Incentivizing Equitable Care

Problem and background

Since 2013, Oregon has been a national leader in implementing robust quality measurement for its Medicaid system, delivered through Coordinated Care Organizations (CCOs). This robust quality measurement has included:

- Regular quality and access measures reporting, and
- A successful Quality Incentive Program that focuses CCO attention and drives notable improvements in care delivery, patient experience and outcomes.

The final evaluation of Oregon's 2012-2017 Section 1115(a) Demonstration Waiver renewal concluded that Oregon's "financial incentives were strongly associated with improvements in performance."[1] This shows that the Quality Incentive Program offers a powerful opportunity to address structural barriers that prevent equitable access to high-quality care.

Although statewide and CCO-level incentive metrics demonstrate that care quality for Oregon Health Plan members has improved in aggregate since 2013, many measures reveal inequities when analyzed by race/ethnicity, language and disability.[2,3] Structural racism makes it more likely that people in communities of color and Tribal communities are subjected to inequitable employment, housing, placing them at higher risk of poor health outcomes.[4] This structural racism has also created barriers to accessing quality health care, resulting in worse health outcomes. To rectify this and provide all Oregon Health Plan members equitable access to high-quality care, Oregon must prioritize strategies that:

- Improve cultural responsiveness,
- Mitigate social stigmas and the harm of racism, and
- Create equitable access. [1,2,5]

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

[2] Metrics & Scoring Committee Equity Impact Assessment, May 2021 https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MSC-Equity-Impact-Assessment-Report.pdf

[3] Oregon Health System Transformation: CCO Metrics 2017 Final Report, June 2018 https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2017-CCO-Performance-Report-Quality-Access-Data.pdf

[4] COVID-19 Vaccine Advisory Committee recommendations 2021 https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3580.pdf

[5] CCO OHPB Listening Session Final Recommendation. https://www.oregon.gov/oha/OHPB/Documents/OHPB-CCO-Listening-Session-Recommendations-Final.pdf

Given the demonstrated impacts of structural racism on health outcomes for people in communities of color and Tribal communities, Oregon plans to use every available tool to eliminate health inequities. As discussed in the *Value-Based Global Budget* concept paper, the proposed changes in the CCO Quality Incentive Program are part of a comprehensive strategy to ensure equity and improve the quality of care. By harnessing the power of the Quality Incentive Program so that equity is the primary organizing principle and aligning this proposal with other levers outlined in the waiver, OHA will create a multifaceted approach that encourages the system to eliminate health inequities that disproportionately harm many communities in Oregon. These communities include Oregon's Nine Federally-Recognized Tribes and Tribal communities, Latino/Latina/Latinx, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, communities of color, people with disabilities, people with limited English proficiency, and immigrant and refugee communities.

Proposed strategies

To ensure all Oregon Health Plan members can access and receive high-quality care while prioritizing groups of people who face inequities and structural racism, both contemporary and historical, Oregon proposes restructuring the Quality Incentive Program so that equity is the primary organizing principle. Oregon proposes changing STC 38 to reflect modified decision-making power that incorporates greater community and member voice, as well as adjusting STCs 39 and 36e.iii to better align with proposed program changes.

Oregon intends to refine its Quality Incentive Program to prioritize health equity, using several complementary strategies:

1. Ensure space for focused equity work by restructuring the Quality Incentive Program into two complementary components:
    a. A small set of upstream metrics focused on supporting health equity and requiring sustained effort over the period of this waiver;
    b. A set of downstream metrics chosen from CMS's Medicaid Adult and Child Core Sets (and potentially the future Medicaid MCO Quality Rating System measure set) focused on factors such as quality, access, and outcomes with a particular emphasis on reducing inequities;
2. Redistribute decision-making power among communities; and
3. Rethink the incentive structure to better advance equity.

1. Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity

To ensure all Medicaid members have access to care and receive high-quality care while prioritizing people in communities that face contemporary and historical inequities, Oregon proposes separating the Quality Incentive Program into two complementary and interrelated components, each of which will be incentivized to improve equity.

a) A small set of "upstream" metrics focused on factors affecting health equity

The first component of the new measurement structure will contain up to five metrics incentivized for the duration of the waiver. These metrics are expected to require long-term, sustained effort to achieve. For this waiver period, the upstream set is largely identified. For the next waiver period, OHA would work with the Health Equity Quality Metrics Committee (restructured from the existing Health Plan Quality Metrics Committee, see strategy #2 on page 4 for more detail) and other interested parties to plan and potentially develop new measures.

Given the extensive lead time required to develop new metrics, OHA has identified four existing metrics for the upstream measure set. A fifth metric could be added and, depending on timing considerations, the new Health Equity Quality Metrics Committee may guide measure development.

These metrics were developed during the current and previous waiver periods in response to analysis of harms to specific populations and community-identified needs. They're designed to incentivize systems-level changes that advance health equity, and they address domains for which no standardized metrics currently exist. The following table outlines the four existing metrics that will be included in the upstream metrics.

Upstream Health Equity Metric	Year incentivized	Additional Information
Mental, Physical and Oral Health Assessment Within 60 Days for Children in DHS Custody[6]	2013	Incentivizes timely assessments for children in foster care, so their physical, oral and behavioral health needs are identified and can be addressed.
Meaningful Language Access to Culturally Responsive Health Care Services [7]	2021	Incentivizes the provision of high-quality interpreter services when needed and access to care and information (explanations of benefits, take-home resources, and more) in members' preferred languages, enabling them to more effectively participate in their own care.
Health Aspects of Kindergarten Readiness (HAKR)[8]	2022[9]	Incentivizes more CCO members having their social needs acknowledged and addressed. .

[6] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2014-Assessments-Children-DHS-Custody-Guidance-Document.pdf

[7] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx

[8] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx

[9] For Social Emotional Health component of HAKR bundle

Upstream Health Equity Metric	Year incentivized	Additional Information
Social Determinants of Health: Social Needs Screening and Referral[10]	2023[11]	Incentivizes more culturally responsive services being offered to help children start kindergarten ready to learn.

These domains were chosen because of their focus on Oregon Health Plan members who experience historical and/or contemporary injustices and structural racism. The measure development webpages provide more information from the public workgroups and other interested parties who worked through measure specification and pilot testing. This measure set will allow the state to monitor improvements in access to resources that directly address these injustices.

b) A set of "downstream" metrics that focuses on traditional quality and access measures

The second component of the new measurement structure will align with measures of health care processes, outcomes, and utilization that are used nationally (downstream metrics). These metrics will draw from traditional quality and access measure sets. Downstream metrics will be selected from the CMS Medicaid Adult and Child Core sets and other CMS-required measures (e.g., may include Medicaid MCO Quality Rating System measures in the future).[12] OHA will develop criteria to ensure that the selected metrics address the full breadth of health care quality considerations: cost, quality, access, and health equity, as well as address oral, behavioral, and physical health. As before, Oregon's Metrics and Scoring Committee will select the metrics, but as described below, a newly redesigned and separate committee called the Health Equity Quality Metrics Committee will have oversight and approval.

This approach builds on work Oregon is required to undertake on the Medicaid Child Core Set and Behavioral Health measures in the Medicaid Adult Core Set when reporting becomes mandatory in 2024. Aligning with the CMS Core Sets will promote cost savings and enable comparison to other state Medicaid programs' performance. The downstream metrics will be monitored and publicly reported at the subpopulation level to ensure quality and access for members within race/ethnicity, language, and disability groups whenever possible. Downstream metrics will continue to be incentivized for continuous quality improvement and, as addressed in Strategy 3 below, will use new benchmarking approaches where possible to address inequities among racial and ethnic groups.

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[10] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx

[11] Potential implementation

[12] Oregon recognizes that because of variations in benefit packages among states, the Medicaid Adult Core set does not include measures of adult oral health. To fill that gap, Oregon may include in the downstream set of measures one or two adult oral health measures from the Dental Quality Alliance or similar national measure steward.

2. Redistribute decision-making power to communities

To ensure that the Quality Incentive Program drives system-level improvements as well as improvements to patient care, those who are most affected by health inequities will have power within the committee structure that selects downstream metrics.

OHA is committed to redistributing power in the Quality Incentive Program and plans to modify the structure of Committees that are responsible for selecting and incentivizing metrics. While maintaining a public committee process for metrics selection, OHA intends to work with the legislature to amend the statutes establishing the metrics committees so the current Health Plan Quality Metrics Committee can change its membership, focus and role to become the Health Equity Quality Metrics Committee (HEQMC). HEQMC members will represent the interests of those most affected by health inequities including Oregon Health Plan members, community members from diverse communities, individuals with lived experience of health inequities, and health equity professionals and researchers.

This Committee will oversee and approve the downstream metrics selected by the Metrics and Scoring Committee and will advise OHA about how to design the program to best address member and community concerns and priorities. As OHA adopts broader community engagement strategies, input received in those forums will also inform measure selection and implementation. In addition, OHA will consider member and community voices in the presentation of measure performance. For example, OHA will continue to produce an annual CCO Incentive Metrics report and supplement the quantitative data typically included in this report with qualitative information, including priorities identified by members of the HEQMC.

3. Rethink the incentive structure to better advance equity

Oregon's current Quality Incentive Program consists of one set of metrics incentivized for the initial round of payments and a subset incentivized for the challenge pool. Using this approach, any incentive funds that are not earned in the initial round are distributed in the challenge pool round. In the initial and challenge pool rounds, CCOs can earn incentives by meeting either an overall benchmark or a CCO-specific "improvement target," which is calculated to close the gap between the CCO's baseline performance and the benchmark. Each year, the entire pool of available quality funds is paid out; if any funds are not paid out in the initial round, they are then paid out in the challenge pool round.

While this overall structure will remain the same for the 2022-2027 waiver, OHA proposes to work with the new Health Equity Quality Metrics Committee and the Metrics and Scoring Committee to select which upstream and downstream metrics are incentivized to best improve health equity. OHA will present the committees with a range of approaches from which to select.

For instance, for the downstream metrics, one option is that the only metrics eligible for the challenge pool would be those that address significant inequities, and payment of challenge pool funds would be contingent on reducing inequities in the downstream metrics where performance can be compared to other state Medicaid programs.

Another option is to focus on closing inequitable performance gaps in all eligible metrics, not only in the challenge pool. This could be accomplished by making payment of incentives contingent on achieving CCO-specific improvement target for a metric (as opposed the aspirational benchmark for the metric) for all subpopulations with at least 50 members. In this option CCOs would not be able to rely on simply making progress toward a benchmark unless they make progress for all subpopulations.

For the upstream metrics focused on rectifying the systems and structures that create inequities, CCO incentives will be paid per metric as either individual CCO improvement targets or the benchmark is reached. Funds not earned after payout for the upstream metrics, as well as any funds not earned in the initial round of payout for the downstream metrics, will be paid out in the challenge pool round. Oregon is exploring how best to fund the quality incentive payments: as a withhold, bonus, or some combination of the two.

Current waiver authority

The CCO Quality Incentive Program was originally outlined in Oregon's 2012 demonstration extension and amendment, and as such any modifications to the program need to be negotiated with each subsequent waiver renewal. In this waiver application, Oregon proposes to restructure the CCO Quality Incentive Program to prioritize advancing health equity in support of the Oregon Health Authority's goal to eliminate health inequities by 2030. Listed below are the primary strategies to prioritize advancing health equity and the associated special term and condition (STC) which may require modification:

1. **Restructure the Quality Incentive Program into two complementary components to reserve space for upstream work focused on equity**

   STC 39: Additional Quality Measures and Reporting at the CCO Level. The CCOs will be required to collect and validate data and report to the state on the metrics listed in this section, which may be revised or added to over time as the demonstration matures. CMS also encourages the CCOs to report on the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP.

2. **Redistribute decision-making power among communities**

   STC 38: Metrics and Scoring Committee. The state's strategy for a robust measurement includes the Metrics and Scoring Committee. The Committee reviews data and the relevant literature determines which measures will be included in the CCO incentive program and establishes the performance benchmarks and targets to be used in this incentive program. The Committee will endorse specifications for each measure. In future years, the Committee will review earlier decisions and adjust as needed. The Metrics and Scoring Committee recommends metrics that will be used to determine financial incentives for CCOs.

3. **Rethink the incentive structure to better advance equity**

   STC 36e.iii: The state will establish an incentive pool. Incentives must be designed to reduce costs and improve health care outcomes. When developing the incentive pool, the state will take into consideration how to offer incentives for outcomes/access improvement and expenditure trend decreases to reduce the incentive for volume-based billing. The incentive pool will comply with the relevant portions of 438.6. The state will alert the CCOs that the incentive pool will be tied to each CCO's performance on the quality and access metrics established under Section VII, and that the whole incentive pool amount will be at risk. The state will provide larger incentive awards for CCOs with higher absolute performance on the quality and access metrics compared to an appropriate benchmark and provide larger incentive awards to CCOs that improve performance over time compared to their own past performance.

What these policies would mean for OHP members

With the revised incentive structure, all OHP members can expect to continue to see improvements in health equity outcomes and health care quality by CCOs. OHP members and communities also will have a greater voice in the quality incentive program. The pace of improving health inequities by CCOs will be measured, monitored and publicly reported. On measures of health care quality, CCOs will have accountability for improved performance not just for their overall members but also for racial and ethnic groups within their CCO membership.

The revised program includes locally developed measures of health equity. For example, the meaningful language access measure is intended to help members receive high-quality interpreter services when needed and access care and information (explanations of benefits, take-home resources, and more) in their preferred languages and easily understood formats, so they can more effectively participate in their own care. The social-emotional health measure is intended to help families connect to needed services, including culturally responsive services, so children start kindergarten ready to learn. The assessments for children in DHS custody measure is intended to ensure that kids in foster care get timely assessments of their physical, oral and behavioral health, so their needs are identified and met. The social needs screening and referral measure will require CCOs will build partnerships with community-based organizations and improve processes so Oregon Health Plan members' unmet social needs (food insecurity, housing insecurity, and transportation needs) are addressed.

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