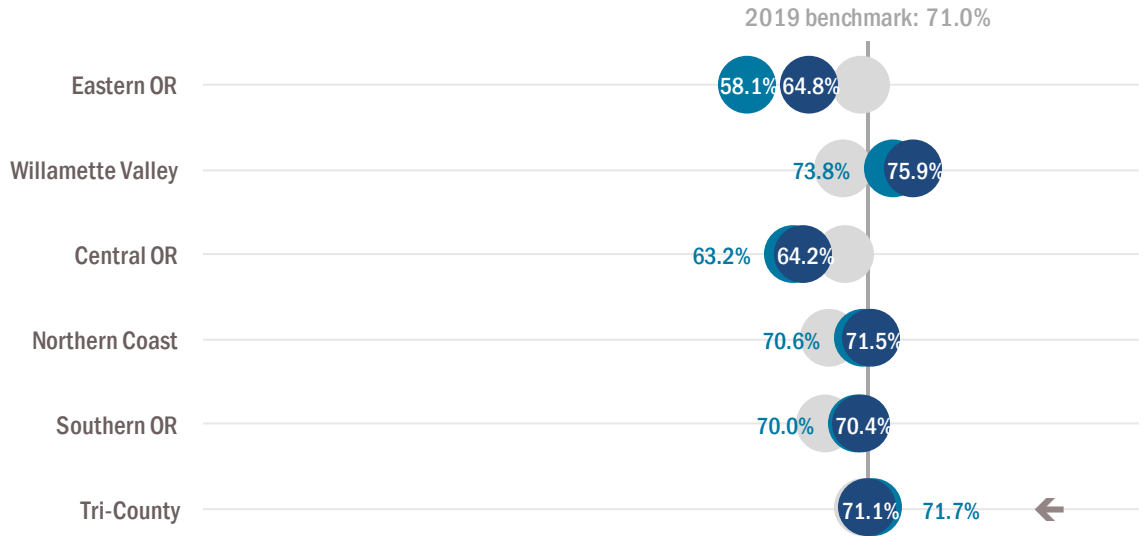

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CONTROLLING HIGH BLOOD PRESSURE

Controlling hypertension in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.

*CCO's reporting includes some aggregated data for both Medicaid and non-Medicaid patients.

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

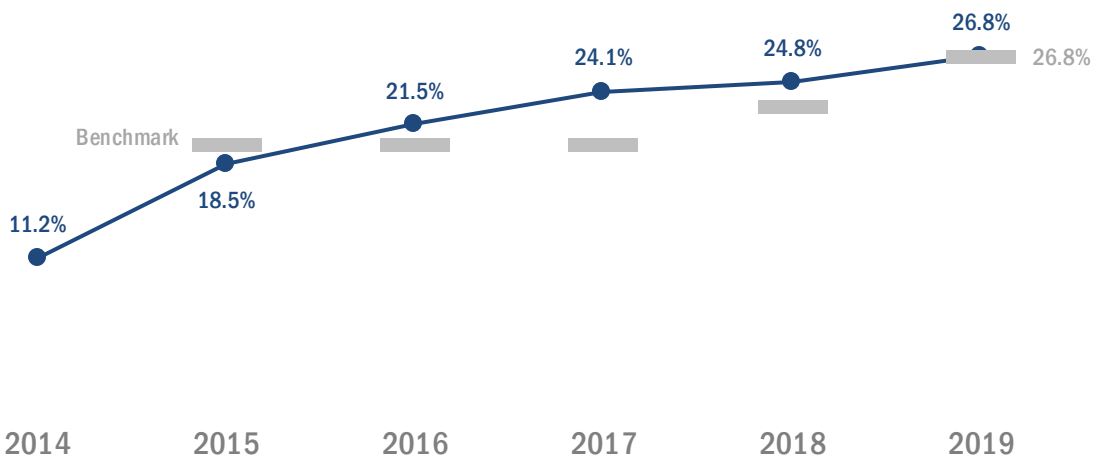
2019 benchmark source:
2017 CCO 90th percentile

2019 data (n=146,076)

- Statewide change since 2018: **+8.1%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **11**

This measure will no longer be incentivized beginning in 2020.

Statewide



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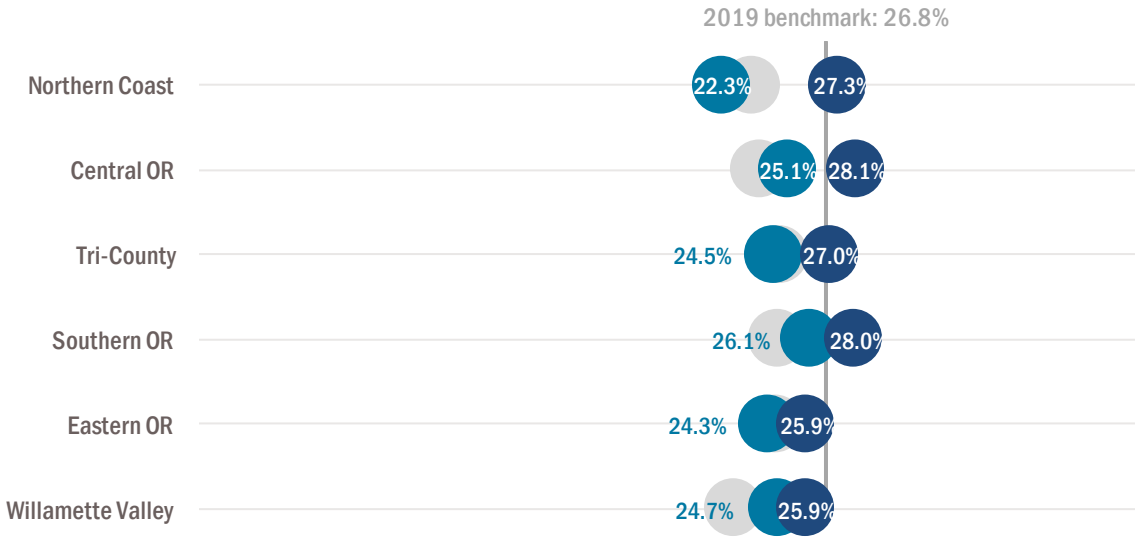

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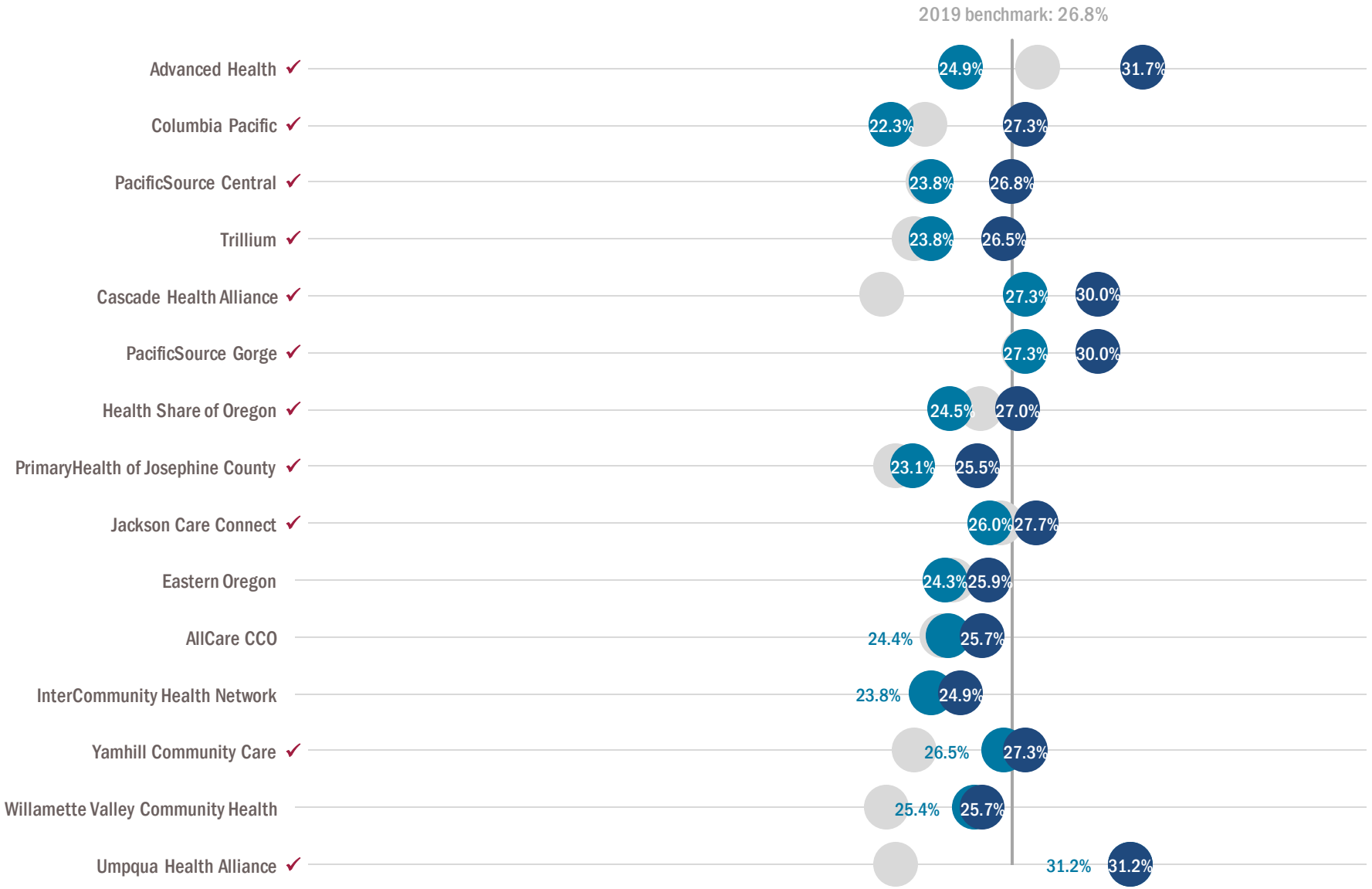
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages) in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



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

Dental sealants for children (6-9)

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

Data source:
Administrative (billing) claims

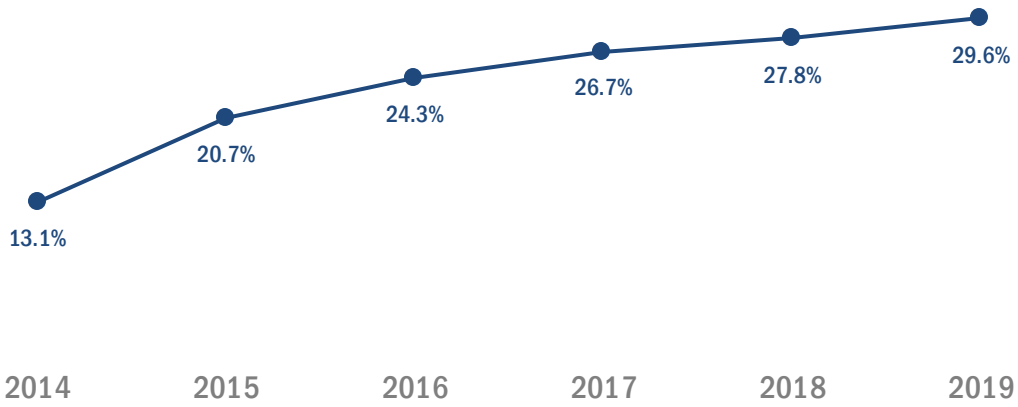
2019 benchmark source:
2017 CCO 90th percentile

2019 data (n=64,920)

- Statewide change since 2018: **+6.5%**
- Number of CCOs that improved: **13**

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.

Statewide



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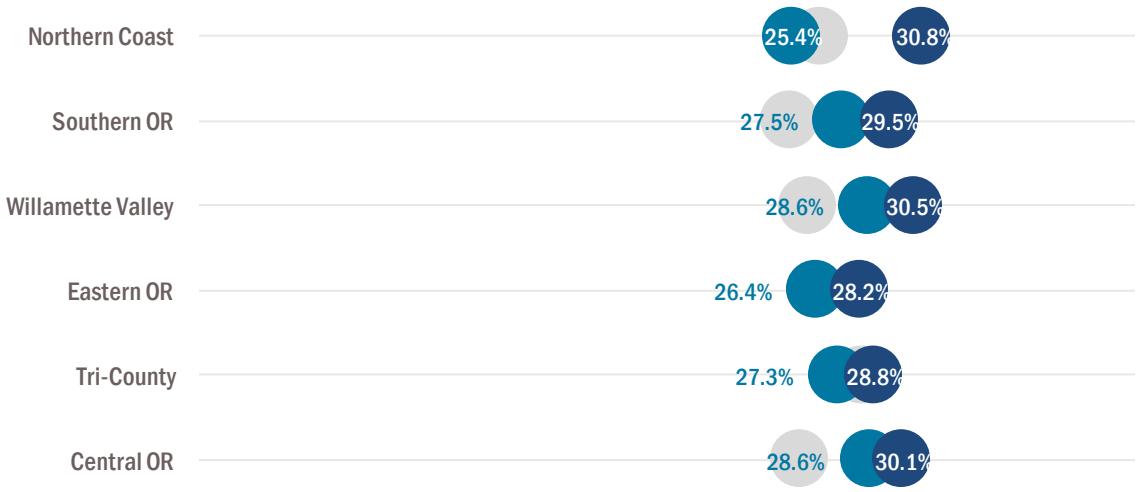

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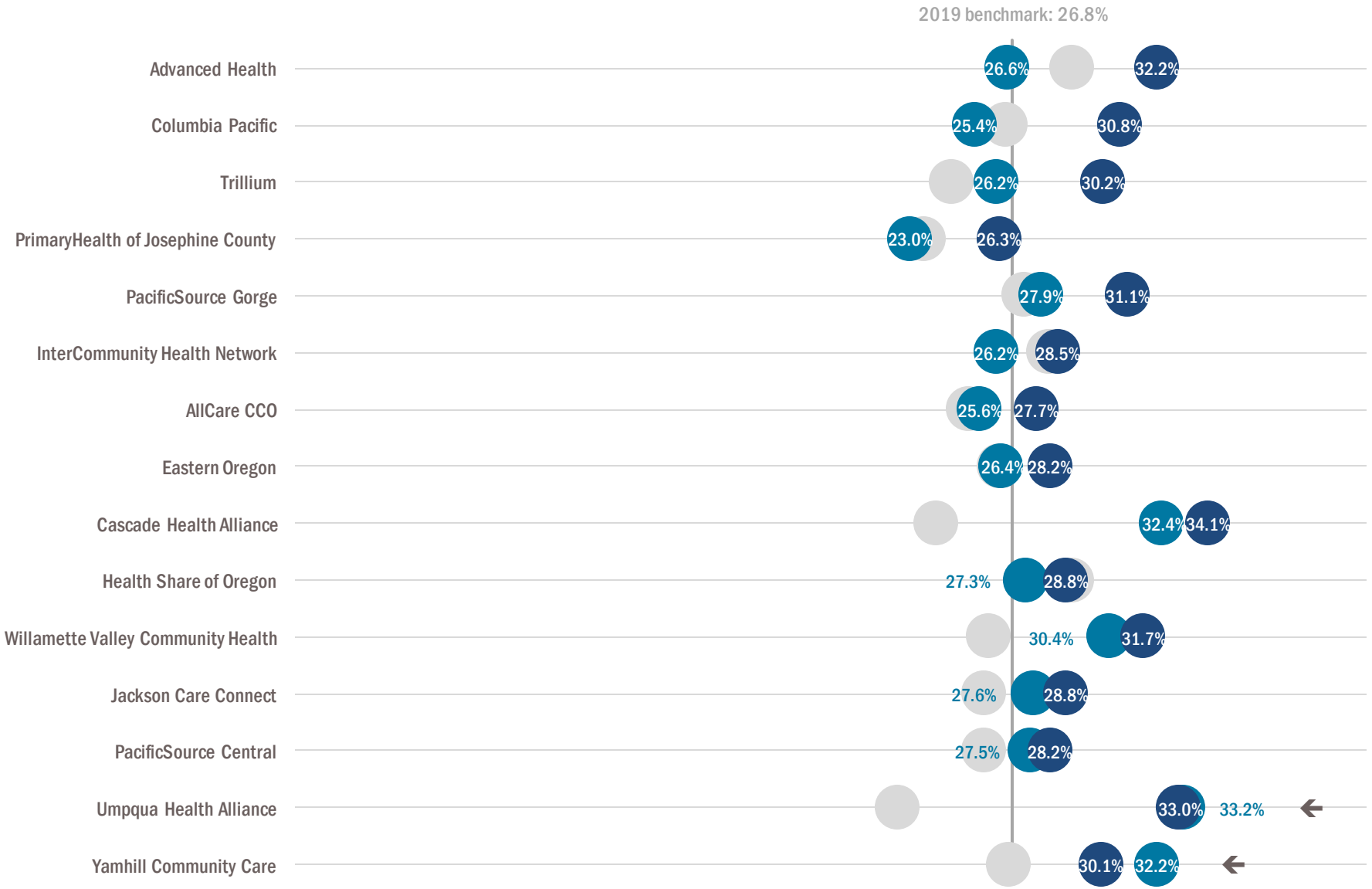
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 6-9)

Dental sealants on permanent molars for children (ages 6-9) in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

Dental sealants for children (10-14)

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

Data source:
Administrative (billing) claims

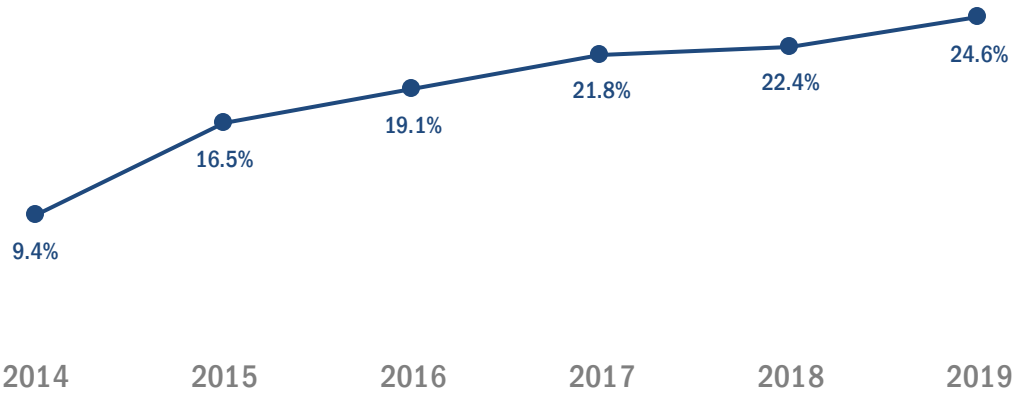
2019 benchmark source:
2017 CCO 90th percentile

2019 data (n=81,156)

- Statewide change since 2018: **+9.8%**
- Number of CCOs that improved: **14**

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.

Statewide



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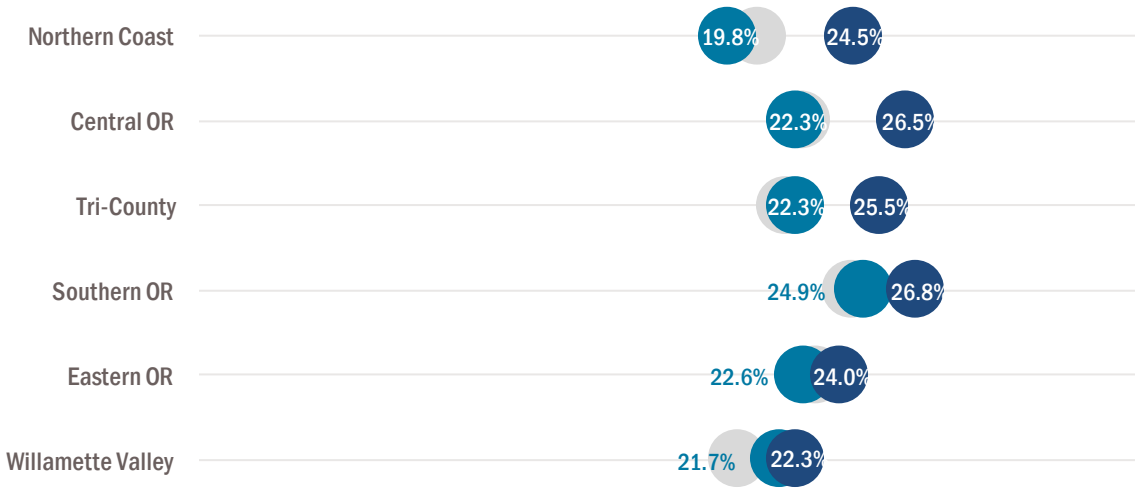

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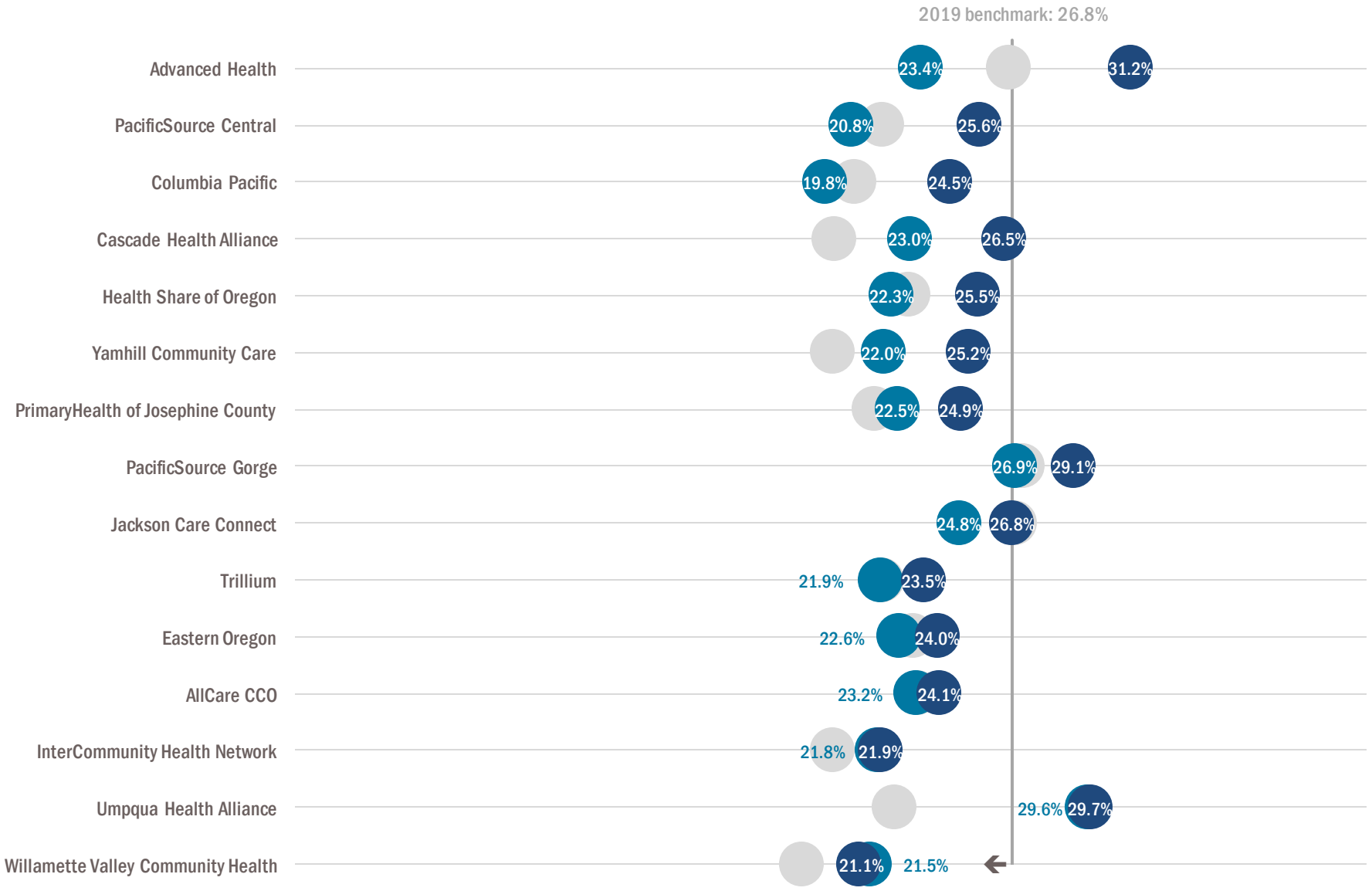
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14) in 2018 and 2019, by CCO.

Grey dots represent 2017.



DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up

Percentage of adult patients (ages 12 and older) who had appropriate screening and follow-up planning for depression.

Data source:
Electronic Health Records

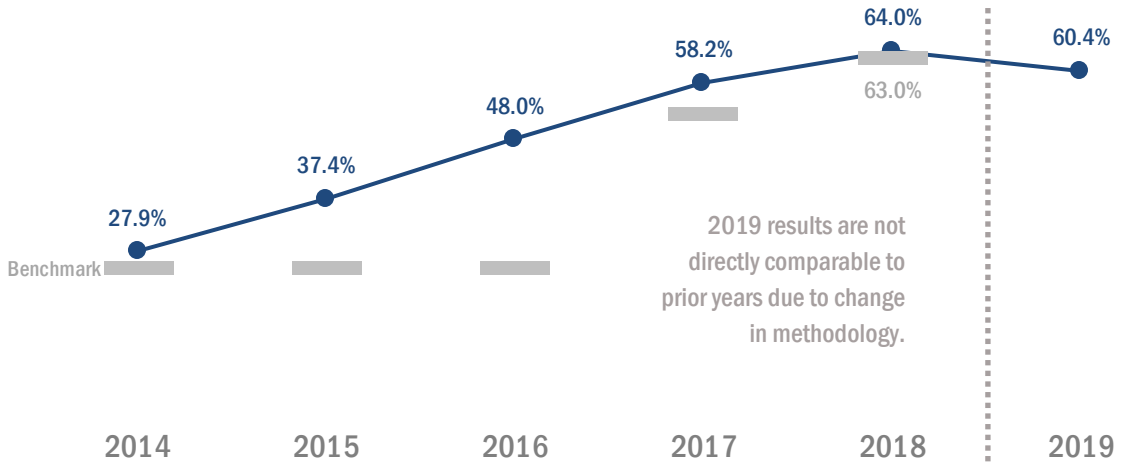
2019 benchmark source:
N/A, reporting-only

2019 data (n=390,417)

- Statewide change since 2018: **-5.6%**
- Number of CCOs that improved: **3**
- Number of CCOs achieving target: **15**

Because of a change in measure specifications, the Metrics and Scoring Committee lacked comparable data to set a benchmark for 2019.

Statewide



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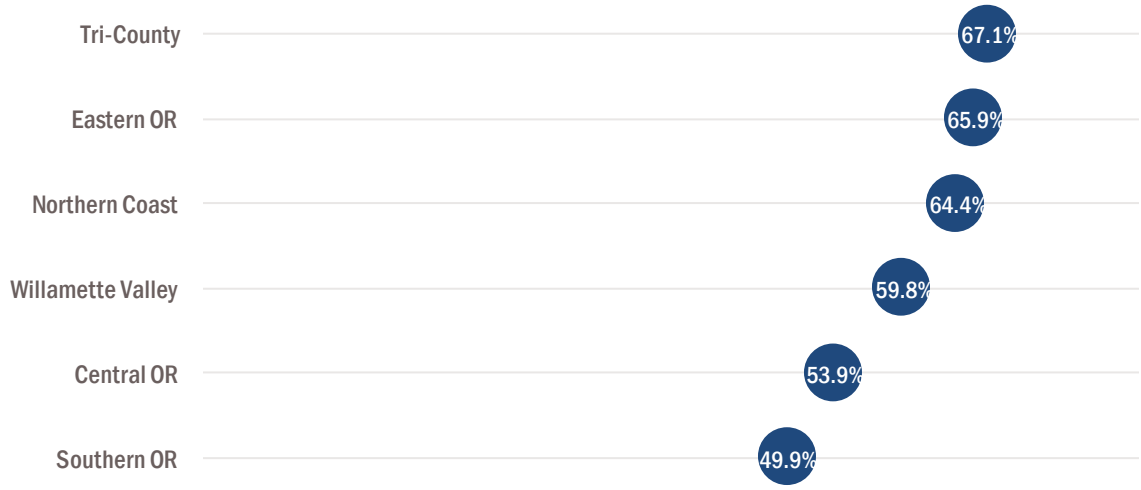

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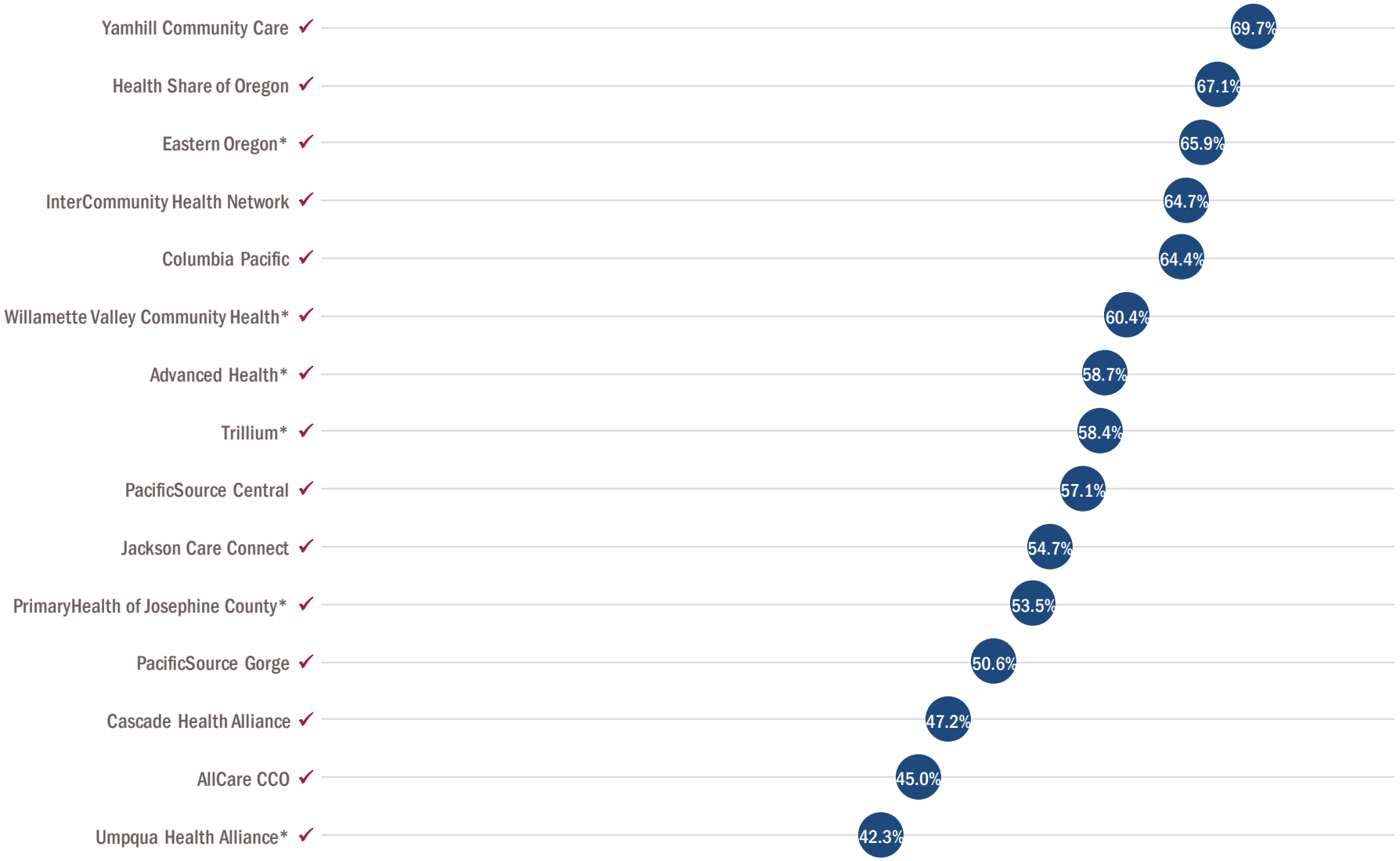
DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up plan in 2018 and 2019, by CCO.

✓ indicates CCO successfully reported measure. Grey dots represent 2017.

*CCO's reporting includes some aggregated data for both Medicaid and non-Medicaid patients.

Year to year trends are not possible due to change in methodology.



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

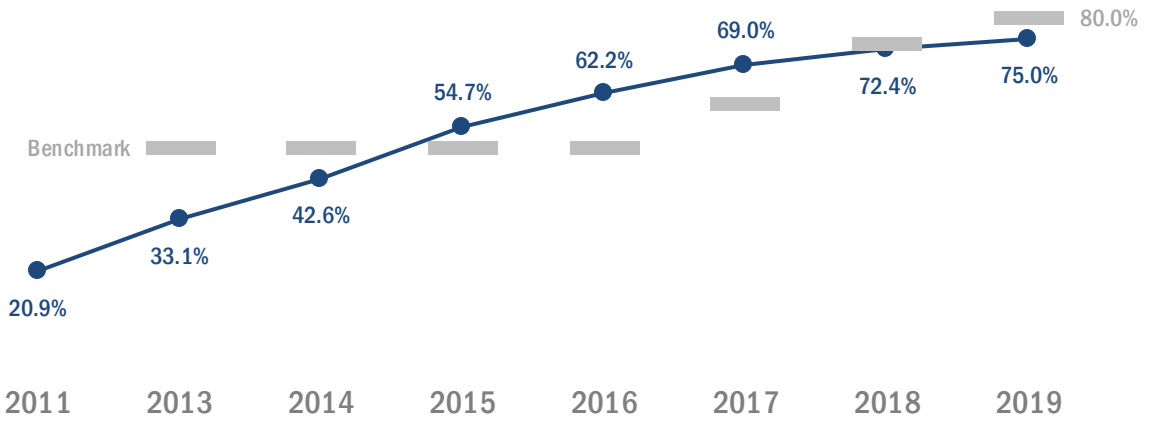
2019 benchmark source:
Committee consensus

2019 data (n=46,945)

- Statewide change since 2018: **+3.6%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **13**

This measure will no longer be incentivized beginning in 2020.

Statewide



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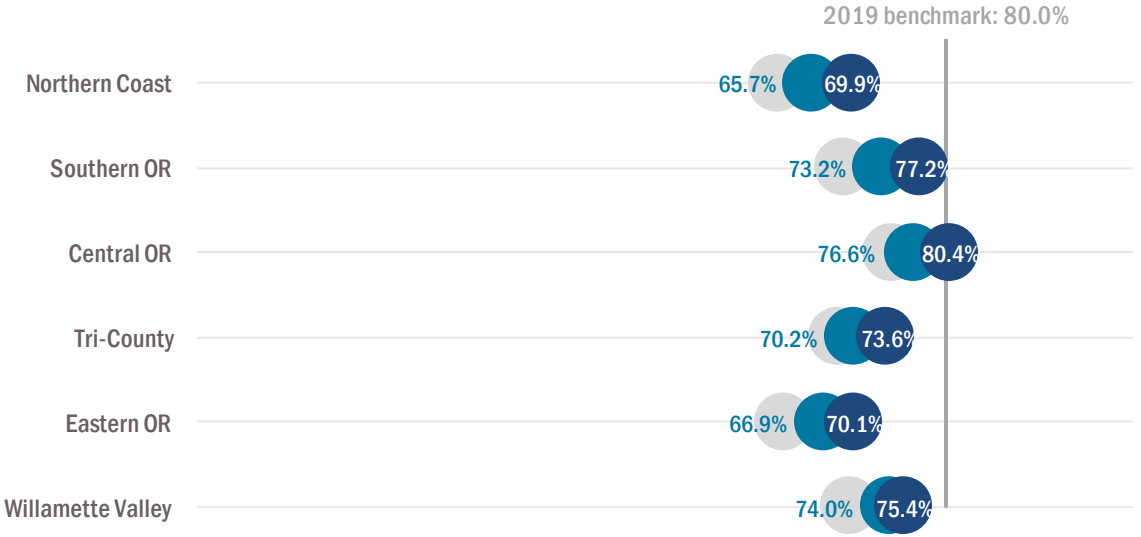

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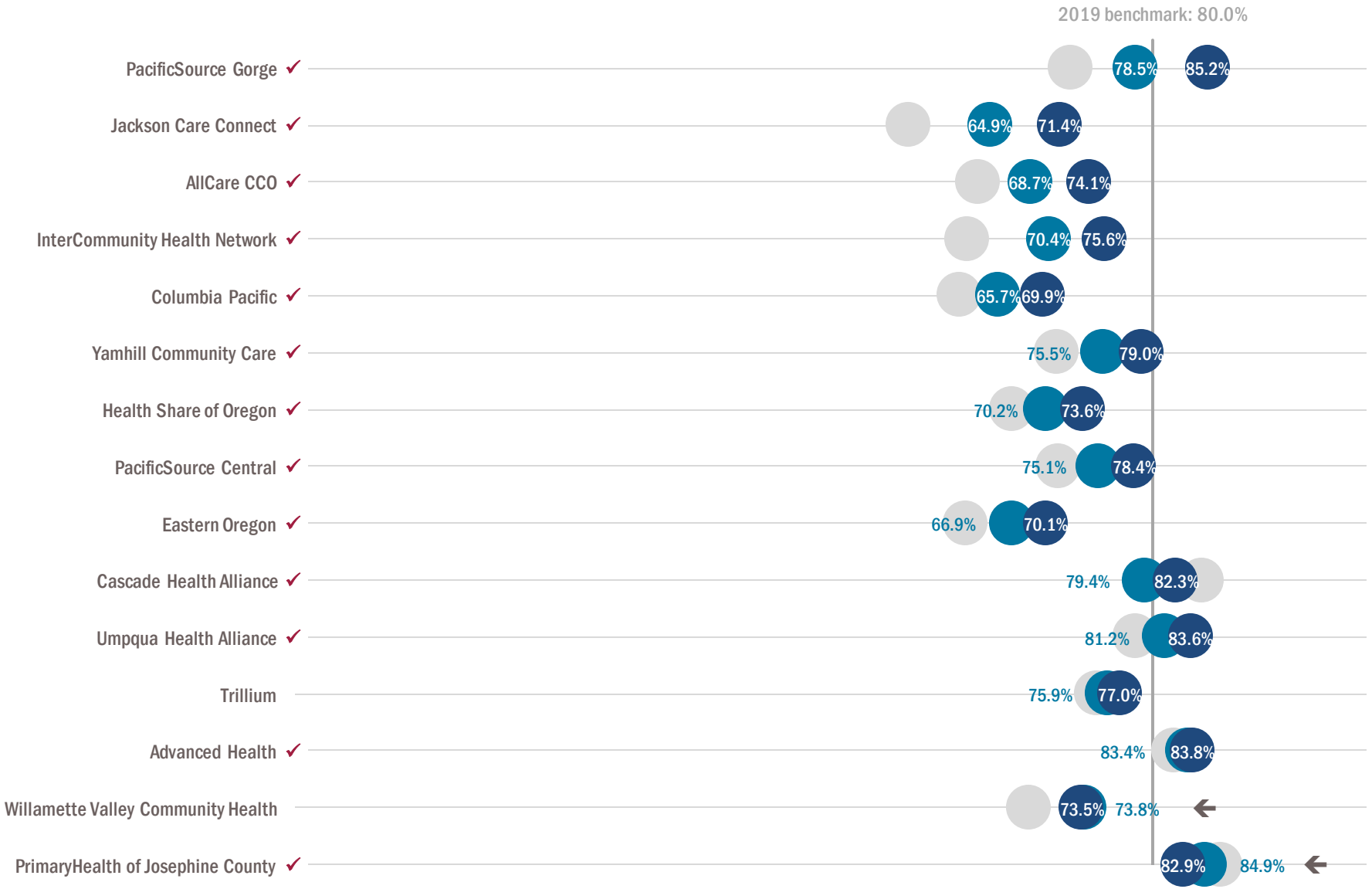
DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



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

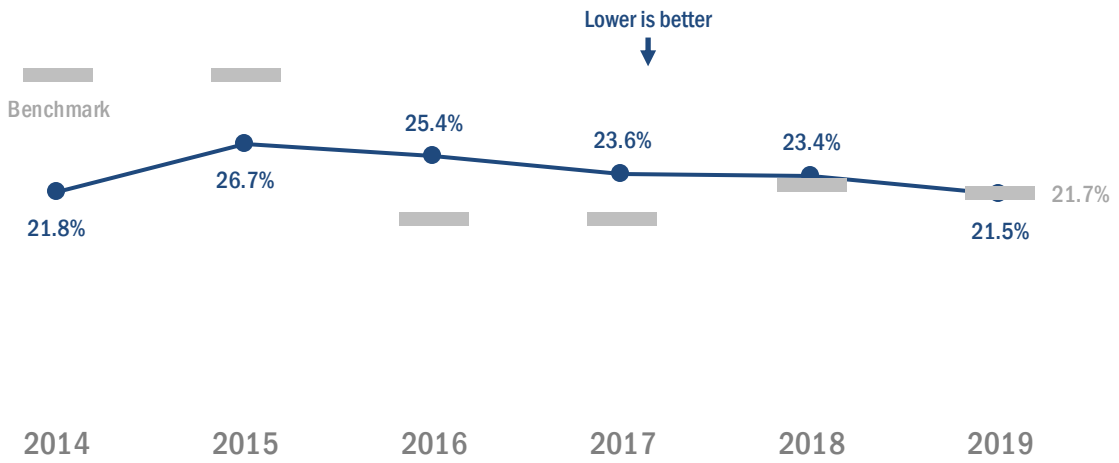
2019 benchmark source:

2018 national Commercial 90th percentile

2019 data (n=56,900)

- Statewide change since 2018: **-8.1%**
- Number of CCOs that improved: **9**
- Number of CCOs achieving target: **8**

Statewide



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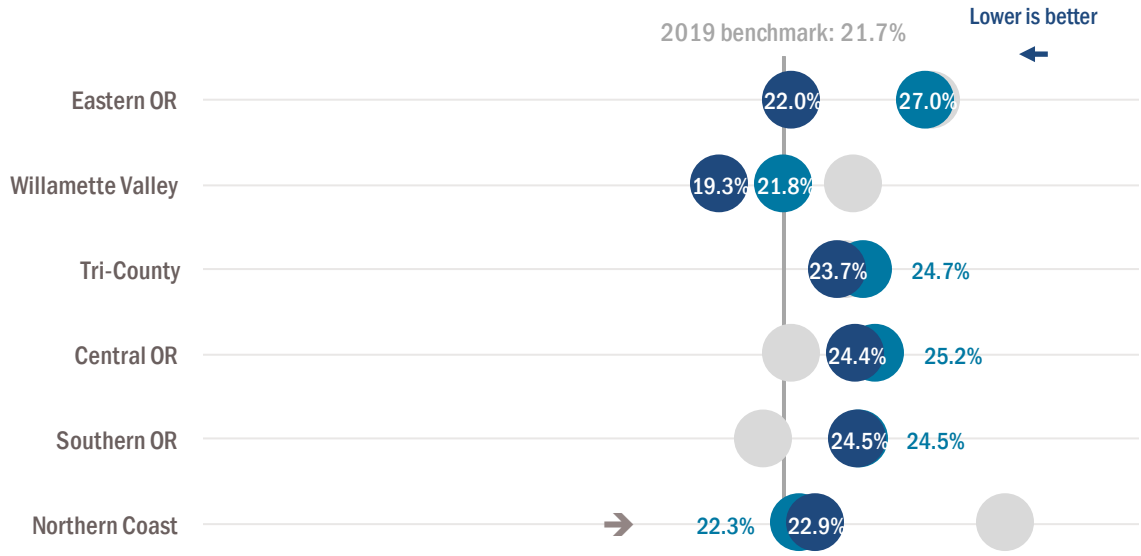

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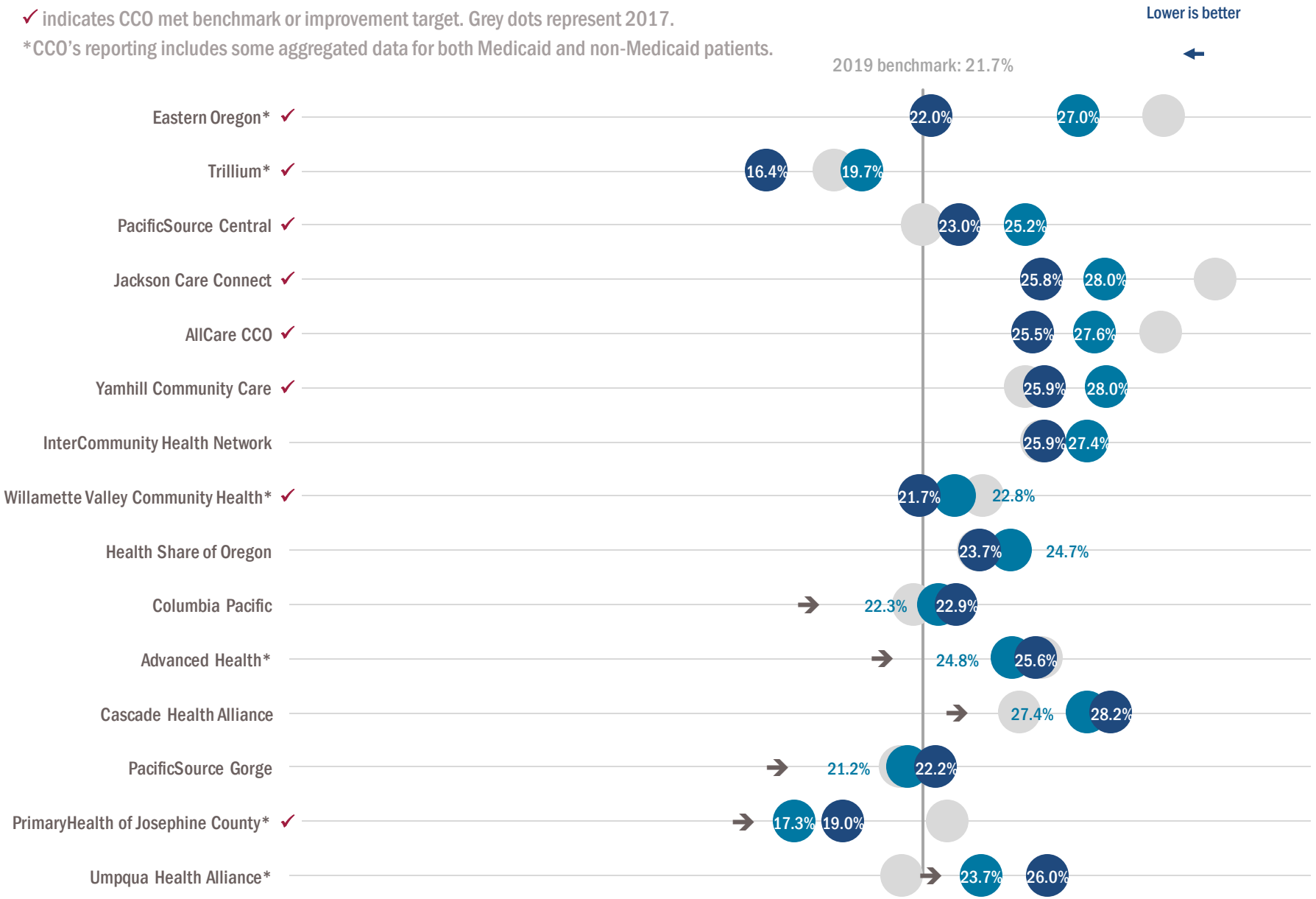
DIABETES CARE: HbA1c POOR CONTROL

Diabetes care, Hba1c poor control in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.

*CCO's reporting includes some aggregated data for both Medicaid and non-Medicaid patients.



DISPARITY MEASURE: ED UTILIZATION AMONG MEMBERS WITH MENTAL ILLNESS

Disparity measure

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

Data source:
Administrative (billing) claims

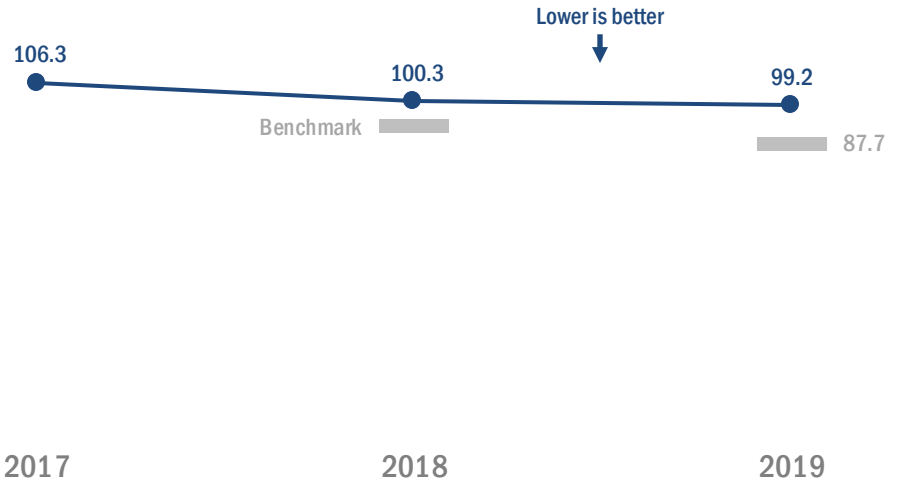
2019 benchmark source:
2017 CCO 90th percentile

2019 data (n=1,810,781 member months)

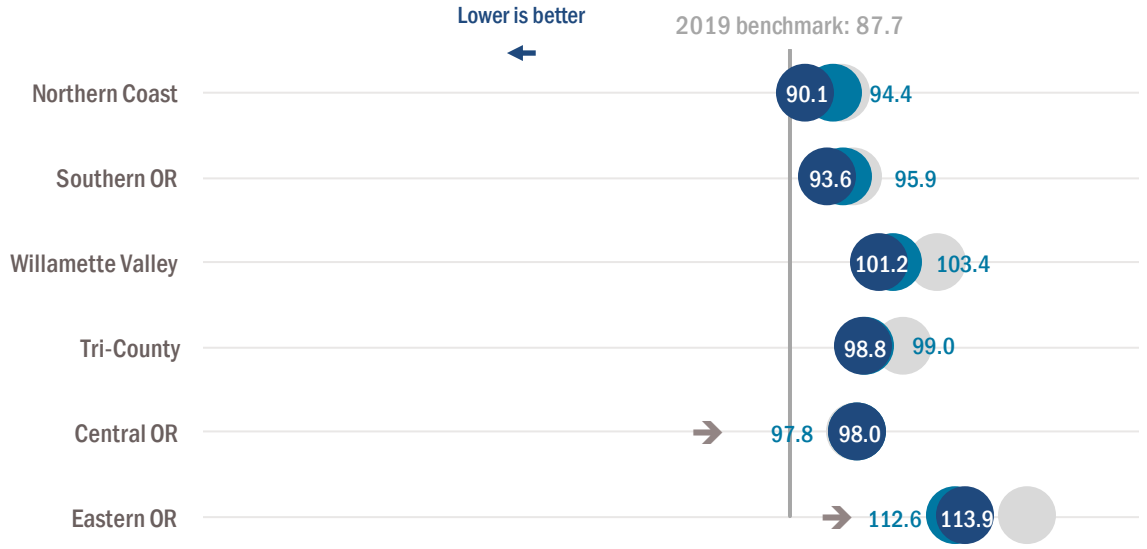
- Statewide change since 2018: **-1.1%**
- Number of CCOs that improved: **9**
- Number of CCOs achieving target: **7**

Rates are shown per 1,000 member months, which means that in one month, there are on average 99.2 visits occurring per 1,000 CCO members.

Statewide



By region



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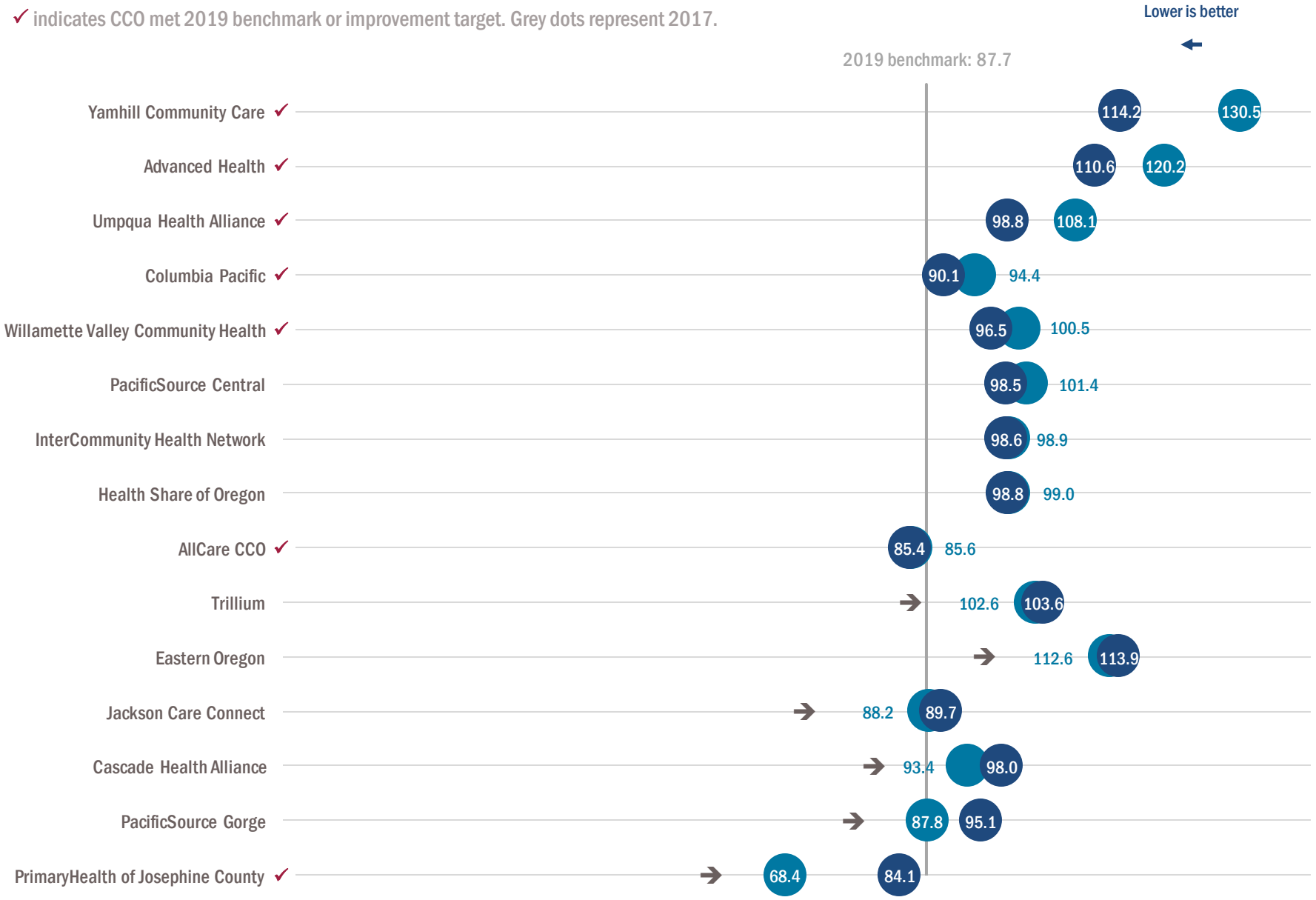
DISPARITY MEASURE: ED UTILIZATION AMONG MEMBERS WITH MENTAL ILLNESS

Emergency department utilization among members with mental illness in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



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

2019 benchmark source:

2017 CCO 90th percentile

2019 data (n=141,412)

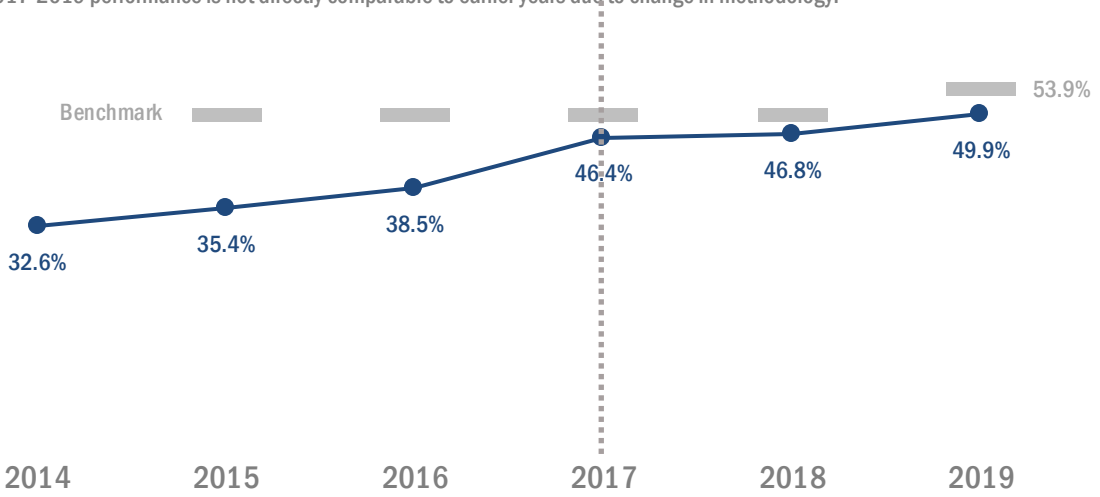
- Statewide change since 2018: **+6.6%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **8**

2018 was the first year adolescents ages 15-17 were included in the incentivized measure.

This measure will no longer be incentivized beginning in 2020.

Statewide

Note: 2017-2019 performance is not directly comparable to earlier years due to change in methodology.



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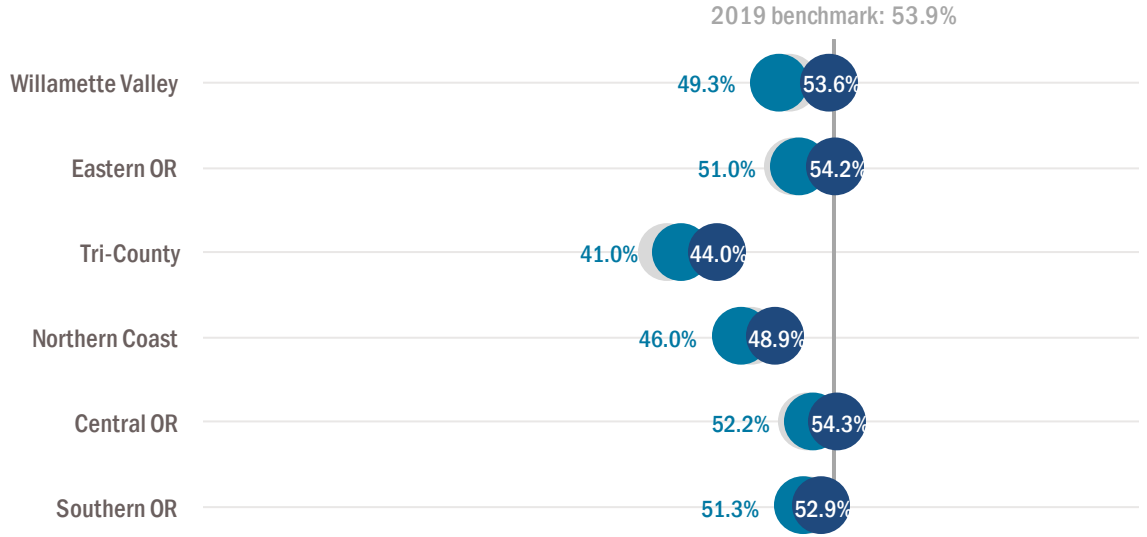

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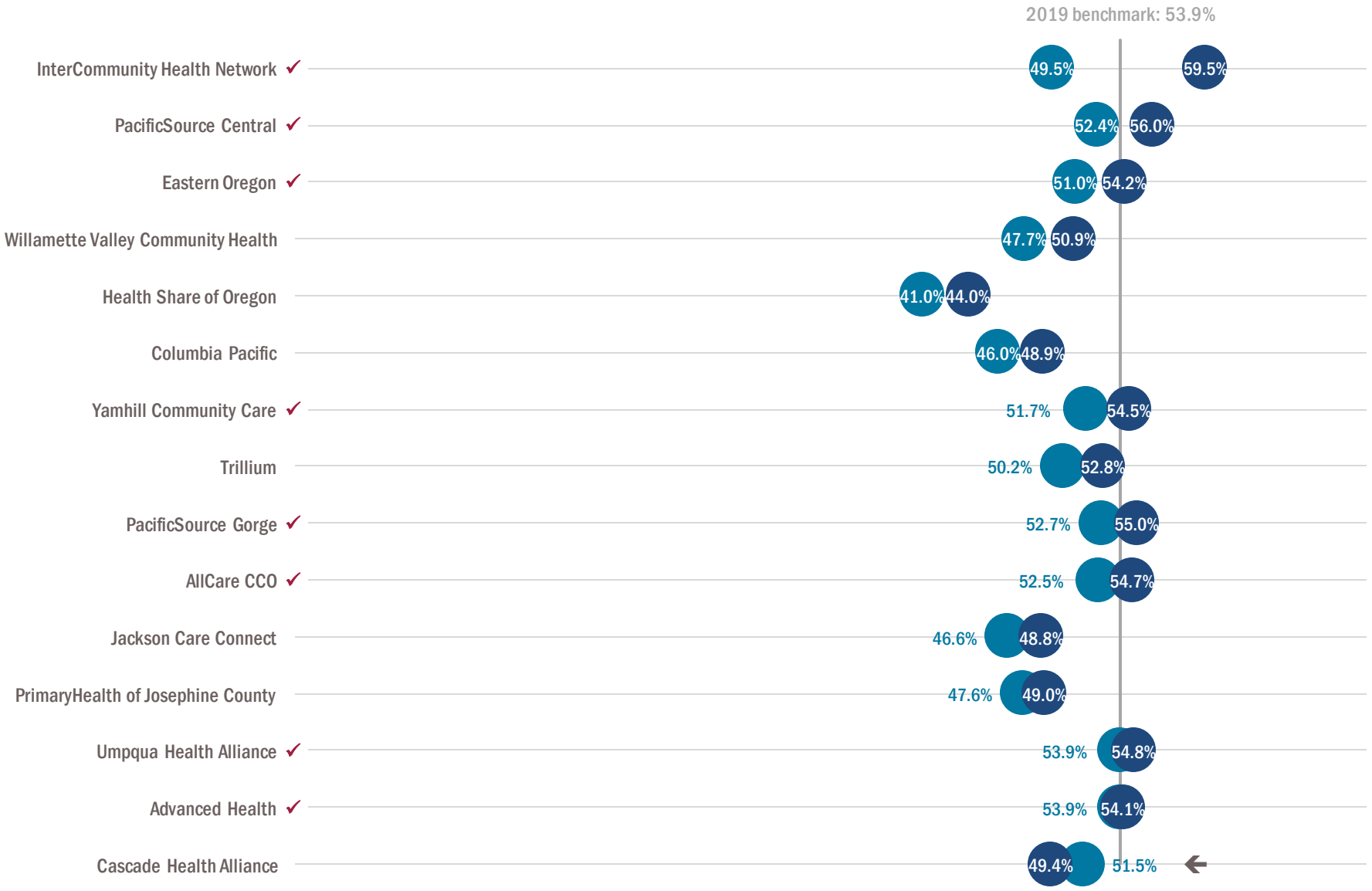
EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-50)

Effective contraceptive use among adult women at risk of unintended pregnancy in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target. Grey dots represent 2017.



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

2019 benchmark source:

2017 CCO 90th percentile

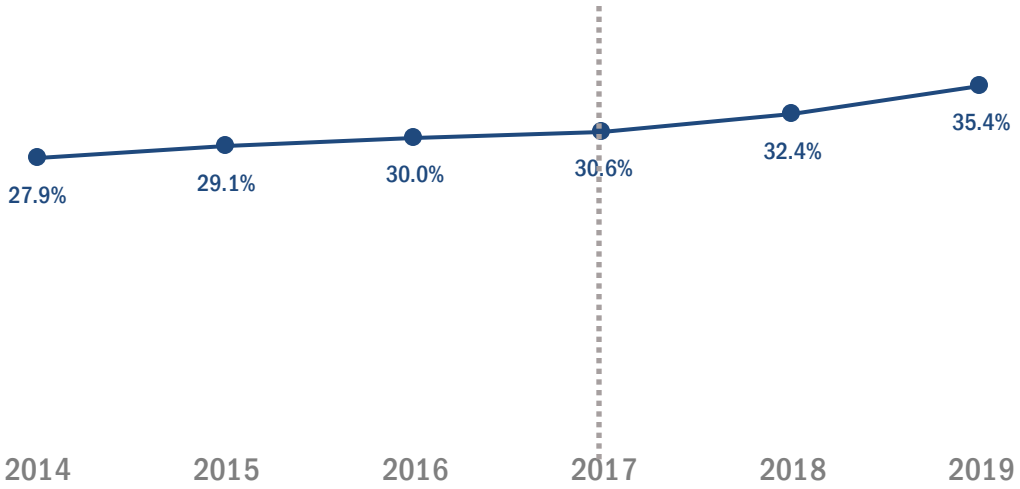
2019 data (n=20,258)

- Statewide change since 2018: **+9.3%**
- Number of CCOs that improved: **12**

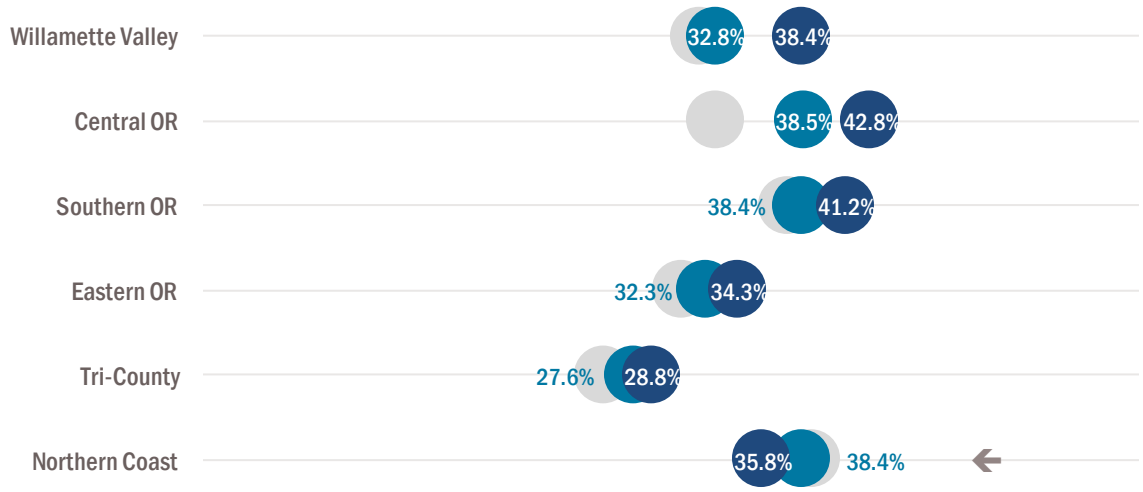
Results are stratified by age group (adolescents and adults) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

Statewide

Note: 2017-2019 performance is not directly comparable to earlier years due to change in methodology.



By region



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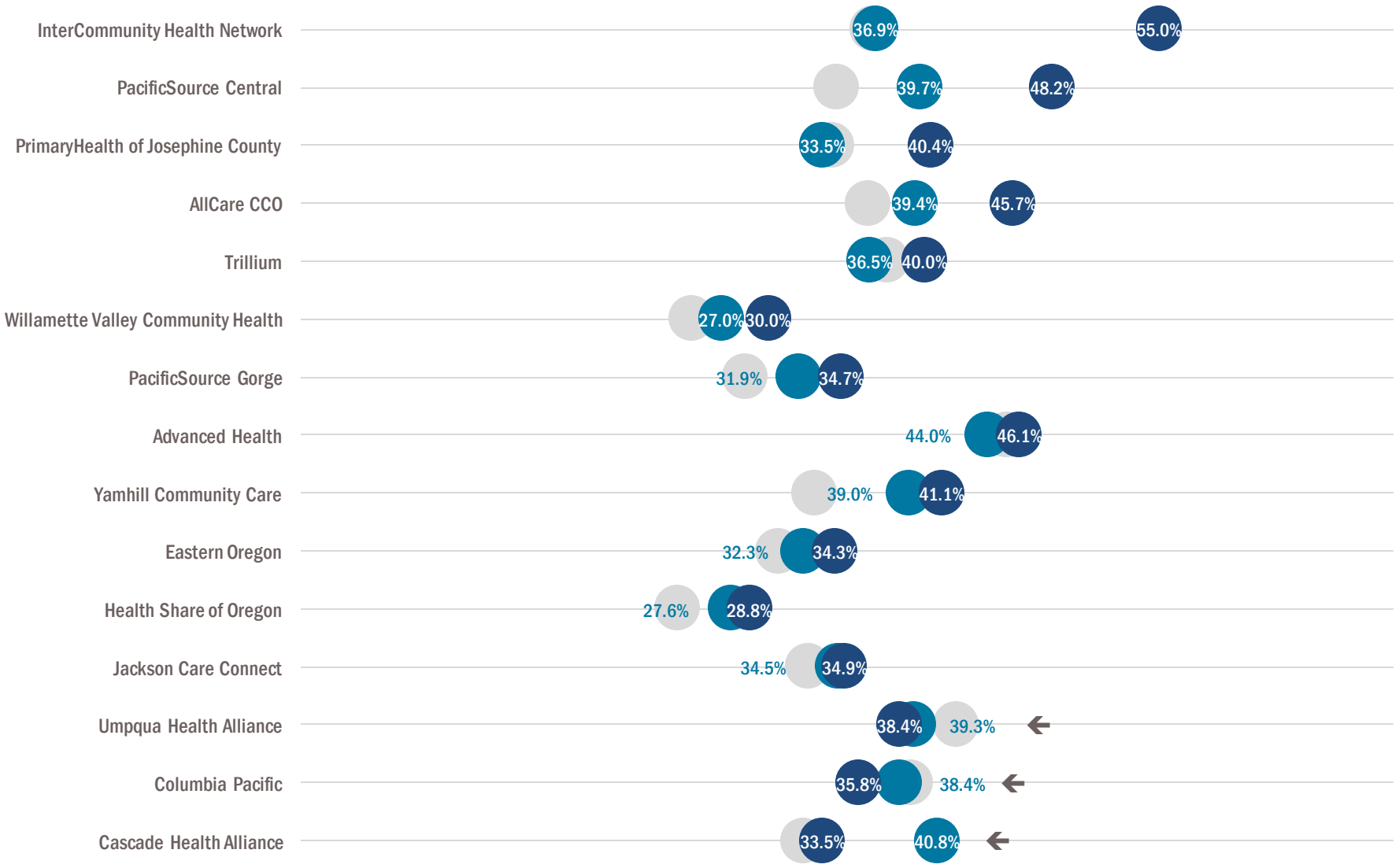
EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 15-17)

Effective contraceptive use among adolescent women at risk of unintended pregnancy in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

Effective contraceptive use (18-50)

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

2019 benchmark source:

2017 CCO 90th percentile

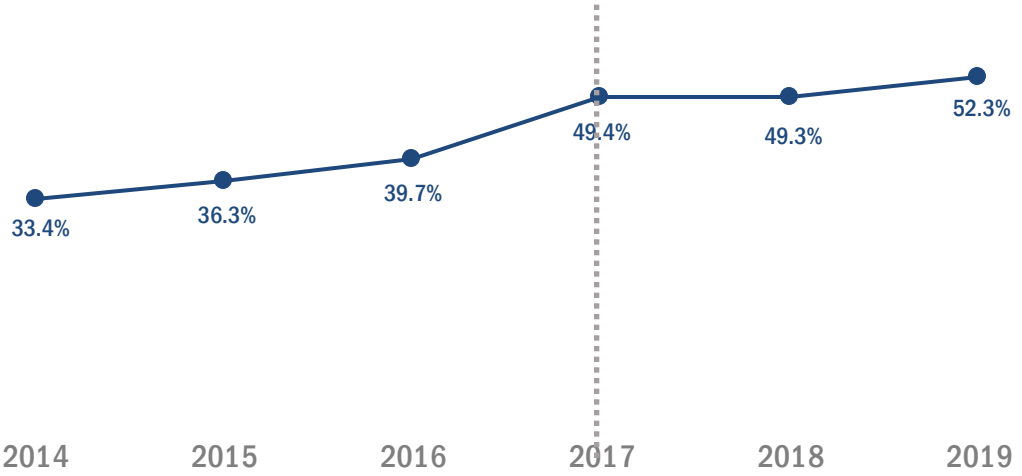
2019 data (n=121,154)

- Statewide change since 2018: **+6.1%**
- Number of CCOs that improved: **13**

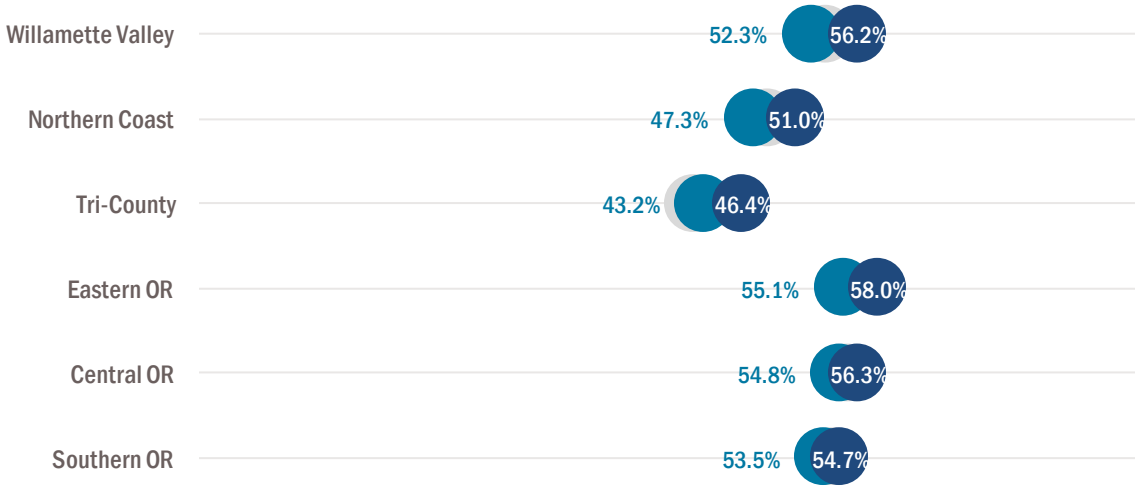
Results are stratified by age group (adolescents and adults) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

Statewide

Note: 2017-2019 performance is not directly comparable to earlier years due to change in methodology.



By region



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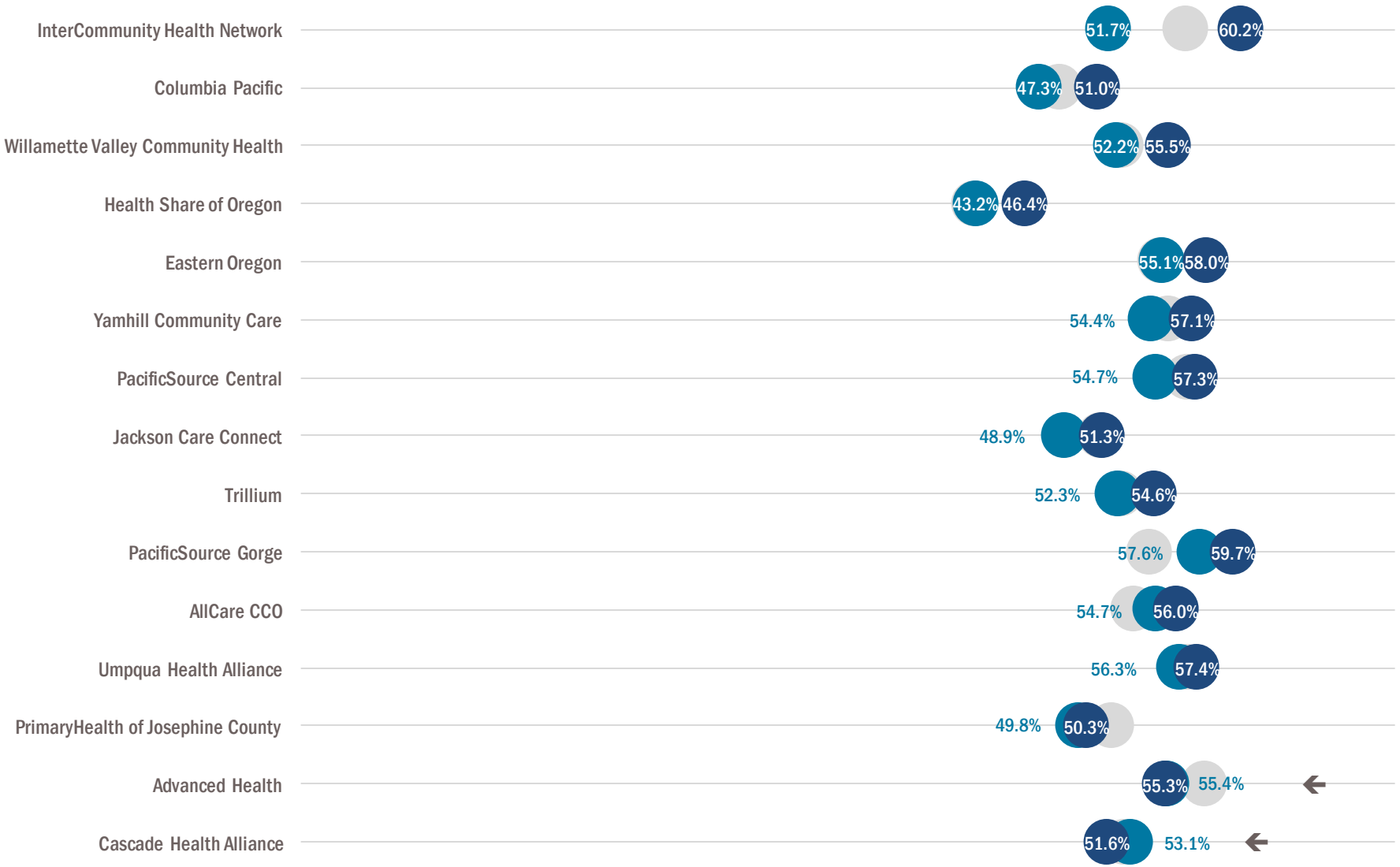
EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (ages 18-50)

Effective contraceptive use among women ages 18-50 at risk of unintended pregnancy in 2018 and 2019, by CCO.

Grey dots represent 2017.



ORAL EVALUATION FOR ADULTS WITH DIABETES

Oral evaluation for diabetes

Percentage of adult CCO members identified as having diabetes who received at least one dental service within the reporting year.

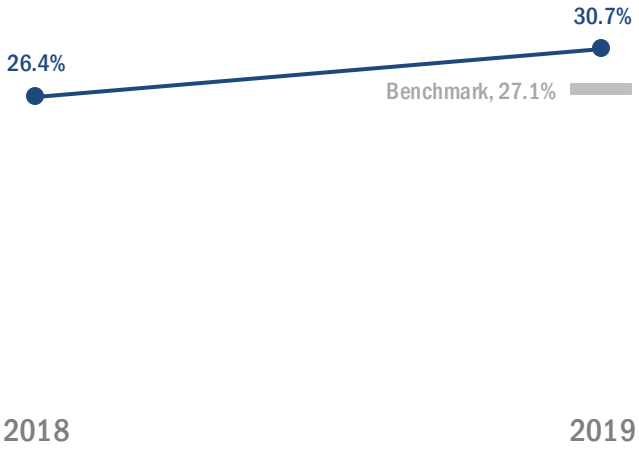
Data source:
Administrative (billing) claims

2019 benchmark source:
2017 CCO 75th percentile

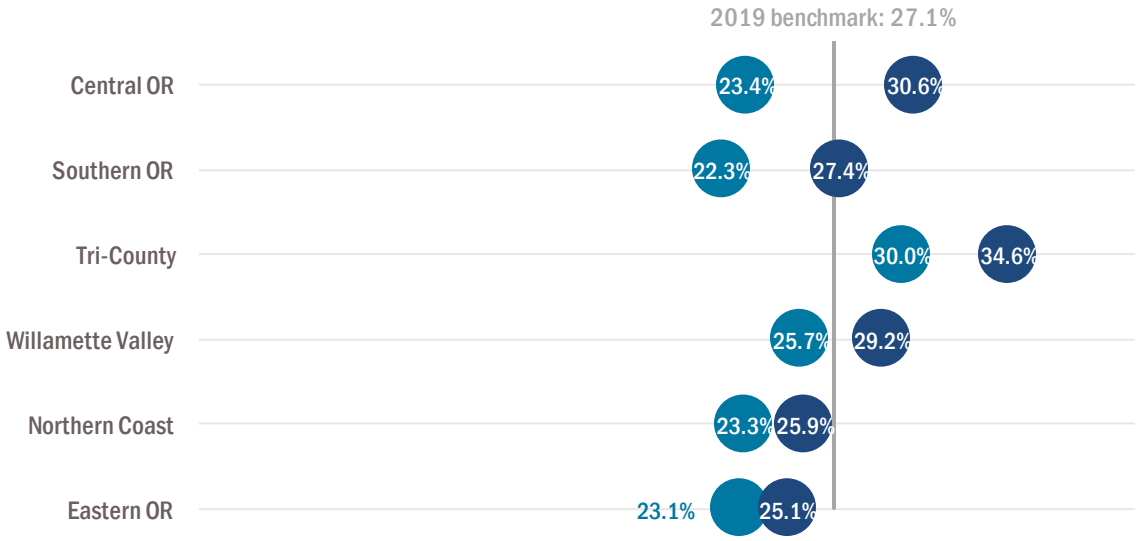
2019 data (n=36,430)

- Number of CCOs achieving target: **13**

Statewide



By region



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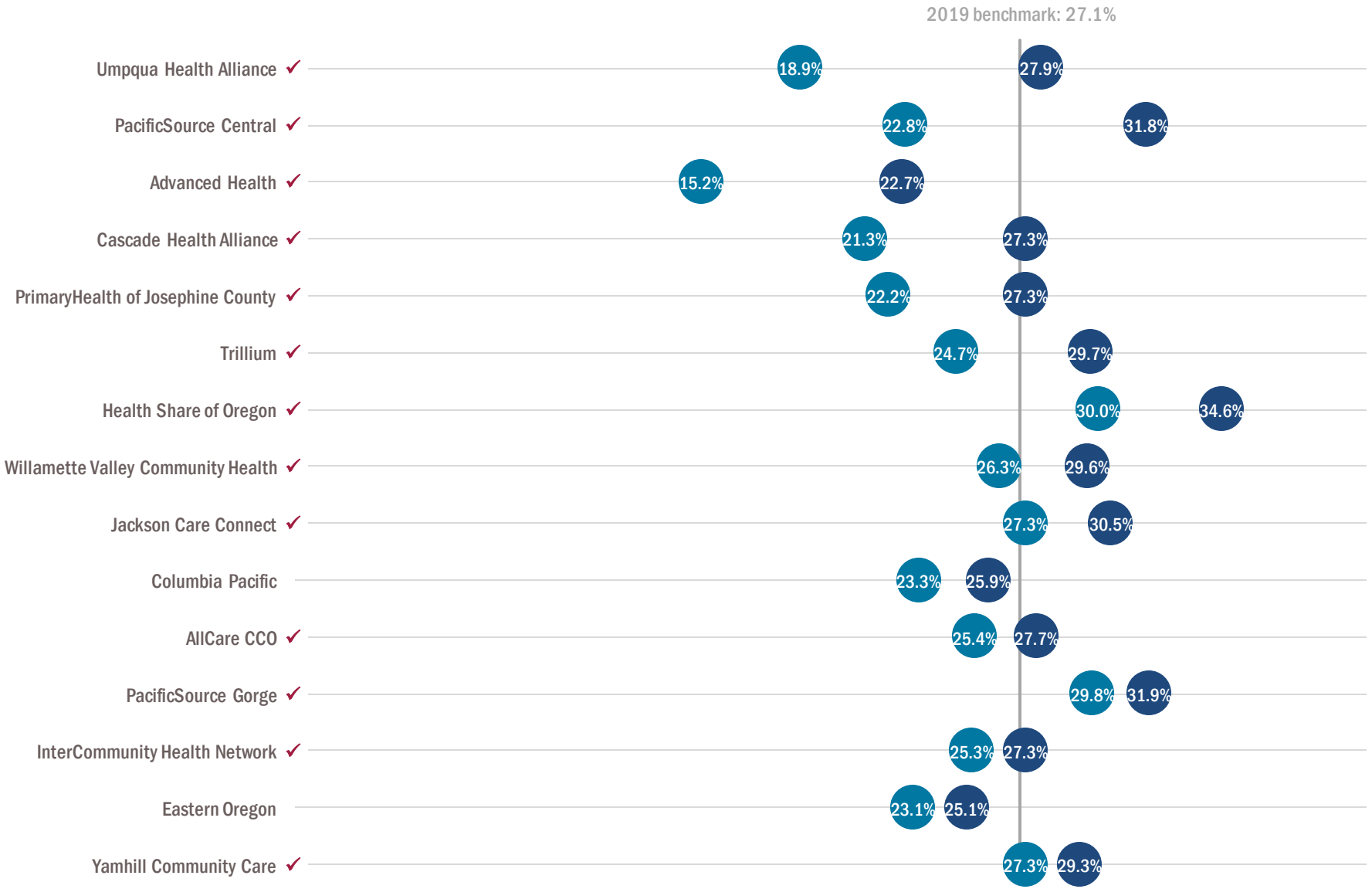
ORAL EVALUATION FOR ADULTS WITH DIABETES

Oral evaluations for adults with diabetes in 2018 and 2019, by CCO.

✓ indicates CCO met 2019 benchmark or improvement target.

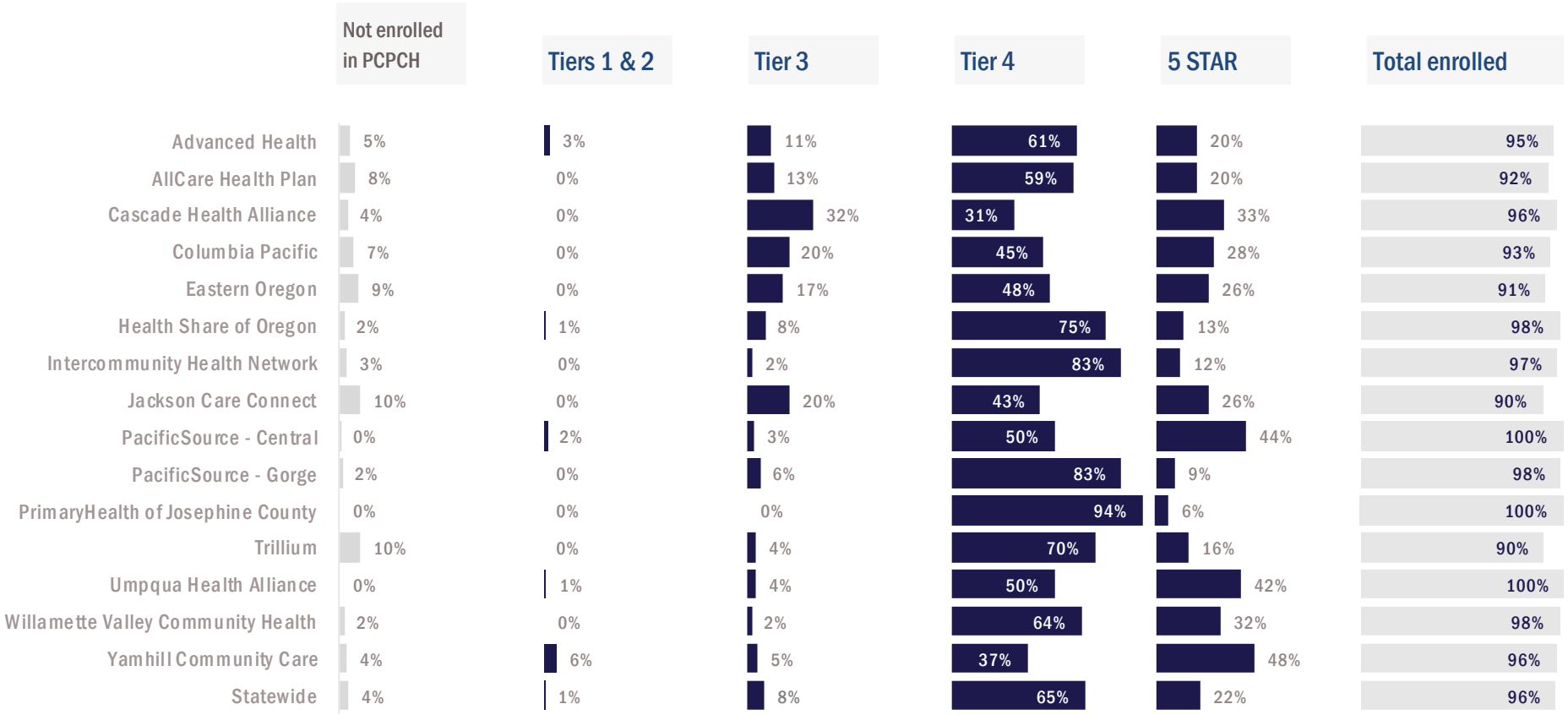


PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Statewide in 2019, 96 percent of CCO members were enrolled in a PCPCH, resulting in a weighted score of 79 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. CCOs now receive credit for this measure according to a tiered formula which provides greater weight for members enrolled in clinics that are recognized at higher tiers of the PCPCH program. 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 68% to be eligible to earn 100 percent of its quality pool. This measure will no longer be incentivized beginning in 2020.

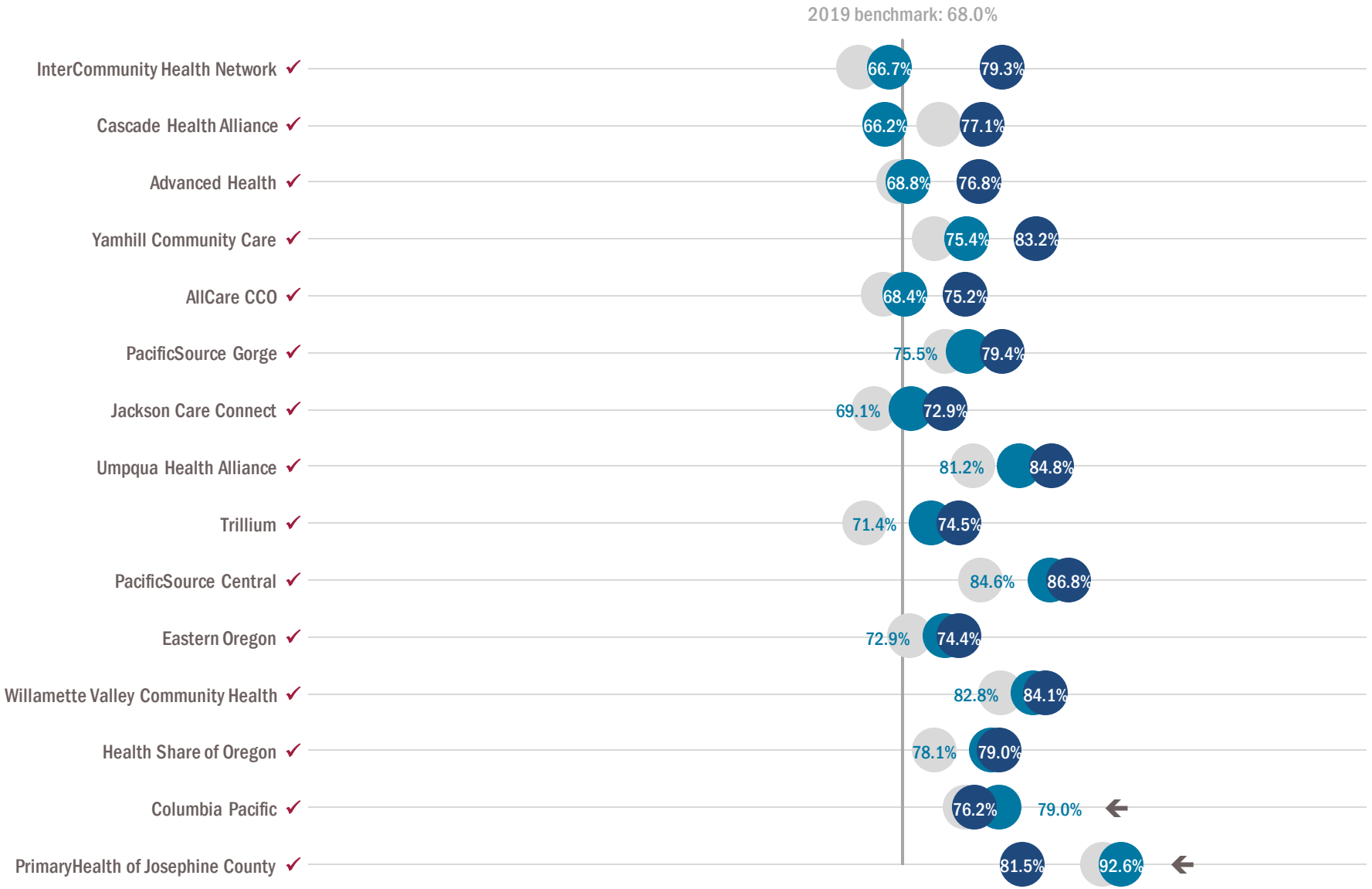


PCPCH weighted score formula: (# of members in Tier 1 clinics *1) + (# of members in Tier 2 clinics*2) + (number of members in Tier 3 clinics*3) + (# members in Tier 4 clinics*4) + (# members in 5 STAR clinics*5) / (total # of CCO members*5)

PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-Centered Primary Care Home enrollment score in 2018 and 2019, by CCO.

✓ indicates CCO met 68 percent threshold. Grey dots represent 2017.



PRENATAL AND POSTPARTUM CARE: RATE OF POSTPARTUM CARE

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

2019 benchmark source:

2018 national Medicaid 75th percentile

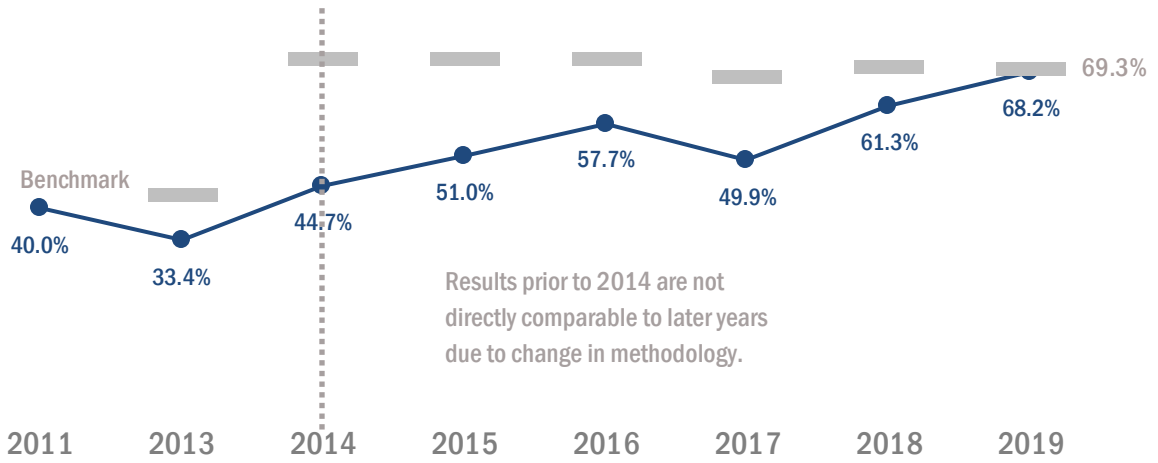
2019 data (n=5,056)

- Statewide change since 2018: **+11.3%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **13**

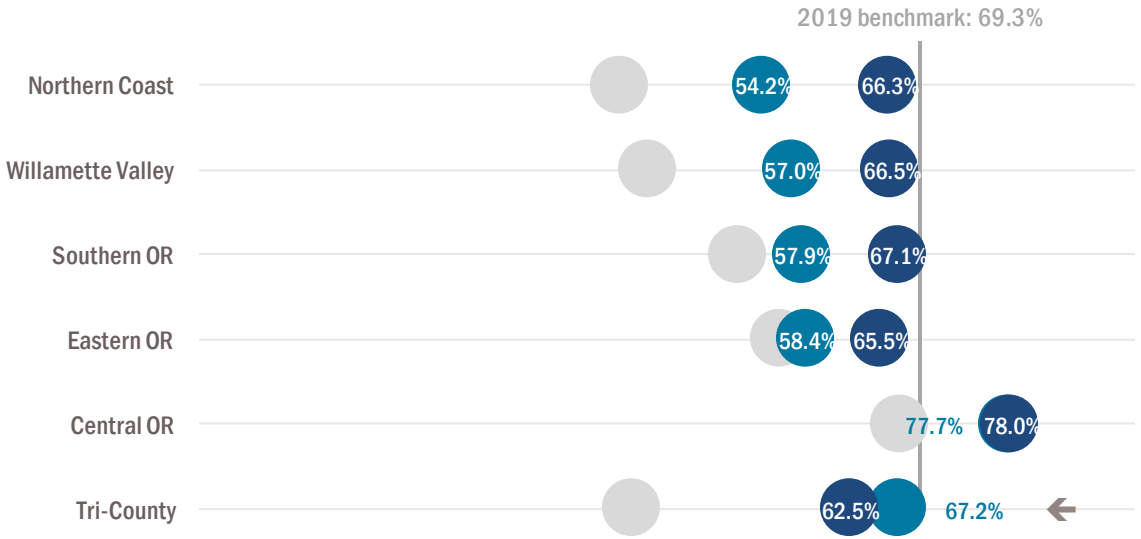
Beginning in 2014, measure specifications were modified to include medical record review. Results prior to 2014 are not directly comparable to later years.

2019 is the first year this measure is incentivized.

Statewide



By region



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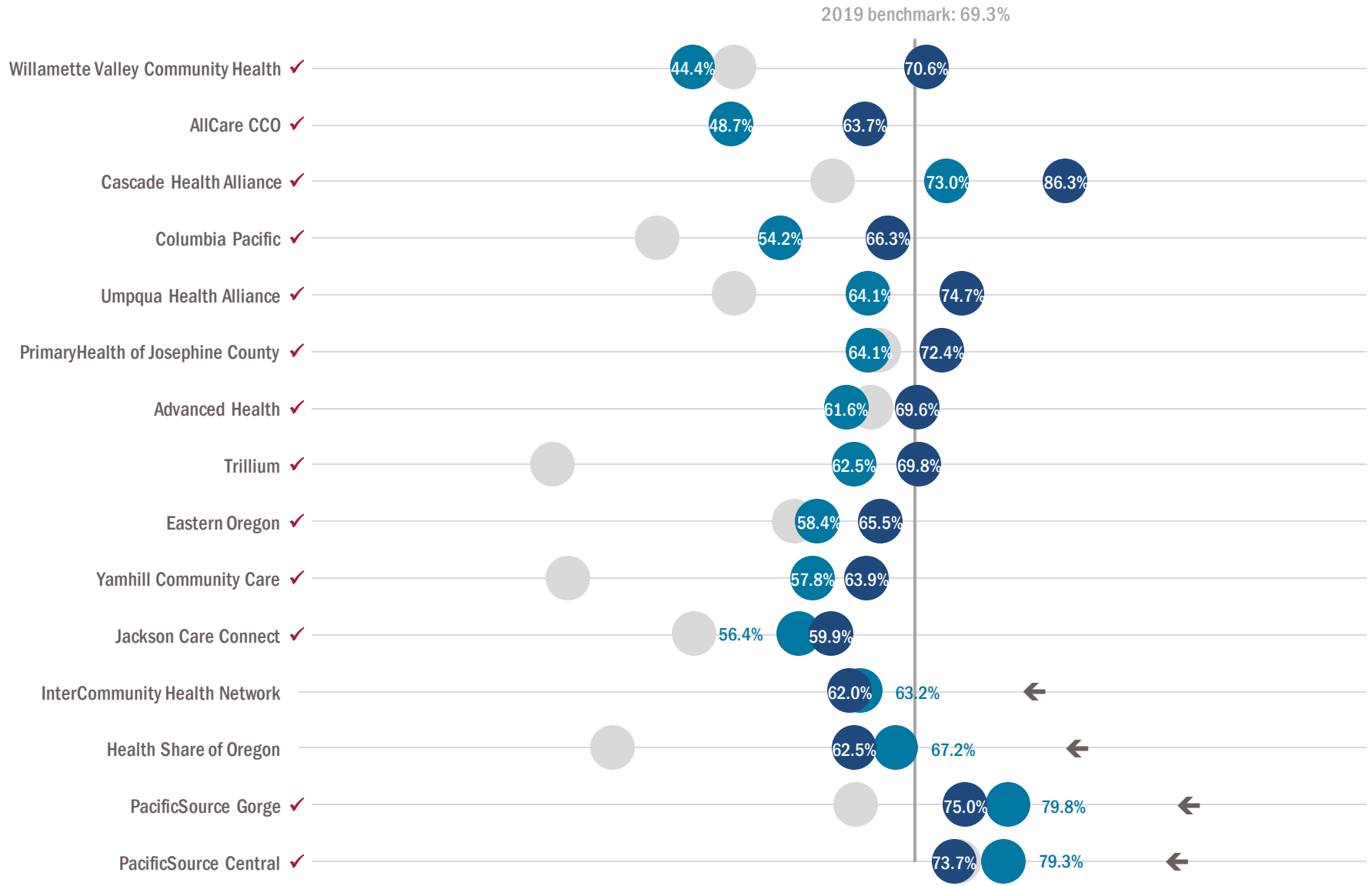
PRENATAL AND POSTPARTUM CARE: RATE OF POSTPARTUM CARE

Percentage of women receiving postpartum care in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2017.



NEW

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)—RATE 1

SBIRT (Rate 1)

Percentage of members 12 years and older who received an age-appropriate screening for alcohol or other substance abuse.

Data source:

Electronic Health Records

2019 benchmark source:

N/A, reporting-only for 2019

2019 data (n=268,159)

- Number of CCOs achieving target: **15**

A claims-based version of this measure was reported in previous years. For the first year of reporting using EHR data, the minimum population threshold to report was 20% of each CCO's membership as of the end of the measurement year. The actual percentage of members included in each CCO's reporting varied significantly, from 21.7% to 90.8%.

Statewide

Region

This measure cannot be stratified by region.

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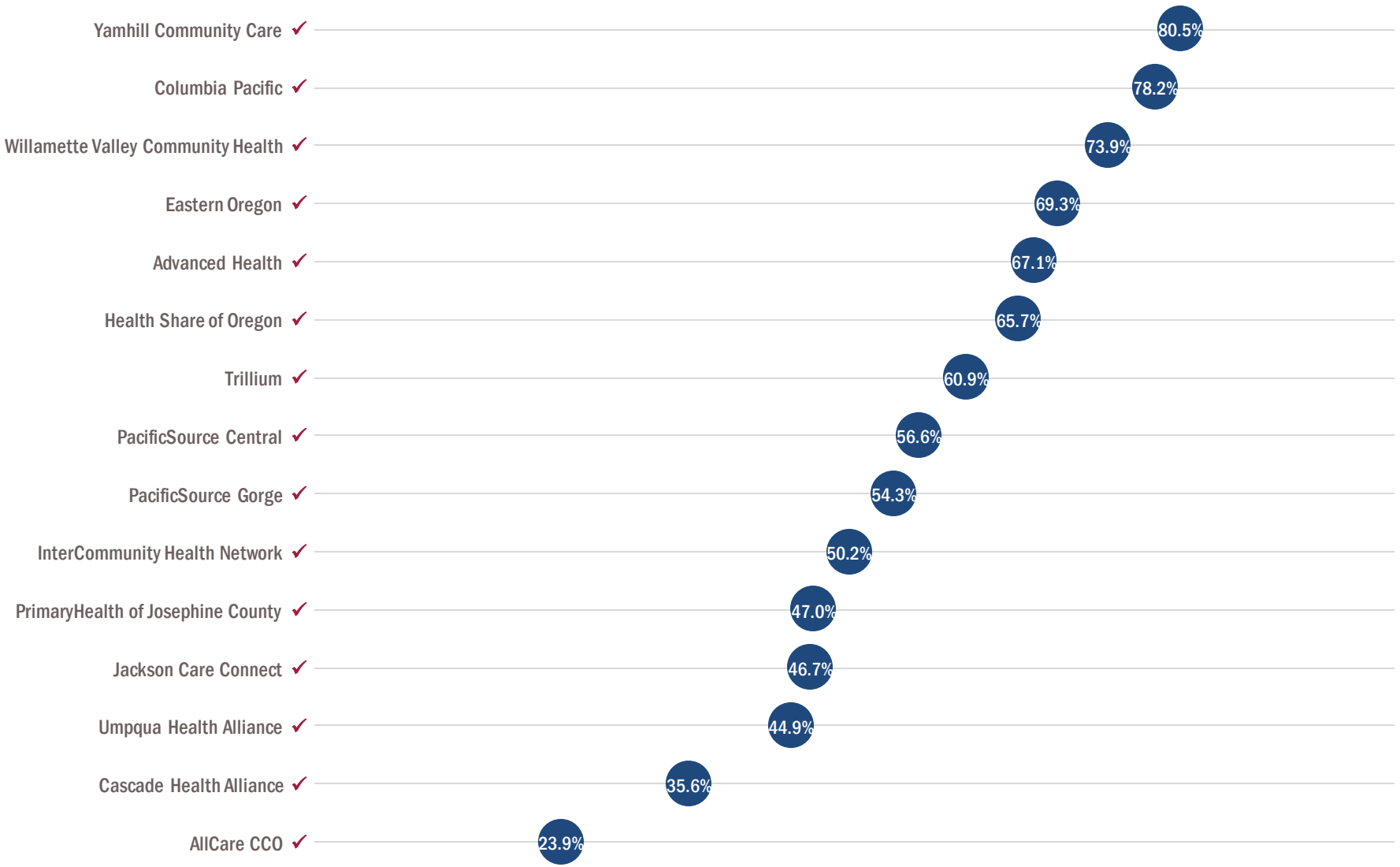
NEW

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)—RATE 1

Screening for alcohol and other substance abuse in 2019, by CCO.

✓ indicates CCO successfully reported measure.



NEW

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)—RATE 2

SBIRT (Rate 2)

Percentage of members who screened positive for alcohol or other substance abuse and received a brief intervention or referral to treatment.

Data source:

Electronic Health Records

2019 benchmark source:

N/A, reporting-only for 2019

2019 data (n=28,254)

- Number of CCOs achieving target: **15**

A claims-based version of this measure was reported in previous years. For the first year of reporting using EHR data, the minimum population threshold to report was 20% of each CCO's membership as of the end of the measurement year. The actual percentage of members included in each CCO's reporting varied significantly, from 21.7% to 90.8%.

Statewide

Region

This measure cannot be stratified by region.

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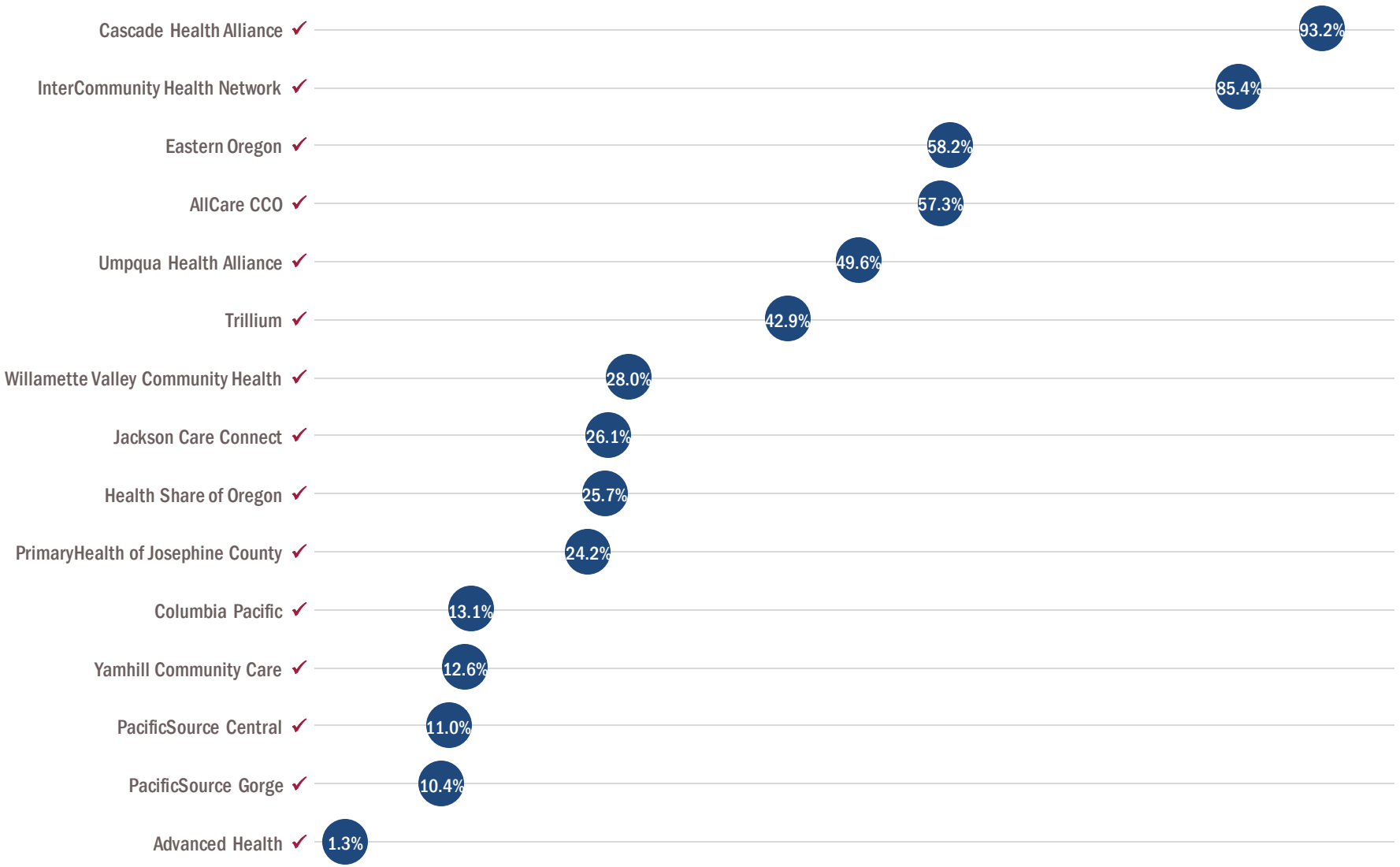
NEW

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)—RATE 2

Screening, brief intervention and referral to treatment in 2019, by CCO.

✓ indicates CCO successfully reported measure.



WEIGHT ASSESSMENT, NUTRITION, AND ACTIVITY COUNSELING FOR CHILDREN AND ADOLESCENTS

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

2019 benchmark source:

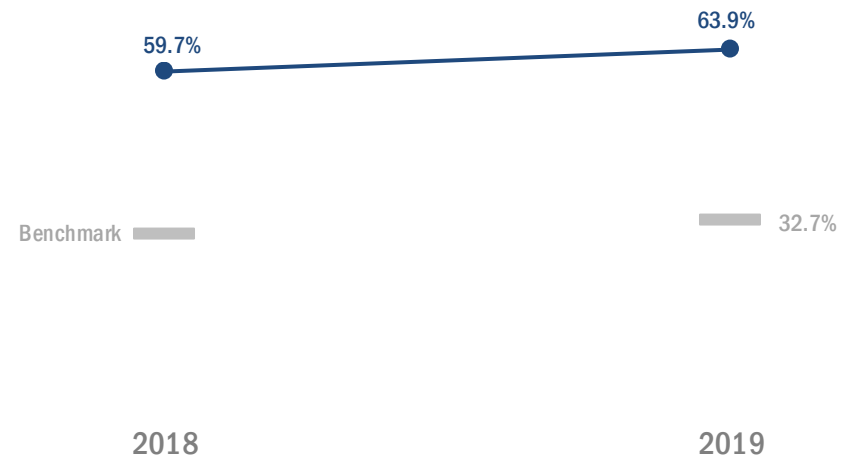
MIPS 2018 Decile 8 (70th percentile)

2019 data (n=210,189)

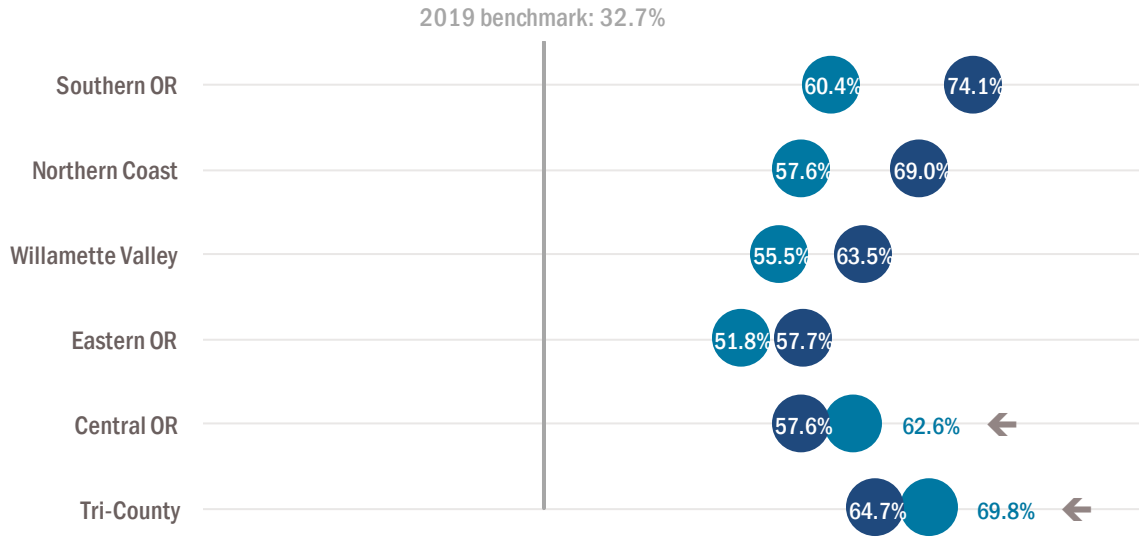
- Statewide change since 2018: **+7.0%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **15**

This measure will no longer be incentivized beginning in 2020.

Statewide



By region



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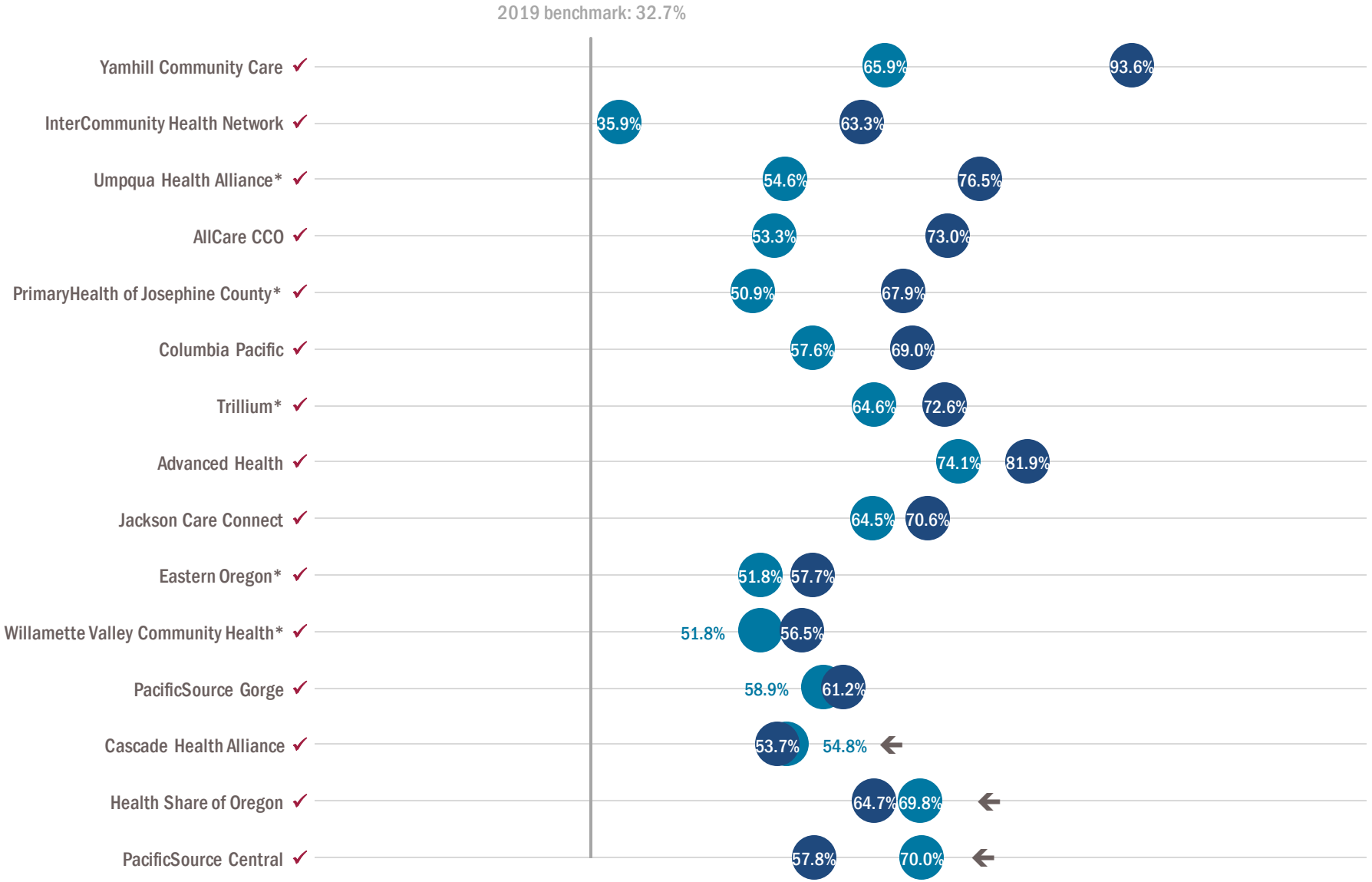
WEIGHT ASSESSMENT, NUTRITION, AND ACTIVITY COUNSELING FOR CHILDREN AND ADOLESCENTS

Weight assessment, nutrition, and activity counseling for children and adolescents in 2018 and 2019, by CCO.

✓ indicates CCO met benchmark or improvement target.

*CCO's reporting includes some aggregated data for both Medicaid and non-Medicaid patients.



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

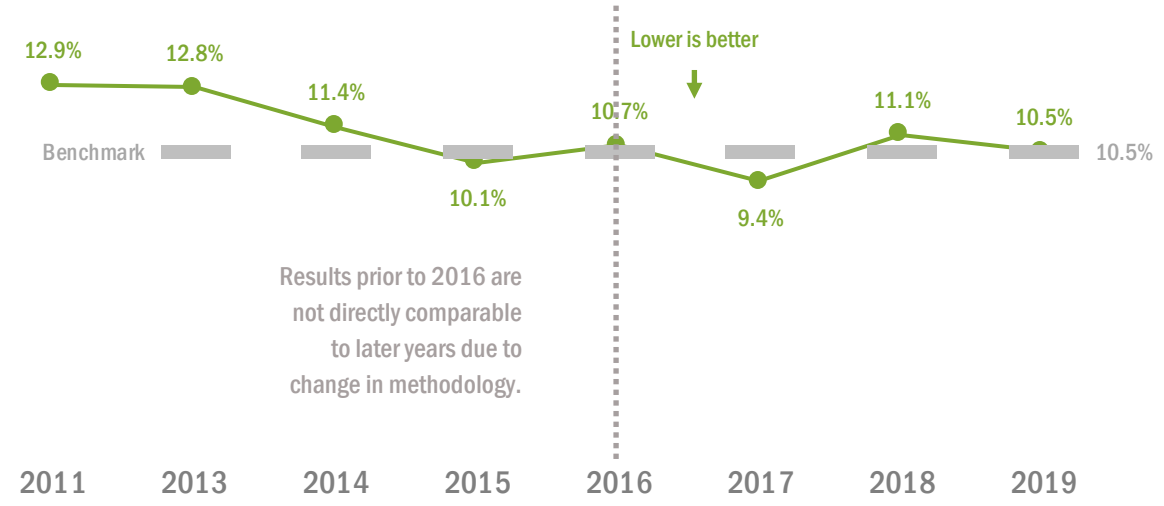
2019 benchmark source:

Average of 2013 commercial and Medicare 75th percentiles

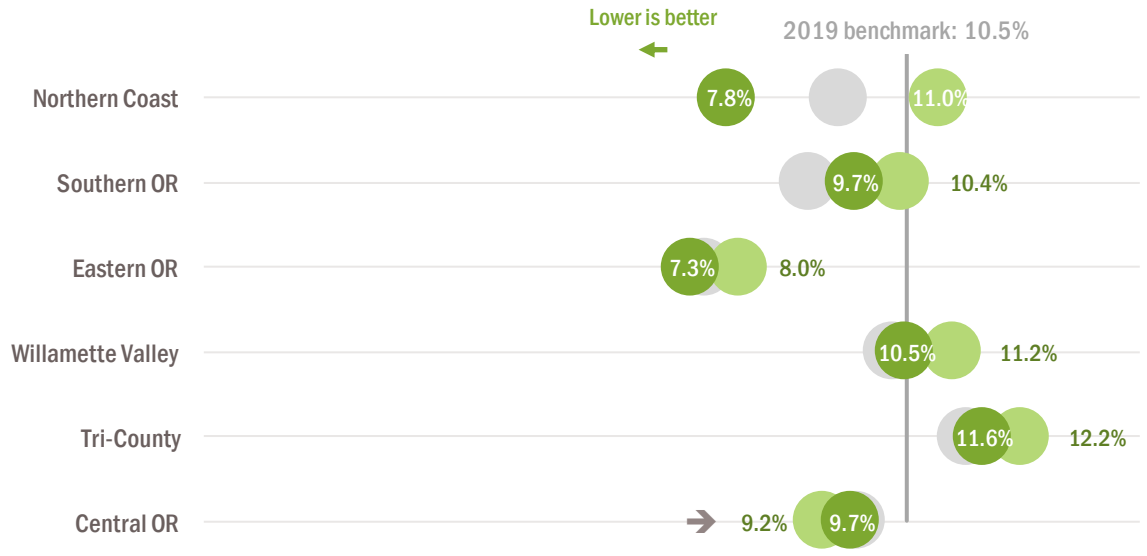
2019 data (n=34,317)

- Statewide change since 2018: **-5.4%**
- Number of CCOs that improved: **10**

Statewide



By region



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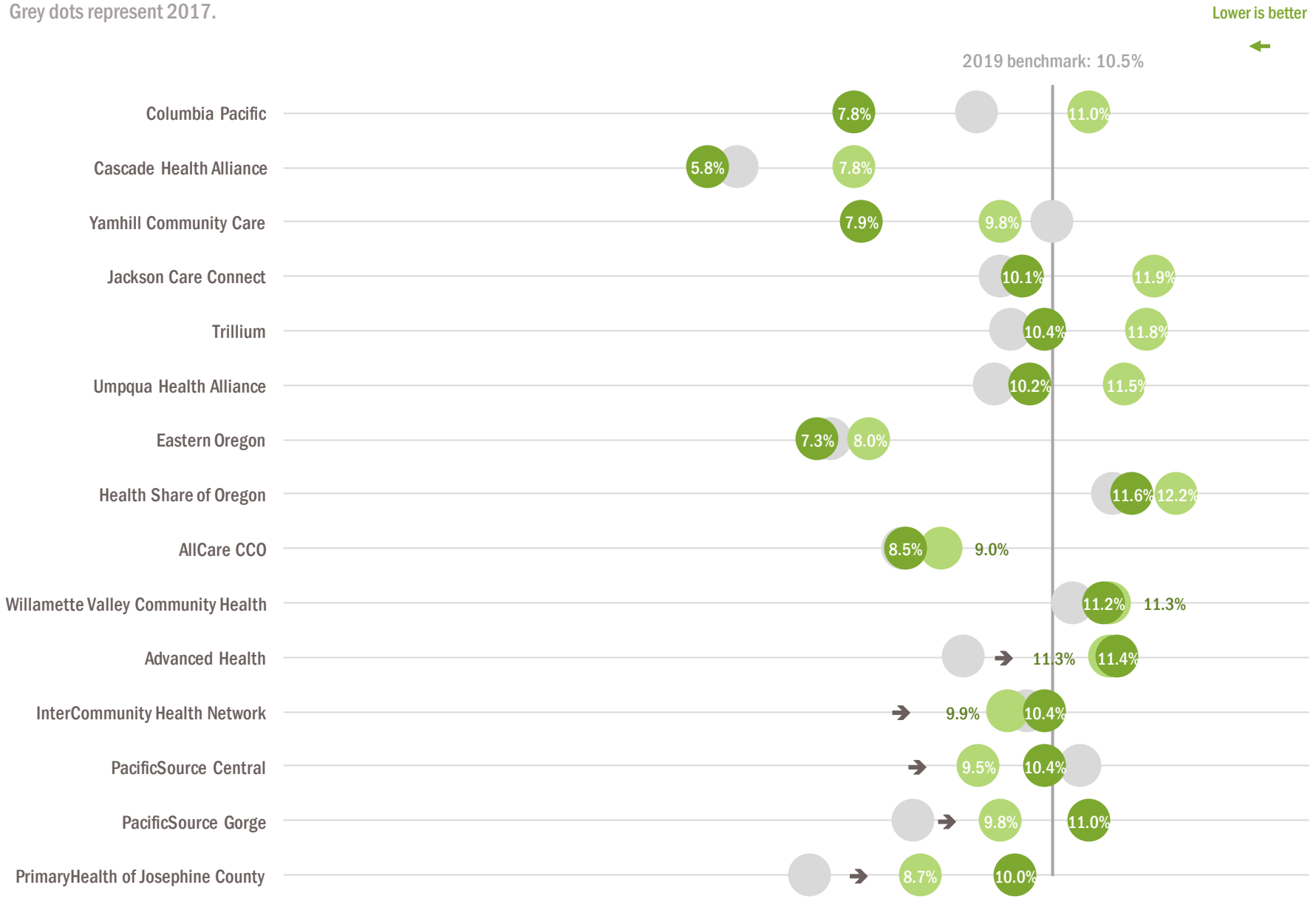
ALL-CAUSE READMISSIONS

Hospital all-cause readmissions in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

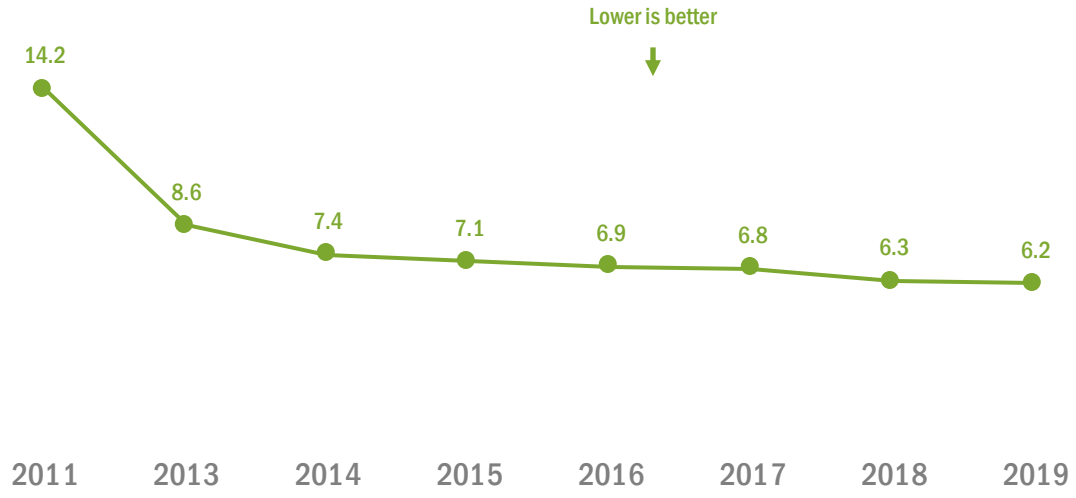
2019 benchmark source:

N/A

2019 data (n=10,440,181 member months)

- Statewide change since 2018: **-1.6%**
- Number of CCOs that improved: **11**

Statewide



By region

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AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2018 and 2019, by CCO.

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

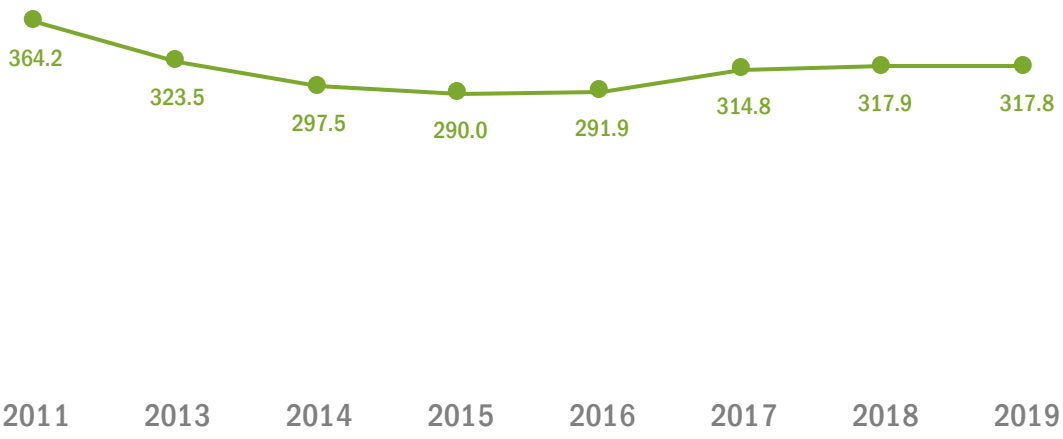
2019 benchmark source:
N/A

2019 data (n=10,440,181 member months)

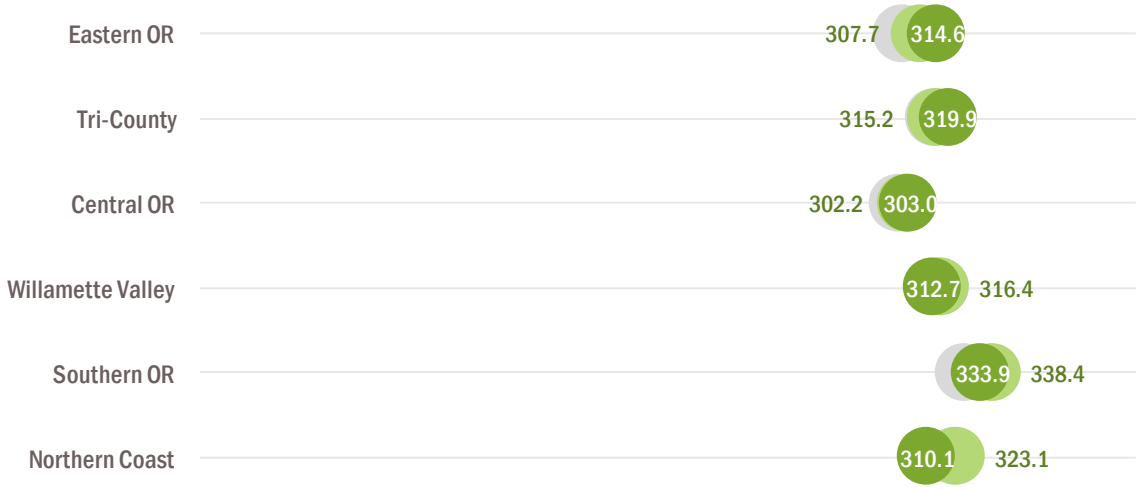
- Statewide change since 2018: **-0.03%**

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.

Statewide



By region



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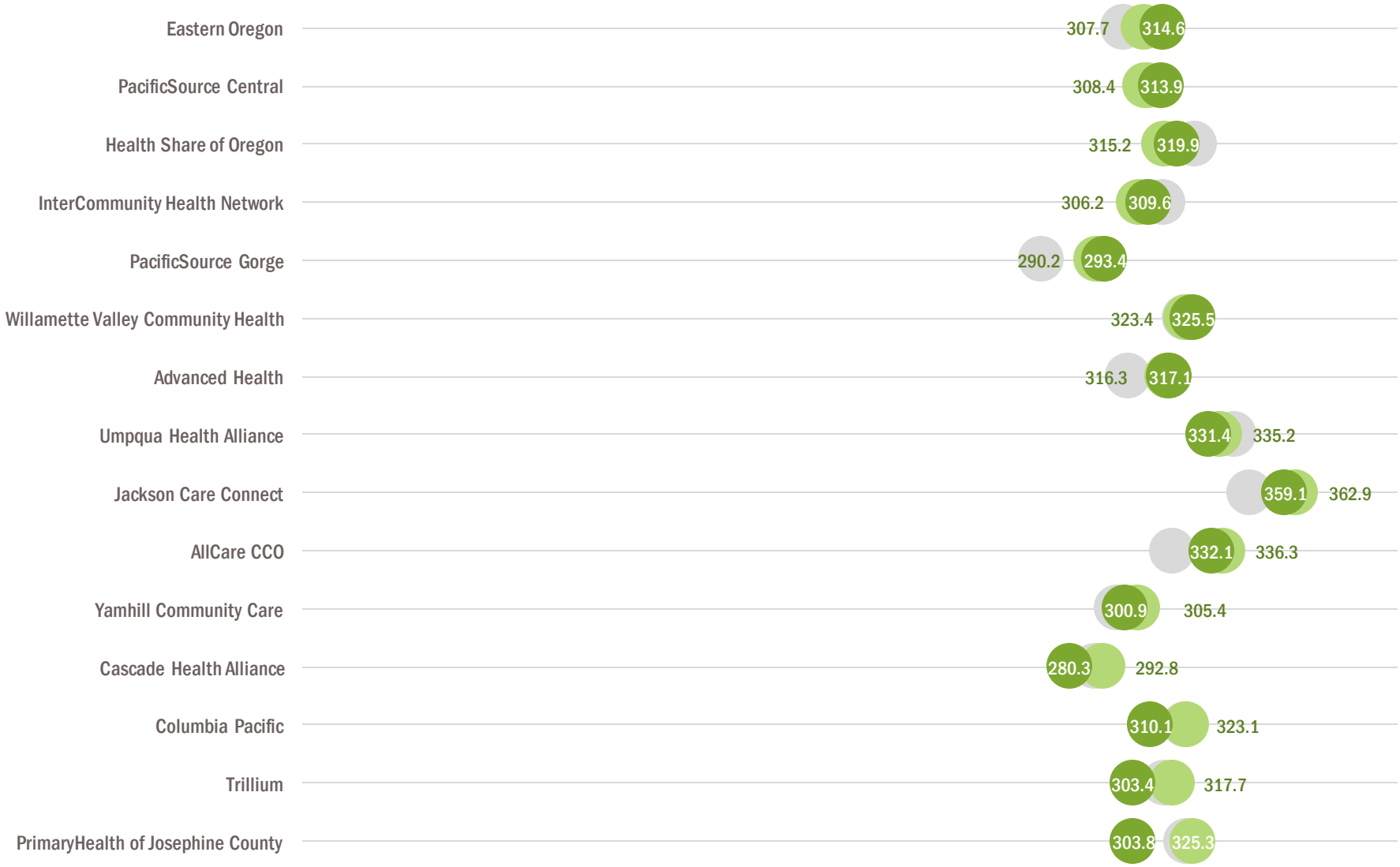
AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2018 and 2019, by CCO.

Grey dots represent 2017.



ANY DENTAL SERVICE

Any dental service

Percentage of members who received any dental service. This metric was added to state quality measures to enhance dental health service integration.

Data source:

Administrative (billing) claims

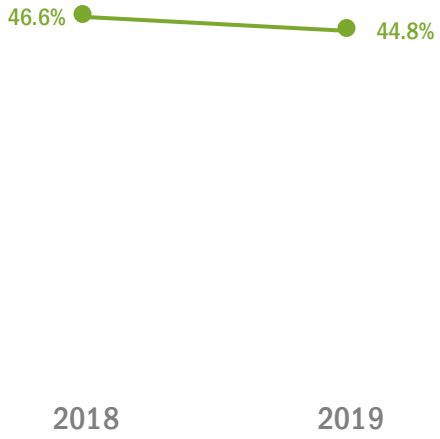
2019 benchmark source:

N/A

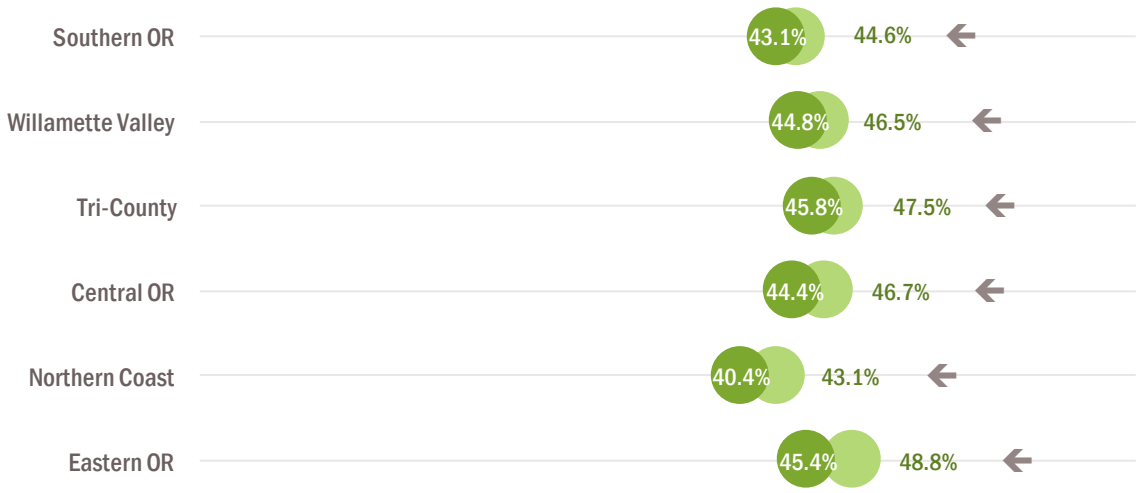
2019 data (n=865,494)

- Statewide change since 2018: **-3.9%**
- Number of CCOs that improved: **0**

Statewide



By region



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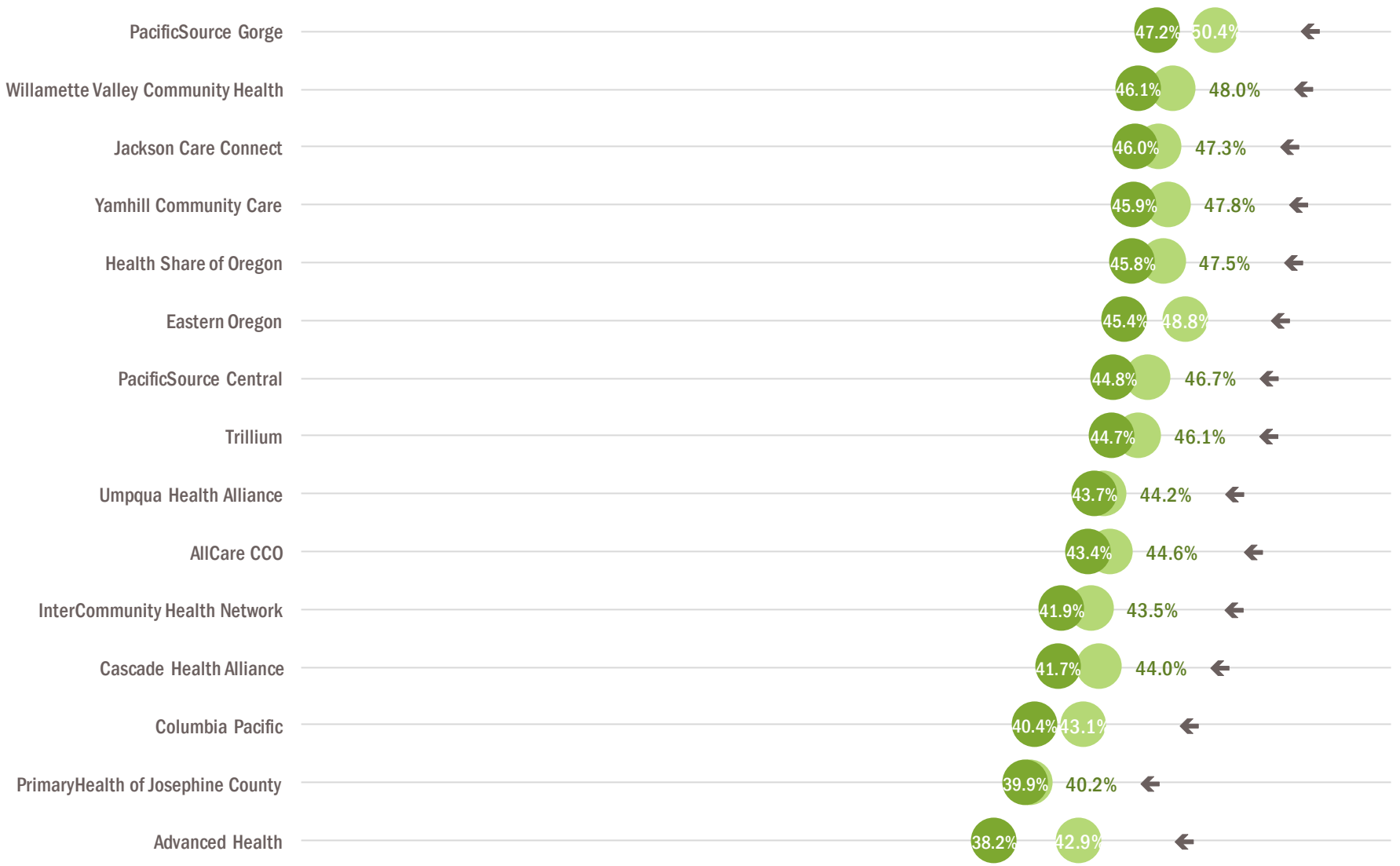
ANY DENTAL SERVICE

Any dental service in 2018 and 2019, 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.

2019 benchmark source:

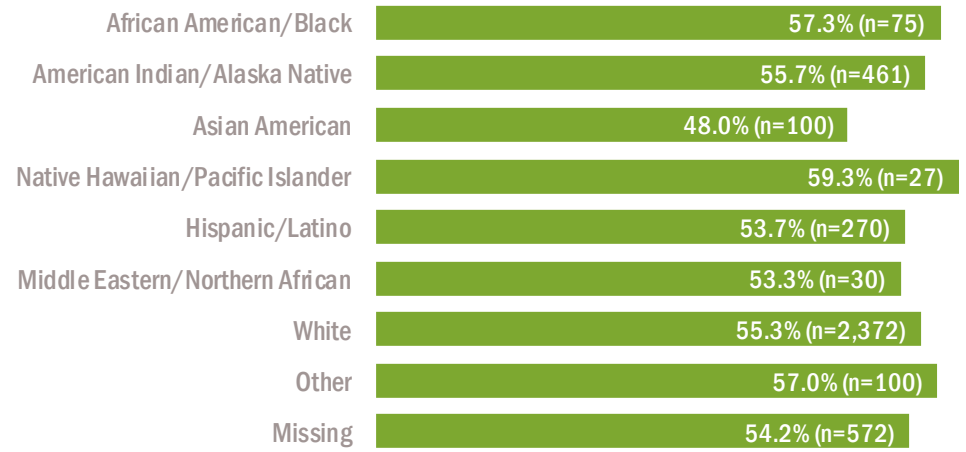
N/A

2019 data (n=4,007)

- Statewide change since 2018: **-1.3%**
- Number of CCOs that improved: **5**

Statewide

By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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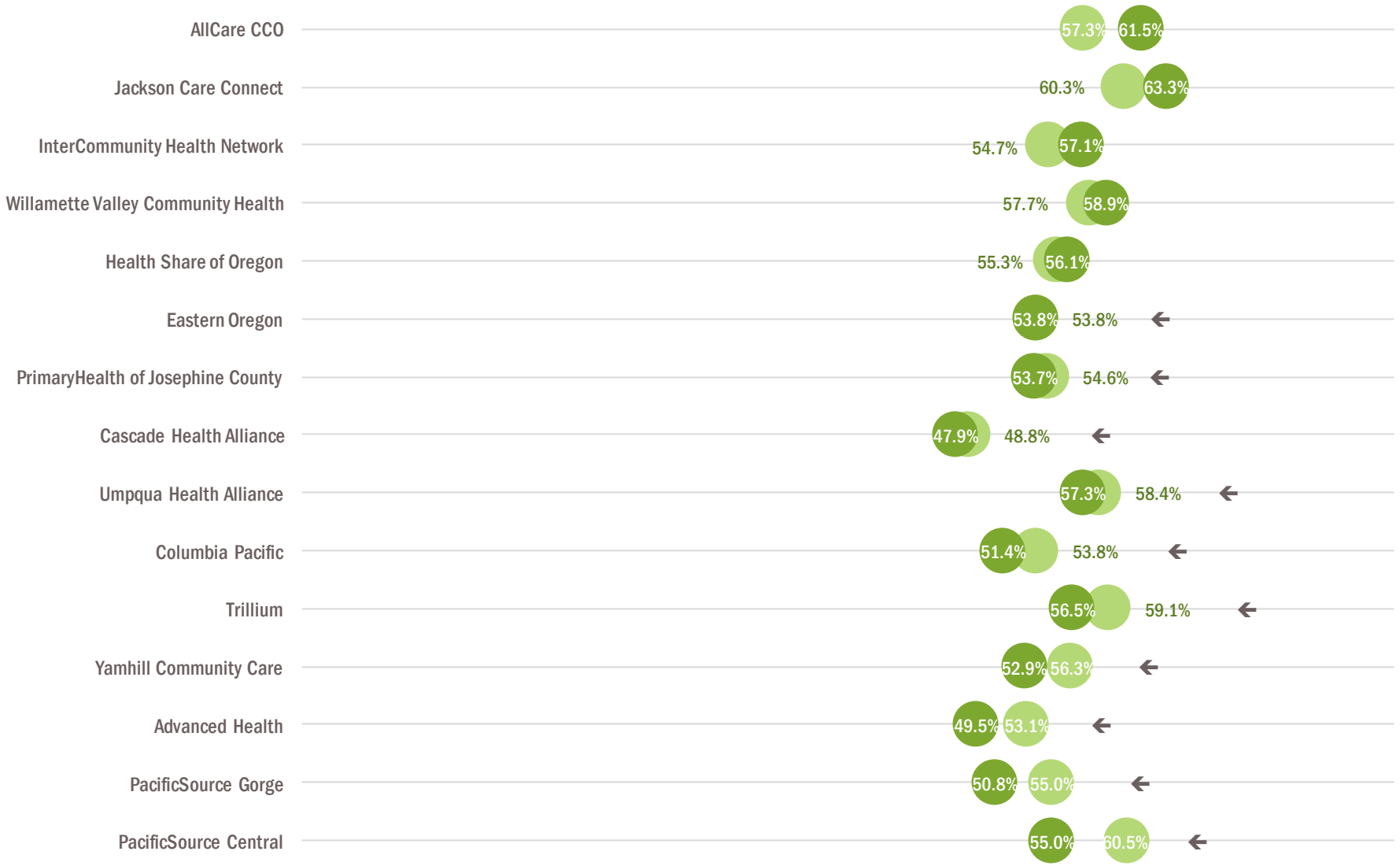
CAHPS: ACCESS TO DENTAL CARE—ADULTS

CAHPS: Access to dental care among adults in 2018 and 2019, 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.

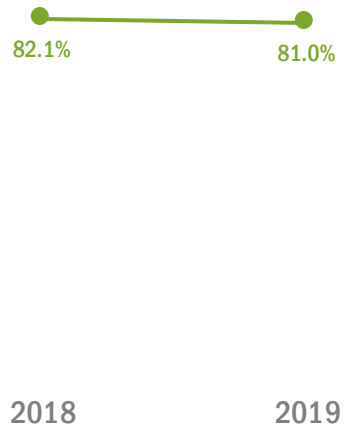
2019 benchmark source:

N/A

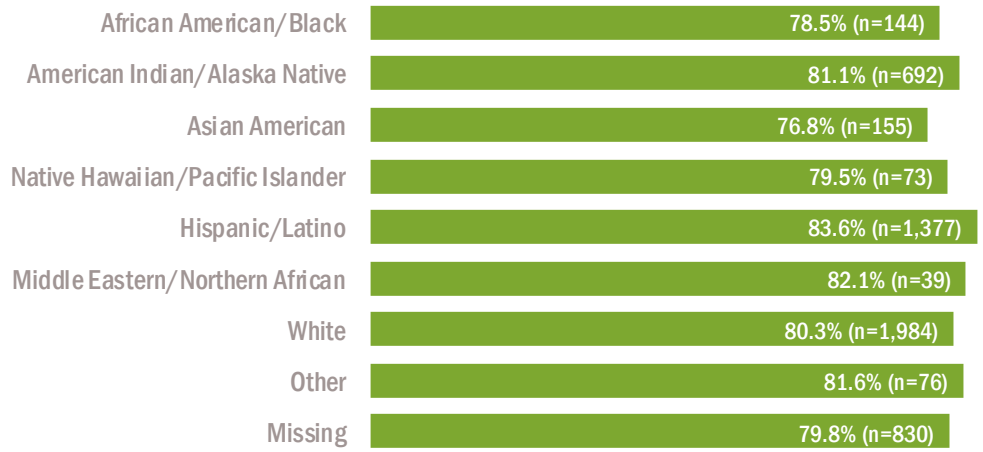
2019 data (n=5,370)

- Statewide change since 2018: **-1.3%**
- Number of CCOs that improved: **6**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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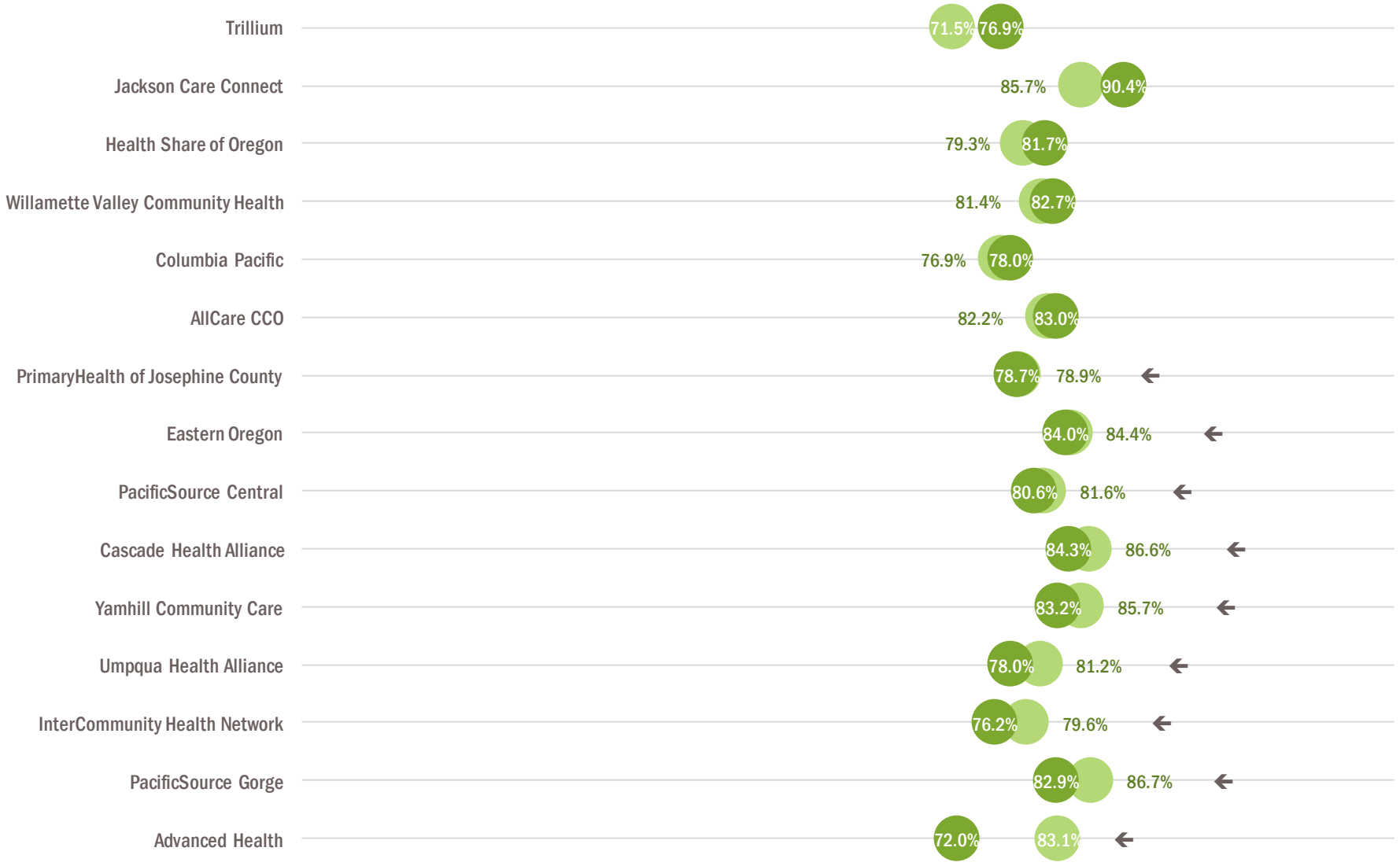
CAHPS: ACCESS TO DENTAL CARE—CHILDREN

CAHPS: Access to dental care among children in 2018 and 2019, 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.

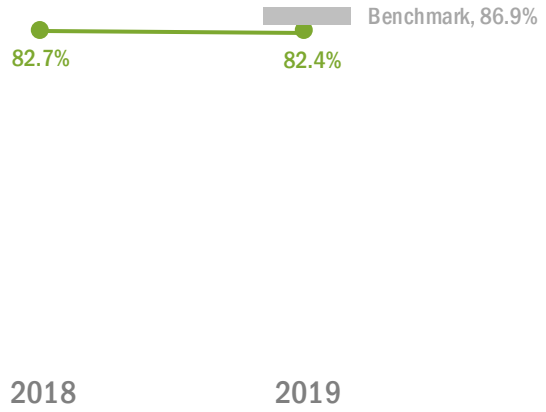
2019 benchmark source:

2018 national Medicaid 90th percentile

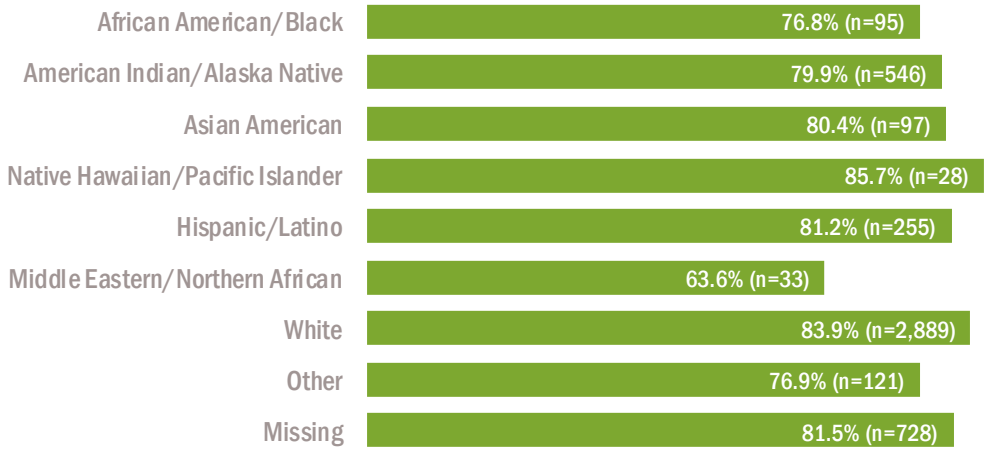
2019 data (n=4,792)

- Statewide change since 2018: **-0.4%**
- Number of CCOs that improved: **4**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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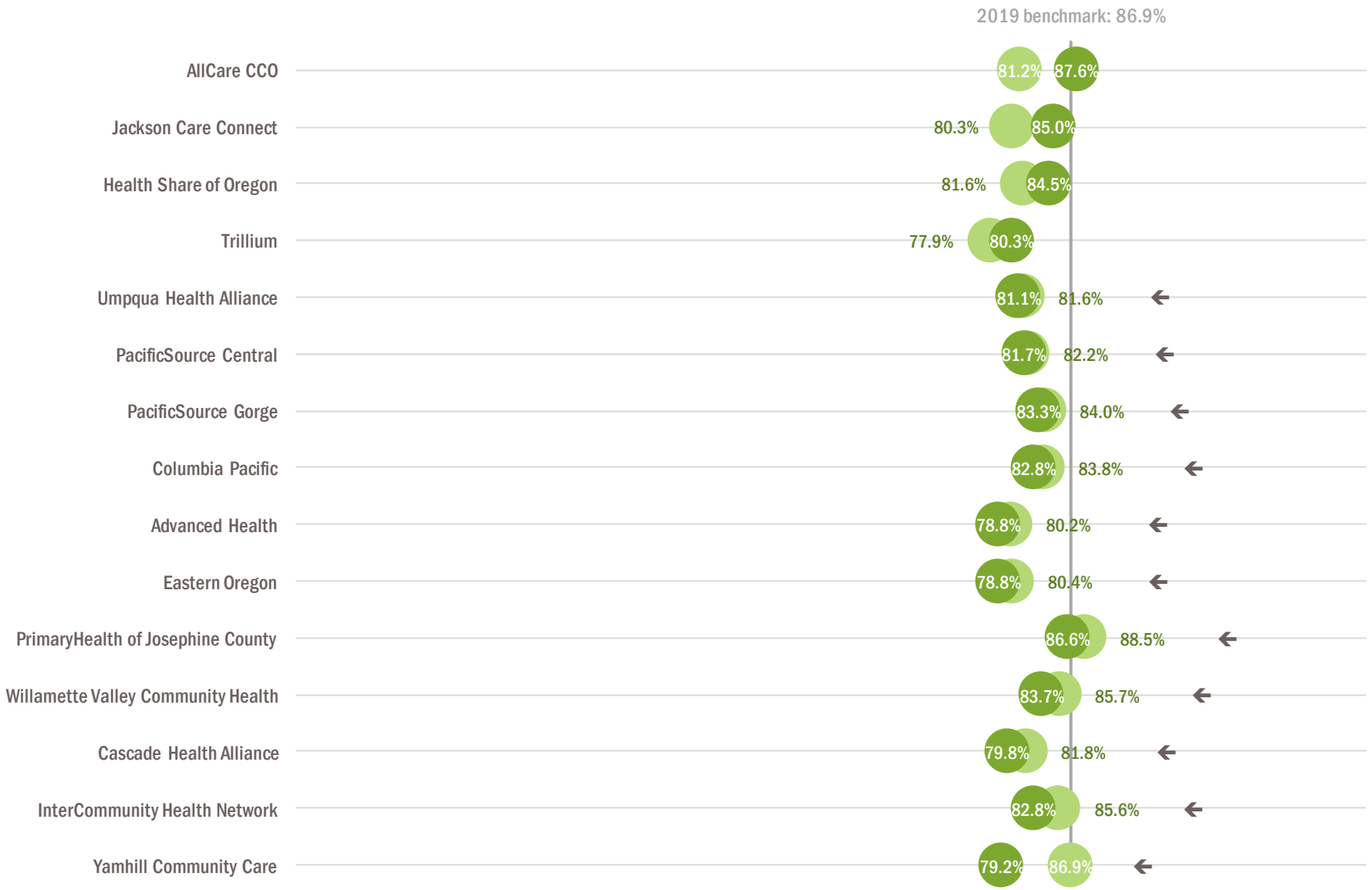
CAHPS: GETTING NEEDED CARE—ADULTS

CAHPS: Adults getting needed care in 2018 and 2019, 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.

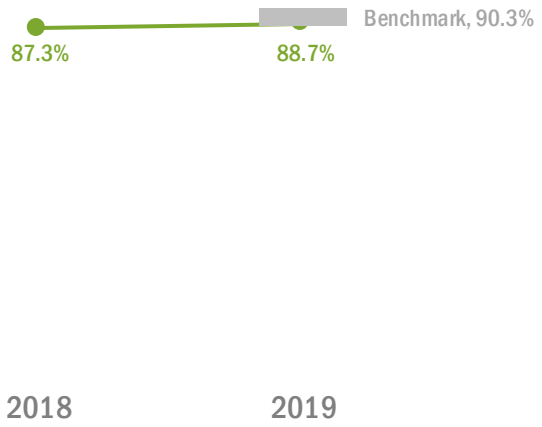
2019 benchmark source:

2018 national Medicaid 90th percentile

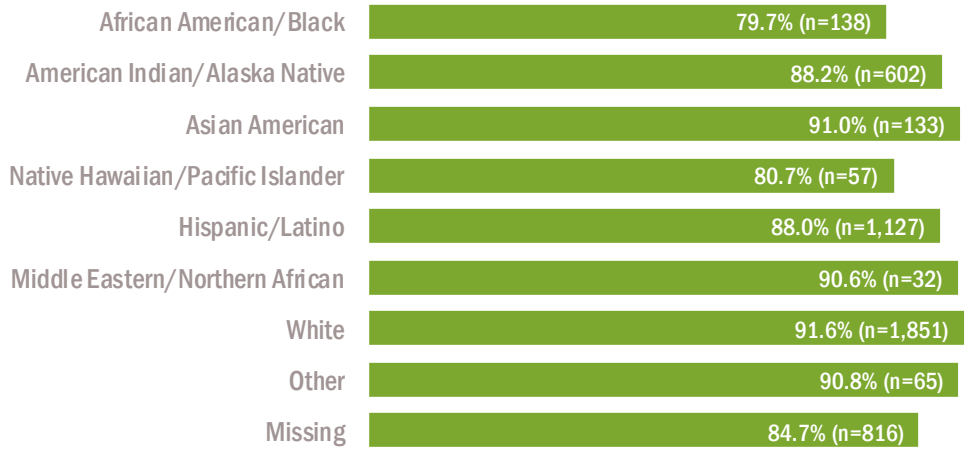
2019 data (n=4,821)

- Statewide change since 2018: **1.6%**
- Number of CCOs that improved: **10**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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CAHPS: GETTING NEEDED CARE—CHILDREN

CAHPS: Children getting needed care in 2018 and 2019, 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.

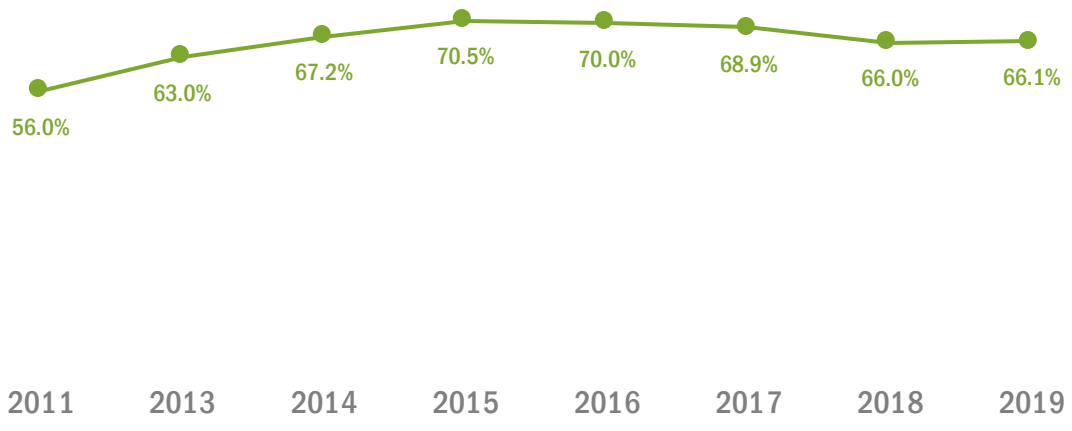
2019 benchmark source:

N/A

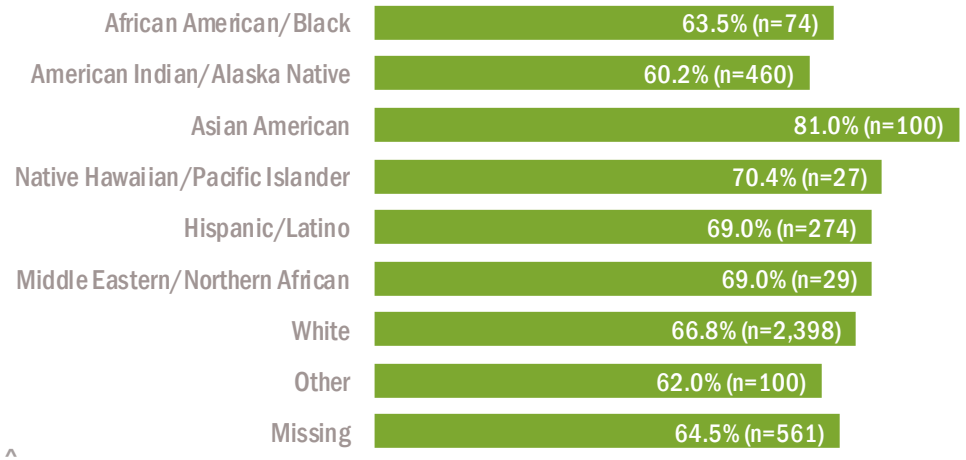
2019 data (n=4,023)

- Statewide change since 2018: **+0.2%**
- Number of CCOs that improved: **6**

Statewide



By race/ethnicity



^

n = subpopulation denominator

Each race category excludes Hispanic/Latino

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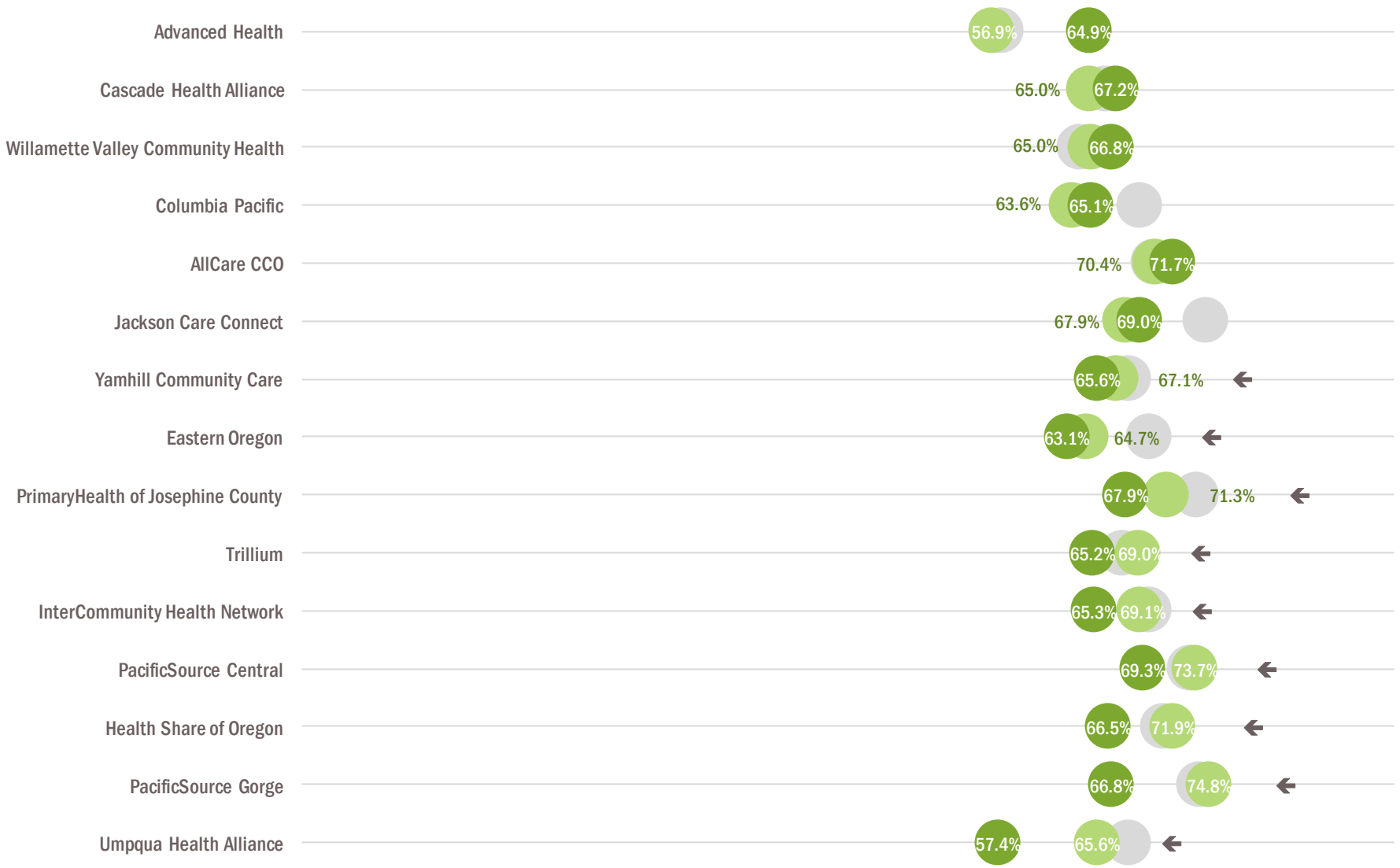
CAHPS: HEALTH STATUS—ADULTS

CAHPS: Health status among adults in 2018 and 2019, by CCO.

Grey dots represent 2017.



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.

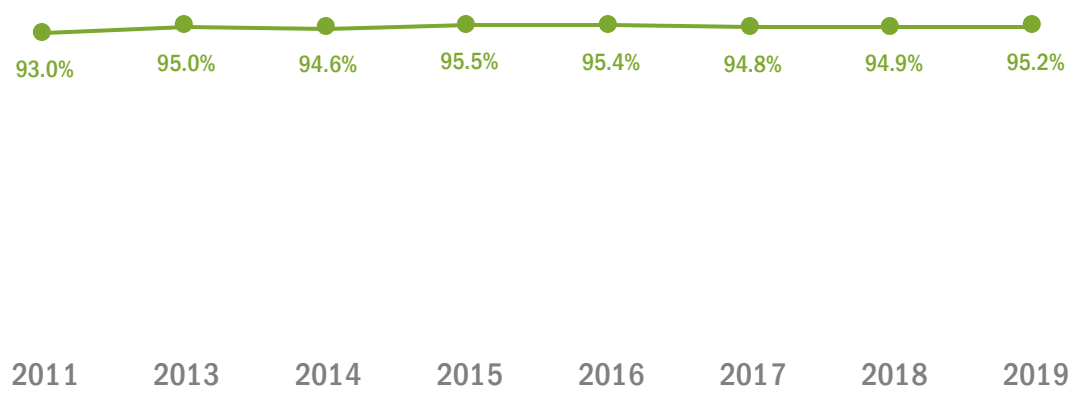
2019 benchmark source:

N/A

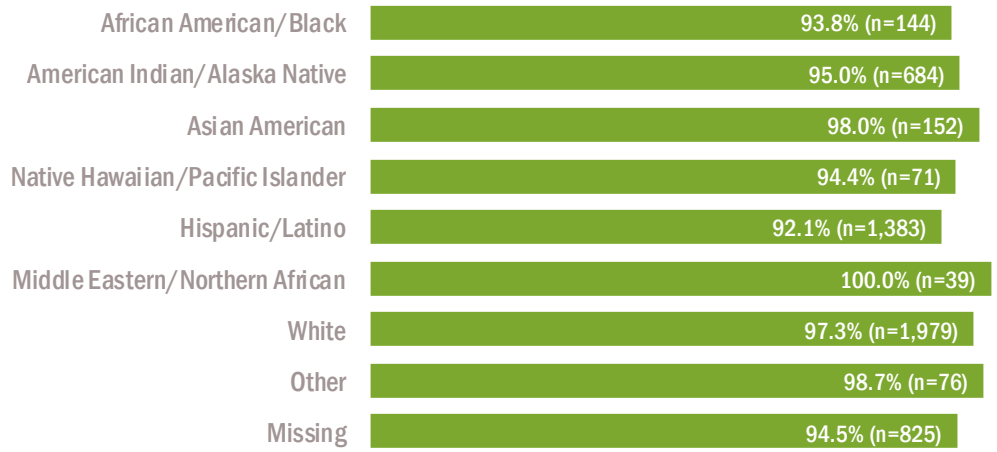
2019 data (n=5,353)

- Statewide change since 2018: **+0.3%**
- Number of CCOs that improved: **8**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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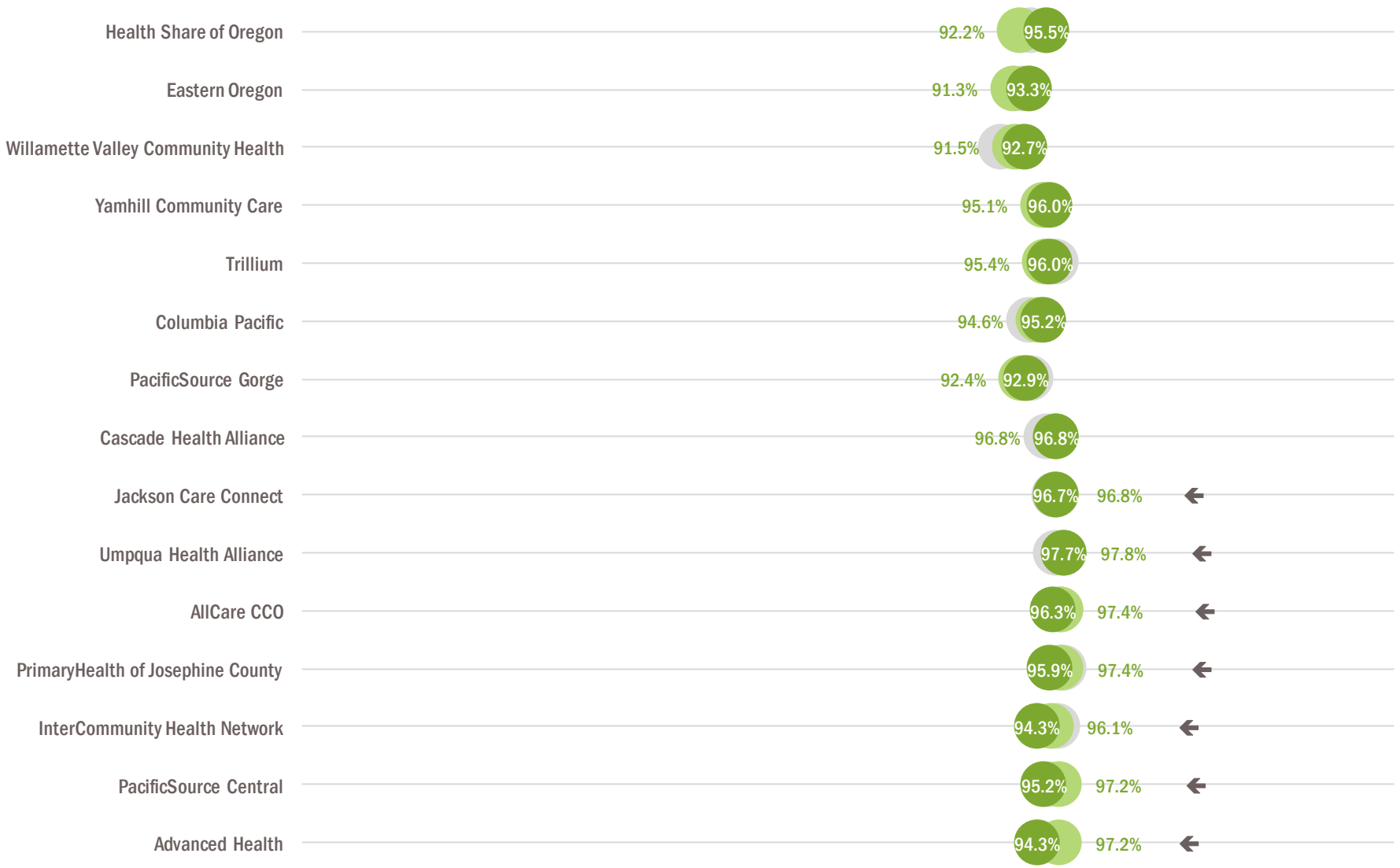
CAHPS: HEALTH STATUS—CHILDREN

CAHPS: Health status among children in 2018 and 2019, by CCO.

Grey dots represent 2017.



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.

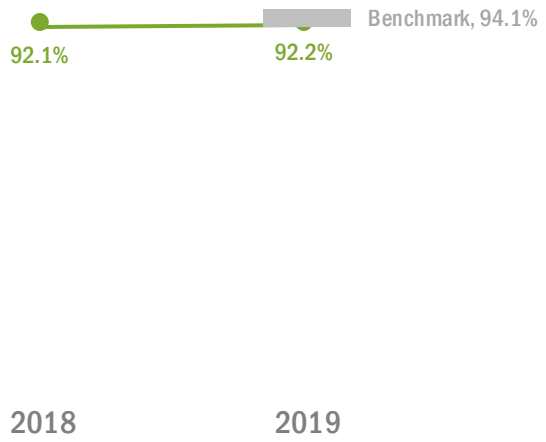
2019 benchmark source:

2018 national Medicaid 90th percentile

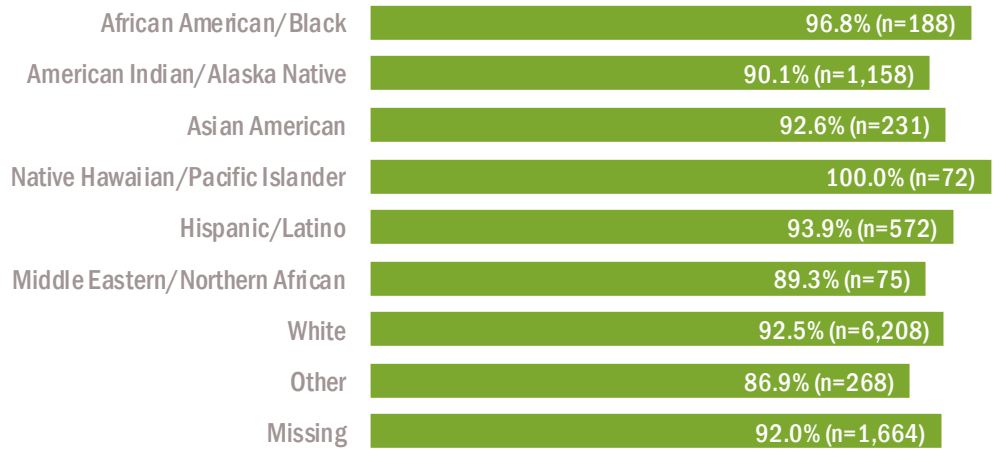
2019 data (n=10,436)

- Statewide change since 2018: **+0.1%**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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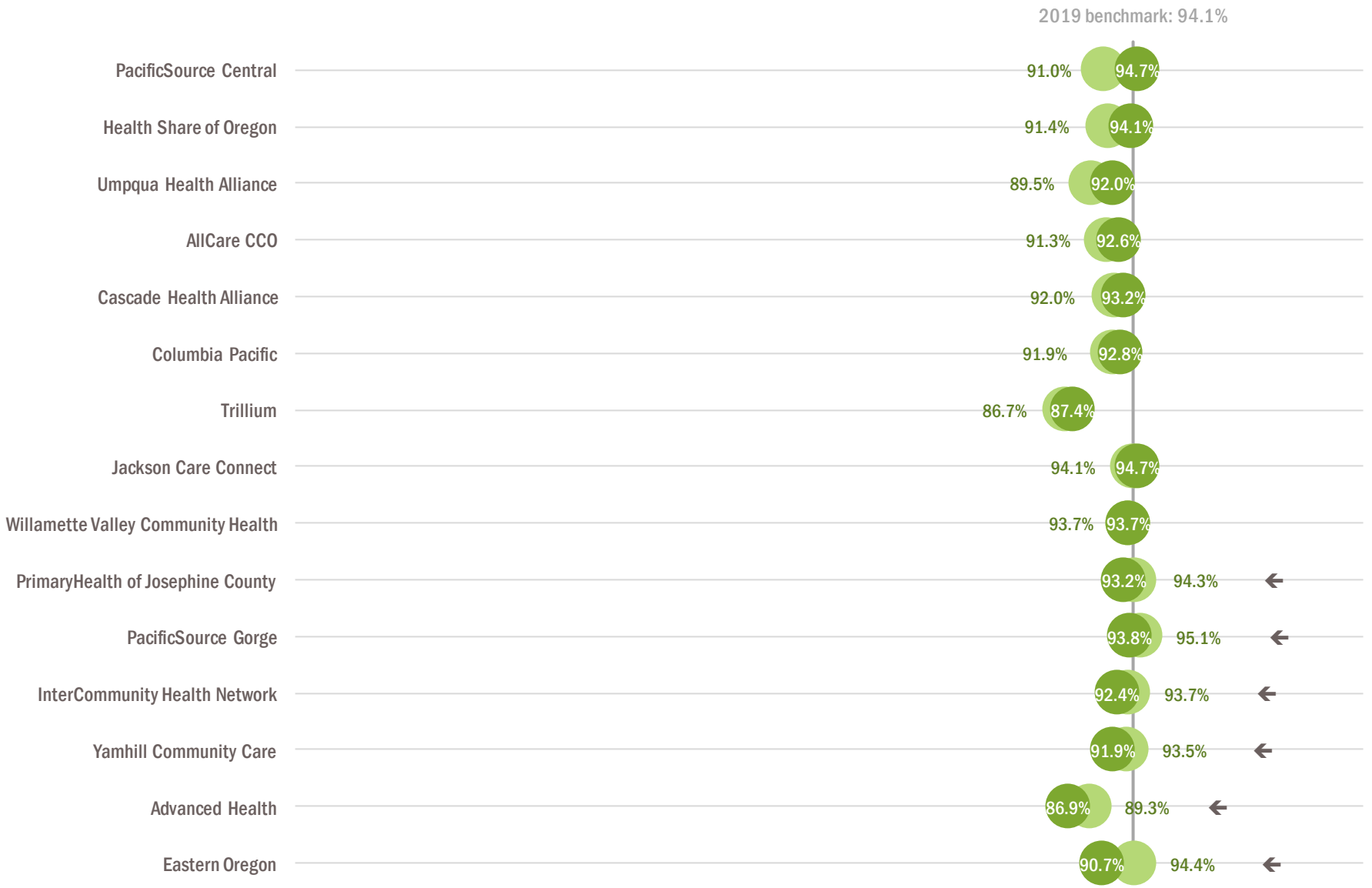
CAHPS: HOW WELL DOCTORS COMMUNICATE—ADULTS

CAHPS: How well doctors communicate among adults in 2018 and 2019, by CCO.



CAHPS: HOW WELL DOCTORS COMMUNICATE—CHILDREN

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.

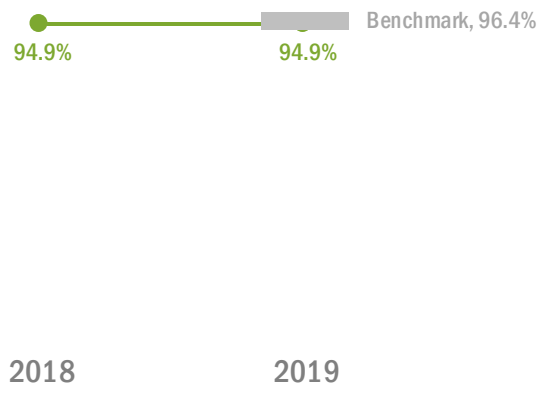
2019 benchmark source:

2018 national Medicaid 90th percentile

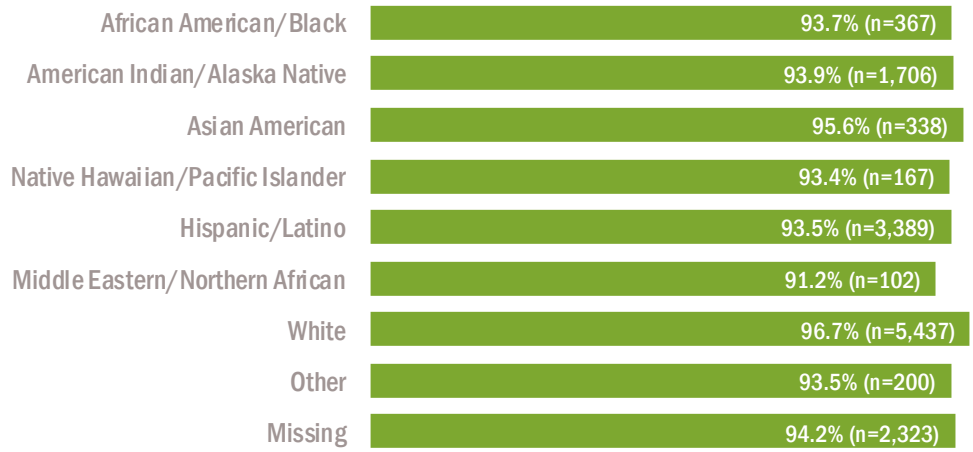
2019 data (n=14,029)

- Statewide change since 2018: **No change**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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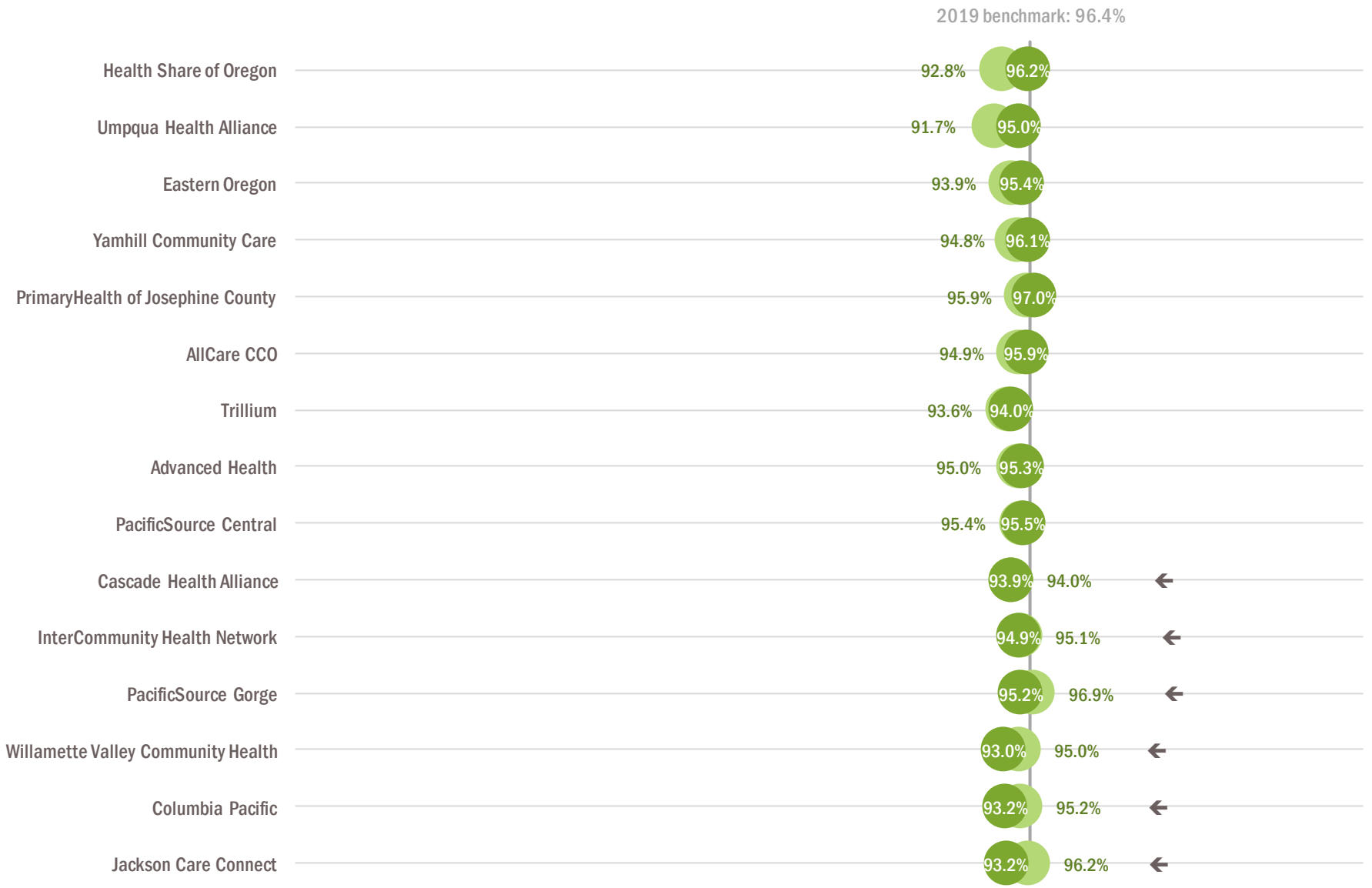
CAHPS: HOW WELL DOCTORS COMMUNICATE—CHILDREN

CAHPS: How well doctors communicate among children in 2018 and 2019, by CCO.



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

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.

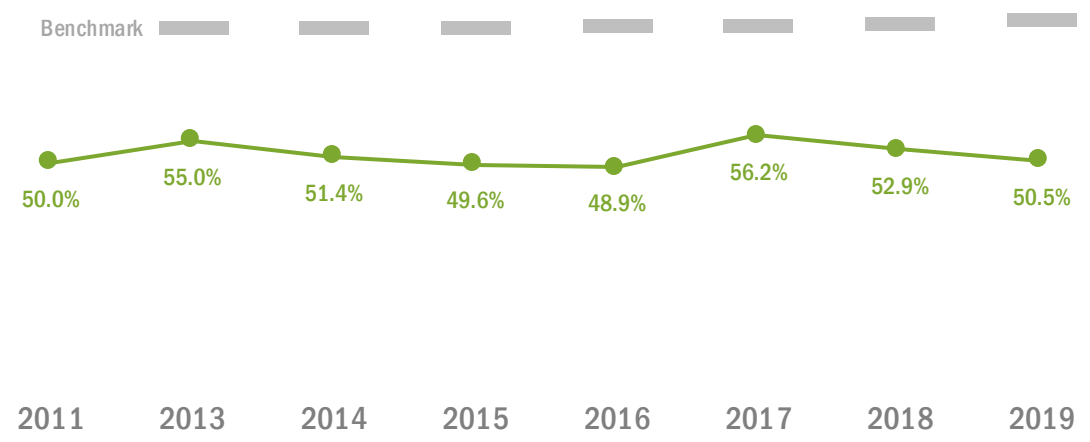
2019 benchmark source:

2018 national Medicaid 90th percentile

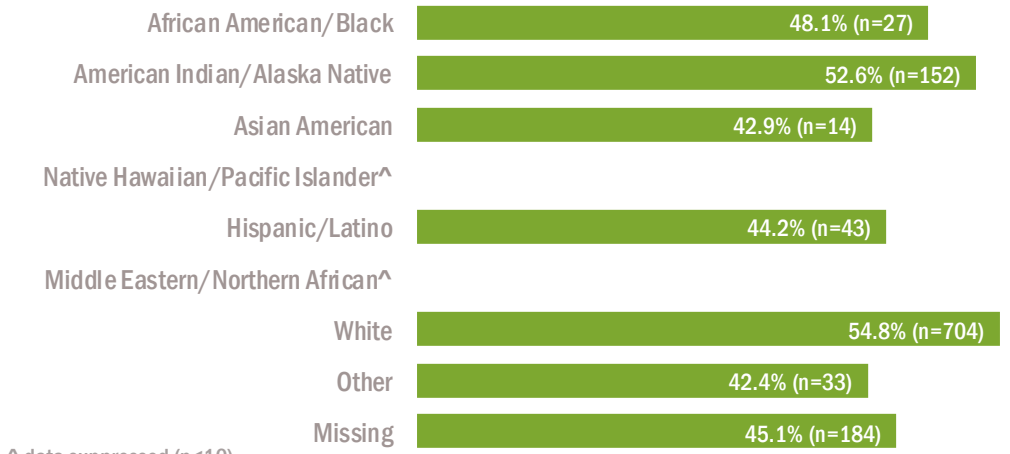
2019 data (n=4,054)

- Statewide change since 2018: **-4.5%**
- Number of CCOs that improved: **6**

Statewide



By race/ethnicity



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

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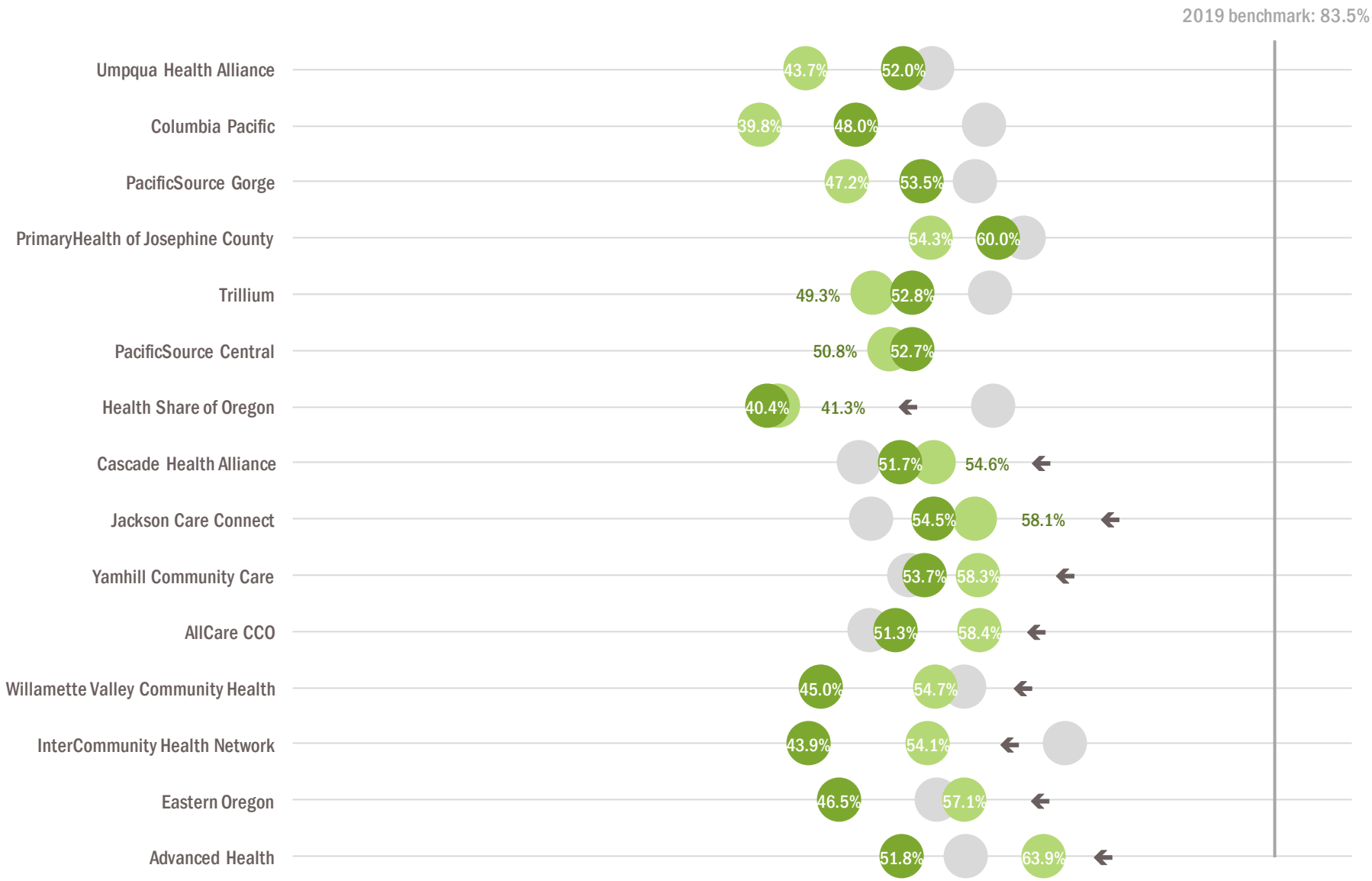
CAHPS: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED TO QUIT

Med cessation: Advised to quit in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

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.

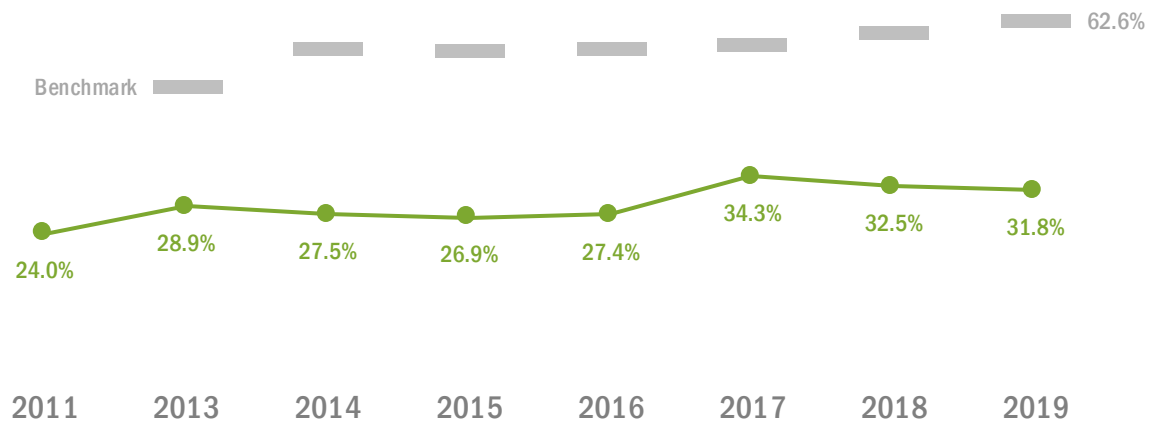
2019 benchmark source:

2018 national Medicaid 90th percentile

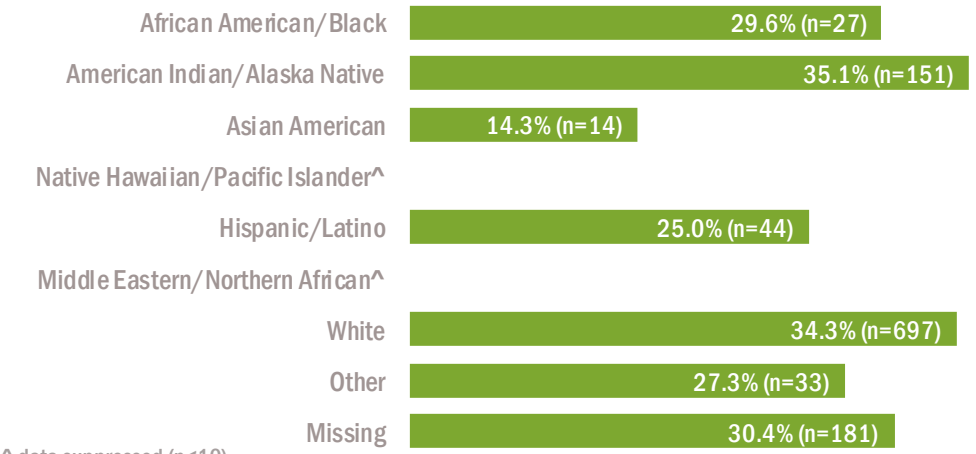
2019 data (n=1,209)

- Statewide change since 2018: **-2.2%**
- Number of CCOs that improved: **7**

Statewide



By race/ethnicity



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

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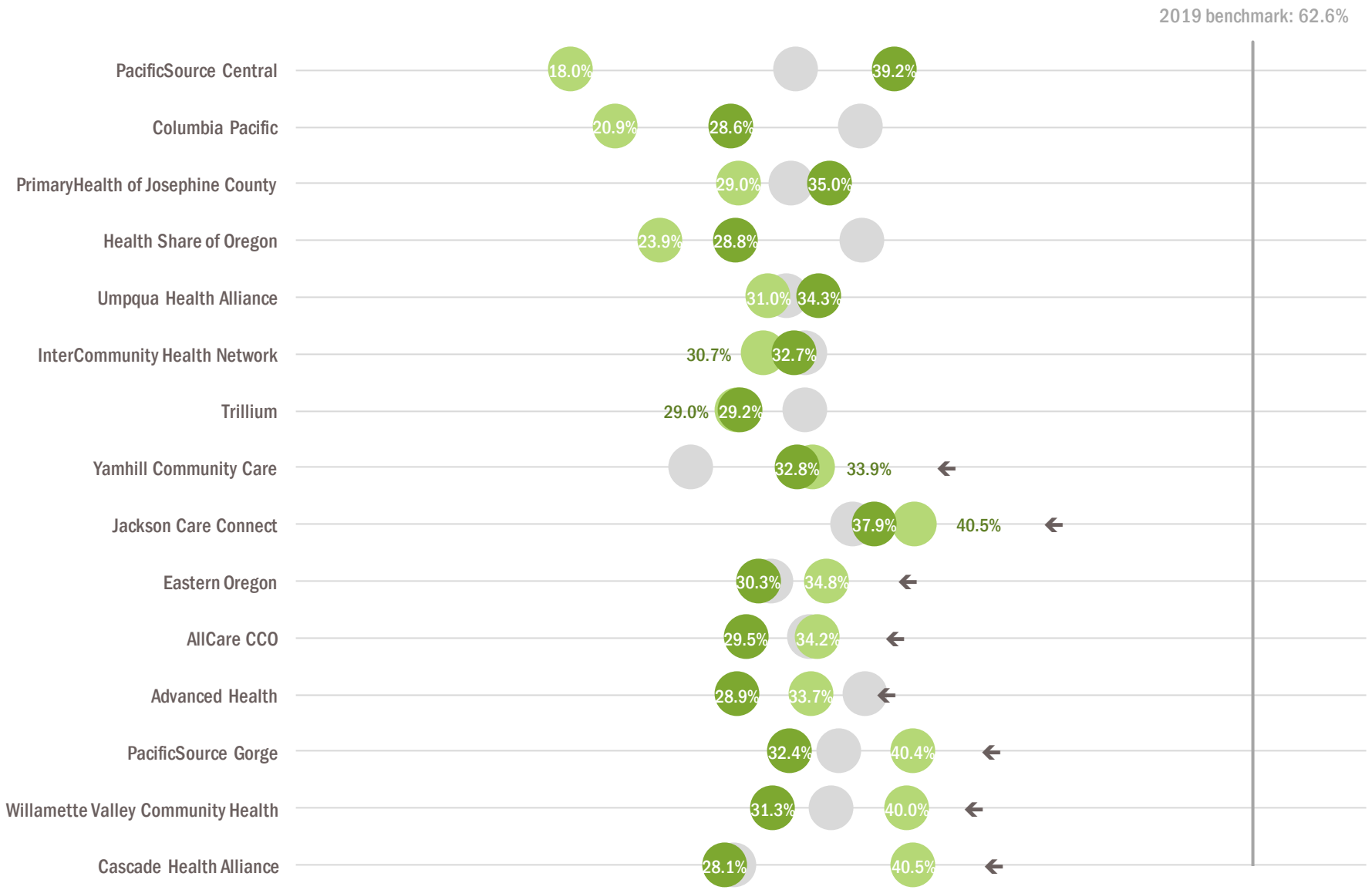
CAHPS: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED MEDICATION

Med assistance: Advised medication in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

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.

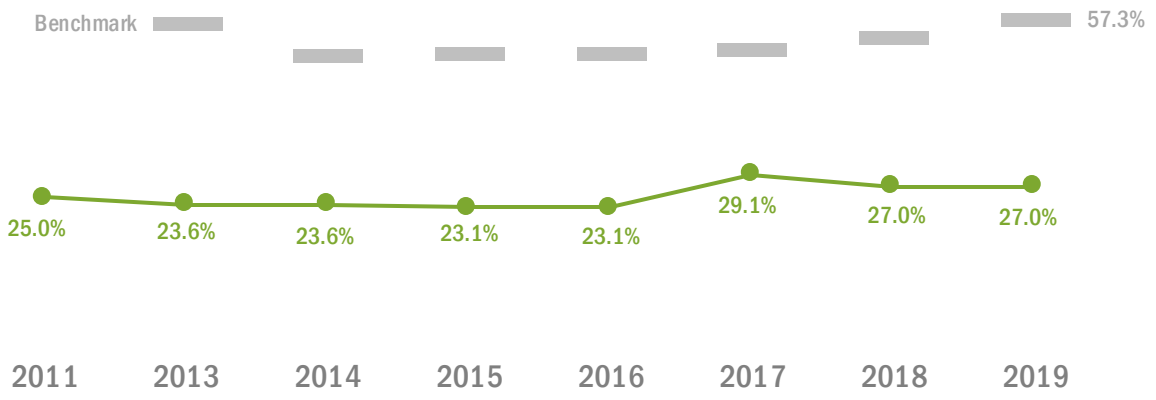
2019 benchmark source:

2018 national Medicaid 90th percentile

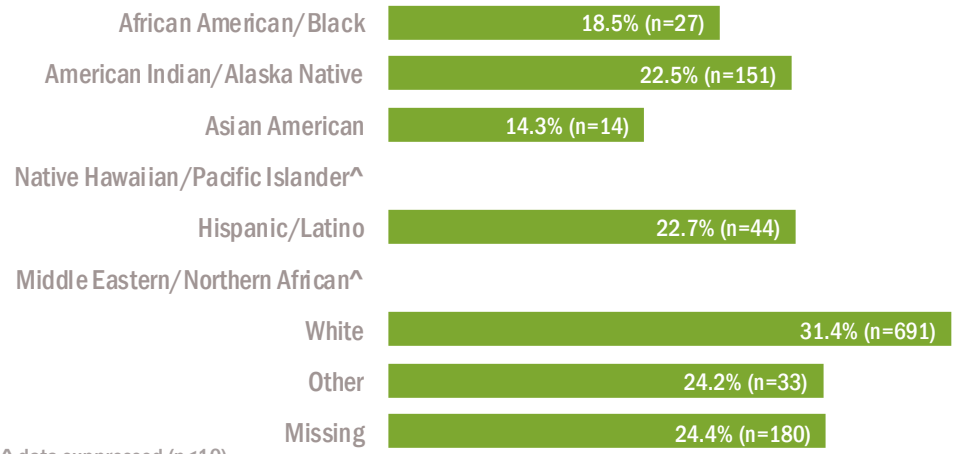
2019 data (n=1,261)

- Statewide change since 2018: **No change**
- Number of CCOs that improved: **8**

Statewide



By race/ethnicity



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

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

Med assistance: Advised strategies in 2018 and 2019, by CCO.

Grey dots represent 2017.

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.

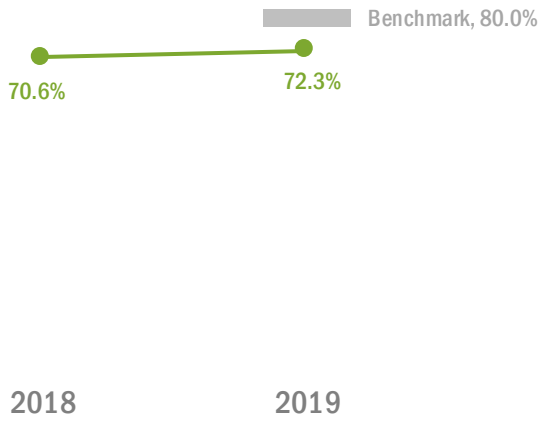
2019 benchmark source:

2018 national Medicaid 90th percentile

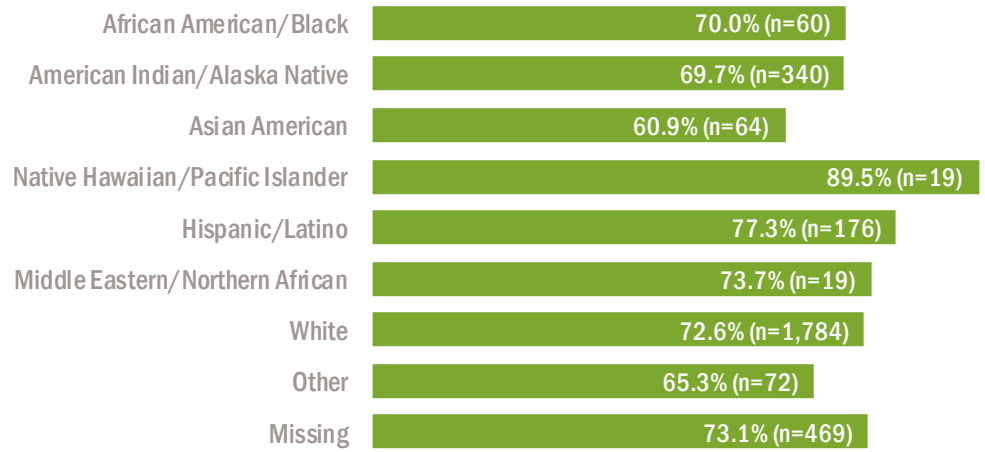
2019 data (n=3,003)

- Statewide change since 2018: **+2.4%**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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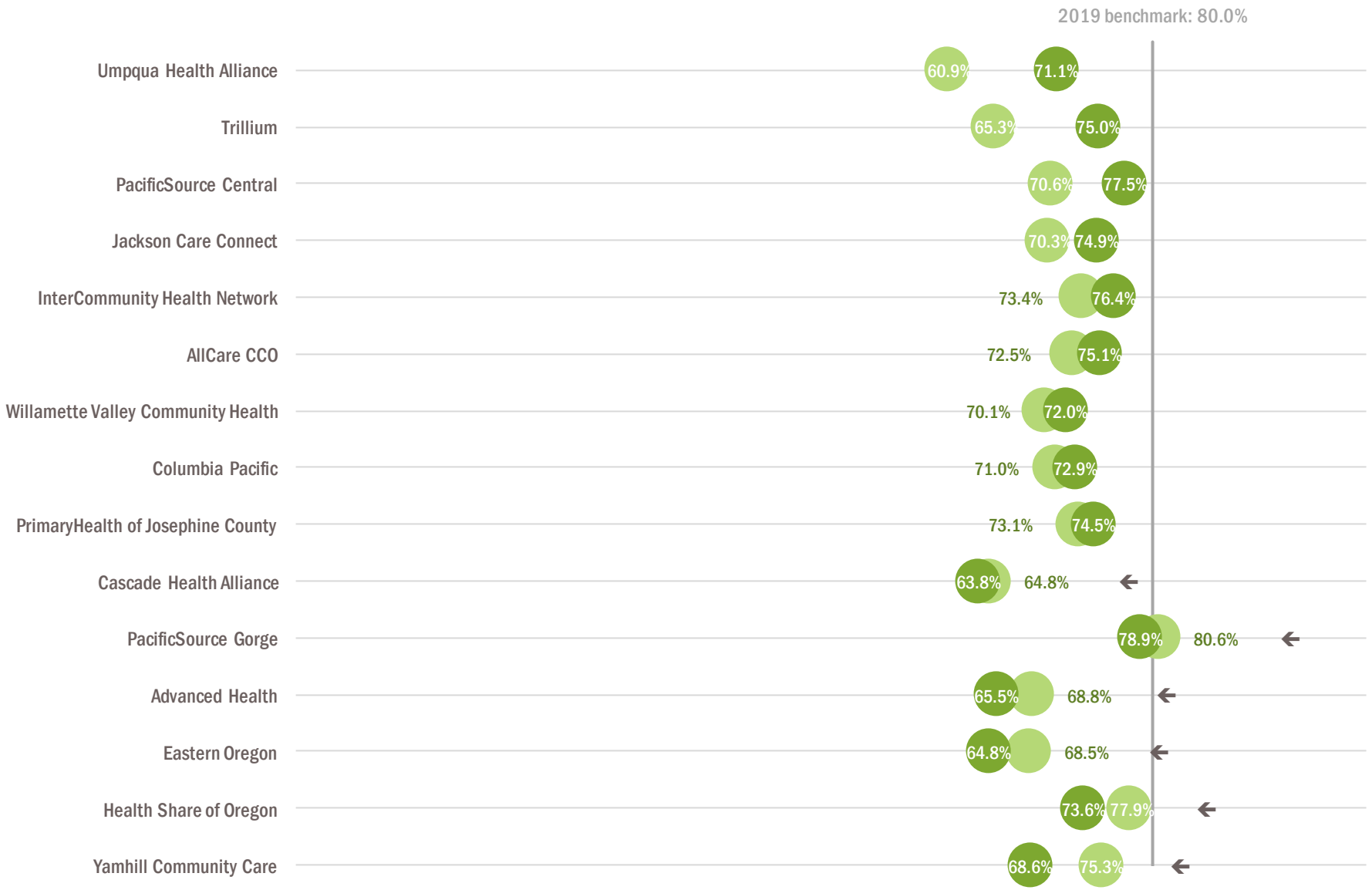
CAHPS: OVERALL RATINGS—ADULTS

CAHPS: Overall ratings among adults in 2018 and 2019, 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.

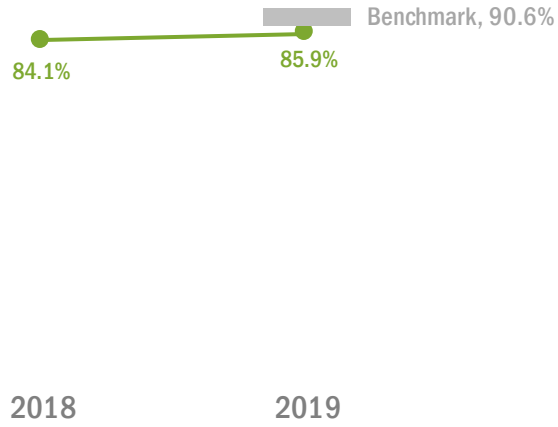
2019 benchmark source:

2018 national Medicaid 90th percentile

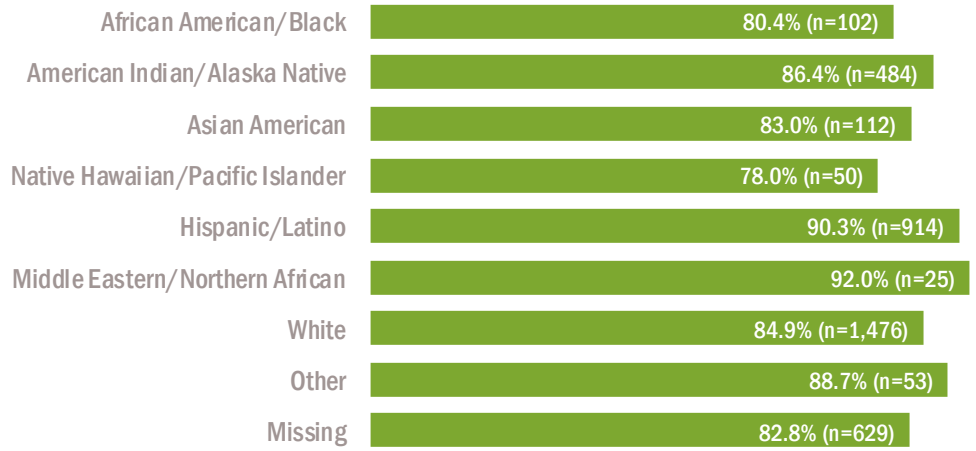
2019 data (n=3,845)

- Statewide change since 2018: **+2.1%**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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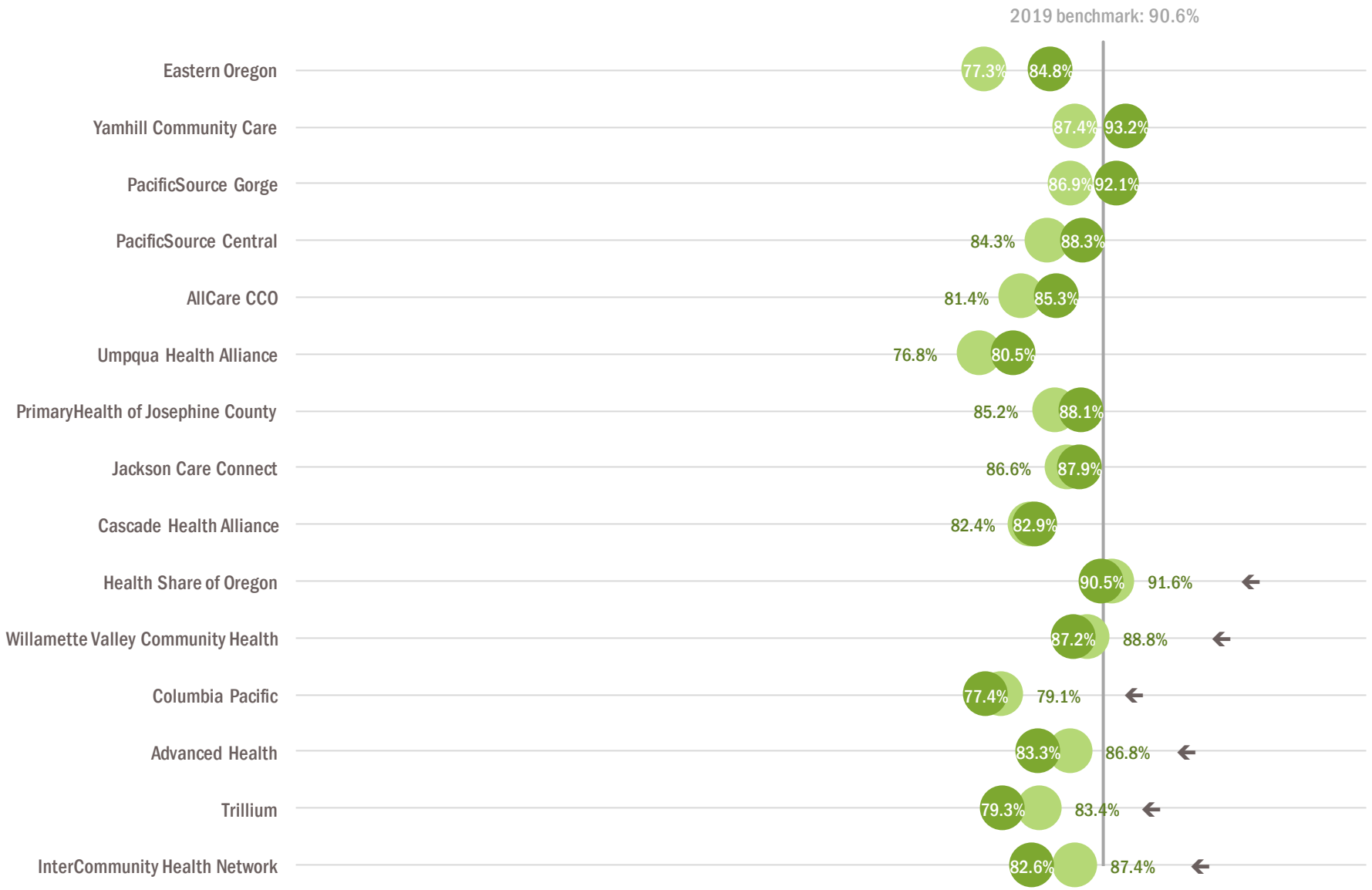
CAHPS: OVERALL RATINGS—CHILDREN

CAHPS: Overall ratings among children in 2018 and 2019, 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.

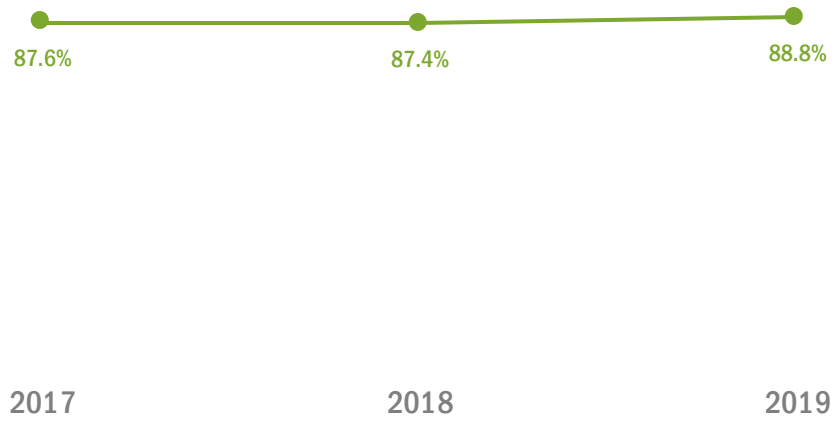
2019 benchmark source:

N/A

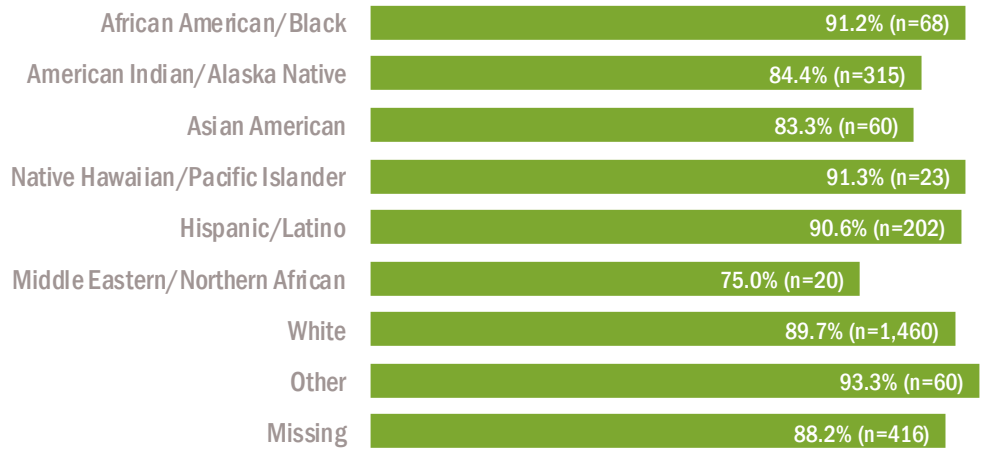
2019 data (n=2,624)

- Statewide change since 2018: **+1.6%**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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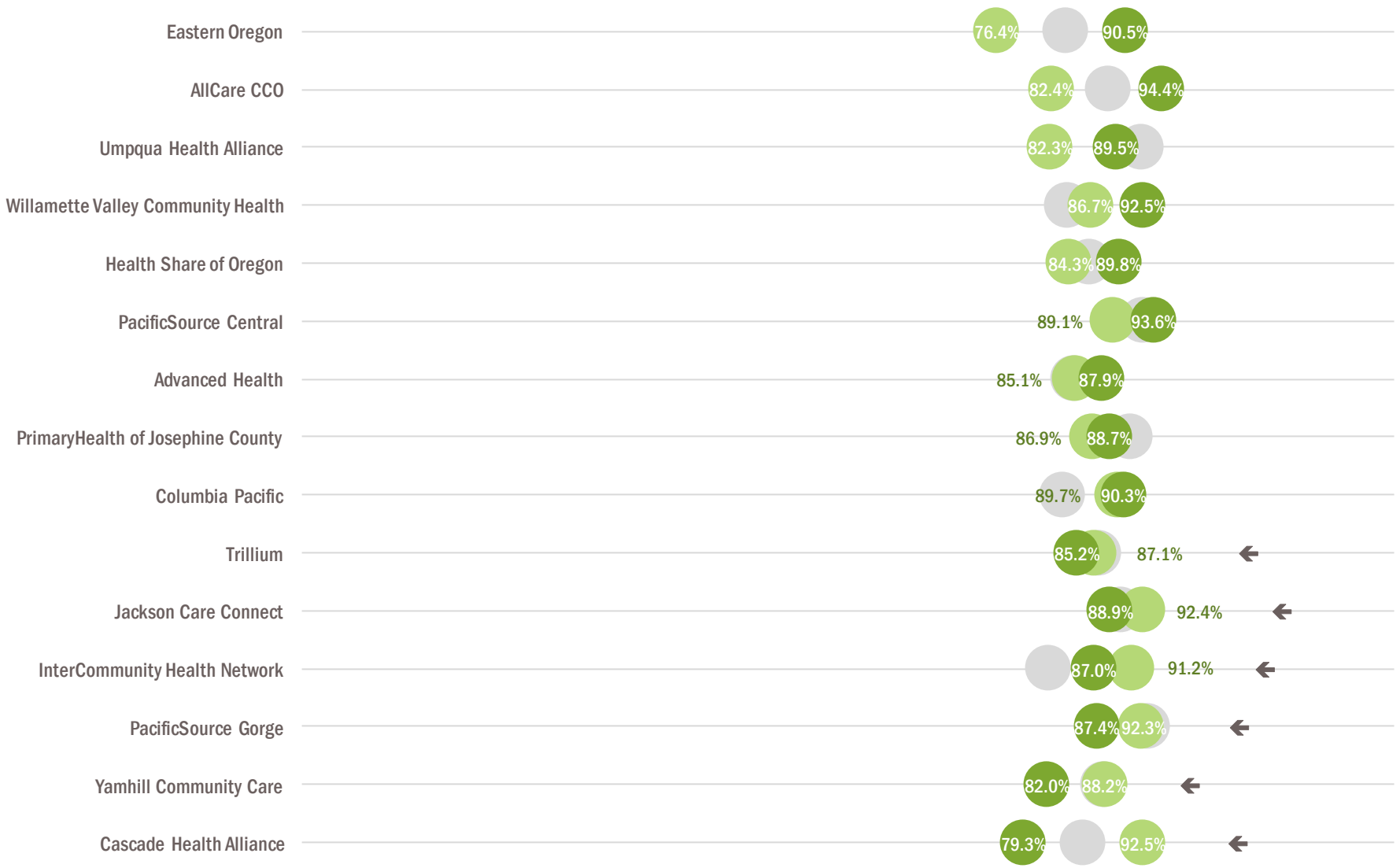
CAHPS: SATISFACTION WITH CARE—ADULTS

CAHPS: Satisfaction with care among adults in 2018 and 2019, by CCO.

Grey dots represent 2017.



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.

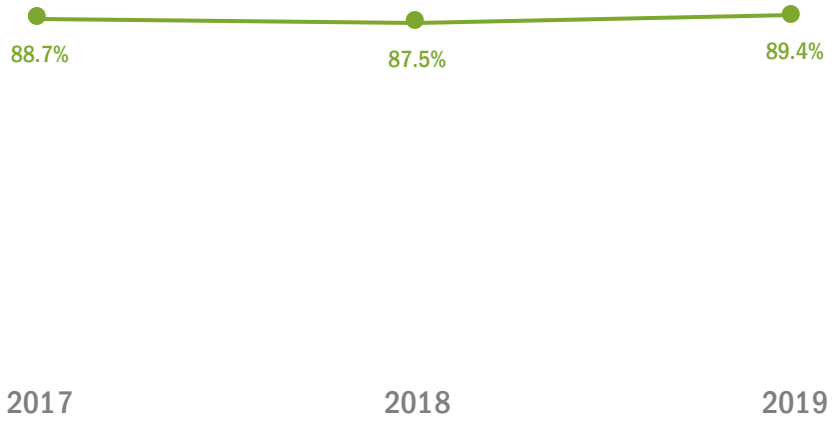
2019 benchmark source:

N/A

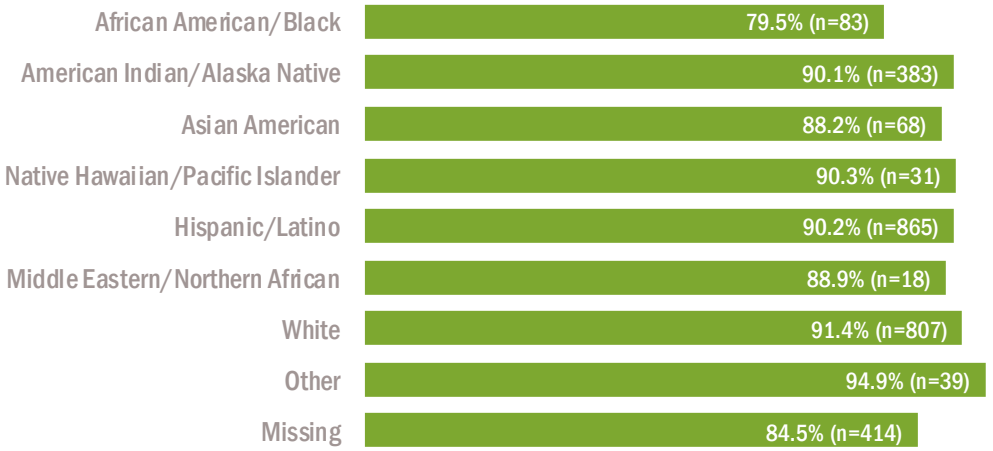
2019 data (n=2,708)

- Statewide change since 2018: **+2.2%**
- Number of CCOs that improved: **9**

Statewide



By race/ethnicity



n = subpopulation denominator
Each race category excludes Hispanic/Latino

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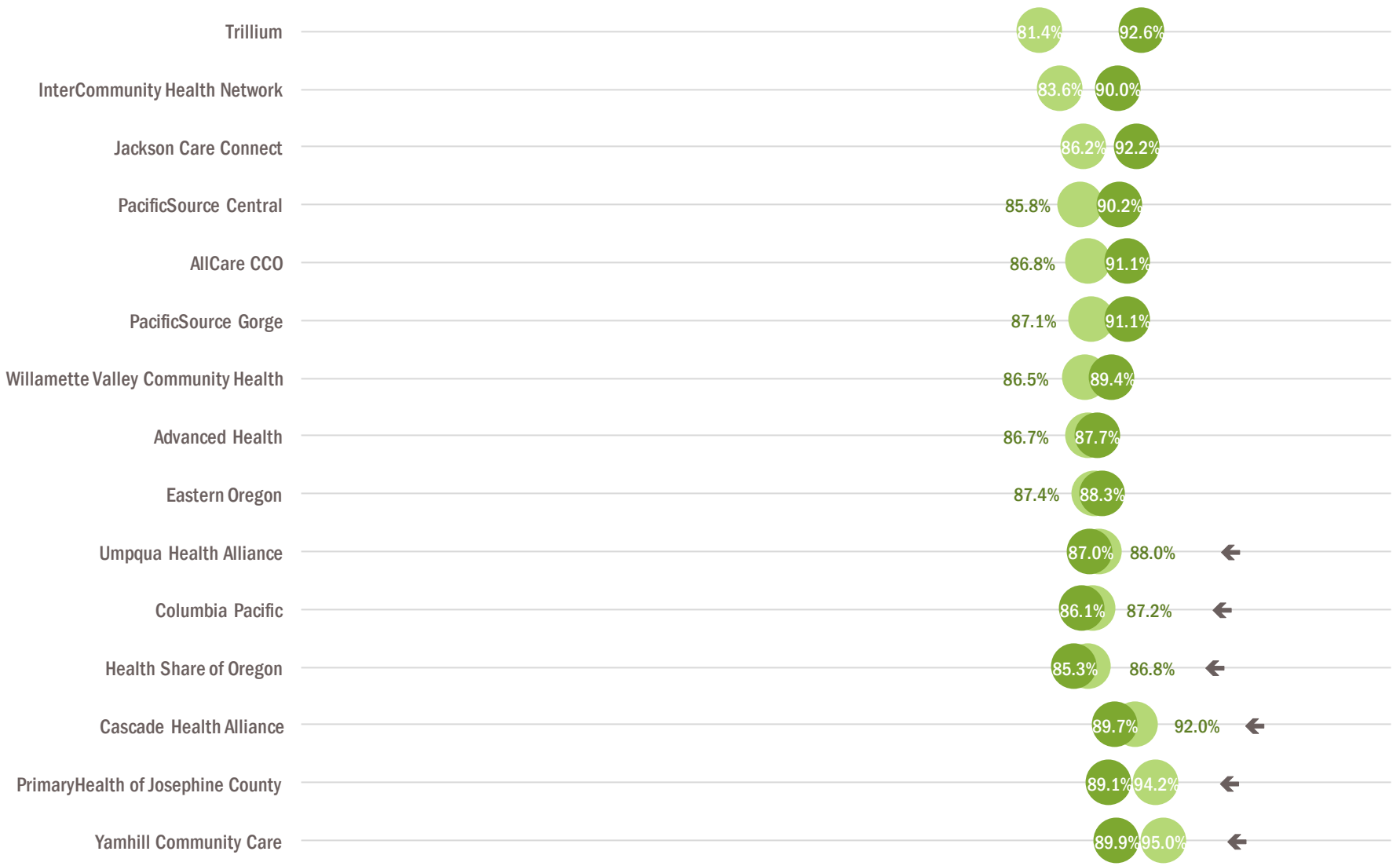
CAHPS: SATISFACTION WITH CARE—CHILDREN

CAHPS: Satisfaction with care among children in 2018 and 2019, by CCO.

Grey dots represent 2017.



CHILDHOOD 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

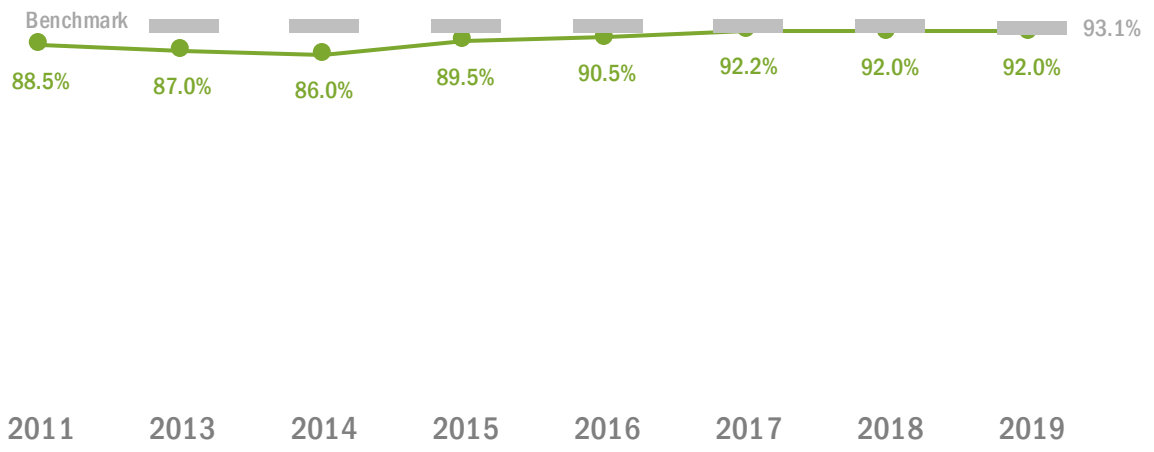
2019 benchmark source:

2018 national Medicaid 75th percentile

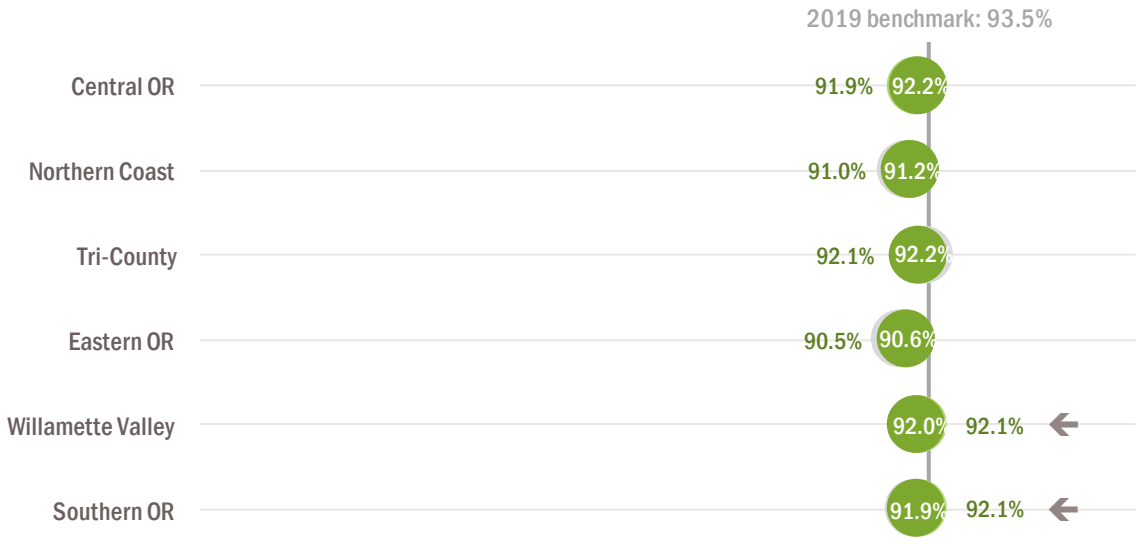
2019 data (n=246,624)

- Statewide change since 2018: **No change**
- Number of CCOs that improved: **6**

Statewide



By region



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CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS

Childhood and adolescent access to primary care providers in 2018 and 2019, by CCO.

Grey dots represent 2017.

CHLAMYDIA SCREENING

Chlamydia screening

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

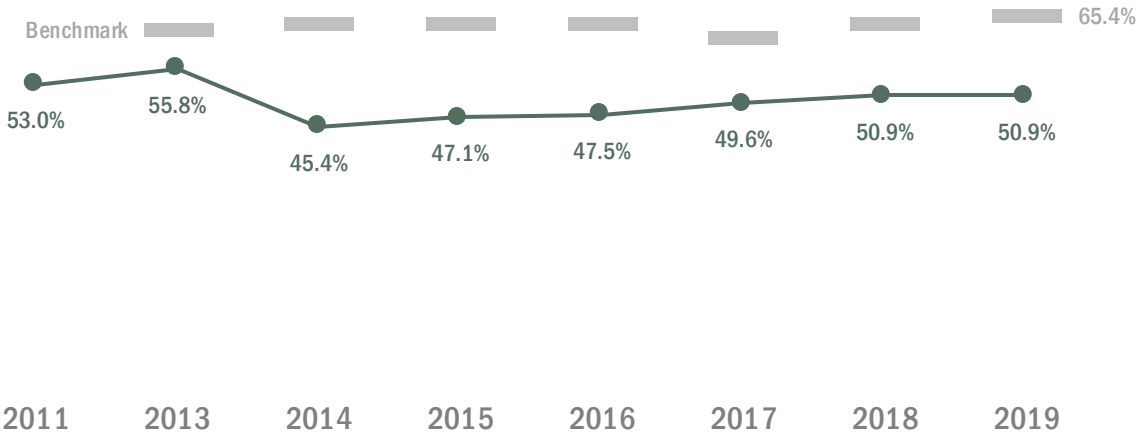
Data source:
Administrative (billing) claims

2019 benchmark source:
2018 national Medicaid 75th percentile

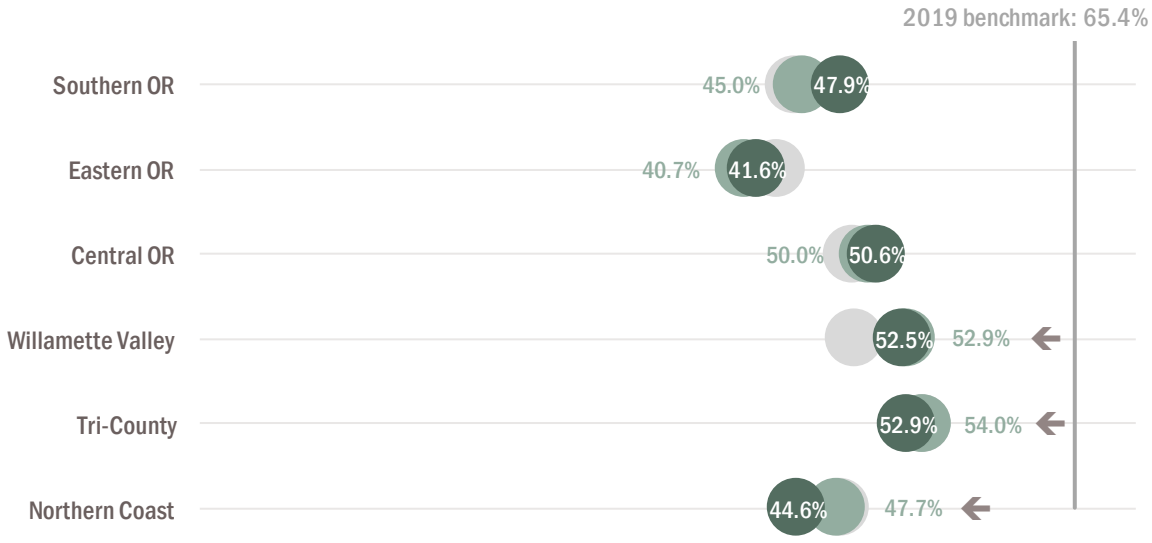
2019 data (n=29,977)

- Statewide change since 2018: **No change**
- Number of CCOs that improved: **8**

Statewide



By region



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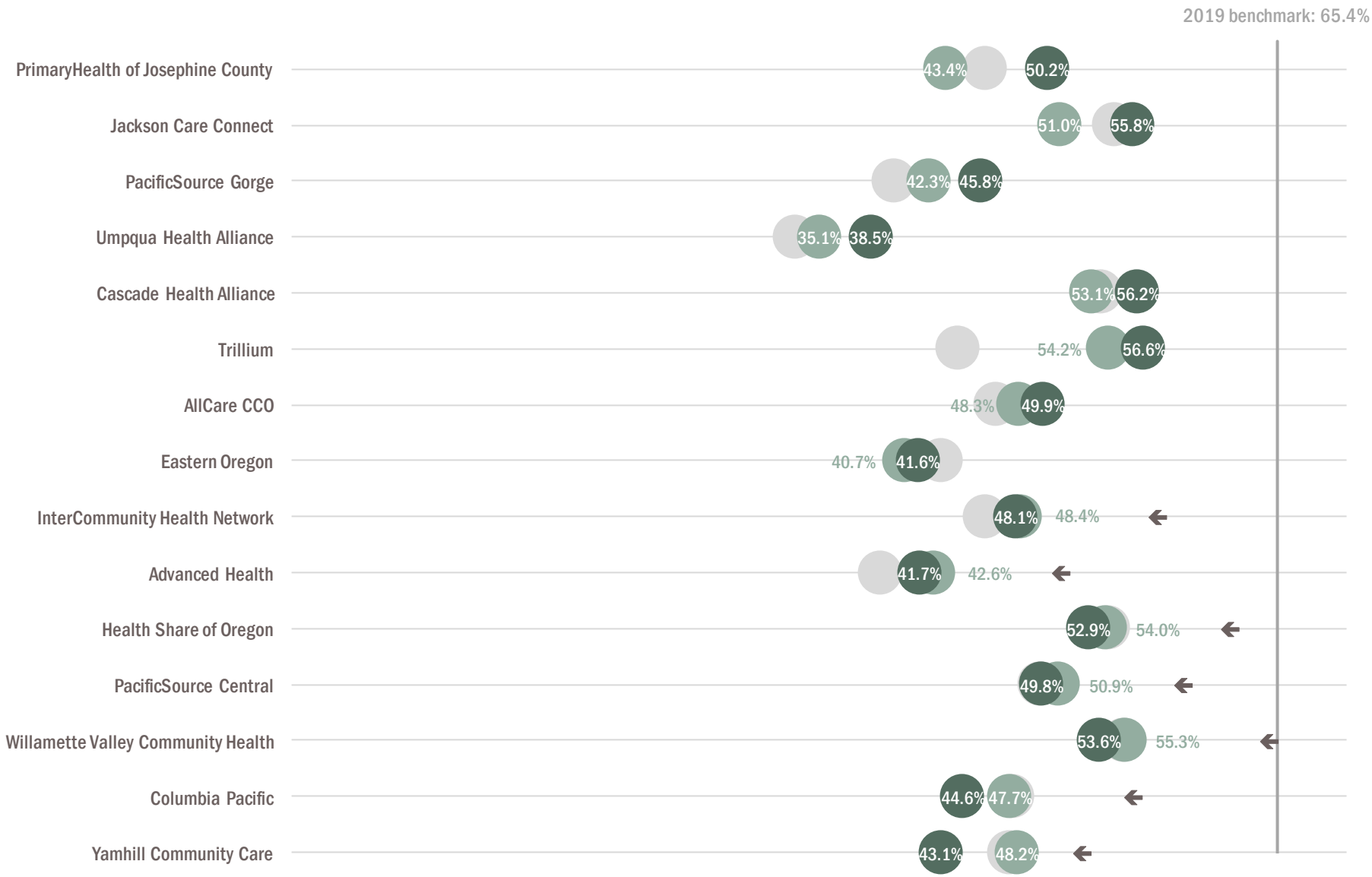
CHLAMYDIA SCREENING

Chlamydia screening in 2018 and 2019, by CCO.

Grey dots represent 2017.



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.

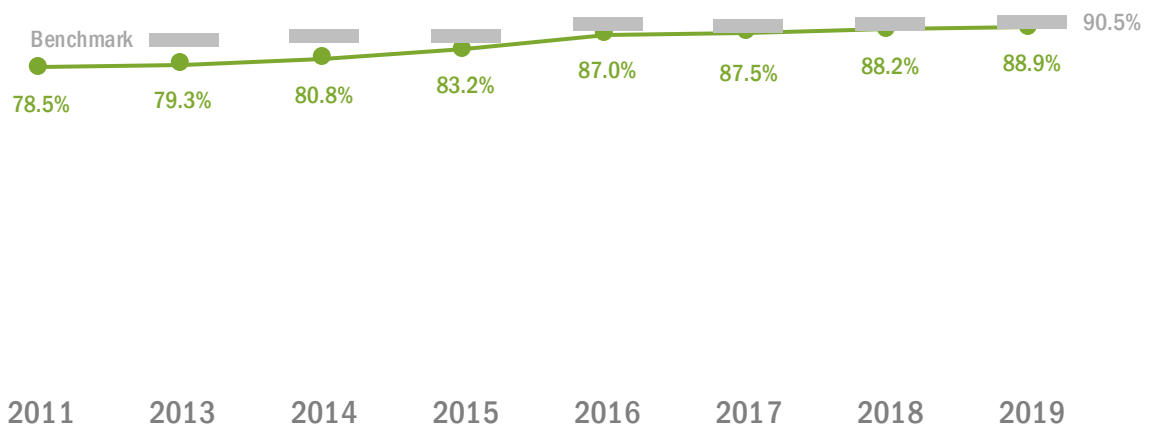
Data source:
Administrative (billing) claims

2019 benchmark source:
2018 national Medicaid 75th percentile

2019 data (n=34,080)

- Statewide change since 2018: **+0.8%**
- Number of CCOs that improved: **8**

Statewide



By region

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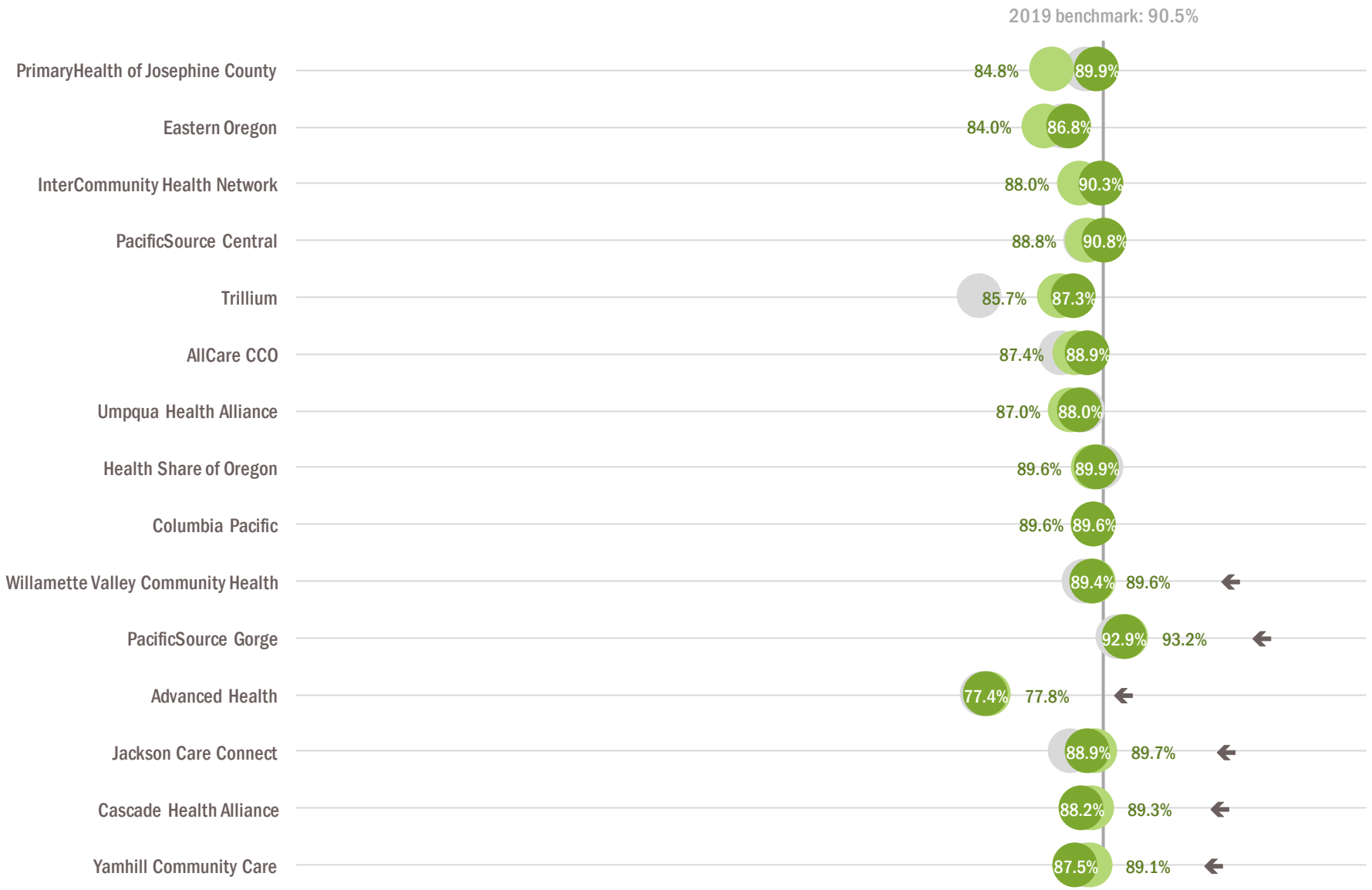
COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

HbA1c testing for members with diabetes in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

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, for which the patient received a follow-up visit within 7 days.

Data source:

Administrative (billing) claims

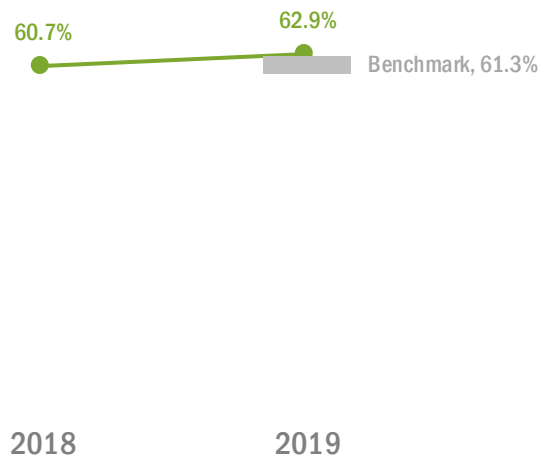
2019 benchmark source:

2018 national Medicaid 90th percentile

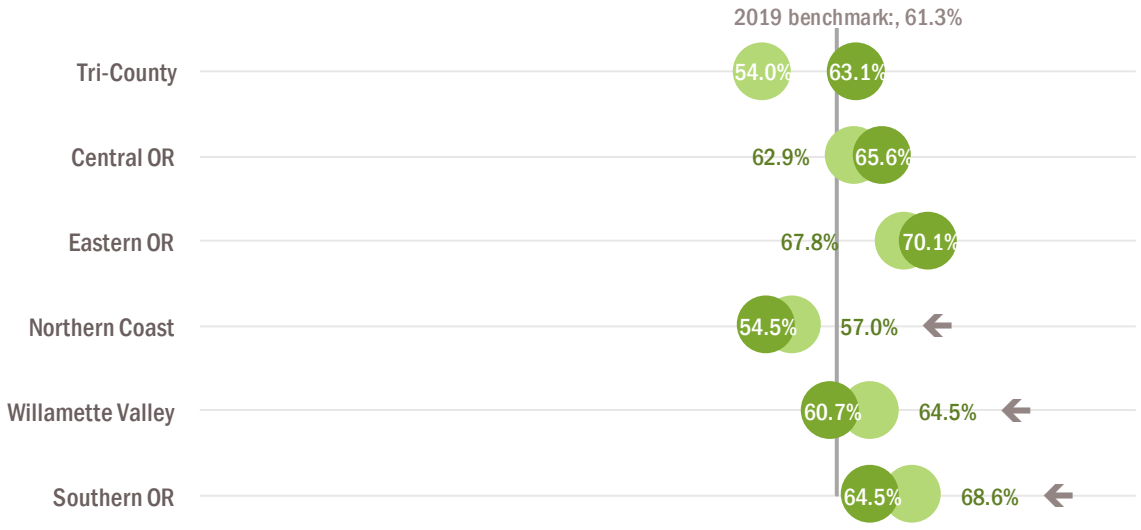
2019 data (n=9,195)

- Statewide change since 2018: **+3.6%**
- Number of CCOs that improved: **7**

Statewide



By region



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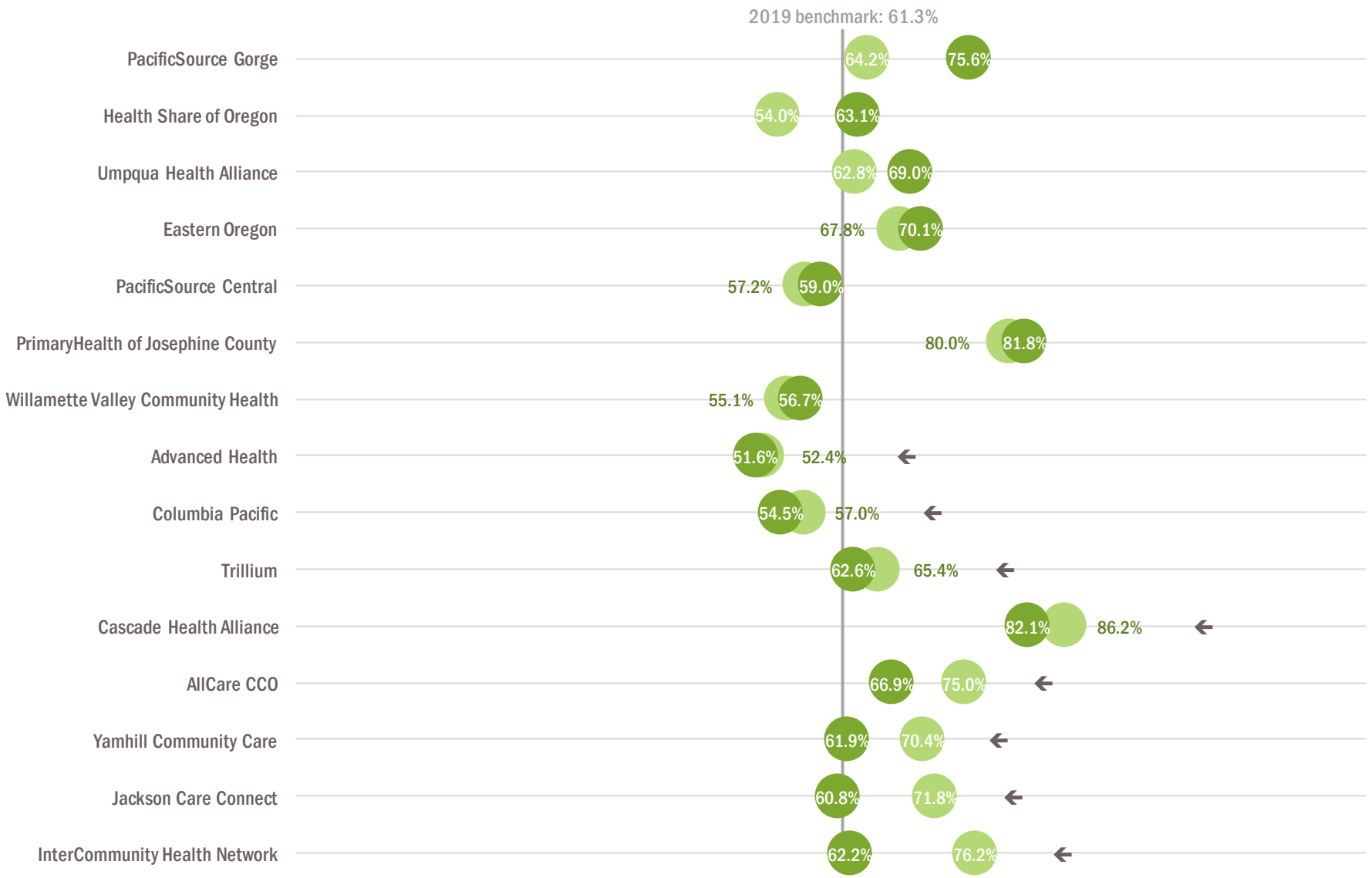
FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (7 DAY)

7 day follow-up after ED for mental illness in 2018 and 2019, by CCO.



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

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, for which the patient received a follow-up visit within 30 days.

Data source:

Administrative (billing) claims

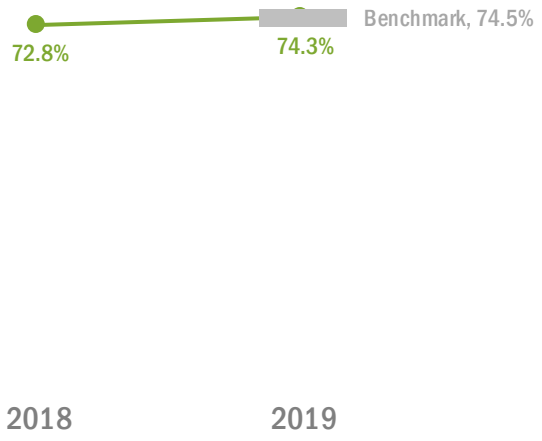
2019 benchmark source:

2018 national Medicaid 90th percentile

2019 data (n=9,195)

- Statewide change since 2018: **+2.1%**
- Number of CCOs that improved: **7**

Statewide



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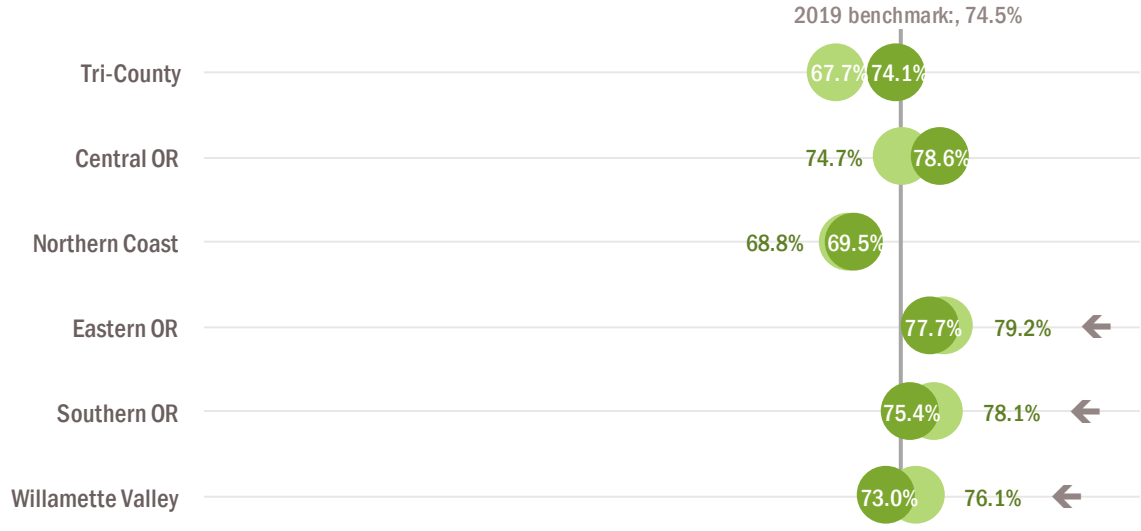

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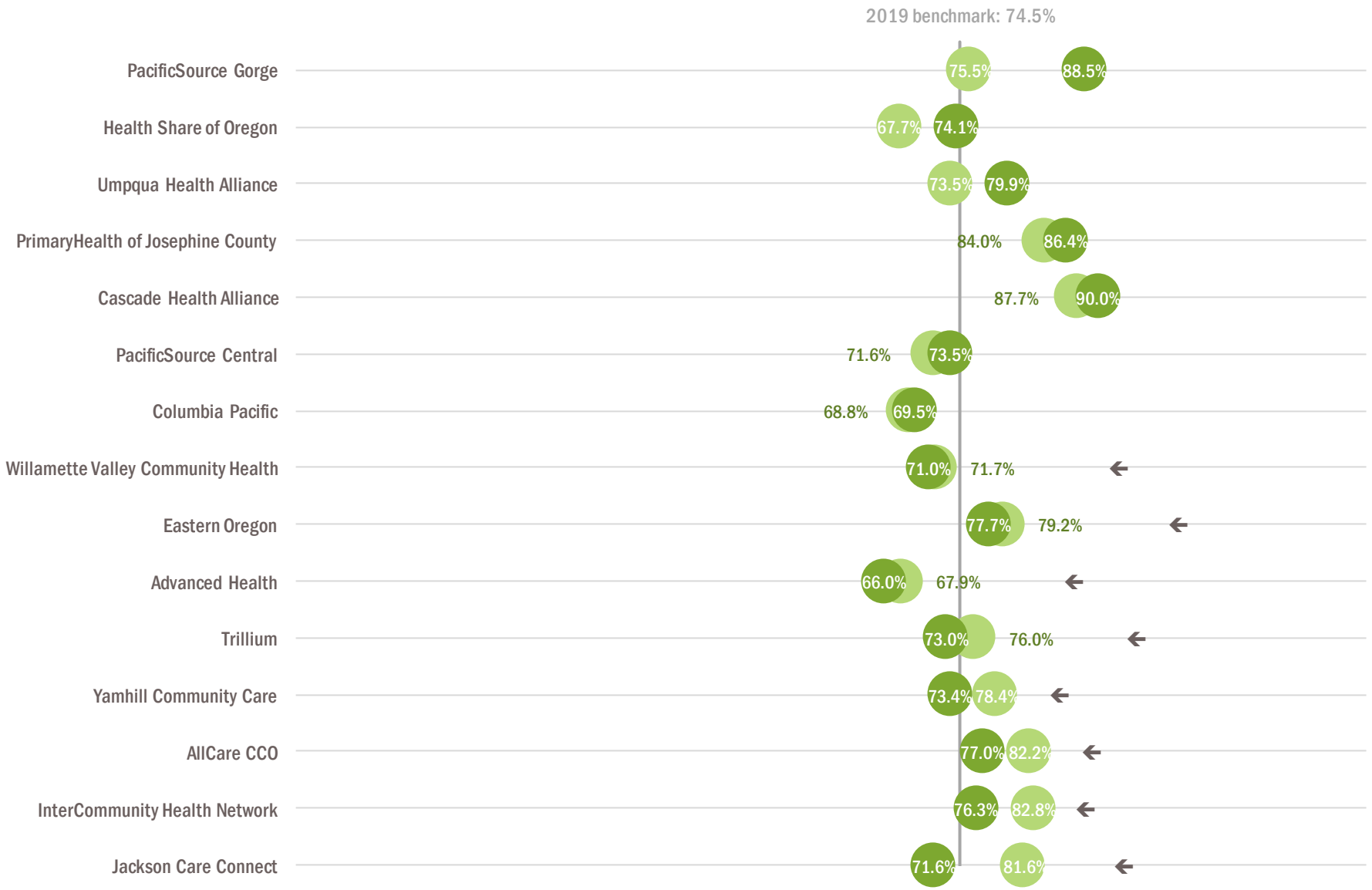
FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS (30 DAY)

30 day follow-up after ED for mental illness in 2018 and 2019, by CCO.



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

7 day follow-up ED dental

Percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within 7 days of the ED visit.

Data source:

Administrative (billing) claims

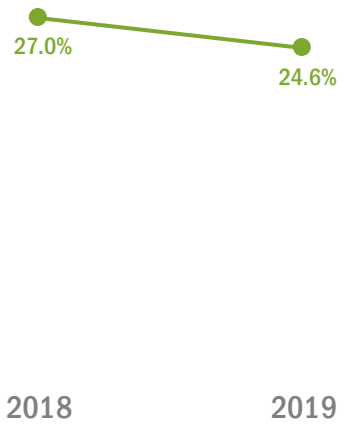
2019 benchmark source:

N/A

2019 data (n=7,886)

- Statewide change since 2018: **-8.9%**
- Number of CCOs that improved: **5**

Statewide



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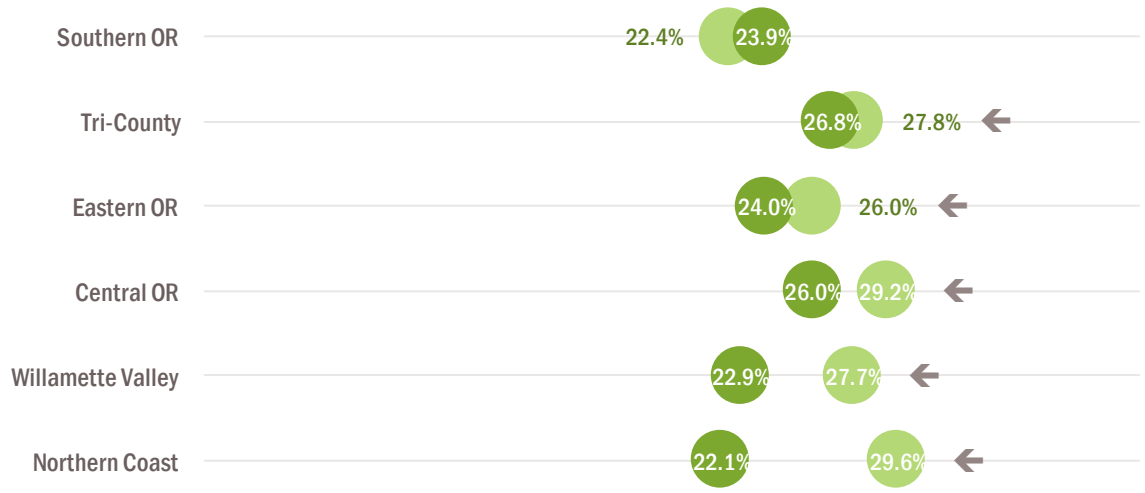

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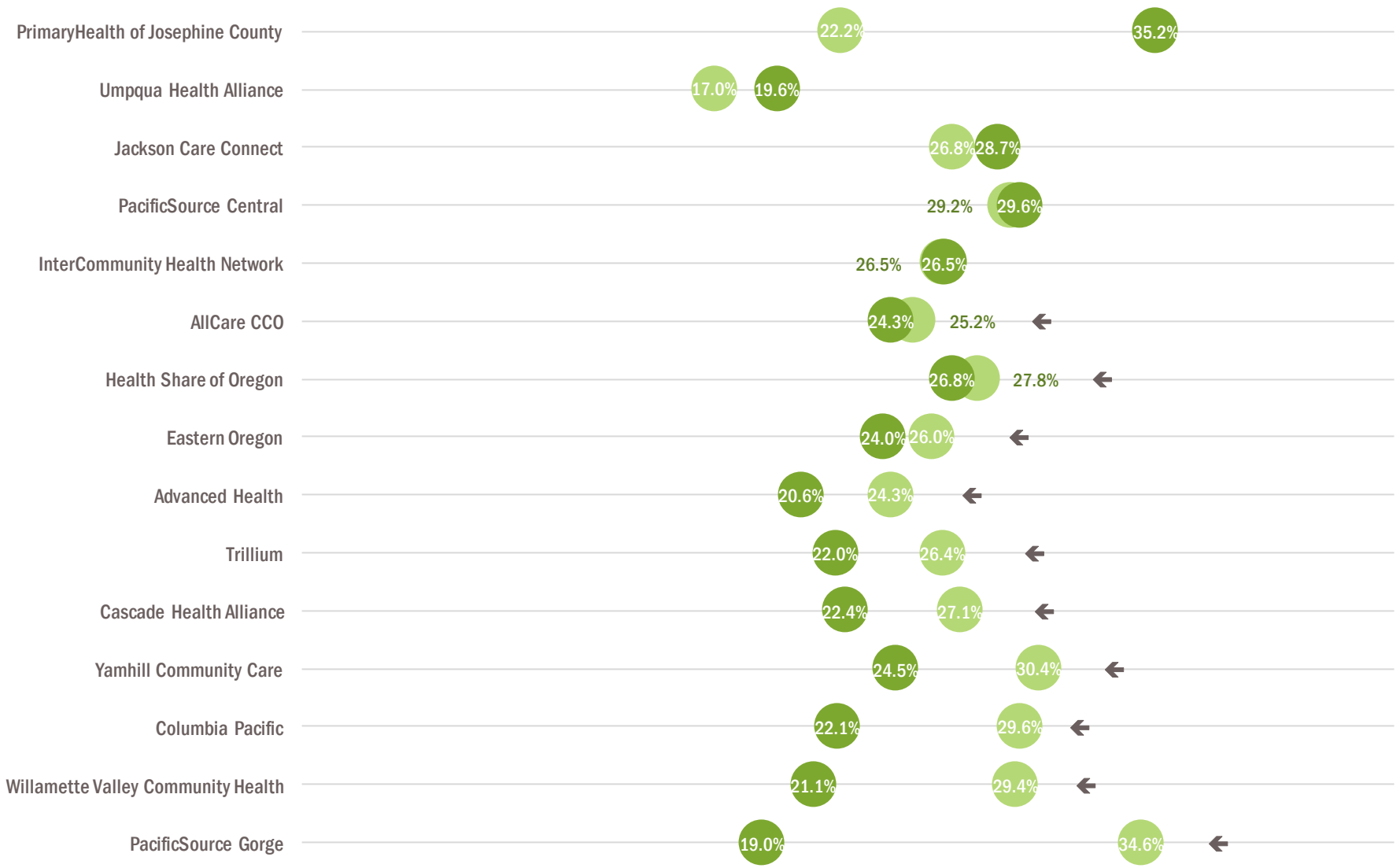
FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (7 DAY)

7 day follow-up after ED for non-traumatic dental reasons in 2018 and 2019, by CCO.



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

30 day follow-up ED dental

Percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within 30 days of the ED visit.

Data source:

Administrative (billing) claims

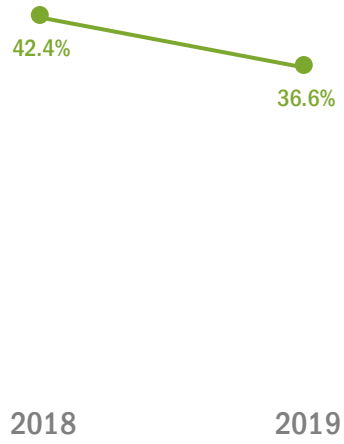
2019 benchmark source:

N/A

2019 data (n=7,886)

- Statewide change since 2018: **-13.7%**
- Number of CCOs that improved: **3**

Statewide



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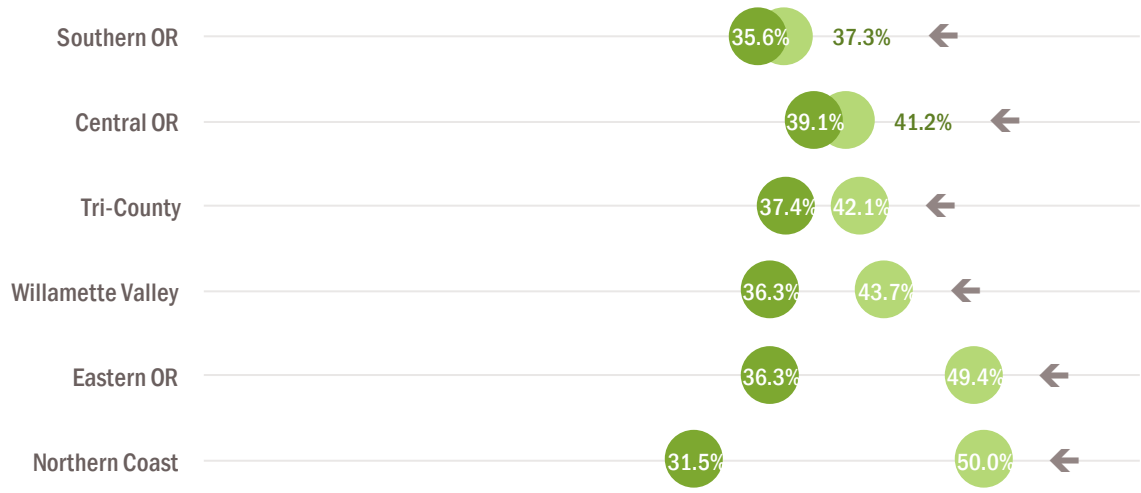

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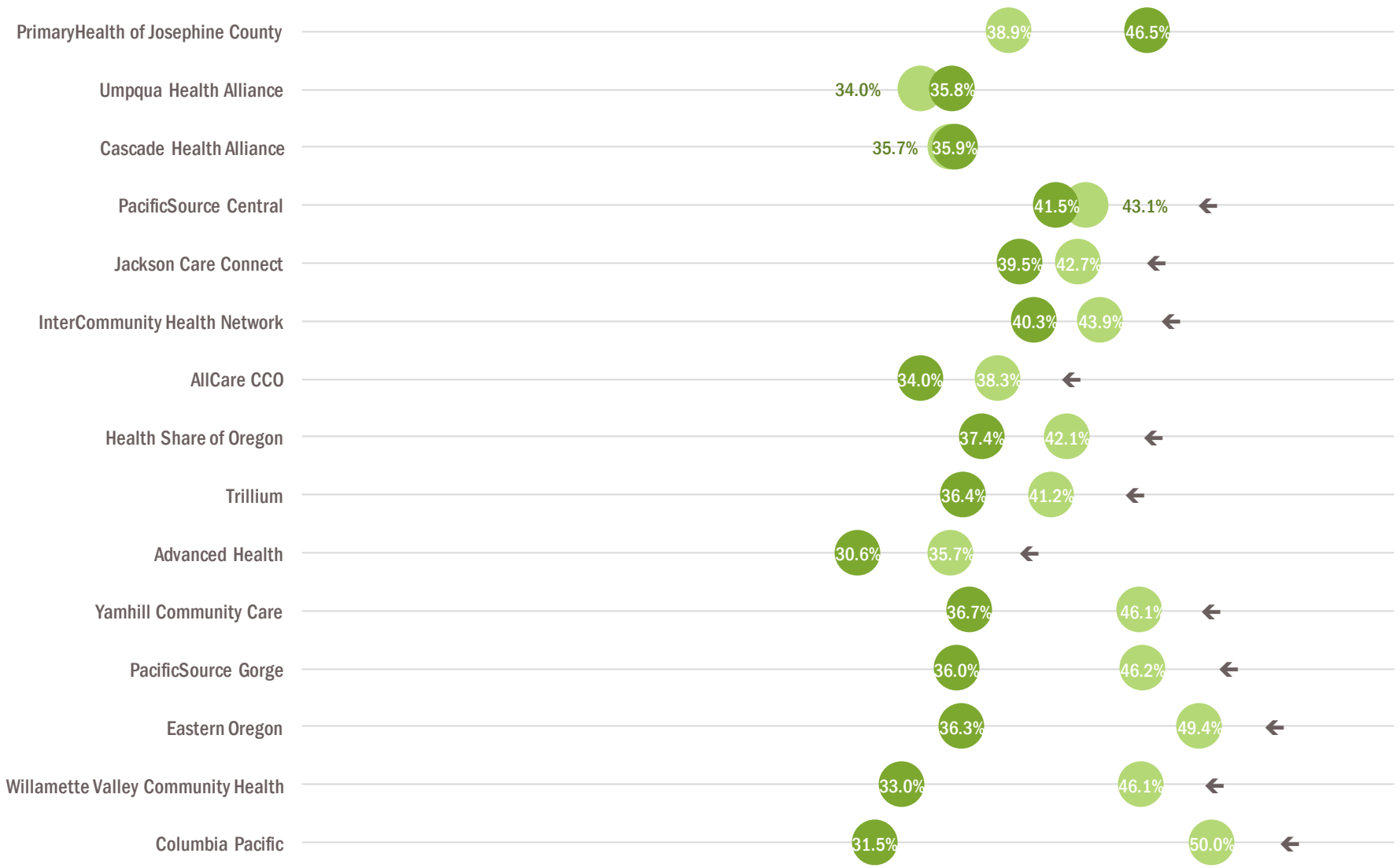
FOLLOW-UP AFTER ED VISIT FOR NON-TRAUMATIC DENTAL REASONS (30 DAY)

30 day follow-up after ED for non-traumatic dental reasons in 2018 and 2019, by CCO.



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up mental illness

Percentage of mental illness-related hospitalizations (for members 6 years and older) for which the patient received a follow-up visit within 7 days.

Data source:

Administrative (billing) claims

2019 benchmark source:

2017 CCO 75th percentile

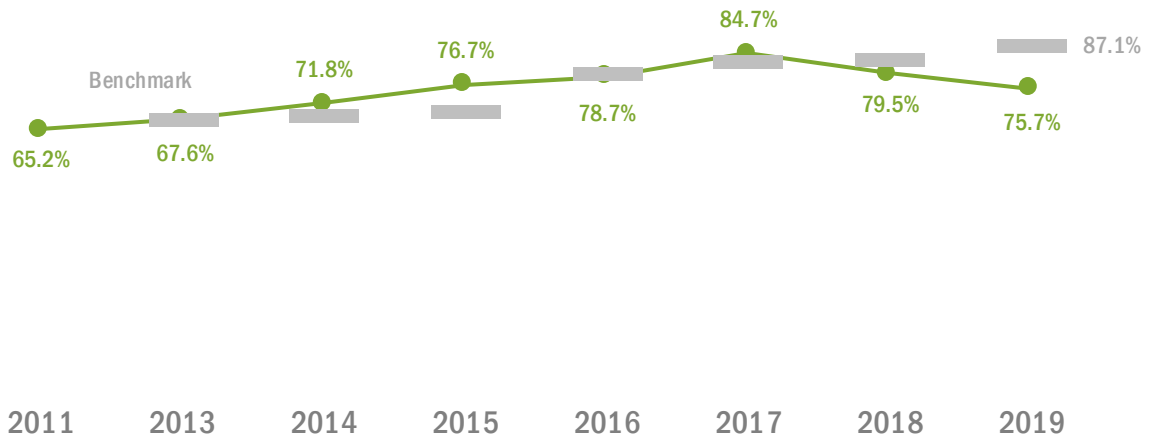
2019 data (n=3,779)

- Statewide change since 2018: **-5.5%**
- Number of CCOs that improved: **6**

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.

Statewide



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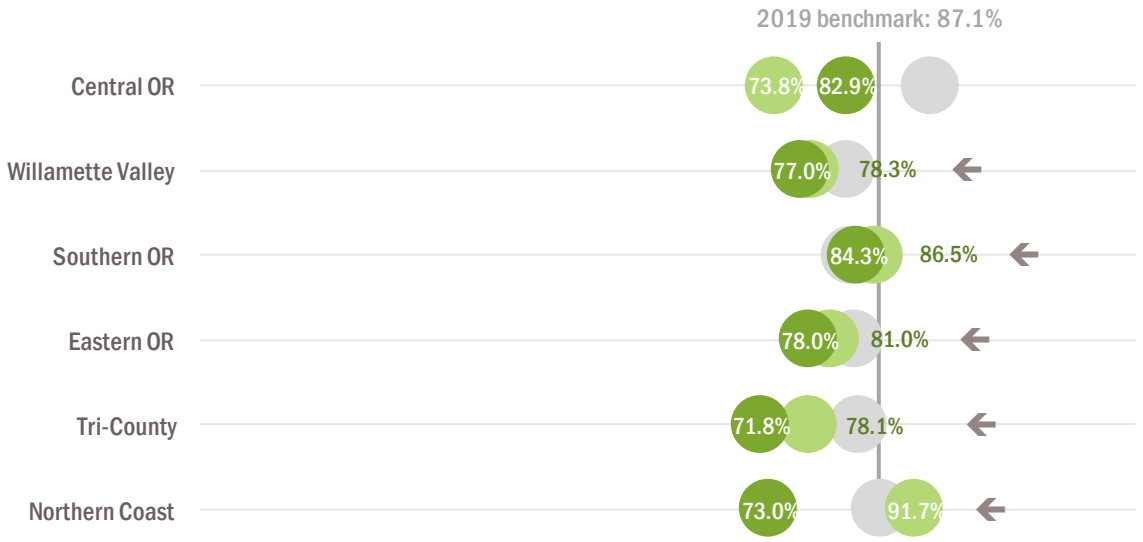

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FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness in 2018 and 2019, by CCO.

Grey dots represent 2017.

* note small denominator (n<30)

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

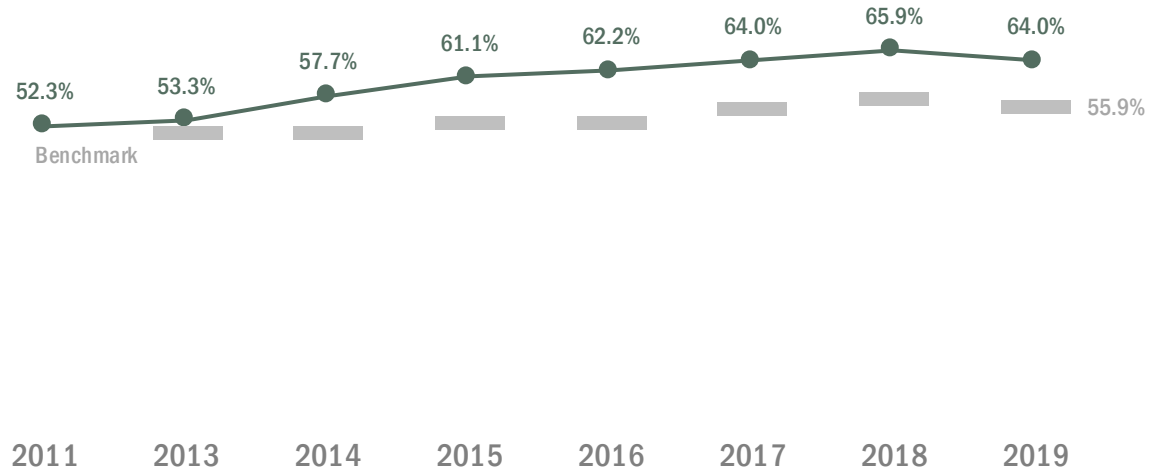
2019 benchmark source:
2018 national Medicaid 90th percentile

2019 data (n=2,331)

- Statewide change since 2018: **-2.9%**
- Number of CCOs that improved: **7**

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

Statewide



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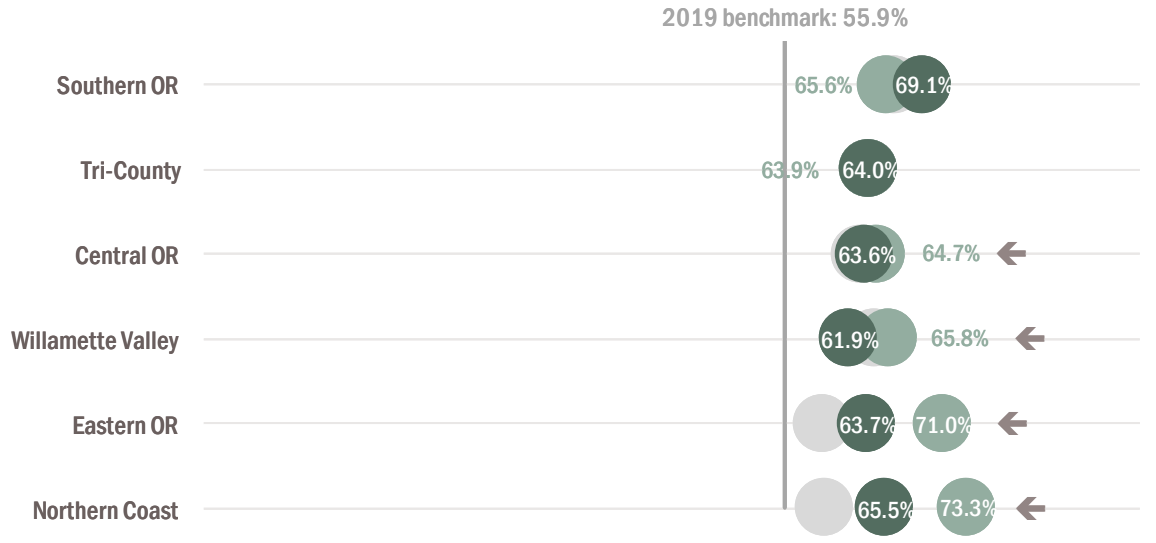

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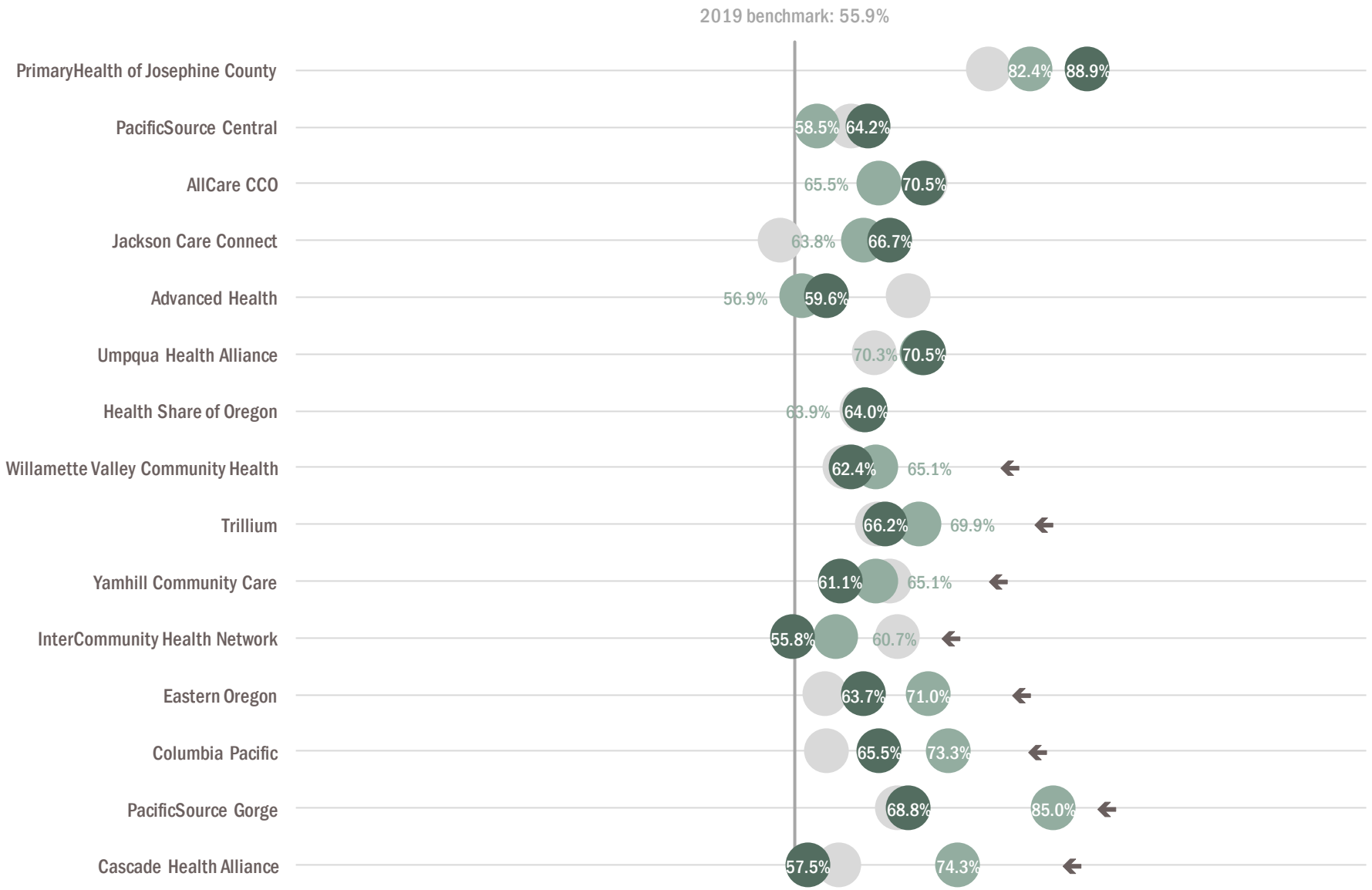
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication in 2018 and 2019, by CCO.

Grey dots represent 2017.



FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION & 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

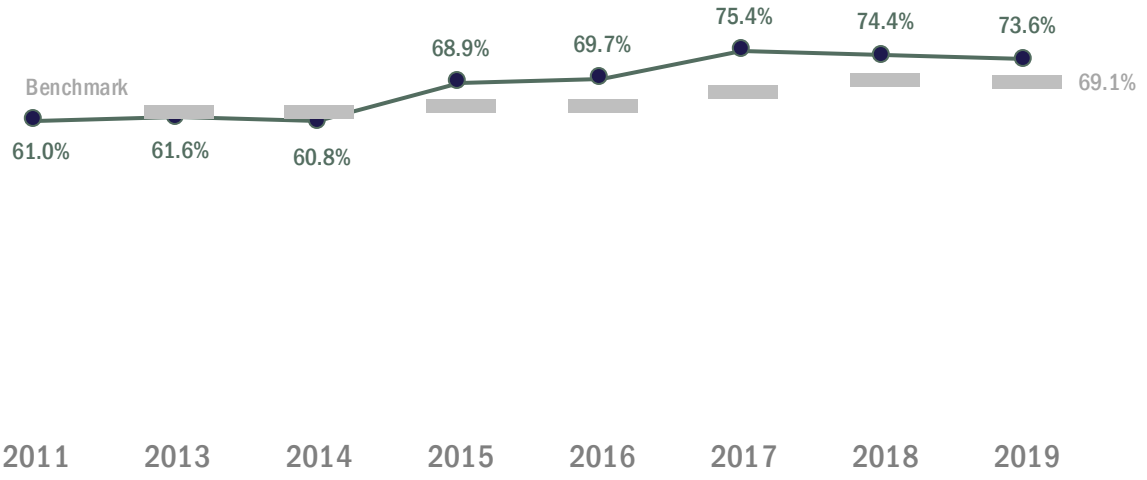
2019 benchmark source:

2018 national Medicaid 90th percentile

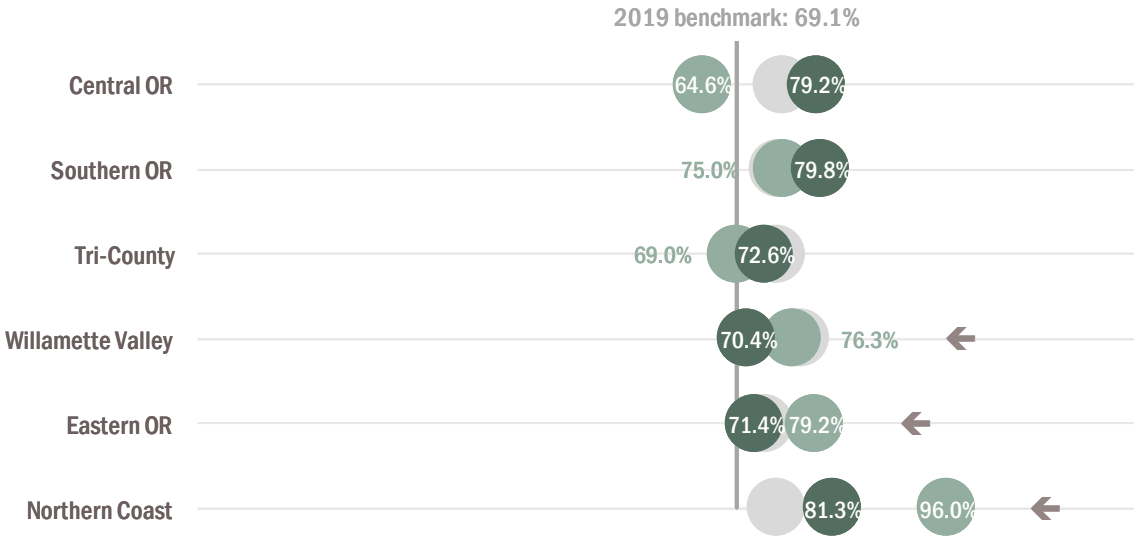
2019 data (n=724)

- Statewide change since 2018: **-1.1%**
- Number of CCOs that improved: **7**

Statewide



By region



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

Continuing follow-up for children prescribed ADHD medication in 2018 and 2019, by CCO.

Grey dots represent 2017.

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

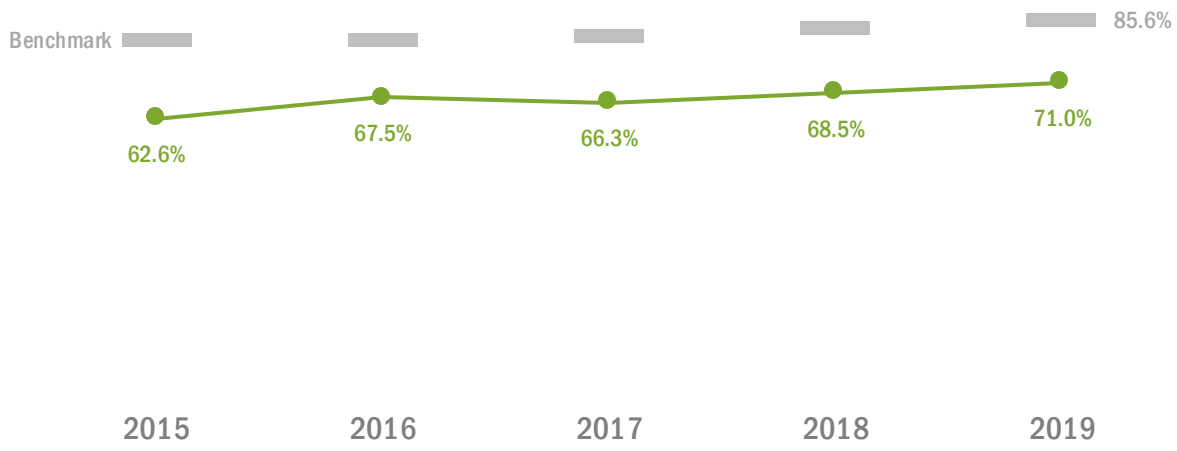
2019 benchmark source:

2018 national Medicaid 75th percentile

2019 data (n=15,665)

- Statewide change since 2018: **3.6%**
- Number of CCOs that improved: **10**

Statewide



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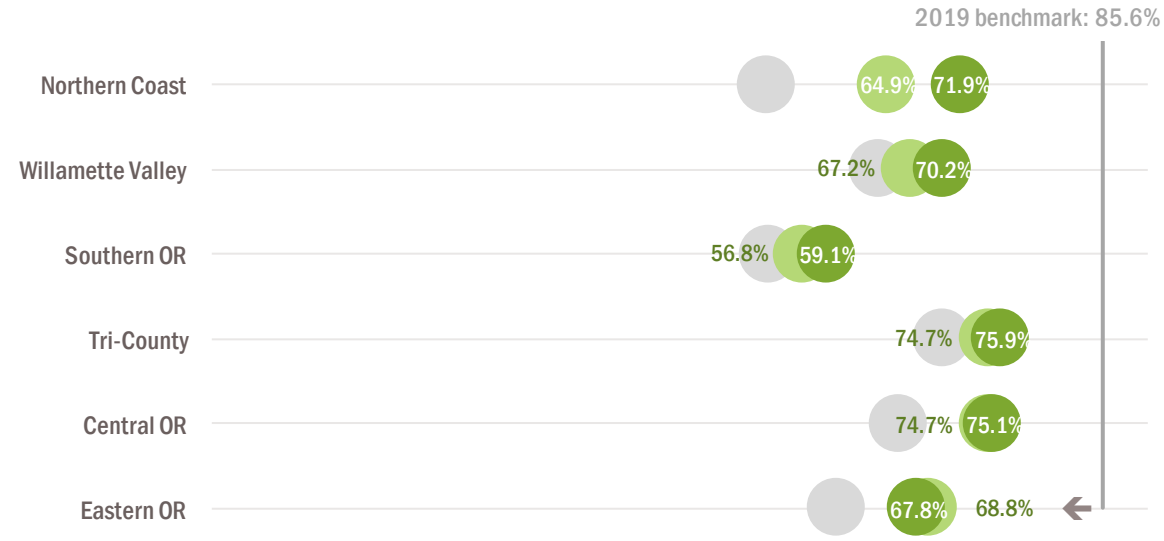

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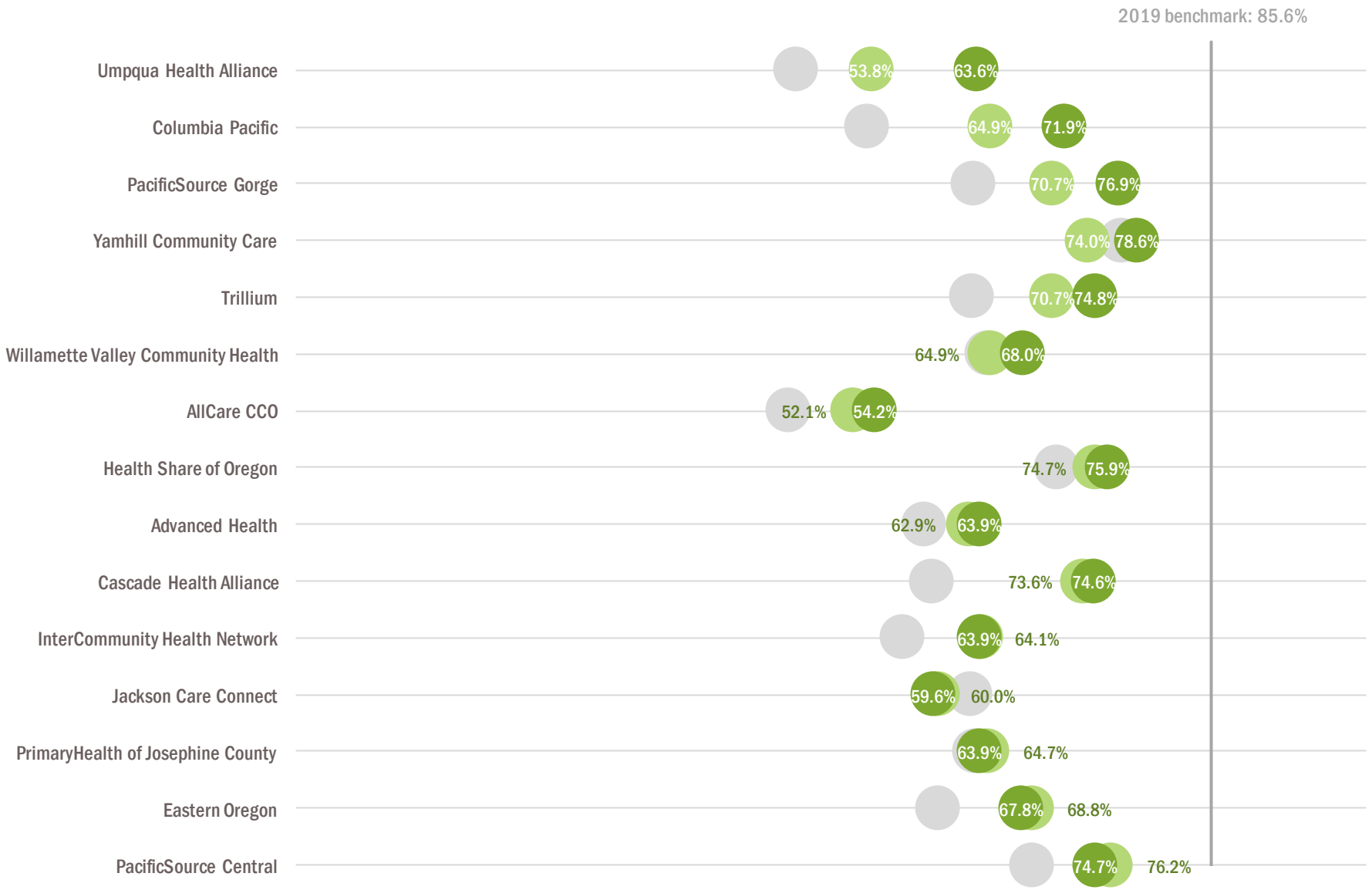
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1

Immunizations for adolescents in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

2019 benchmark source:

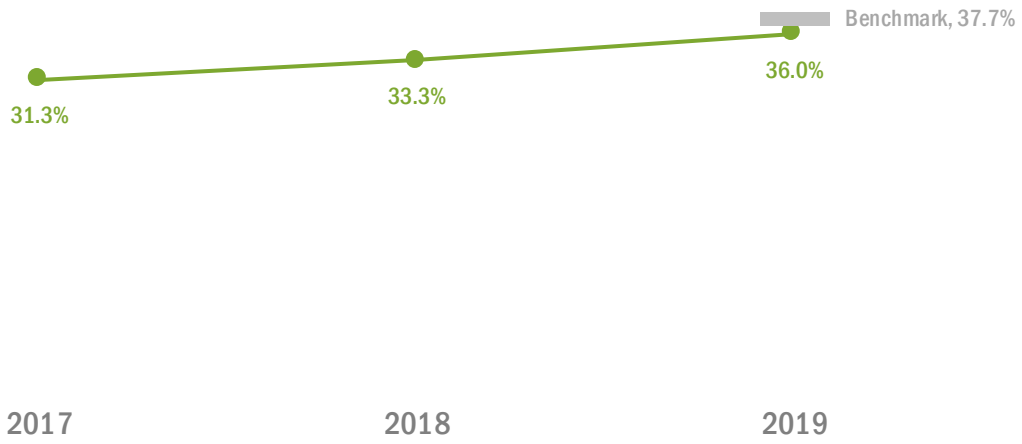
2018 national Medicaid 75th percentile

2019 data (n=15,665)

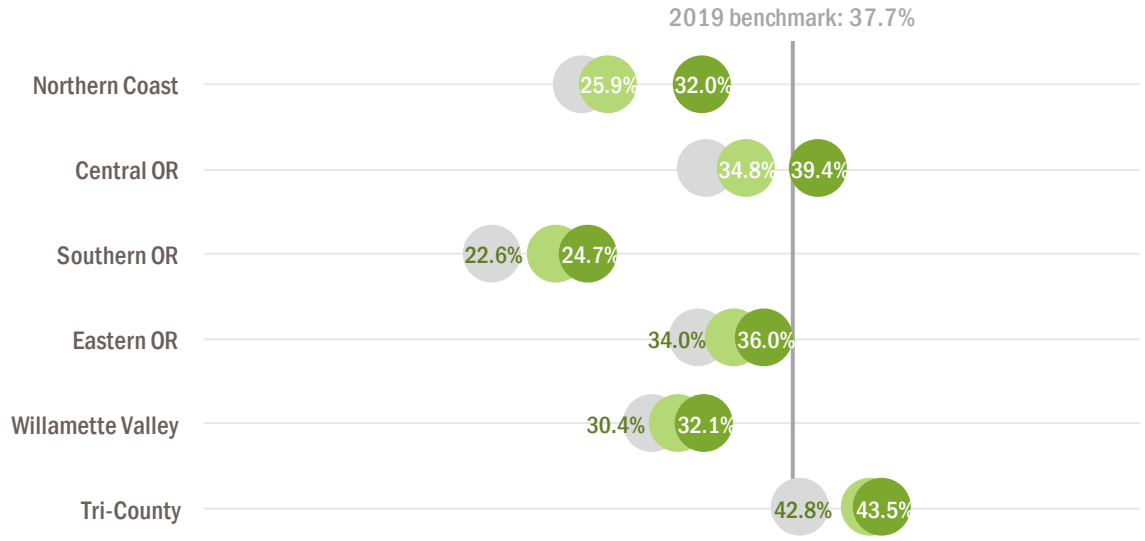
- Statewide change since 2018: **8.1%**
- Number of CCOs that improved: **13**

This measure will be incentivized beginning in 2020.

Statewide



By region



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IMMUNIZATIONS FOR ADOLESCENTS—Combo 2

Immunizations for adolescents in 2018 and 2019, by CCO.

Grey dots represent 2017.

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

IET (Initiation)

Percentage of members (ages 18 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

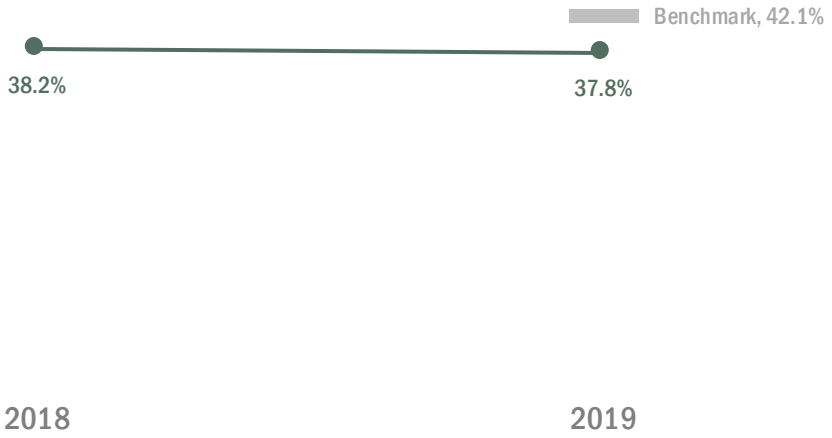
2019 benchmark source:
2018 national Medicaid median

2019 data (n=30,051)

- Statewide change since 2018: **-1.0%**
- Number of CCOs that improved: **5**

This measure will be incentivized beginning in 2020.

Statewide



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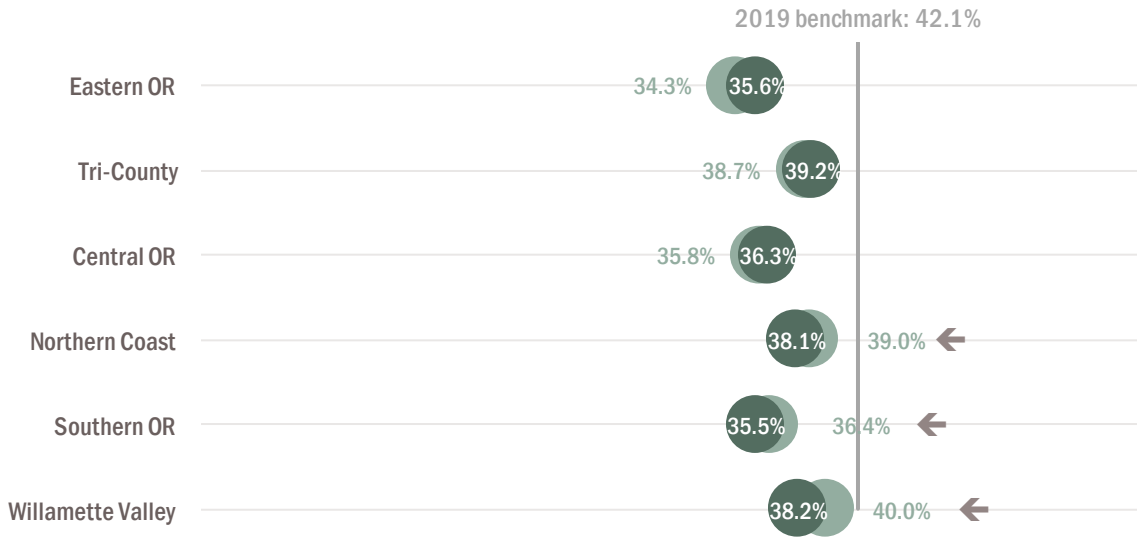

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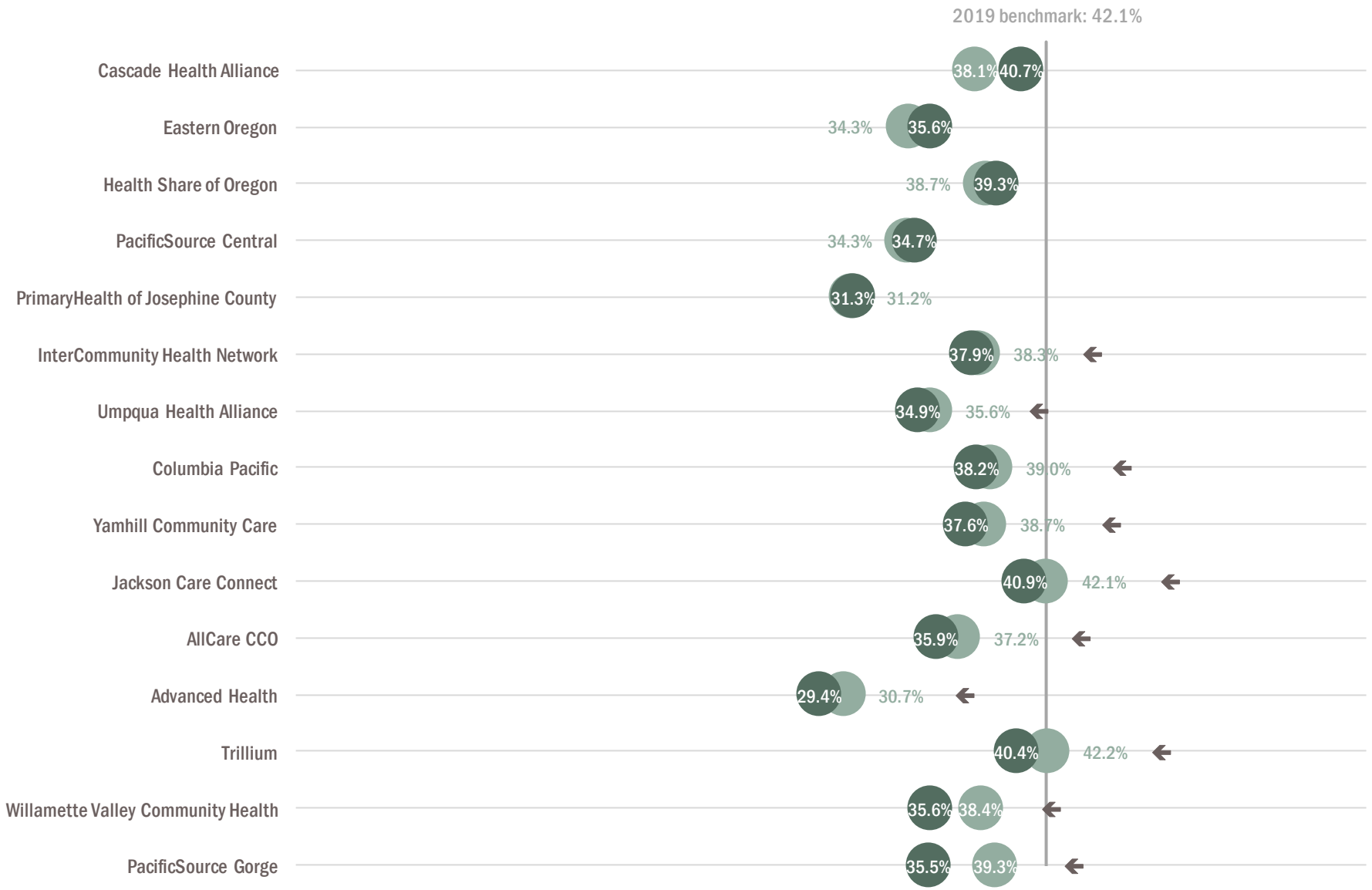
INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)

Initiation of treatment for members newly diagnosed with alcohol or drug dependence in 2018 and 2019, by CCO.



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

Initiation of treatment for members newly diagnosed with alcohol or drug dependence in 2018 and 2019, by age group.

Initiation of treatment for members newly diagnosed with alcohol or drug dependence in 2018 and 2019, by cohort.

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

IET (Engagement)

Percentage of members (ages 18 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

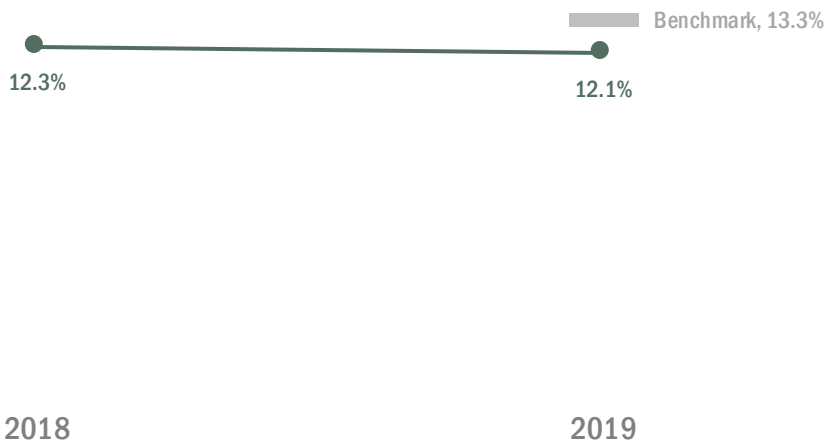
2019 benchmark source:
2018 national Medicaid median

2019 data (n=30,051)

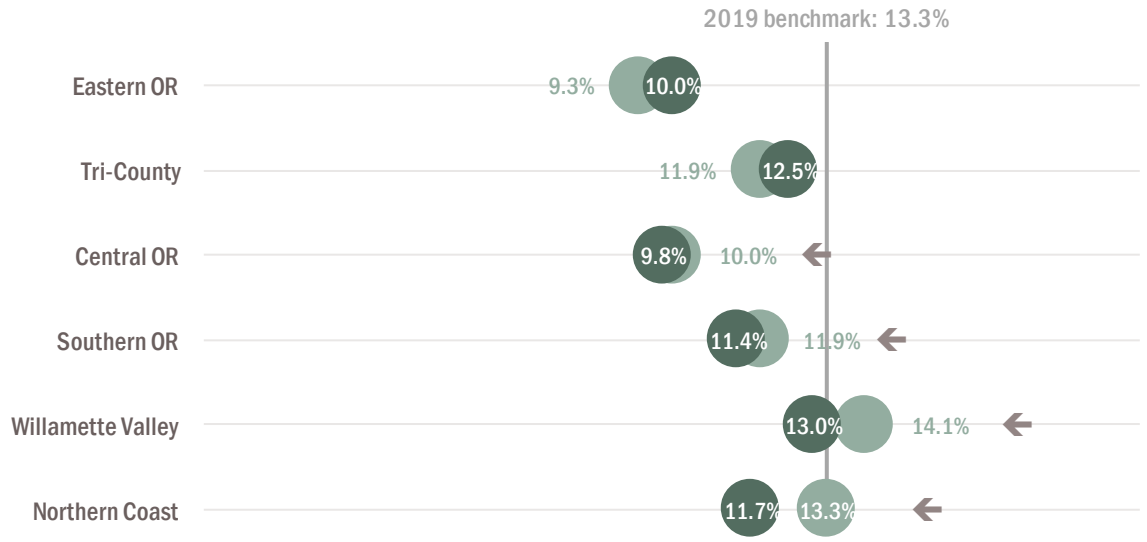
- Statewide change since 2018: **-1.8%**
- Number of CCOs that improved: **6**

This measure will be incentivized beginning in 2020.

Statewide



By region



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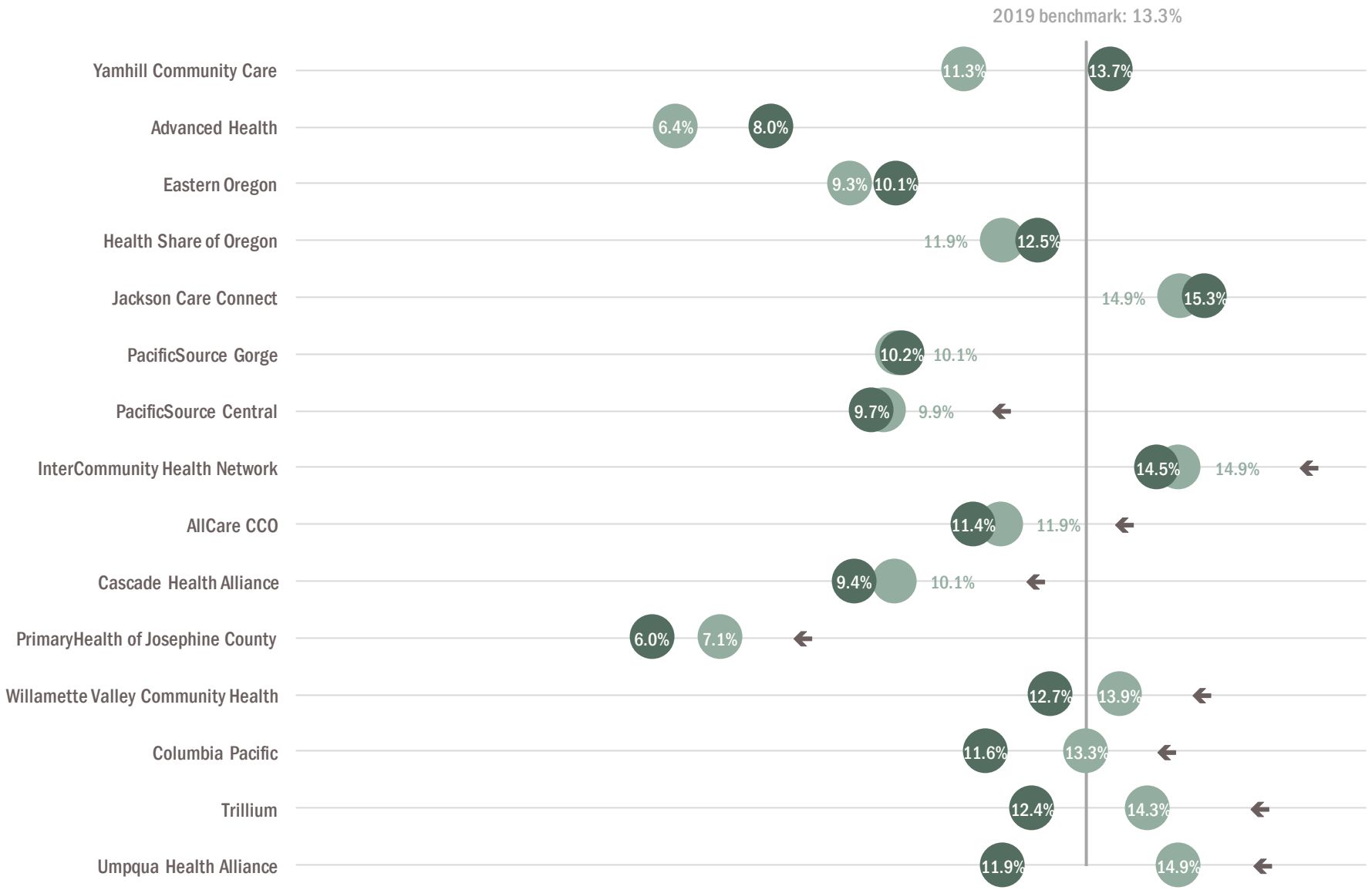
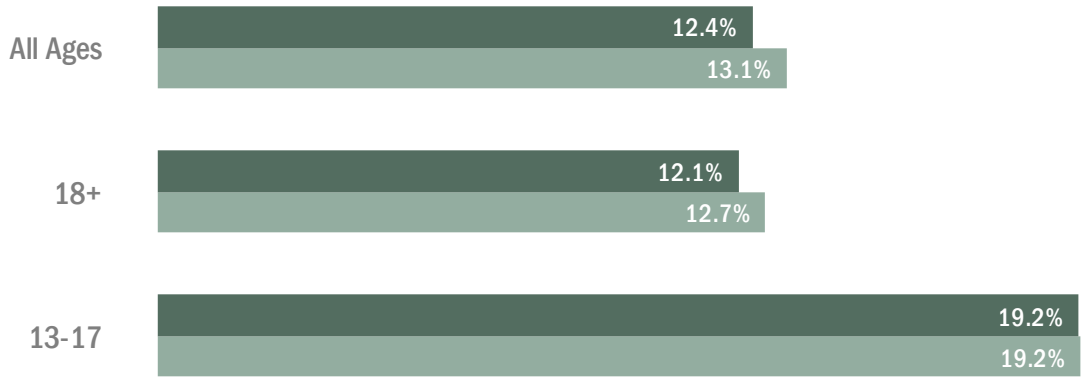
INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Continuation of treatment for members with alcohol or other drug dependence in 2018 and 2019, by CCO.

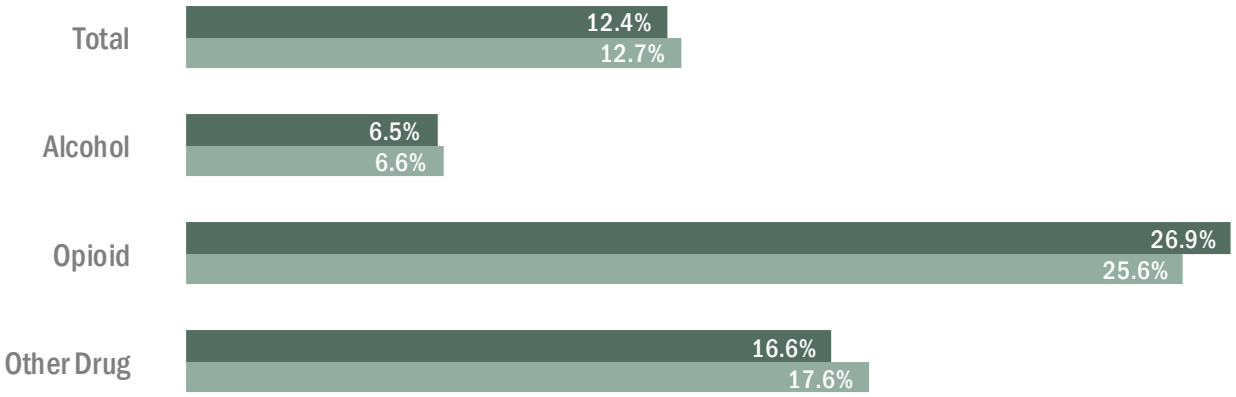


INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Continuation of treatment for members with alcohol or other drug dependence in 2018 and 2019, by age group.



Continuation of treatment for members with alcohol or other drug dependence in 2018 and 2019, by cohort.



PREVENTIVE DENTAL SERVICES (ages 1-5)

NEW

Preventive dental services (ages 1-5)

Percentage of enrolled children ages 1-5 (kindergarten readiness) who received a preventive dental service during the measurement year.

Data source:

Administrative (billing) claims

2019 benchmark source:

N/A

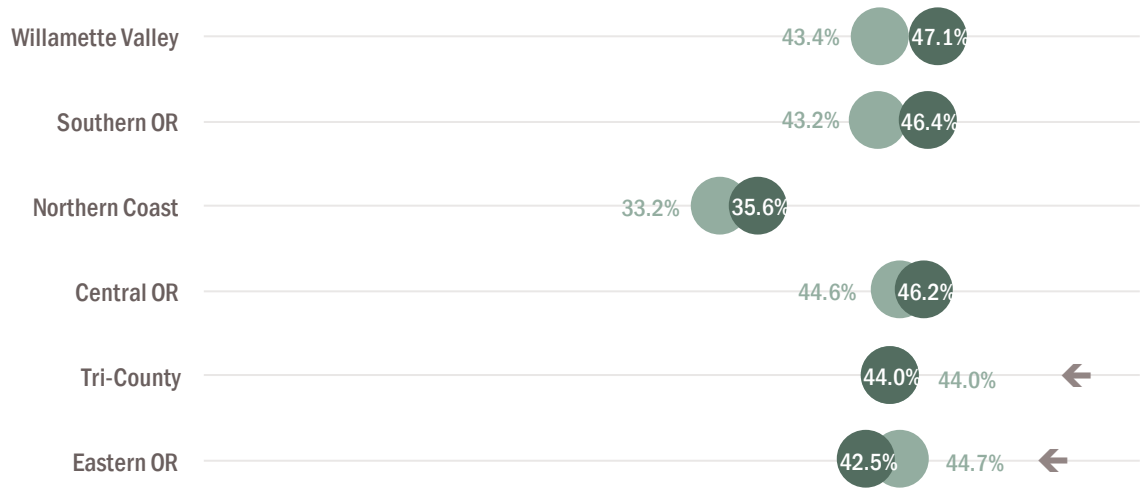
2019 data (n=104,071)

- Statewide change since 2018: **+3.4%**
- Number of CCOs that improved: **11**

This measure will be incentivized beginning in 2020.

Statewide

By region



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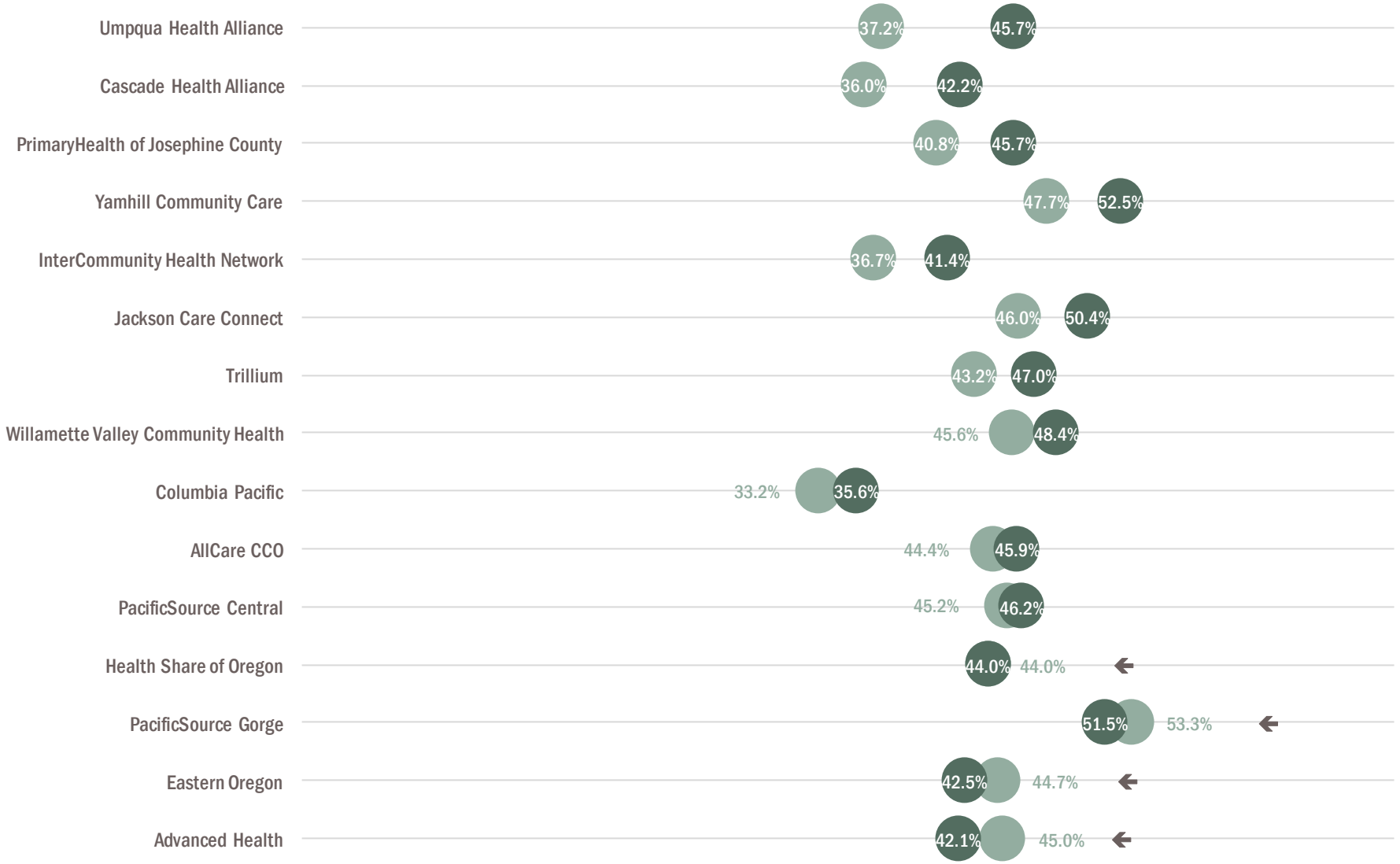
NEW

PREVENTIVE DENTAL SERVICES (ages 1-5)

Preventive dental services for children ages 1 to 5 in 2018 and 2019, by CCO.



NEW

PREVENTIVE DENTAL SERVICES (ages 6-14)

Preventive dental services (ages 6-14)

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

Data source:

Administrative (billing) claims

2019 benchmark source:

N/A

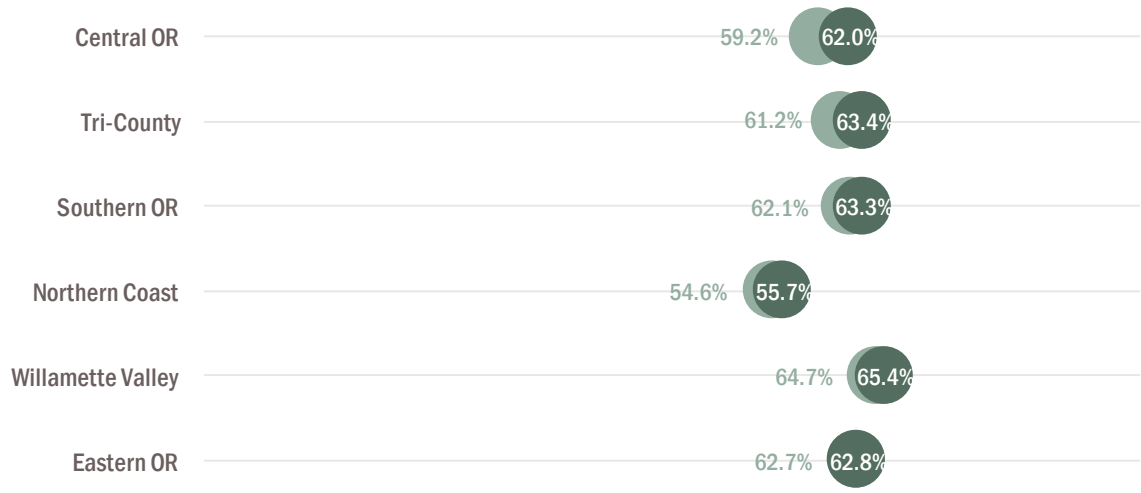
2019 data (n=182,670)

- Statewide change since 2018: **+2.1%**
- Number of CCOs that improved: **10**

This measure will be incentivized beginning in 2020.

Statewide

By region



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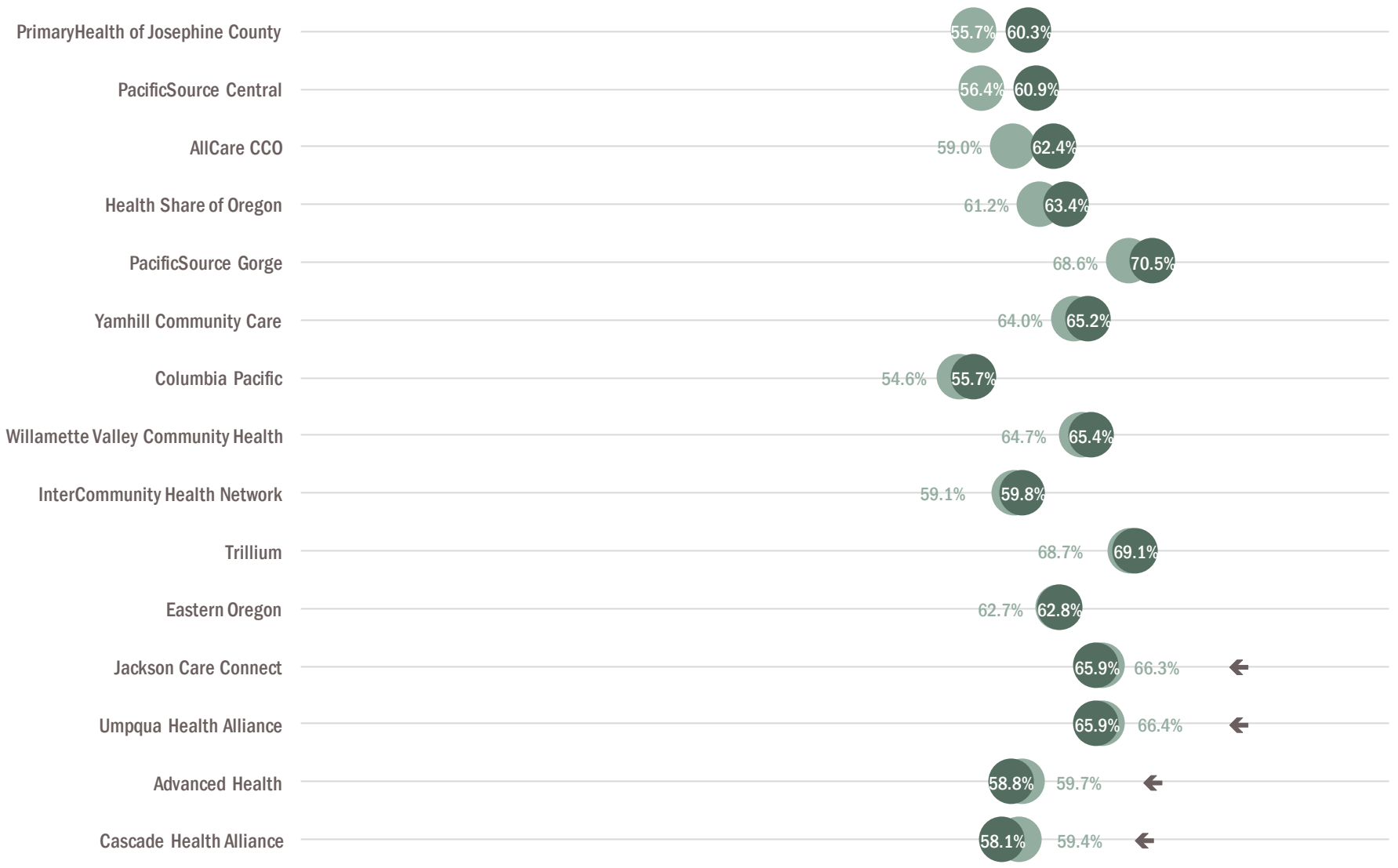
NEW

PREVENTIVE DENTAL SERVICES (ages 6-14)

Preventive dental services for children ages 6 to 14 in 2018 and 2019, by CCO.



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

2019 benchmark source:

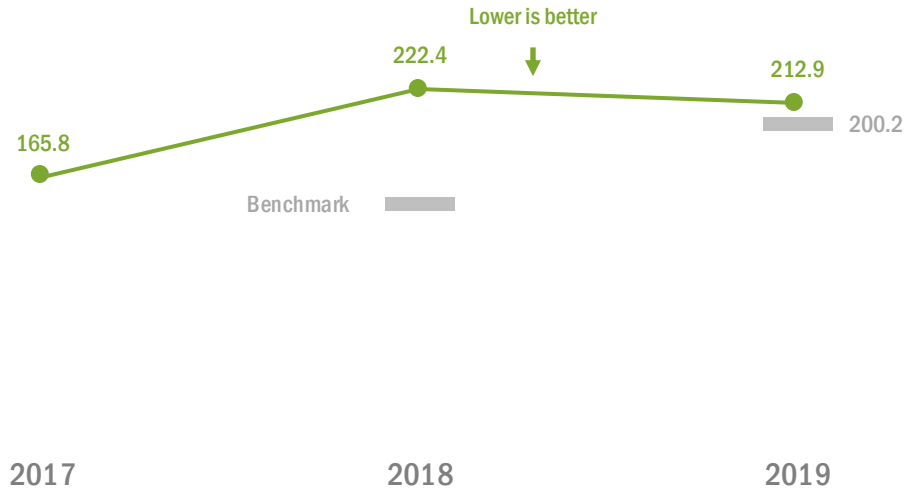
10 percent reduction from 2018

2019 data (n=6,289,173 member years)

- Statewide change since 2018: **-4.3%**
- Number of CCOs that improved: **9**

Rates are shown per 100,000 member years which means that in one year, there are on average 212.9 visits occurring per 100,000 CCO members.

Statewide



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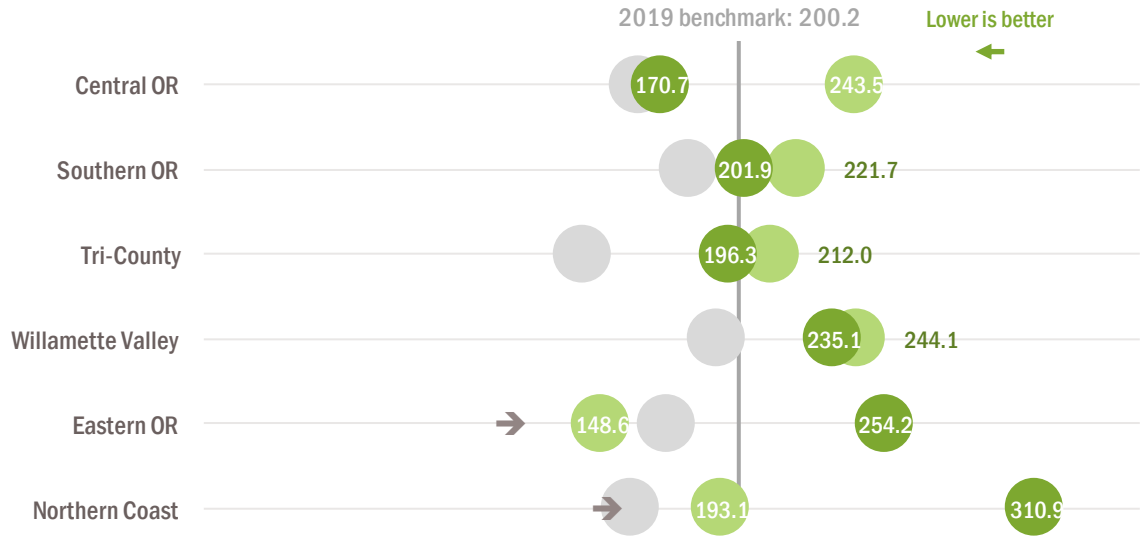

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PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Hospital admissions for short-term diabetes complications in 2018 and 2019, by CCO.

Grey dots represent 2017.

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

2019 benchmark source:

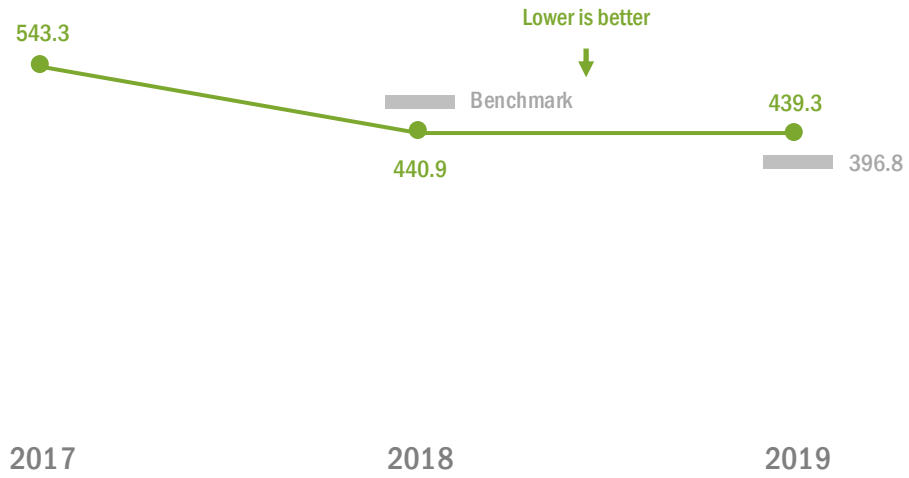
10 percent reduction from 2018

2019 data (n=2,974,919 member years)

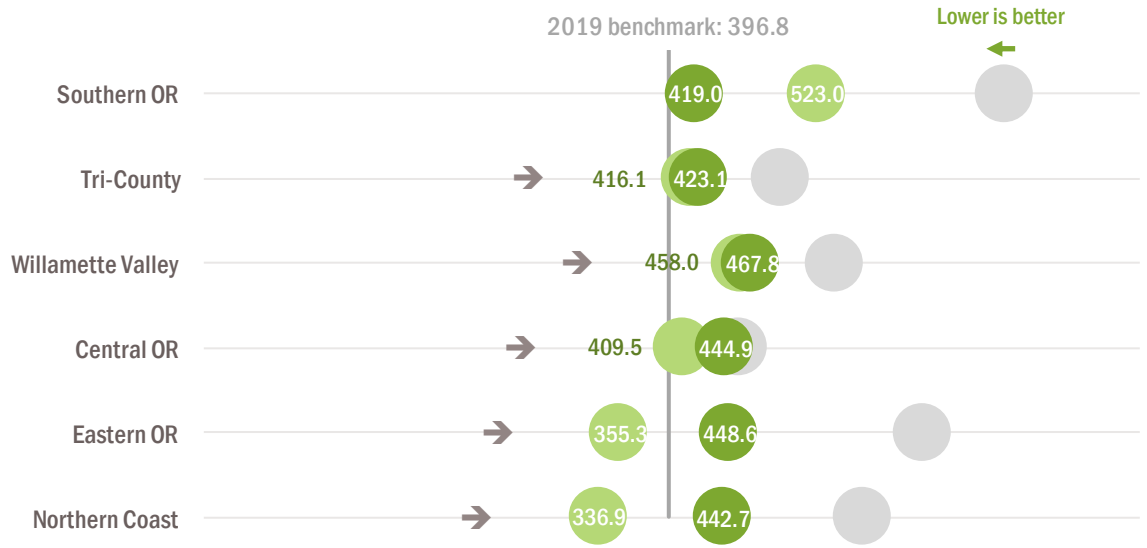
- Statewide change since 2018: **-0.4%**
- Number of CCOs that improved: **6**

Rates are shown per 100,000 member years which means that in one year, there are on average 439.3 visits occurring per 100,000 CCO members.

Statewide



By region



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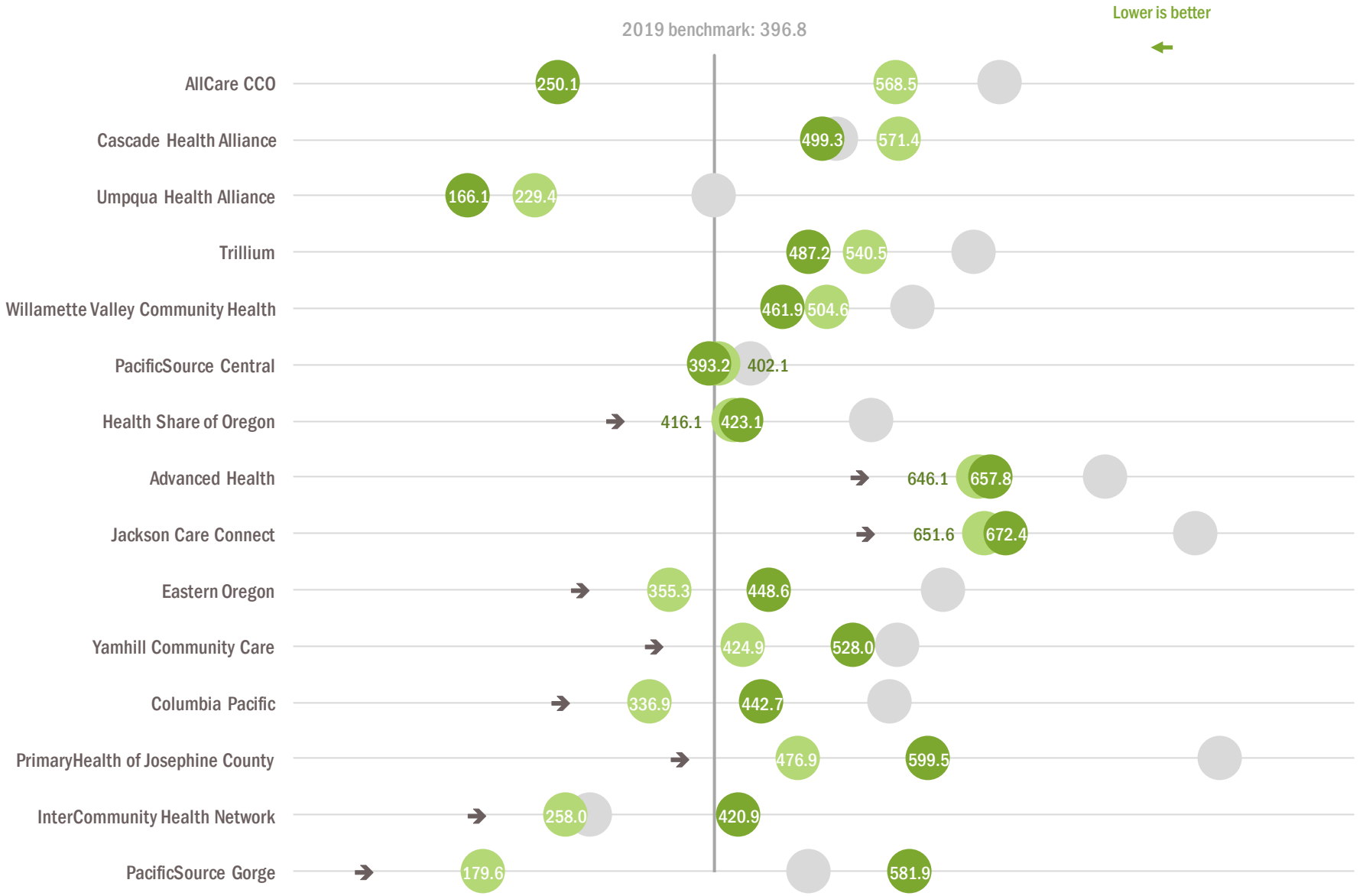
PQI 05: COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Hospital admissions for COPD or asthma in older adults in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

2019 benchmark source:

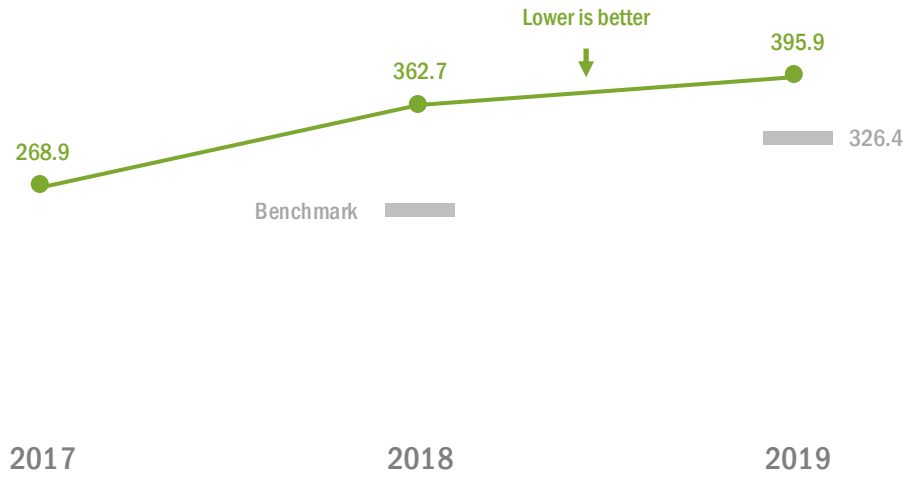
10 percent reduction from 2018

2019 data (n=6,289,173 member years)

- Statewide change since 2018: **+9.2%**
- Number of CCOs that improved: **5**

Rates are shown per 100,000 member years which means that in one year, there are on average 395.9 visits occurring per 100,000 CCO members.

Statewide



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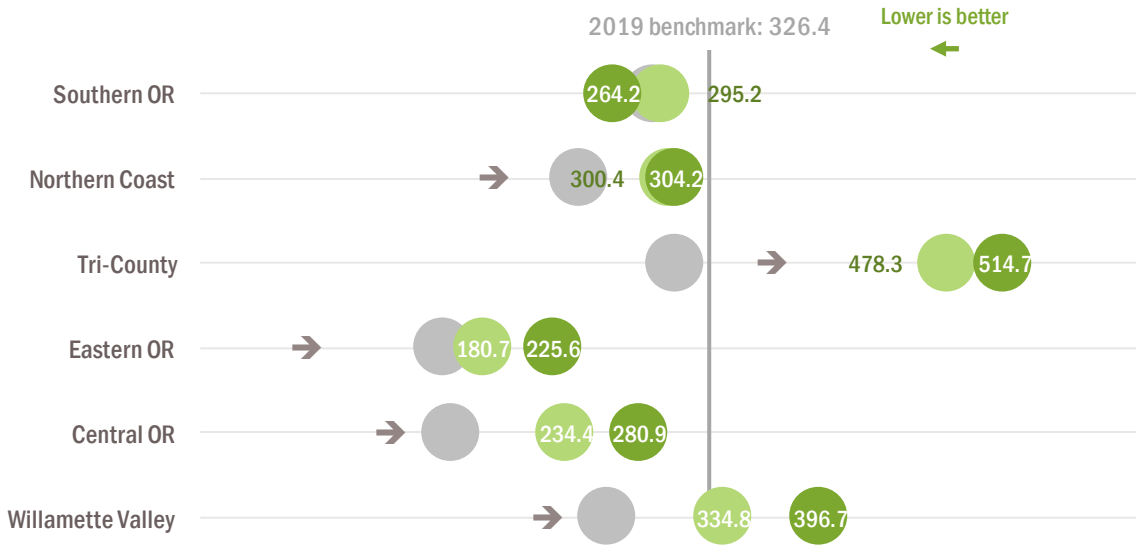

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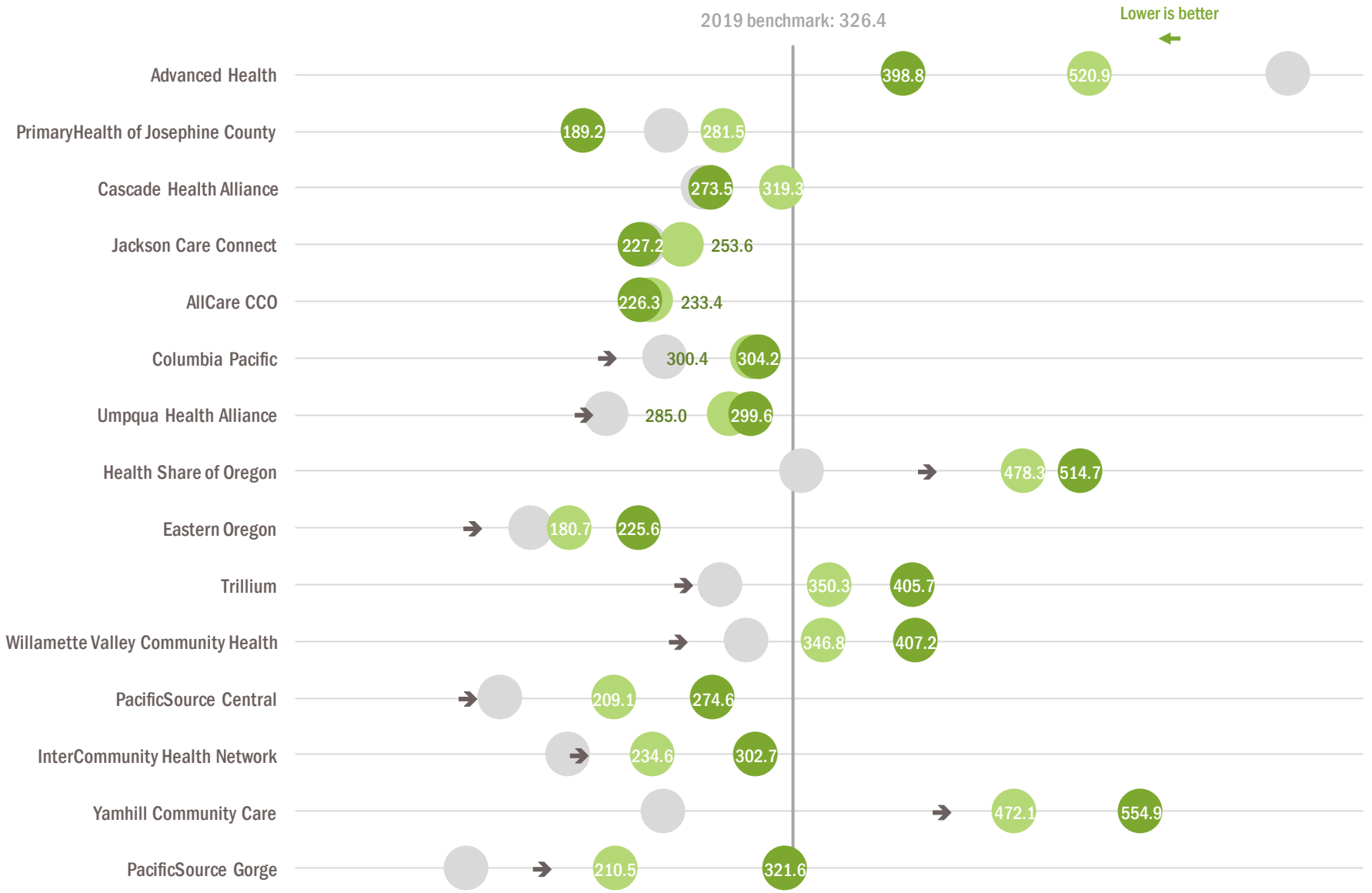
PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Hospital admissions for congestive heart failure in 2018 and 2019, by CCO.

Grey dots represent 2017.



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

2019 benchmark source:

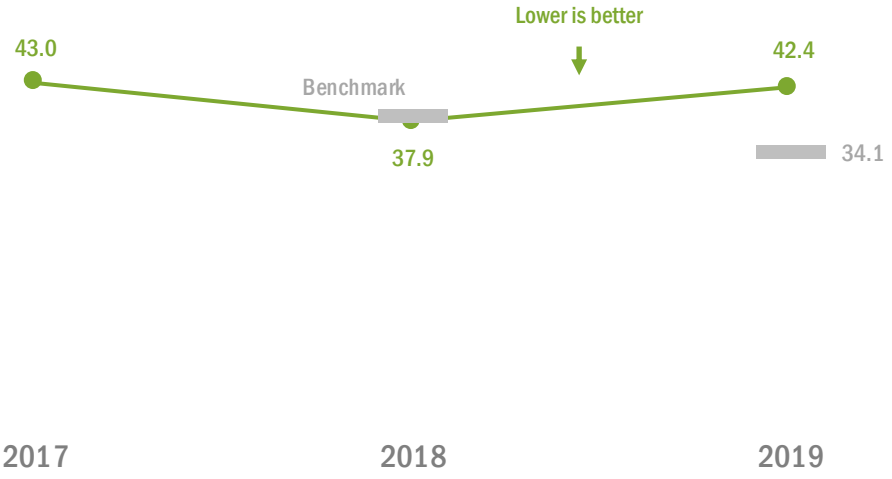
10 percent reduction from 2018

2019 data (n=3,314,207 member years)

- Statewide change since 2018: **+11.9%**
- Number of CCOs that improved: **7**

Rates are shown per 100,000 member years which means that in one year, there are on average 42.4 visits occurring per 100,000 CCO members.

Statewide



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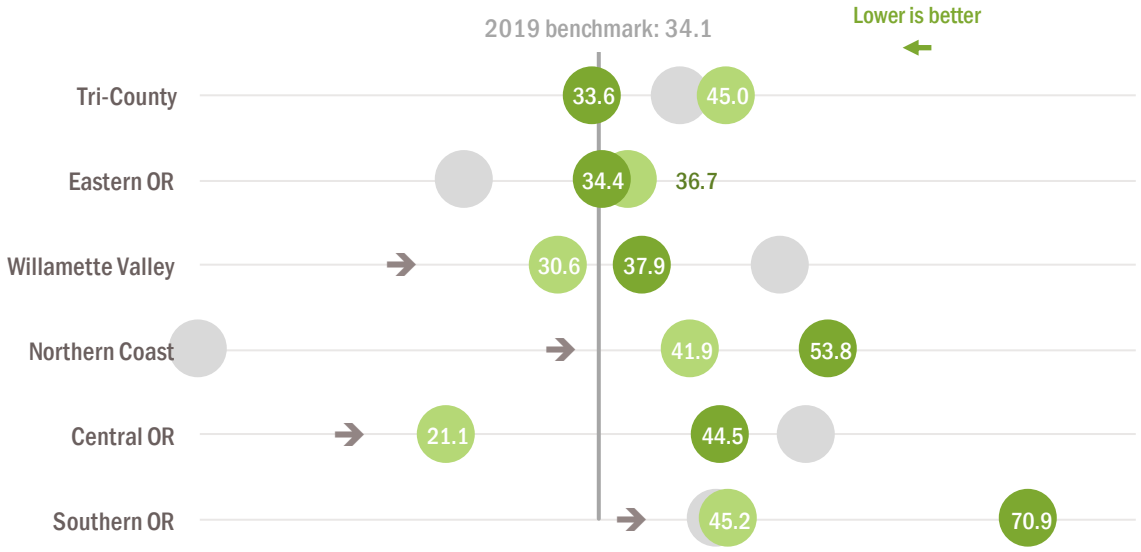

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PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Hospital admissions for asthma in younger adults in 2018 and 2019, by CCO.

Grey dots represent 2017.

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

2019 benchmark source:

2018 national Medicaid 90th percentile

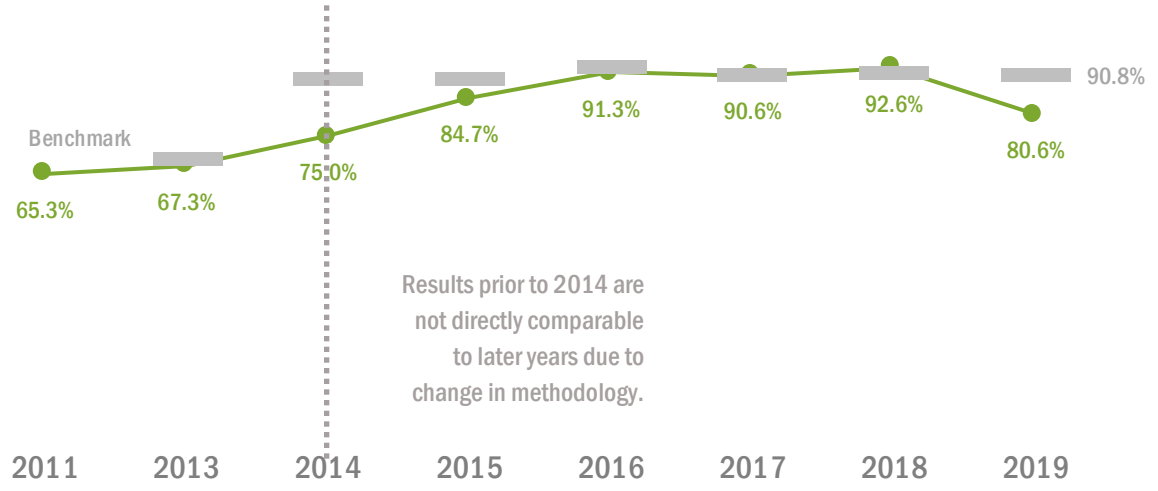
2019 data (n=5,056)

- Statewide change since 2018: **-13.0%**
- Number of CCOs that improved: **0**

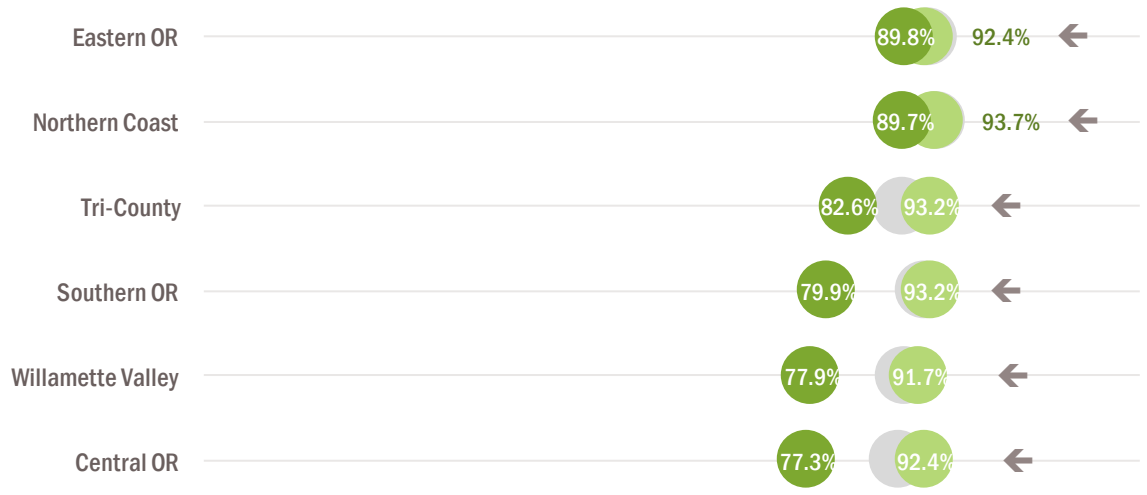
Beginning in 2014, measure specifications were modified to include medical record review. Results prior to 2014 are not directly comparable to later years.

This measure was previously a CCO incentive metric from 2013-2018.

Statewide



By region



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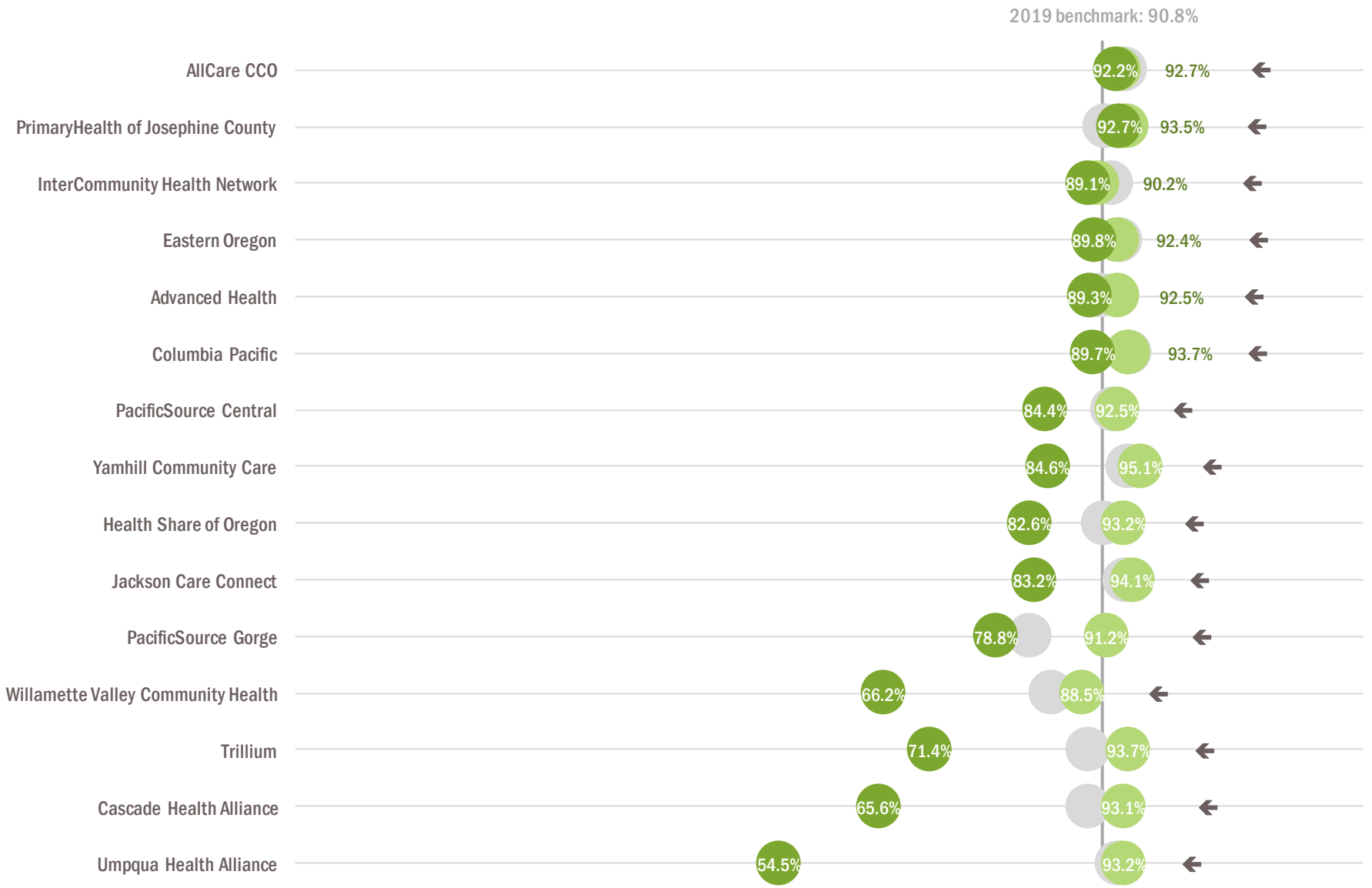
PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care in 2018 and 2019, by CCO.

Grey dots represent 2017.



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.

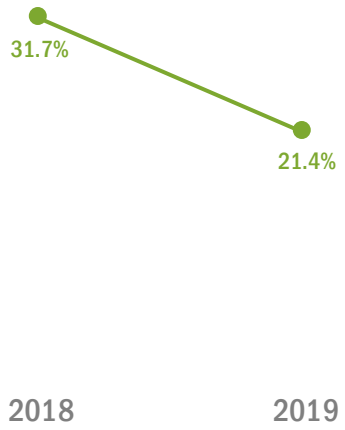
Data source:
Administrative (billing) claims

2019 benchmark source:
N/A

2019 data (n=305,600)

- Statewide change since 2018: **-32.5%**
- Number of CCOs that improved: **0**

Statewide



By region

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TOPICAL FLUORIDE VARNISH

Topical fluoride varnish in 2018 and 2019, 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

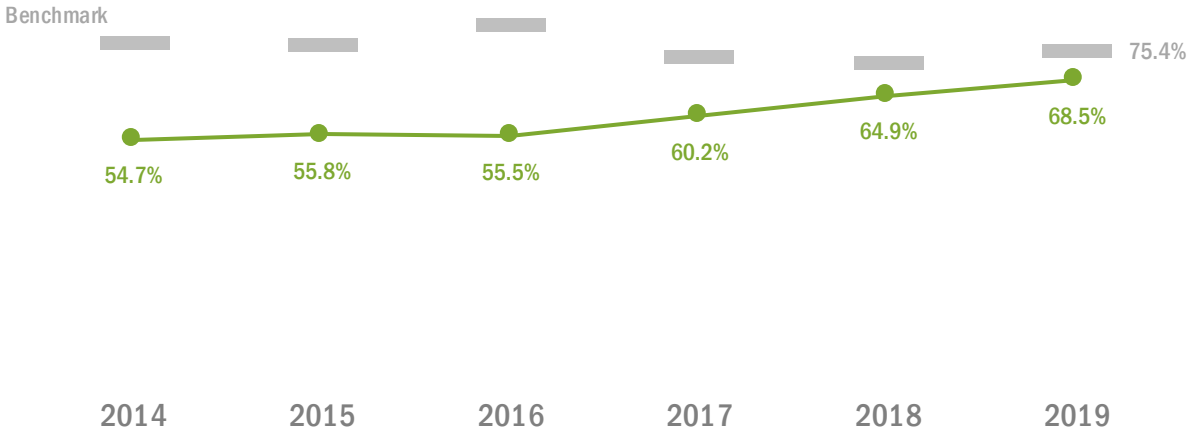
2019 benchmark source:
2018 National Medicaid 90th percentile

2019 data (n=15,536)

- Statewide change since 2018: **+5.4%**
- Number of CCOs that improved: **13**

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.

Statewide



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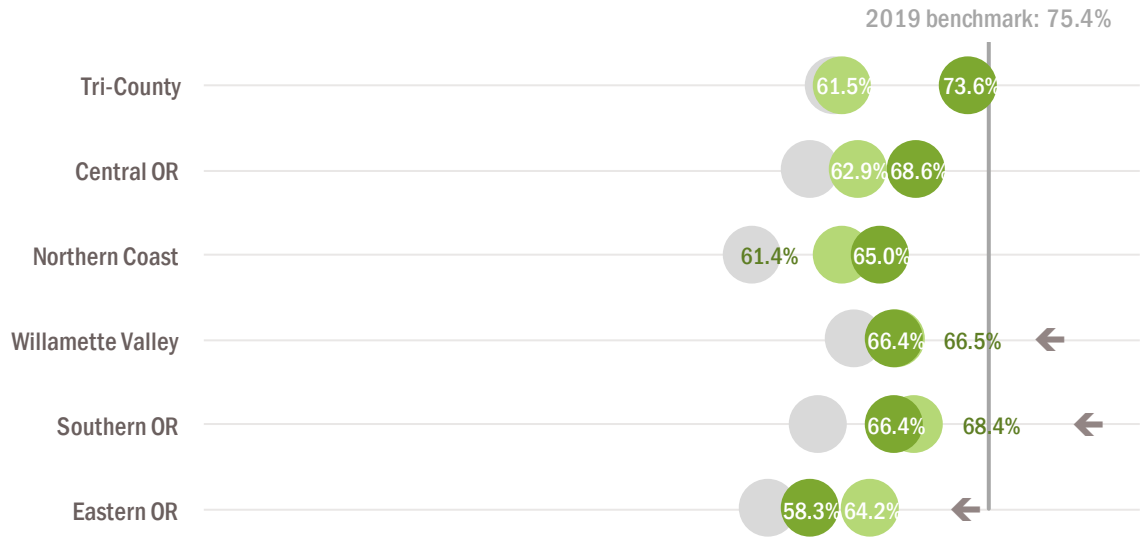

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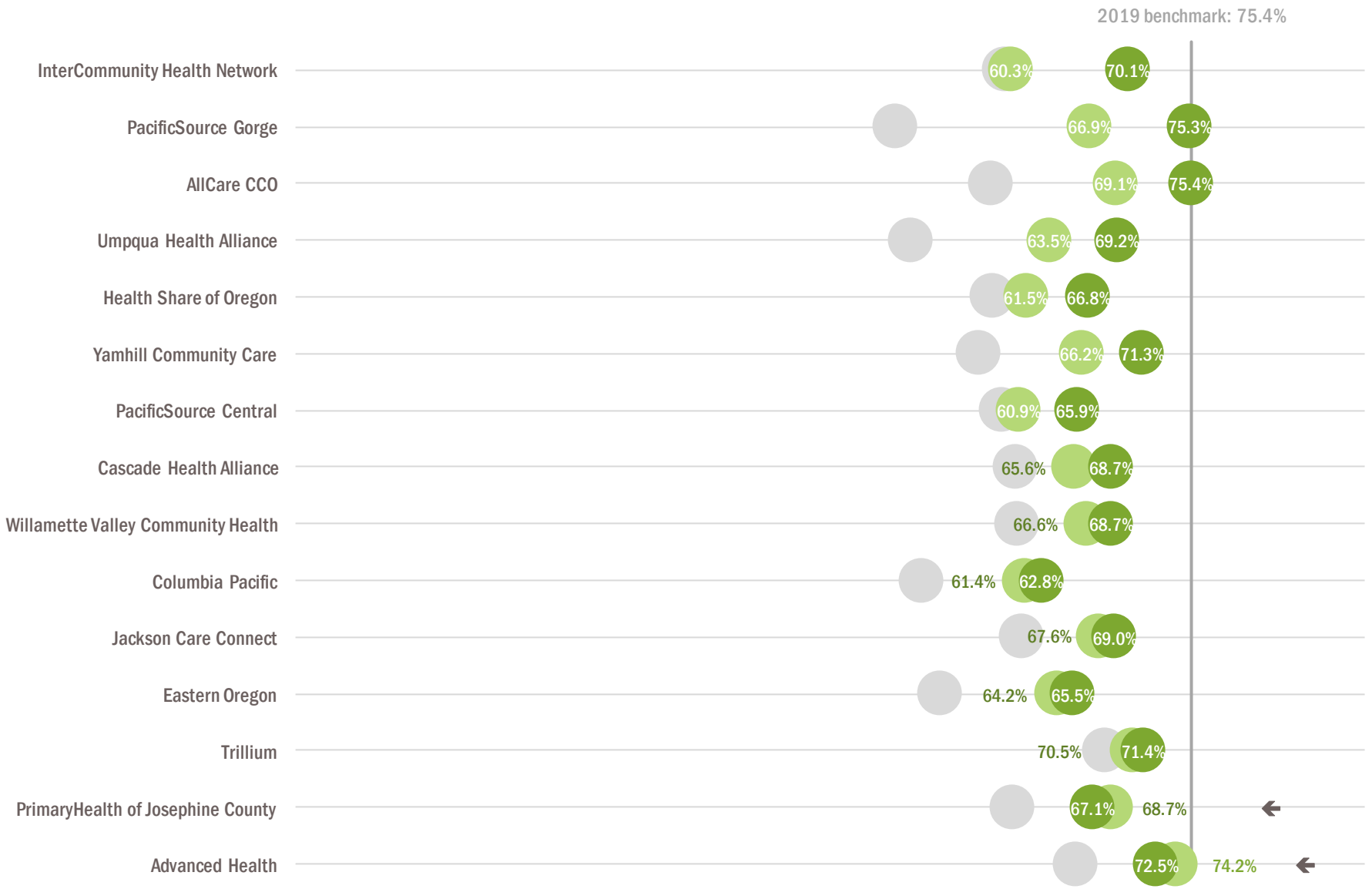
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits in the first 15 months of life in 2018 and 2019, by CCO.

Grey dots represent 2017.



NEW WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE

Well-child visits 3-6 years

Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year.

Data source:

Administrative (billing) claims

2019 benchmark source:

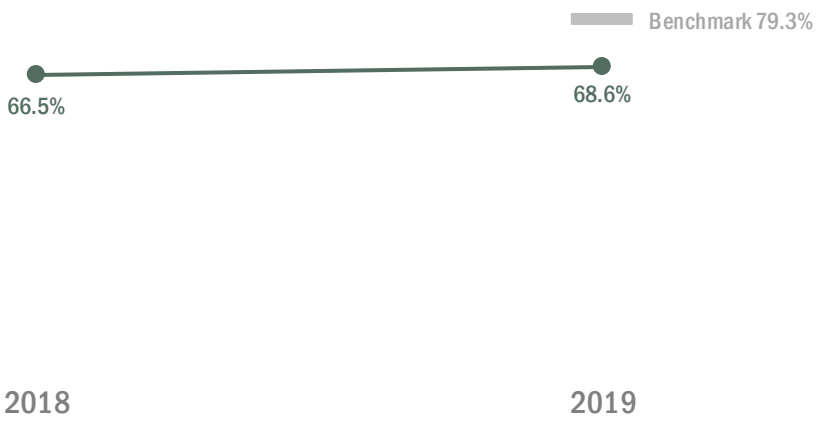
2018 national Medicaid 75th percentile

2019 data (n=65,488)

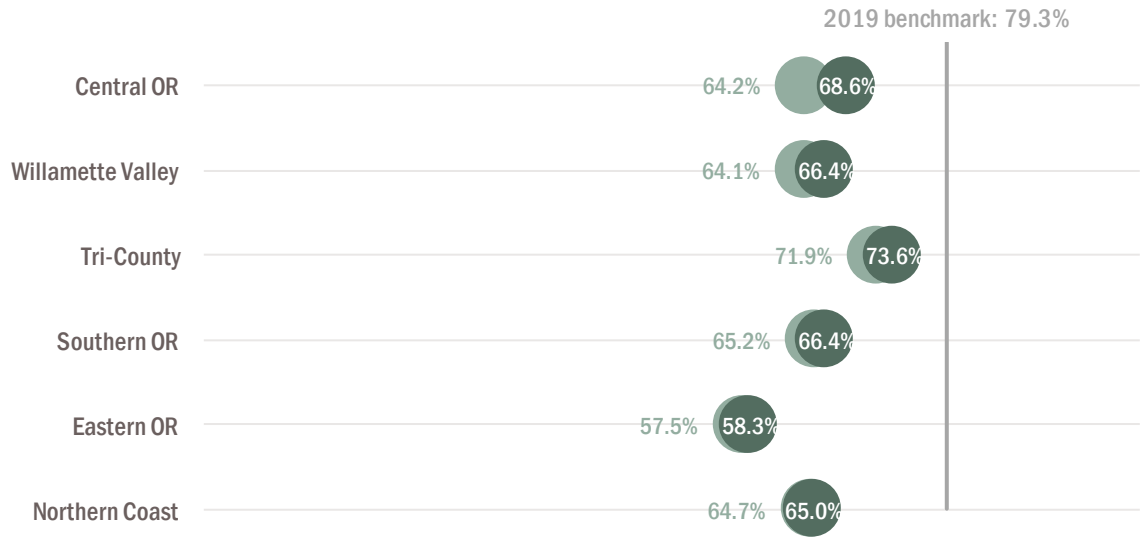
- Statewide change since 2018: **+3.0%**
- Number of CCOs that improved: **11**

This measure will be incentivized beginning in 2020.

Statewide



By region



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NEW

WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE

Well-child visits in the 3rd, 4th, 5th, and 6th years of life in 2018 and 2019, by CCO.

Oregon Health Authority

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