Incentivizing Equitable Care

CCO incentive metrics / quality pool for 2022-2027

Since 2013, Oregon's Quality Incentive Program has based part of coordinated care organizations' (CCOs) payments on performing well on certain health metrics or measurements of how well they are providing access to care for Oregon Health Plan (OHP) members. These health metrics usually change a little bit each year. The program looks at things like the quality of health care OHP members receive and whether they can get health care in the right place and the right time.

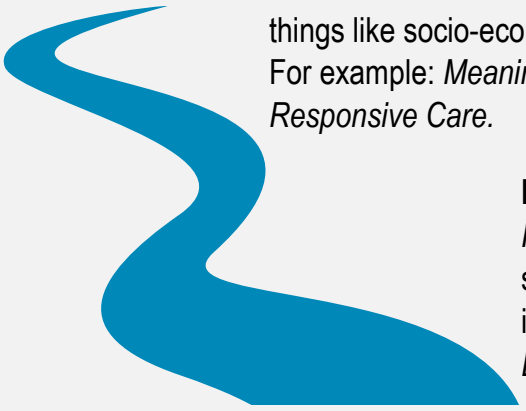
In the new waiver, Oregon plans to build on the program's success by adding a focus on metrics that address upstream factors affecting health equity.

Potential strategies to address health inequities through metrics

1. **Restructure the Quality Incentive Program into two complementary components**

   Oregon wants to make sure all Oregon Health Plan members can find and receive high-quality health care. It also plans to prioritize people in communities who face current and historical inequities. To make sure both get enough attention, Oregon plans to split its current metrics program into two parts: upstream and downstream. We call them "upstream" and "downstream" because it's like a river—by focusing on things that *cause* poor health, we can catch and address them before they show up "downstream" as worse health outcomes.

Upstream and downstream metrics



Upstream
Root causes of health inequities. These metrics focus on things like socio-economic factors and discriminatory beliefs. For example: *Meaningful Language Access to Culturally Responsive Care.*

Downstream
Medical care. These metrics focus on things like screenings, treating chronic disease and immunizations. For example: *Controlling High Blood Pressure.*

Upstream metrics

One part of the incentive program will consist of metrics that address health equity. These metrics will focus upstream to correct historical and contemporary injustices. One example is the metric that looks at providing culturally responsive health care services in an OHP member's preferred language.

Downstream metrics

The other part of the incentive program will line up with standard health metrics used by other Medicaid organizations across the country. Standard health metrics like these are already required by the federal agency that oversees Medicaid, the Centers for Medicare and Medicaid Services. These metrics focus on more traditional medical care, such as diabetes screenings and well child visits.

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

   OHA believes that people in communities that experience health inequities need to have the power to make decisions about what to improve and how to improve it. To help make this happen, OHA plans to work with the Legislature to change the Health Plan Quality Metrics Committee into the Health Equity Quality Metrics Committee (HEQMC). HEQMC will focus on the people who have been most affected by health inequities: OHP members, community members from diverse communities, individuals with lived experience of health inequities, and health equity professionals and researchers.

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

   HEQMC and the Metrics and Scoring Committee will select which metrics will be incentivized to improve health equity the most. To help the Committees decide, OHA will provide race, ethnicity, language and disability data. They'll use that information to decide how to structure the incentive program in a way that encourages CCOs to provide OHP members with equitable access to high-quality care.

What this means for OHP members

In the new waiver, OHP members and communities will have a greater voice in the quality incentive program. The result will be that the program will be measuring and rewarding improvements that matter the most to the community and have the greatest chance of improving health outcomes.

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