Oregon Health System Transformation: CCO Metrics 2017 Final Report

June 2018

Oregon Health Authority

MEASUREMENT PERIOD:
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BACKGROUND / CONTEXT

Medicaid waiver

Medicaid (health coverage for people earning less than 138 percent of the federal level, and people with disabilities) is administered by individual states but must follow certain federal requirements. States may obtain an 1115 Medicaid Demonstration waiver from the federal government, which grants them extra flexibility in how they use federal Medicaid funds in their state, with the goal of improving health care programs. Oregon has had such a waiver since 1994. The 1115 Medicaid waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include: using best practices to manage and coordinate care; transparency in price and quality; and paying for better quality care and better health outcomes, rather than just more services. So what does coordinated care mean?

Coordinated care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs were formed in Oregon in late 2012. In 2017, there were 16 CCOs operating in communities around Oregon .

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

Medicaid expansion

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

Measuring progress

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

BACKGROUND / CONTEXT

State quality metrics

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

CMS core metrics

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

CCO incentive metrics

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

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

Measure specifications and more information

- Information about the CCO incentive program, including specifications for the measures included in this report: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx
- Metrics and Scoring Committee: http://www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx
- Medicaid Demonstration waiver: http://www.oregon.gov/oha/hpa/HP-Medicaid-1115-Waiver/Pages/index.aspx
- This and other metrics reports: http://www.oregon.gov/oha/hpa/analytics-mtx/Pages/HST-Reports.aspx

EXECUTIVE SUMMARY

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

This is the fifth year of Oregon's pay-for-performance program. To earn their full incentive payment, CCOs have to meet benchmarks or improvement targets on at least 12 of the 16 measures and have at least 60 percent of their members enrolled in a patient-centered primary care home. The amount a CCO can earn through the program is based on a percentage of their capitated payments each year. In 2017, the quality pool was 4.25 percent of monthly payments, resulting in more than $178 million

The pay-for-performance model rewards CCOs for the quality of care provided to Medicaid members. This model increasingly rewards CCOs for outcomes, rather than utilization of services, and is one of several key health system transformation mechanisms for achieving Oregon's vision for better health, better care, and lower costs.

The 2017 incentive measures create challenging goals for CCOs to continue to improve the quality of care of Medicaid members. As CCOs made large strides on existing measures in the first few years of the program, the aspirational benchmarks, often based on the most exceptional national performance, require sustained quality improvement efforts to be successful on the measures. In addition, the 2017 challenge pool included three measures: Developmental screenings in the first 36 months of life, effective contraceptive use among adult women, and depression screening and follow-up.

All CCOs showed improvements in a majority of measures and 14 out of 16 CCOs earned 100 percent of their quality pool dollars. The report indicates that through the coordinated care model, there have been continued improvements in a number of areas, such as reductions in emergency department visits, and increases in depression screening and enrollment in patient-centered primary care homes.

New in this report: For the first time, 2017 metric performance is reported by household language. Racial and ethnic identity are shown for one year in bar charts due to increasing data collection challenges involved in standardization issues across methods of digitizing information and issues related to self-reporting race. For annual performance, we show racial categories as entered by three separate eligibility application methods: self-report online, case-worker doing data entry from paper submissions, and case worker doing real-time

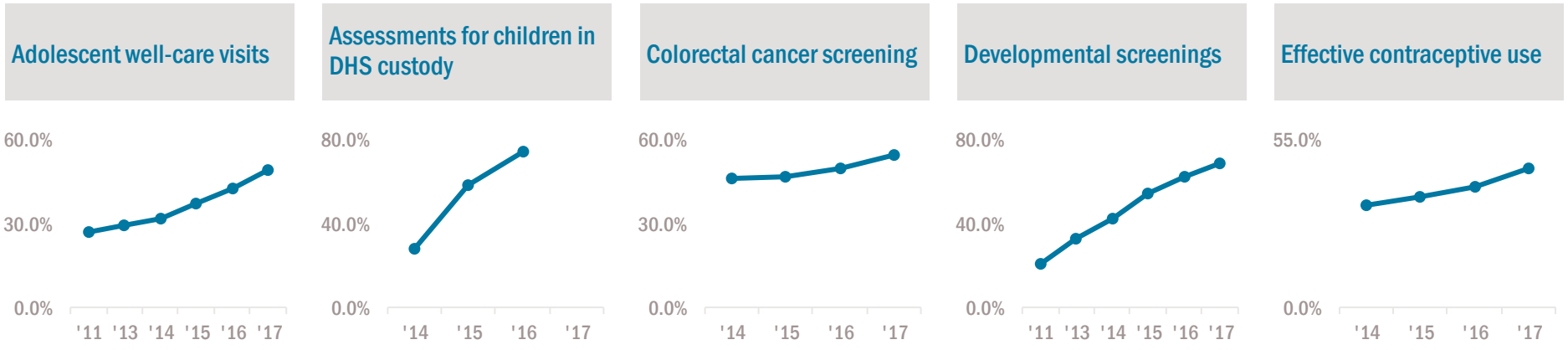
EXECUTIVE SUMMARY

online entry from qualification interviews. Using summarized categories, we report the percentage of the groups who met the measure. OHA continues to work with community partners and colleagues to improve the reliability of this highly important information.

Note that at in early 2018 (after the close of the measurement year) FamilyCare stopped its service delivery operations but maintained a staff to submit data for their last measurement year ending on December 31, 2017 and reported here.

This report indicates that through the coordinated care model, there have been continued improvements in a number of areas, such as:

- **Adolescent well-care visits.** CCOs continue to make large strides on this measure, with all 16 CCOs improving in 2017 and achieving their individual improvement target. Statewide, almost half of adolescents and young adults (ages 12-21) received a well-care visit as recommended by clinical guidelines. This is a 15 percent improvement over 2016, and more than 80 percent since 2011 baseline. While CCOs are improving, overall performance remains relatively low: slightly below the national Medicaid 75th percentile. The CCO Metrics Mid-Year "Deeper Dive" Report provided additional analysis on the measure, and it is a focus area of OHA's Transformation Center technical assistance.
- **Health assessments for children in DHS custody**. The percentage of children in foster care who received a mental, physical, and dental health assessment has increased 11 percent in two years.
- **Colorectal cancer screening.** The 10 percent statewide improvement over last year on this measure now exceeds the 2017 benchmark showing a statewide performance of almost 55 percent.
- **Developmental screening in the first three years of life**. This measure uses a standardized screening tool for developmental, behavioral



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and social delays to support children and families. CCOs have made impressive improvement on this measure: statewide, 2017 performance (69 percent) was more than triple than 2011.

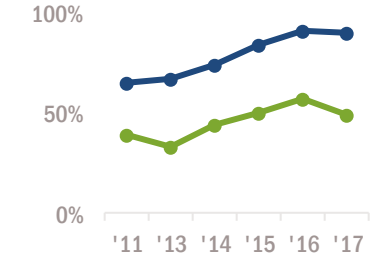
- **Effective contraceptive use among women at risk of unintended pregnancy.** A new measure in 2015, the percentage of adult women ages 18-50 who are using an effective contraceptive has increased 25 percent in just two years.

Measures to watch:

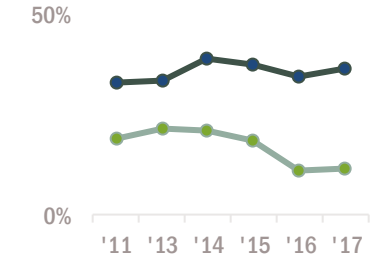
- **Postpartum care.** The percentage of women who had a timely postpartum care visit after giving birth declined in 2017 and is below the national Medicaid 75th percentile. While prenatal care declined slightly also, performance remains near the national 90th percentile. Prenatal care is a CCO incentive measure.
- **Initiation and engagement of alcohol or other drug treatment.** In 2016, the percentage of members newly diagnosed with alcohol or other drug dependences who *initiated* treatment within 14 days of the initial diagnosis, and the percentage of members who *continued* their treatment declined. While initiation of treatment increased slightly in 2017, the percent of members who continued their treatment remained steady. Nationally, performance on this measure is low.
- **Prevention quality indicators.** After a sharp decline in 2014, the rate of adult members who had a hospital stay because of congestive heart failure or short-term diabetes complications has increased each year. Lower is better on this measure.

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

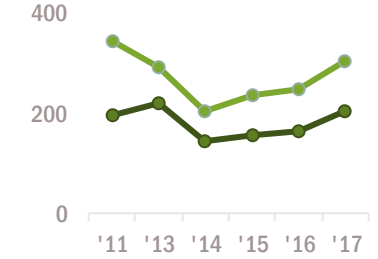
Prenatal and postpartum care rate



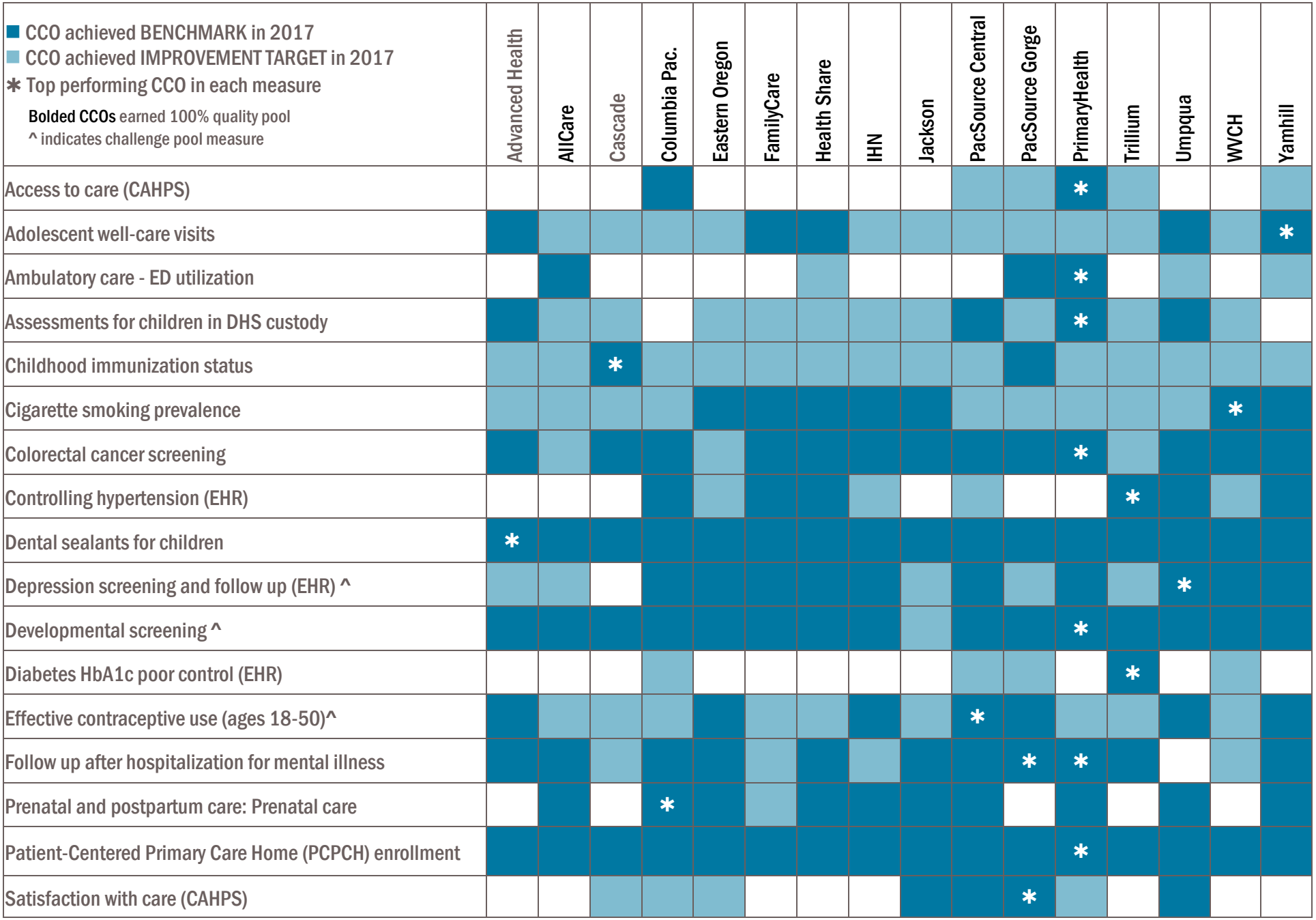
Alcohol or drug treatment
Initiation of treatment
Continuation of treatment



Hospital admissions
Congestive heart failure
Diabetes complications



2017 INCENTIVE METRIC PERFORMANCE OVERVIEW



2017 QUALITY POOL DISTRIBUTION

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

The 2017 quality pool is more than $178 million. This represents 4.25 percent of the total amount all CCOs were paid in 2017. The quality pool is divided among all CCOs based on their number of members (see page 14 for CCO enrollment numbers) and their performance on the 17 incentive metrics.

Quality Pool: Phase One Distribution

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

- Meeting the benchmark or improvement target on 12 of 16 measures; and
- Having at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

CCOs must meet both of these 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 2017 challenge pool is just under $2.4 million. Challenge pool funds are distributed to CCOs that meet the benchmark or improvement target on three measures:

1. Depression screening and follow-up plan
2. Developmental screenings
3. Effective contraceptive use

Through the challenge pool, some CCOs earn more than 100 percent of their maximum quality pool funds. The next page shows the percentage and dollar amounts earned by each CCO.

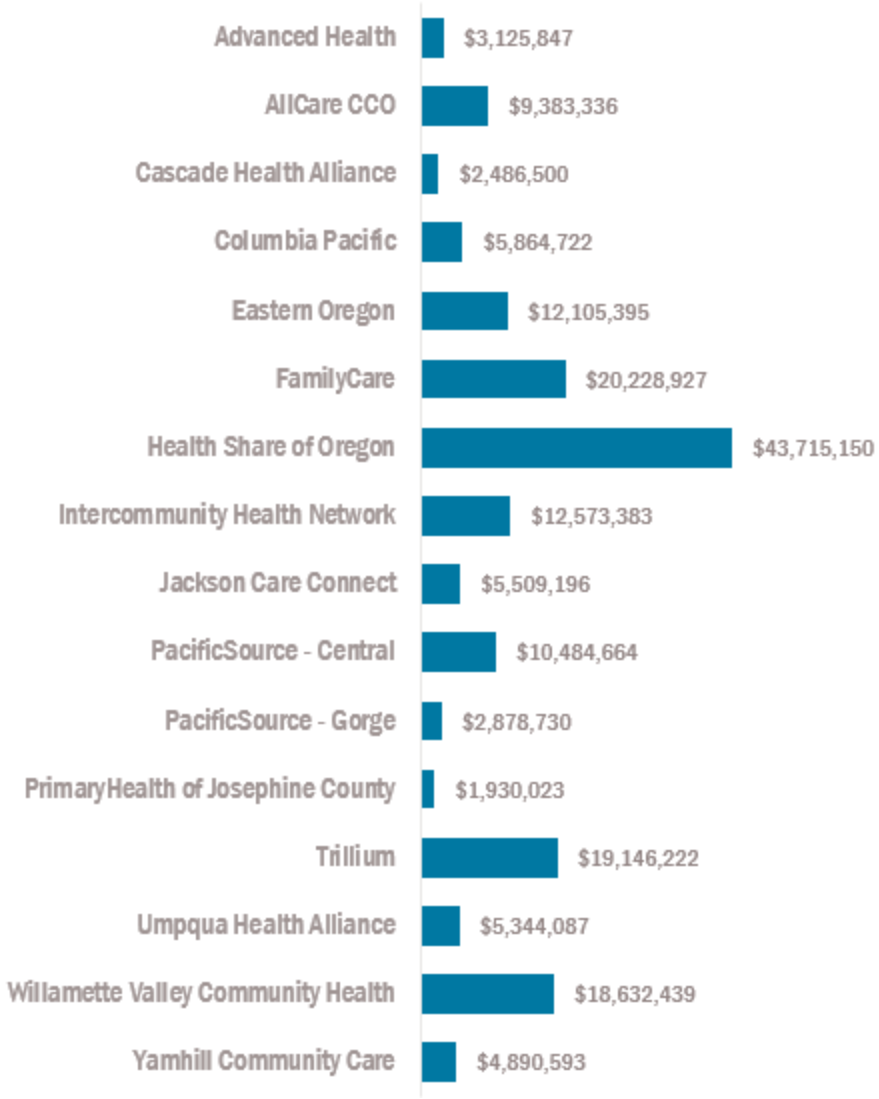
2017 QUALITY POOL DISTRIBUTION

CCO	Phase 1 Distribution			Challenge Pool		Total	
	# Measures met (of 17 possible)	Payment earned in Phase 1*	% Quality pool funds earned	# Challenge measures met	$ Challenge pool earned	Total payment (Phase 1 + Challenge pool)	Total quality pool earned
Advanced Health	10.7	$ 3,072,442	70%	3	$ 53,406	$ 3,125,847	71.3%
AllCare Health Plan	12.7	$ 9,248,658	100%	3	$ 134,678	$ 9,383,336	101.5%
Cascade Health Alliance	10.7	$ 2,455,669	70%	2	$ 30,832	$ 2,486,500	70.9%
Columbia Pacific	14.8	$ 5,799,384	100%	3	$ 65,339	$ 5,864,722	101.1%
Eastern Oregon	13.7	$ 11,974,183	100%	3	$ 131,211	$ 12,105,395	101.1%
FamilyCare	12.7	$ 19,910,457	100%	3	$ 318,471	$ 20,228,927	101.6%
Health Share of Oregon	13.7	$ 43,141,732	100%	3	$ 573,419	$ 43,715,150	101.3%
Intercommunity Health Network	12.6	$ 12,428,525	100%	3	$ 144,858	$ 12,573,383	101.2%
Jackson Care Connect	12.6	$ 5,428,848	100%	3	$ 80,347	$ 5,509,196	101.5%
PacificSource – Central Oregon	15.8	$ 10,349,928	100%	3	$ 134,735	$ 10,484,664	101.2%
PacificSource – Gorge	14.7	$ 2,844,691	100%	3	$ 34,039	$ 2,878,730	101.3%
PrimaryHealth of Josephine County	14.9	$ 1,902,503	100%	3	$ 27,520	$ 1,930,023	101.4%
Trillium	13.6	$ 18,906,370	100%	3	$ 239,853	$ 19,146,222	101.3%
Umpqua Health Alliance	13.7	$ 5,271,510	100%	3	$ 72,577	$ 5,344,087	101.4%
Willamette Valley Community Health	12.8	$ 18,368,465	100%	3	$ 263,973	$ 18,632,439	101.4%
Yamhill Community Care	13.7	$ 4,826,661	100%	3	$ 63,932	$ 4,890,593	101.3%
Total		$ 175,930,026			$ 2,369,190	$ 178,299,214	

* Quality pool distribution is based on number of measures met and CCO size (number of members). See page 14 for CCO enrollment.

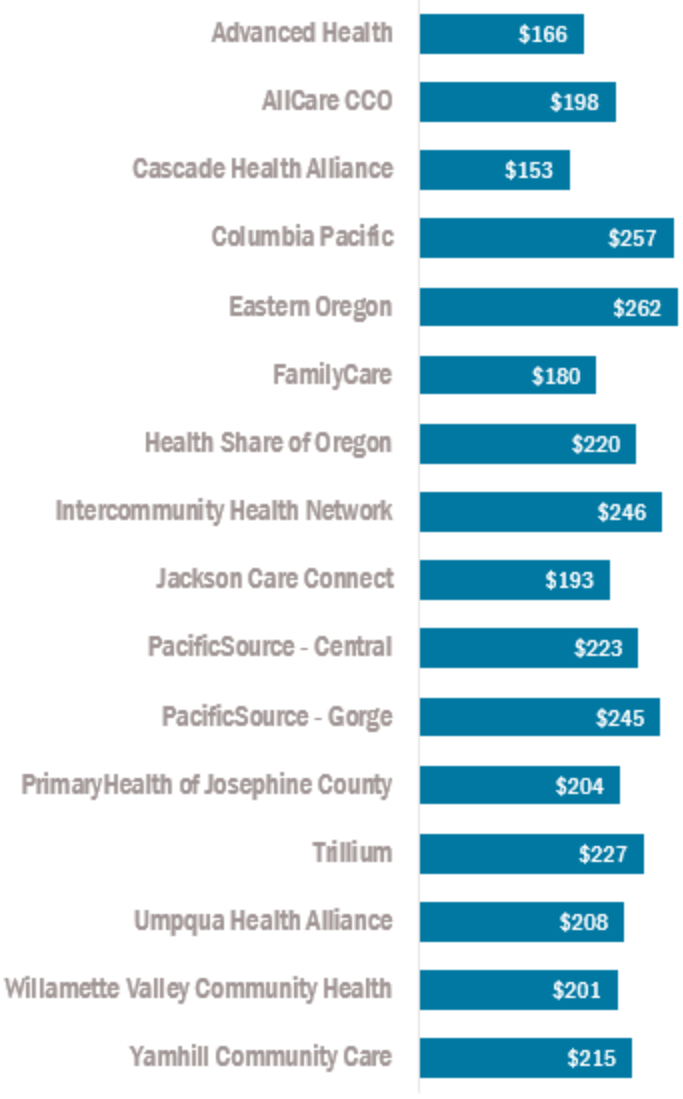
2017 QUALITY POOL DISTRIBUTION

Total quality pool dollars earned, by CCO.

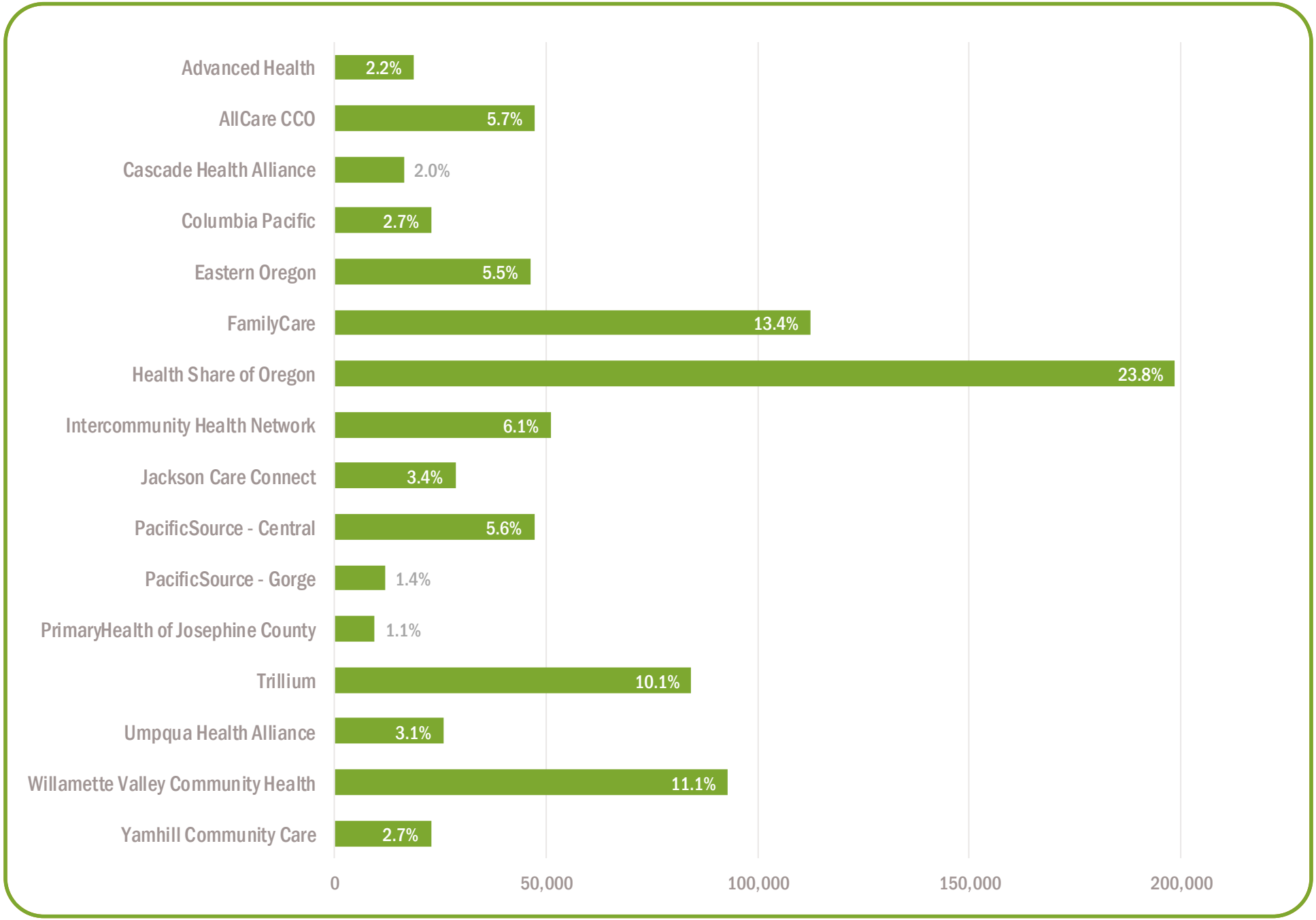


Quality pool earned per member.

(December 2017 enrollment)



TOTAL CCO ENROLLMENT (December 2017)



Appendix A

CCO Incentive Measures

ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

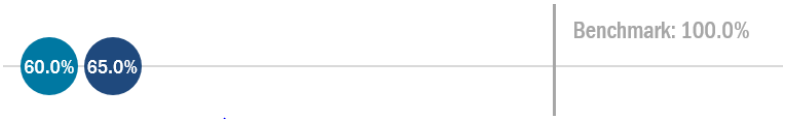
Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. That is, CCOs are not expected to meet the benchmark each year, but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) 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 **2015** (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 2016**. Their **improvement target** is [baseline + 4%] = [60% + 4%] = **64%***

*CCO A's performance in **2016** 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 Metrics and Scoring 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 only 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%.

ACCESS TO CARE (CAHPS SURVEY)

Access to care (CAHPS)

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

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

2017 benchmark source:
2016 national Medicaid 75th percentile; weighted average of adult and child rates.

2017 data (N=5,385)

- Statewide percent change since 2016: **+0.4%**
- Number of CCOs that improved: **8**
- Number of CCOs achieving target: **6**

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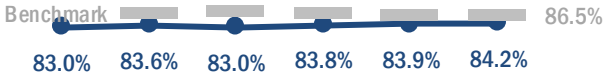
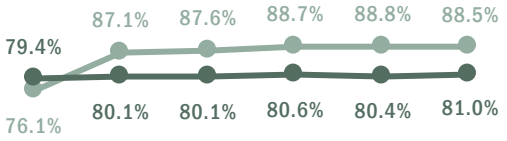
Statewide, access to care has remained steady over time.

All ages combined



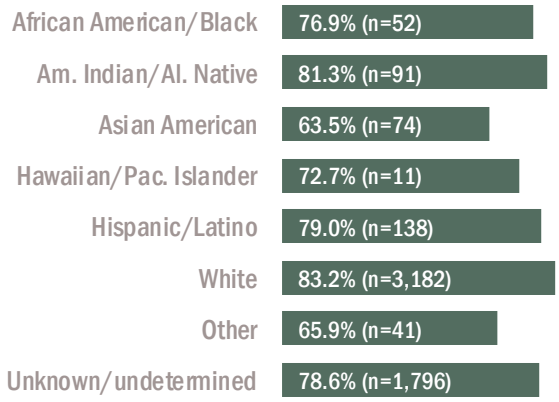
2011 '13 '14 '15 '16 2017

Adults and children



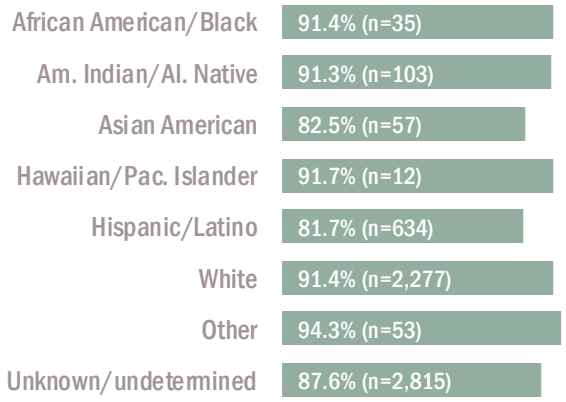
2011 '13 '14 '15 '16 2017

By race and ethnicity (adults) in 2017



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

By race and ethnicity (children) in 2017



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

ACCESS TO CARE (CAHPS SURVEY)

Access to care (all ages) in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.

ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits

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

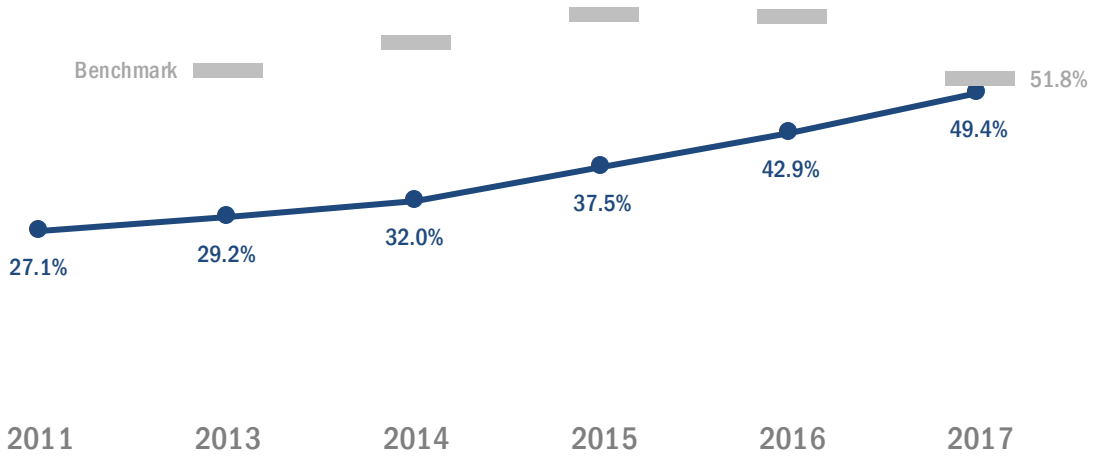
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 75th percentile

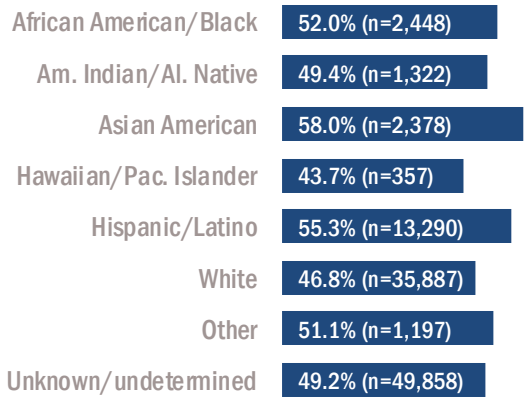
2017 data (N=106,737)

- Statewide change since 2016: **+15.2%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

Statewide, adolescent well-care visits continue to increase.

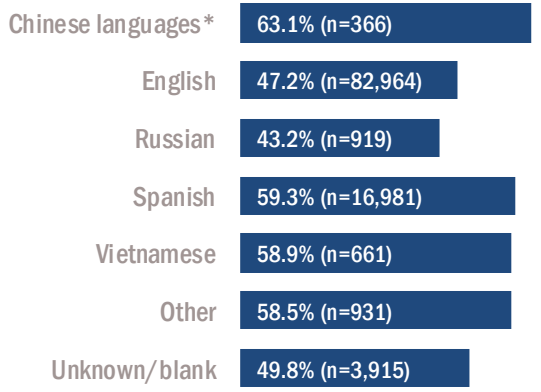


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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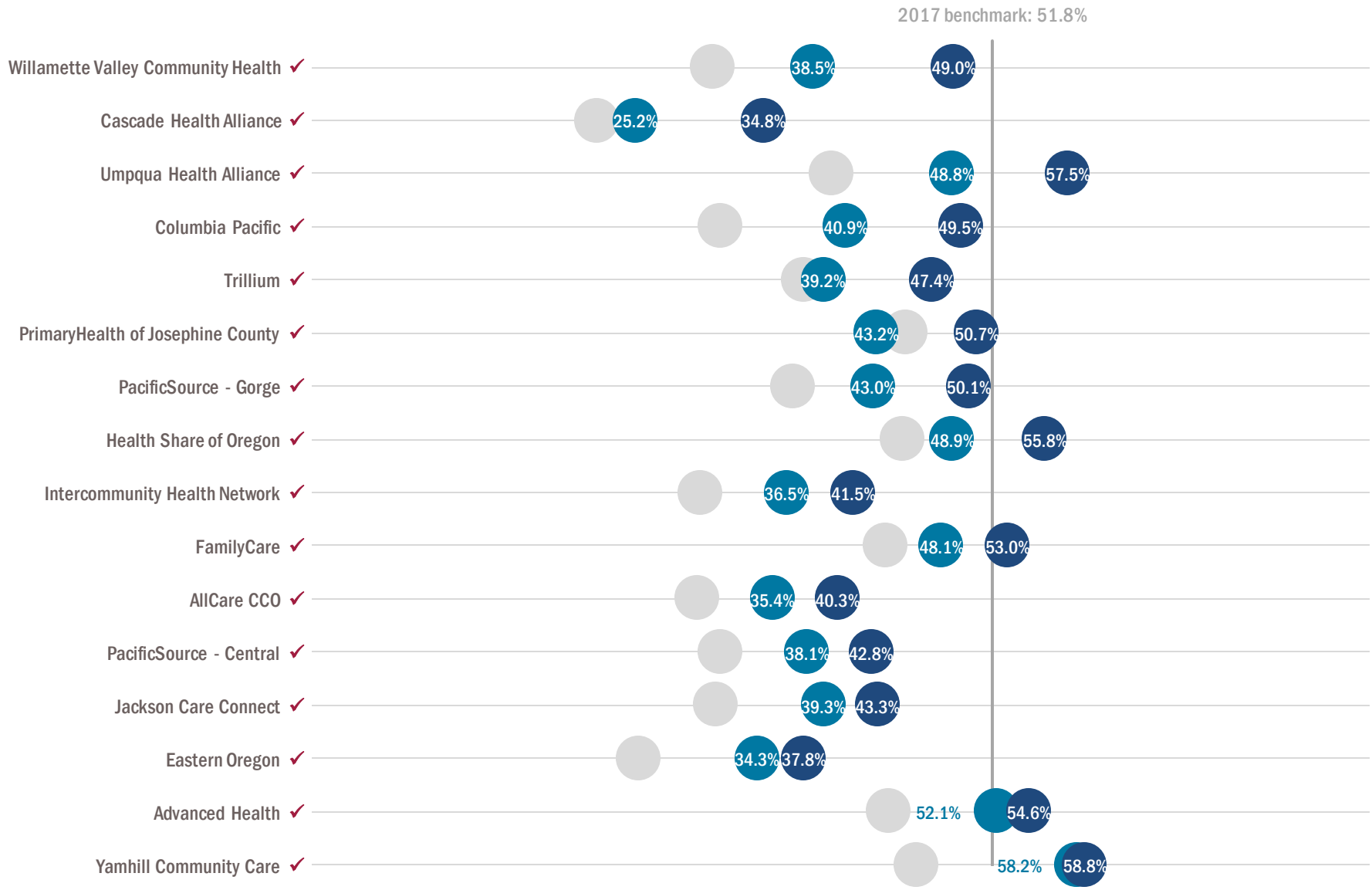
ADOLESCENT WELL-CARE VISITS

Adolescent well-care visits in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



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

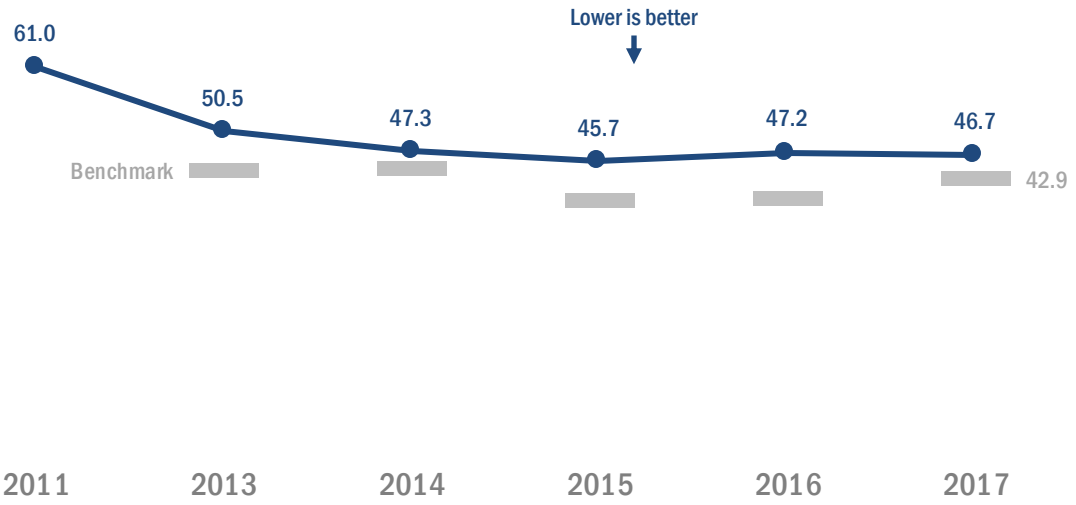
2017 benchmark source:
2016 national Medicaid 90th percentile

2017 data (N=10,026,285 member months)

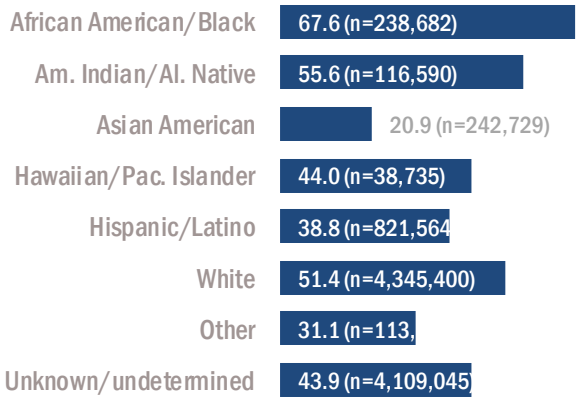
- Statewide percent change since 2016: **-1.1%**
- Number of CCOs that improved: **11**
- Number of CCOs achieving target: **6**

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, emergency department utilization has remained steady since 2014.

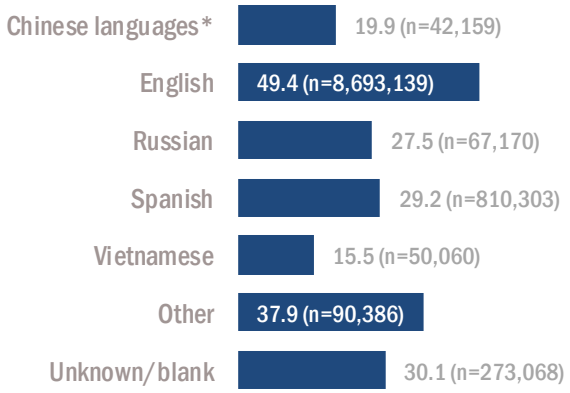


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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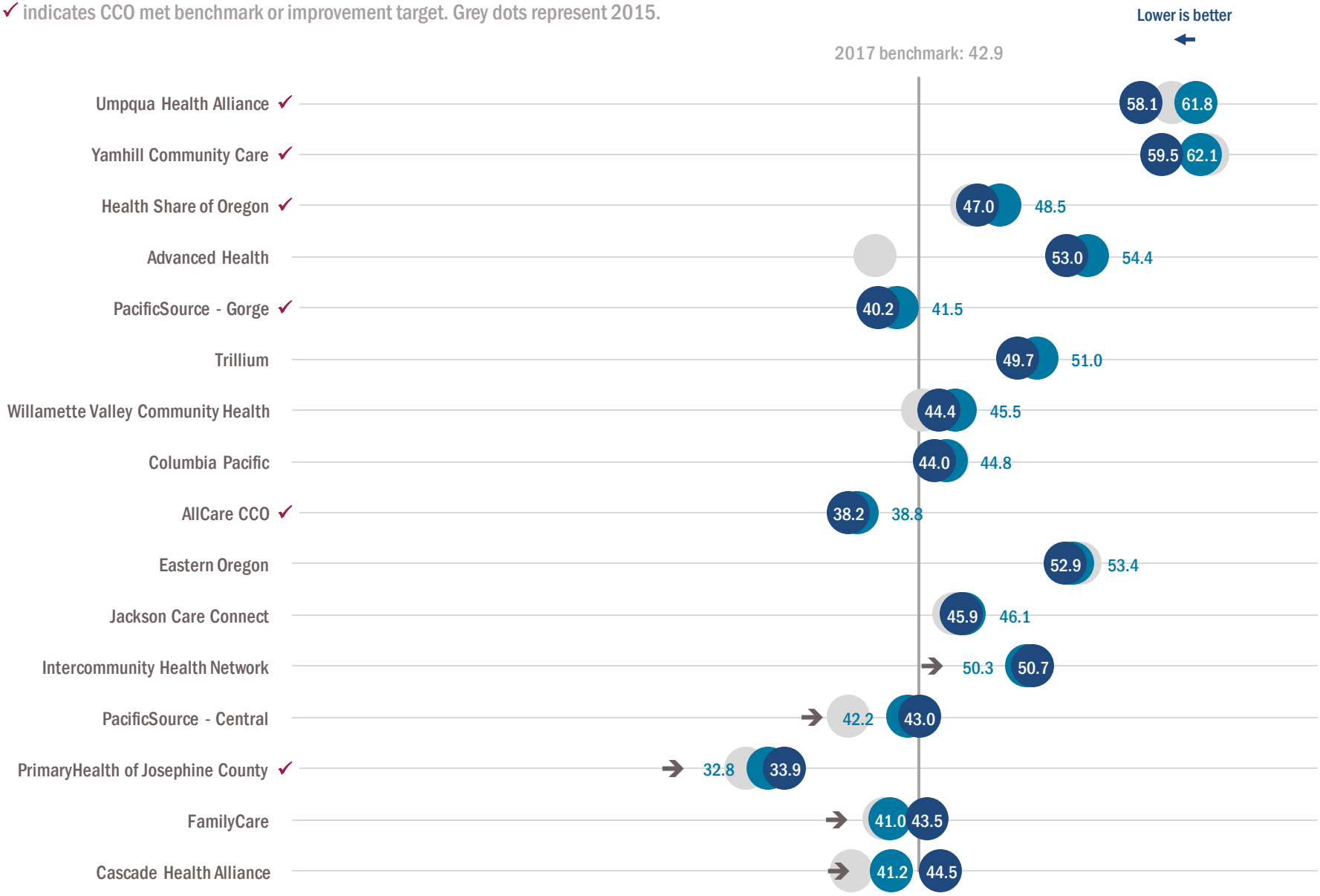
AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

Emergency department utilization in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody

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

Data source:
Administrative (billing) claims + ORKids

2017 benchmark source:
Metrics and Scoring Committee consensus

2017 data (N=2,013)

- Statewide percent change since 2016: **+11.3%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **13**

Results prior to 2014 are not comparable to later years due to change in methodology (dental assessments were added to the metric).

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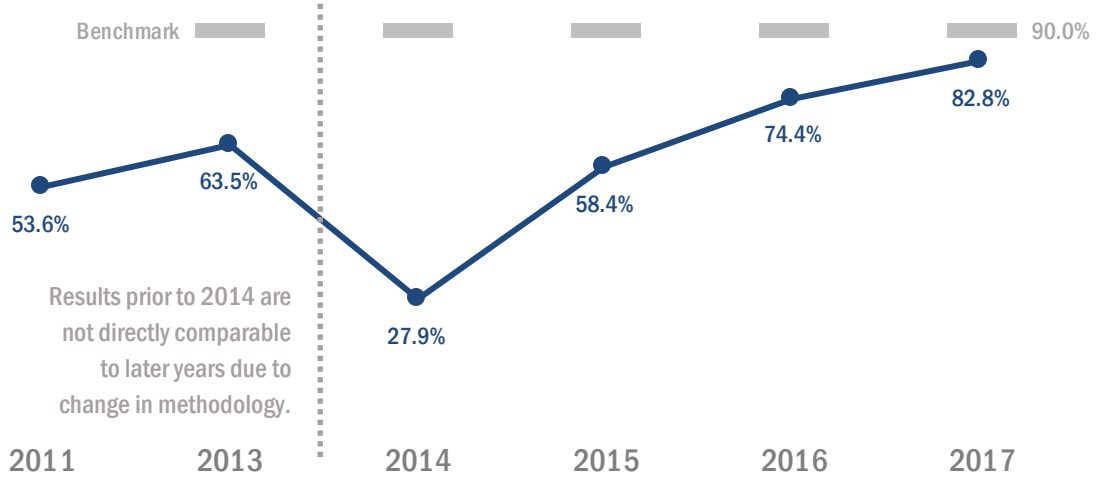
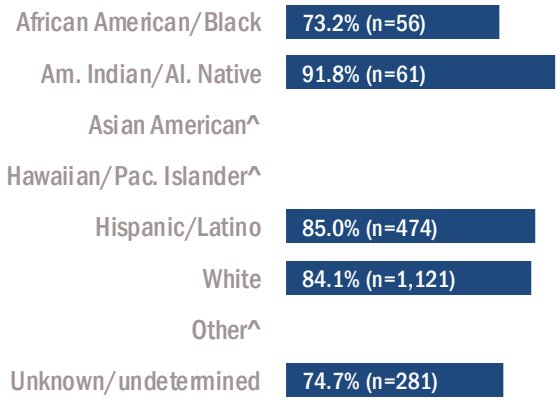
Statewide, assessments for children in DHS custody continue to increase.

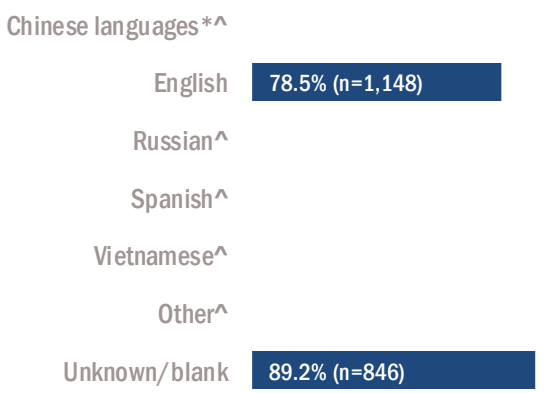


By race and ethnicity (2017)



^ data suppressed (n<30)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

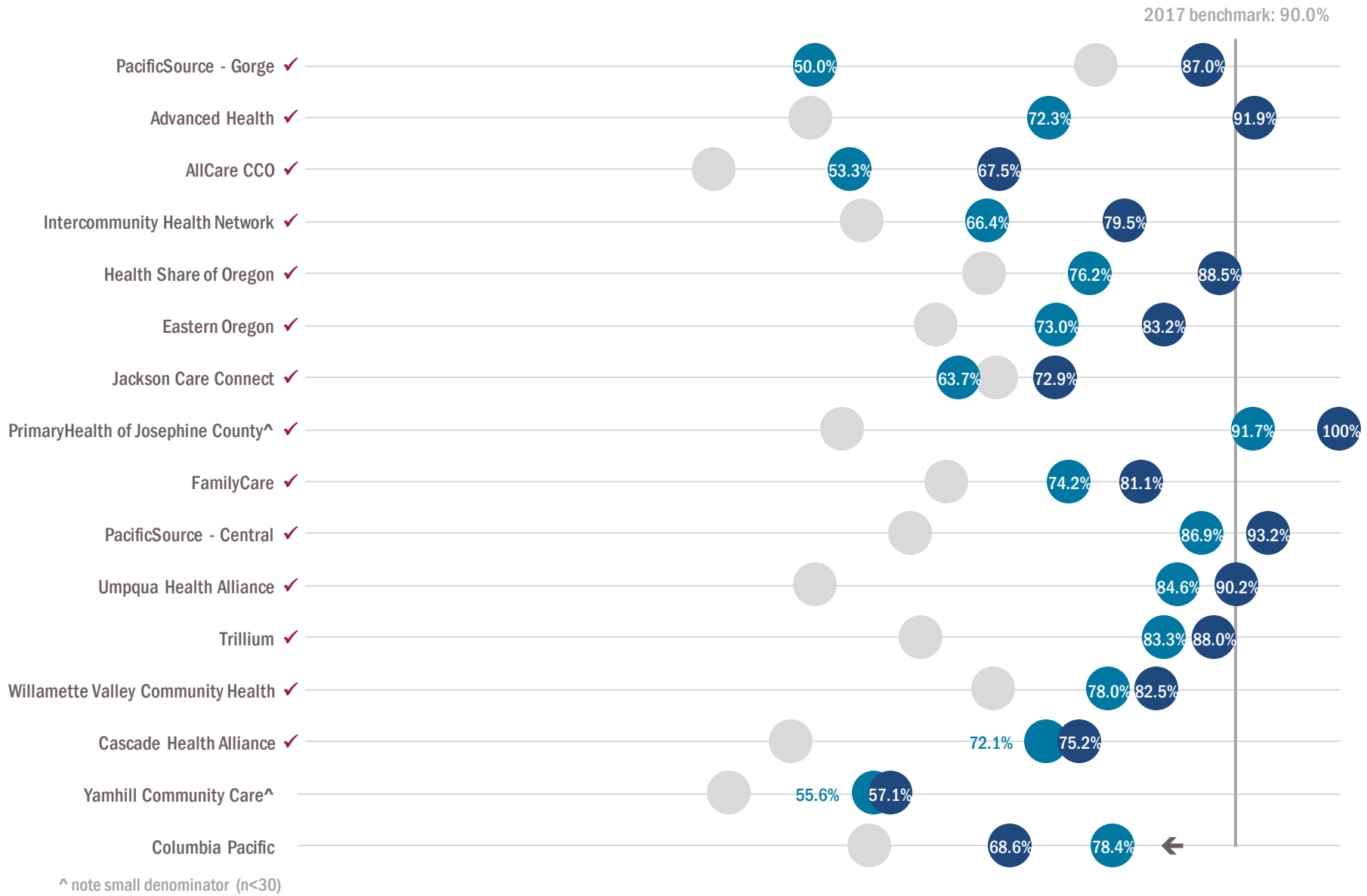


^ data suppressed (n<30)
n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



^ note small denominator (n<30)

CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

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

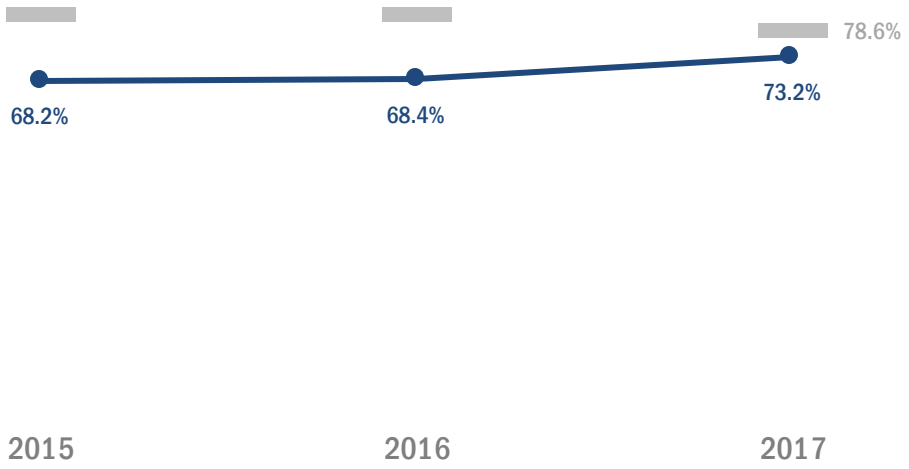
Data source:
Administrative (billing) claims and ALERT immunization data

2017 benchmark source:
2016 national Medicaid 75th percentile

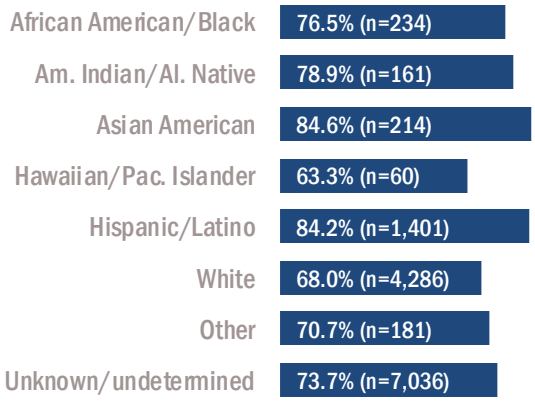
2017 data (N=13,573)

- Statewide percent change since 2016: **+7.0%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

Statewide, childhood immunizations increased in 2017.

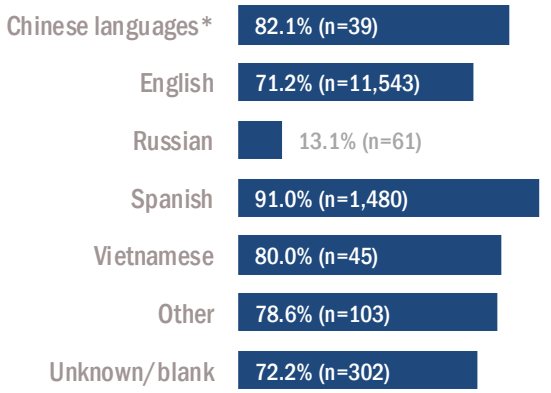


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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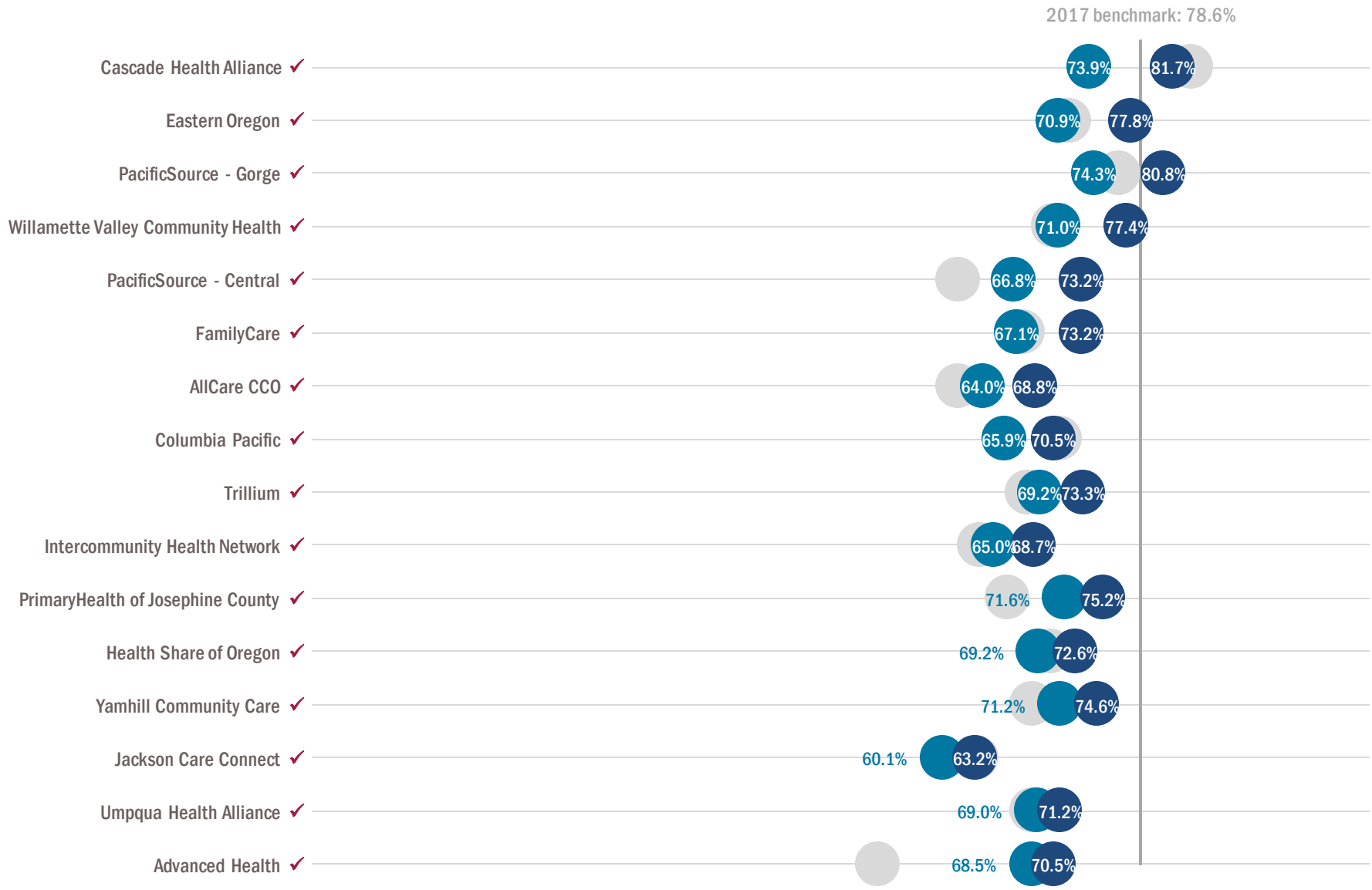
CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



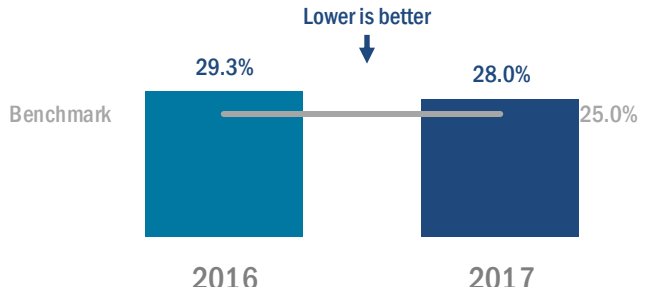
CIGARETTE SMOKING PREVALENCE

Cigarette smoking prevalence

Cigarette smoking prevalence is a bundled measure intended to address both cessation benefits offered by CCOs and cigarette smoking prevalence. The bundled measure has three components, each worth a certain score. CCOs must meet a certain threshold score to meet the measure in a given year. The scoring, or weighting, of the components changes over the years, to allow CCOs time to phase in efforts to reduce prevalence (see table below).

The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products such as chew, snuff, and cigars). Due to variation in how EHRs capture smoking and tobacco use data, and to ensure comparability across EHRs and CCOs, the measure looks at two separate rates: 1) cigarette smoking; and 2) tobacco use. As not all EHRs are able to report on tobacco use, only the cigarette smoking prevalence is used for comparison to the benchmark.

Statewide, cigarette smoking declined slightly in 2017.



2017 data (n=249,316)

1) Number of CCOs meeting cessation benefit requirement: **16**
2) Number of CCOs reporting EHR data: **16**
3) Number of CCOs achieving benchmark or target: **7**

Number of CCOs earning incentive payment: **all 16**

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Measure components	2016		2017		2018	
	Component weighting	Threshold to earn incentive	**Weighting**	**Threshold**	Weighting	Threshold
1) Meeting cessation benefit requirement (pass/fail) ***CCO must meet this component to meet the measure***	40%	60%	**33%**	**66%**	25%	70%
2) Reporting EHR-based prevalence data	40%		**33%**		25%	
3) Reducing prevalence (meeting benchmark/target)	20%		**33%**		50%	

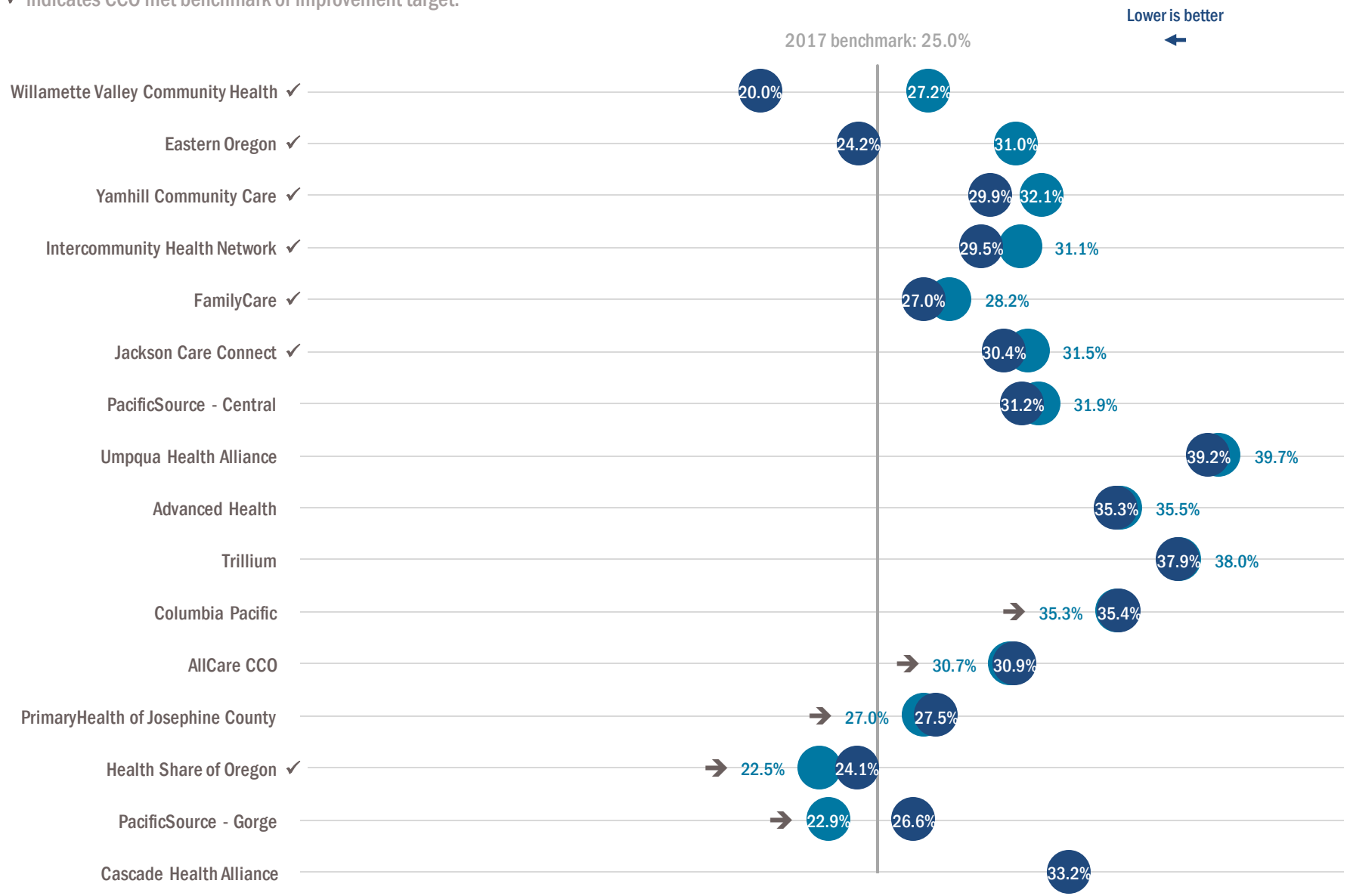
CIGARETTE SMOKING PREVALENCE

✓ indicates CCO achieved measure by achieving at least 66% composite score	Measure component (and weight in 2016)			Composite score
	Providing cessation benefit (33%)	Reporting EHR data (33%)	Achieving benchmark /target (33%)	
✓ AllCare Health Plan	✓	✓		66%
✓ Cascade Health Alliance	✓	✓		66%
✓ Columbia Pacific	✓	✓		66%
✓ Eastern Oregon	✓	✓	✓	100%
✓ FamilyCare	✓	✓	✓	100%
✓ Health Share of Oregon	✓	✓	✓	100%
✓ Intercommunity Health Network	✓	✓	✓	100%
✓ Jackson Care Connect	✓	✓	✓	100%
✓ PacificSource - Central	✓	✓		66%
✓ PacificSource - Gorge	✓	✓		66%
✓ PrimaryHealth of Josephine County	✓	✓		66%
✓ Trillium	✓	✓		66%
✓ Umpqua Health Alliance	✓	✓		66%
✓ Advanced Health	✓	✓		66%
✓ Willamette Valley Community Health	✓	✓	✓	100%
✓ Yamhill Community Care	✓	✓	✓	100%

CIGARETTE SMOKING PREVALENCE

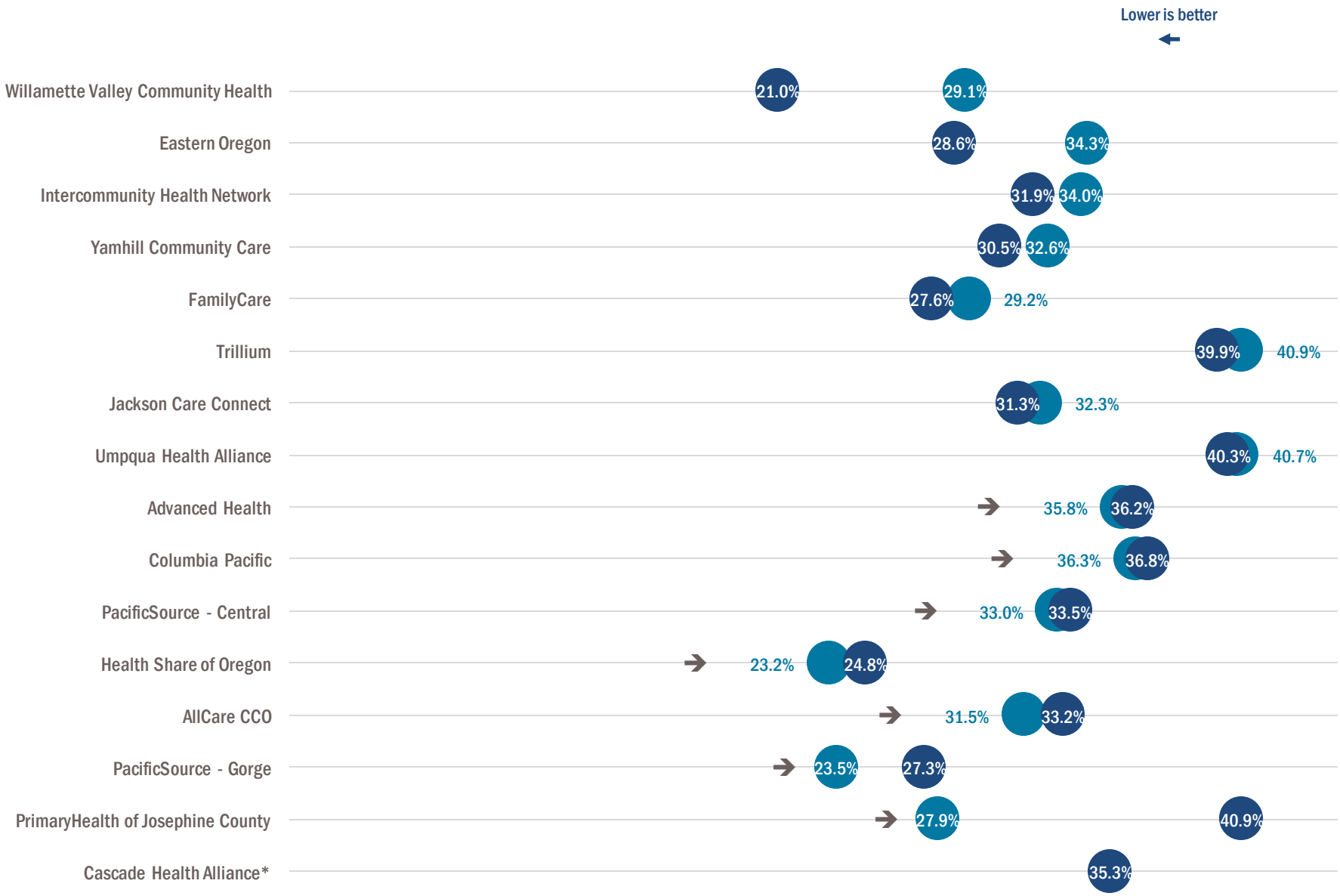
Cigarette smoking prevalence in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target.



TOBACCO USE PREVALENCE

Tobacco smoking prevalence in 2016 and 2017, by CCO.



COLORECTAL CANCER SCREENING

Colorectal cancer screening

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

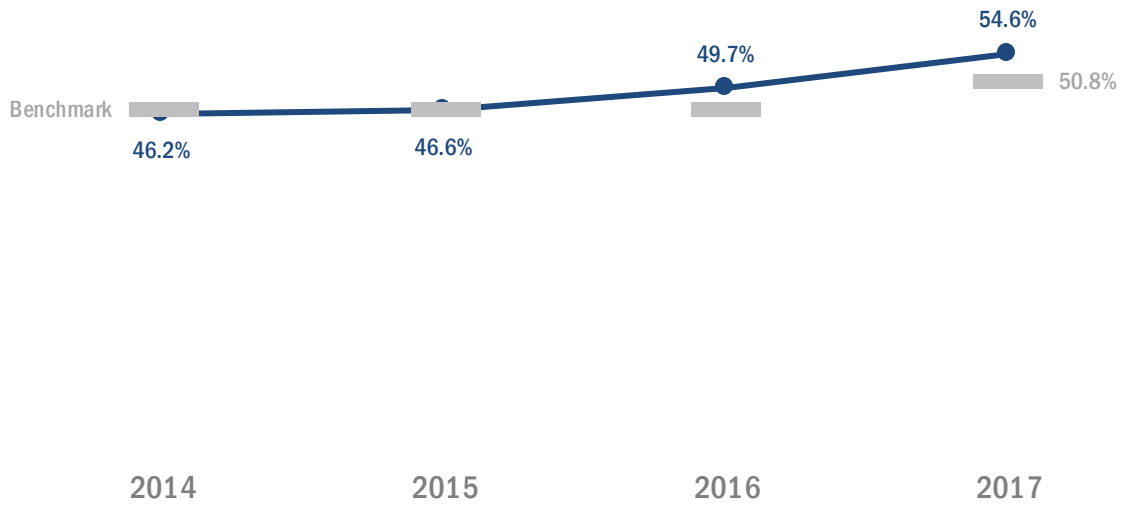
Data source:
Administrative (billing) claims and medical record review

2017 benchmark source:
2015 CCO 90th percentile

2017 data (N=6,273)

- Statewide percent change since 2016: **+9.9%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **all 16**

Statewide, colorectal cancer screening continues to increase.



Race/ethnicity, and household language data are not available for this measure..

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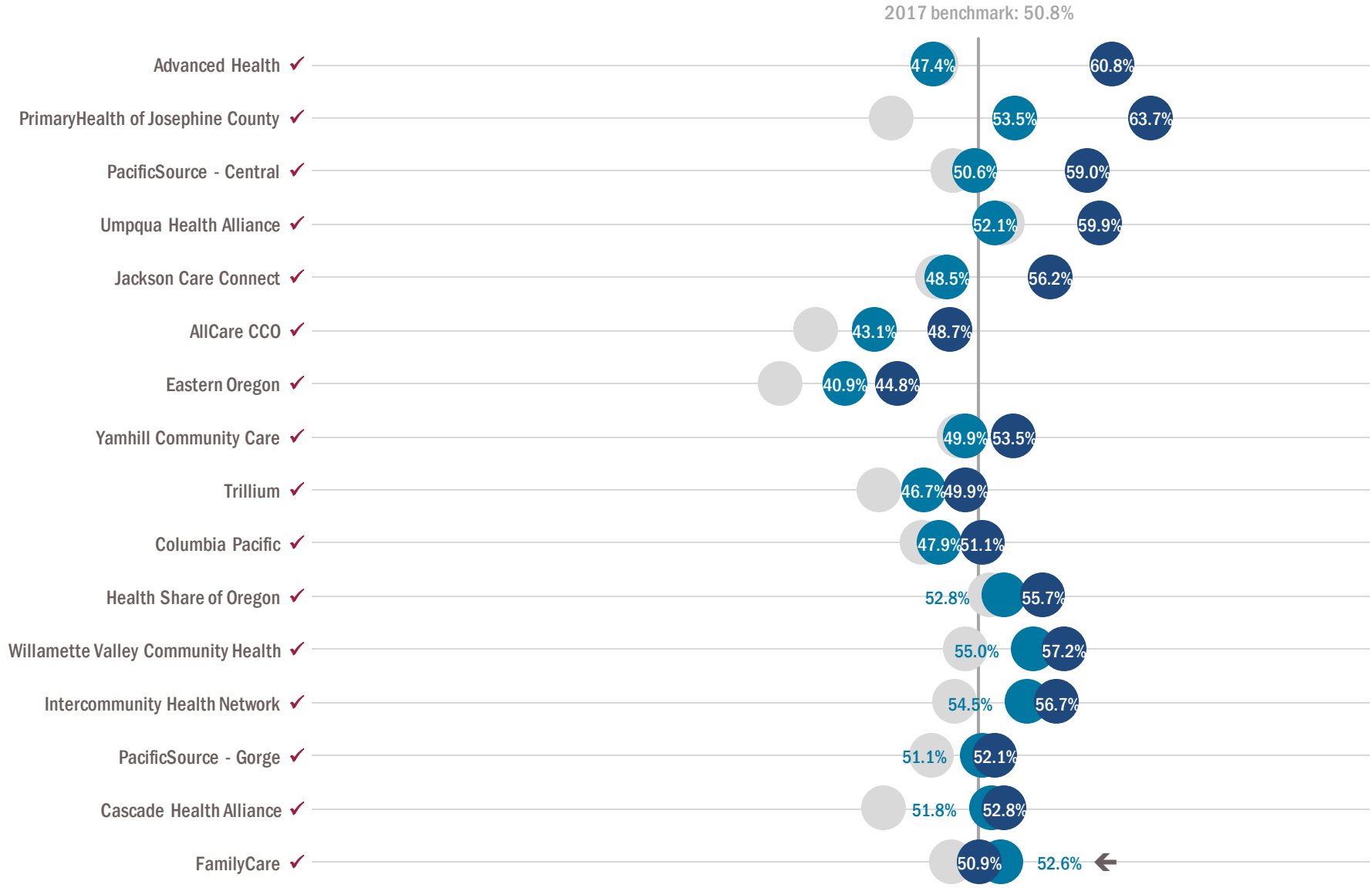
COLORECTAL CANCER SCREENING

Colorectal cancer screening in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



CONTROLLING HYPERTENSION

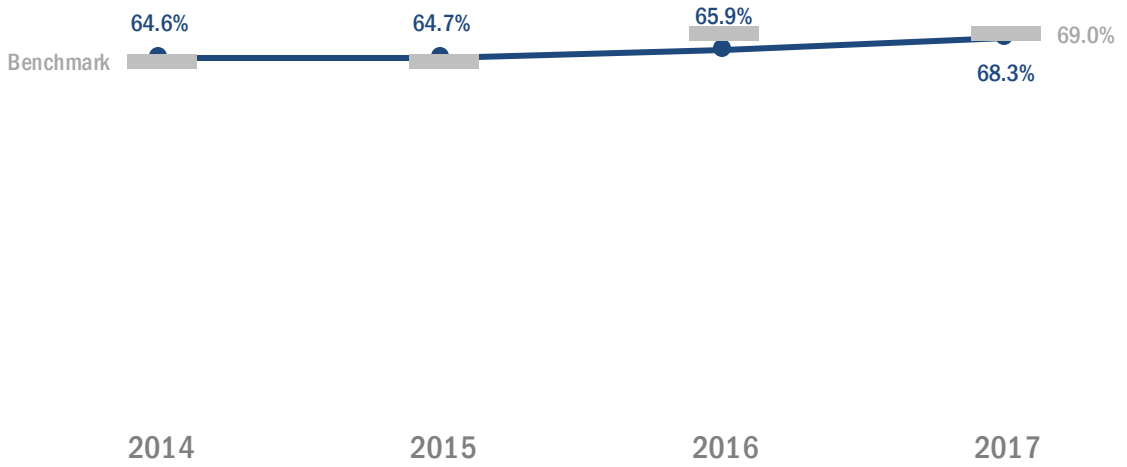
Controlling hypertension

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

2017 benchmark source:
2015 national Medicaid 90th percentile

Statewide, hypertension control increased slightly in 2017.



2017 data (N=97,503)

- Statewide percent change since 2016: **+3.6%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **10**

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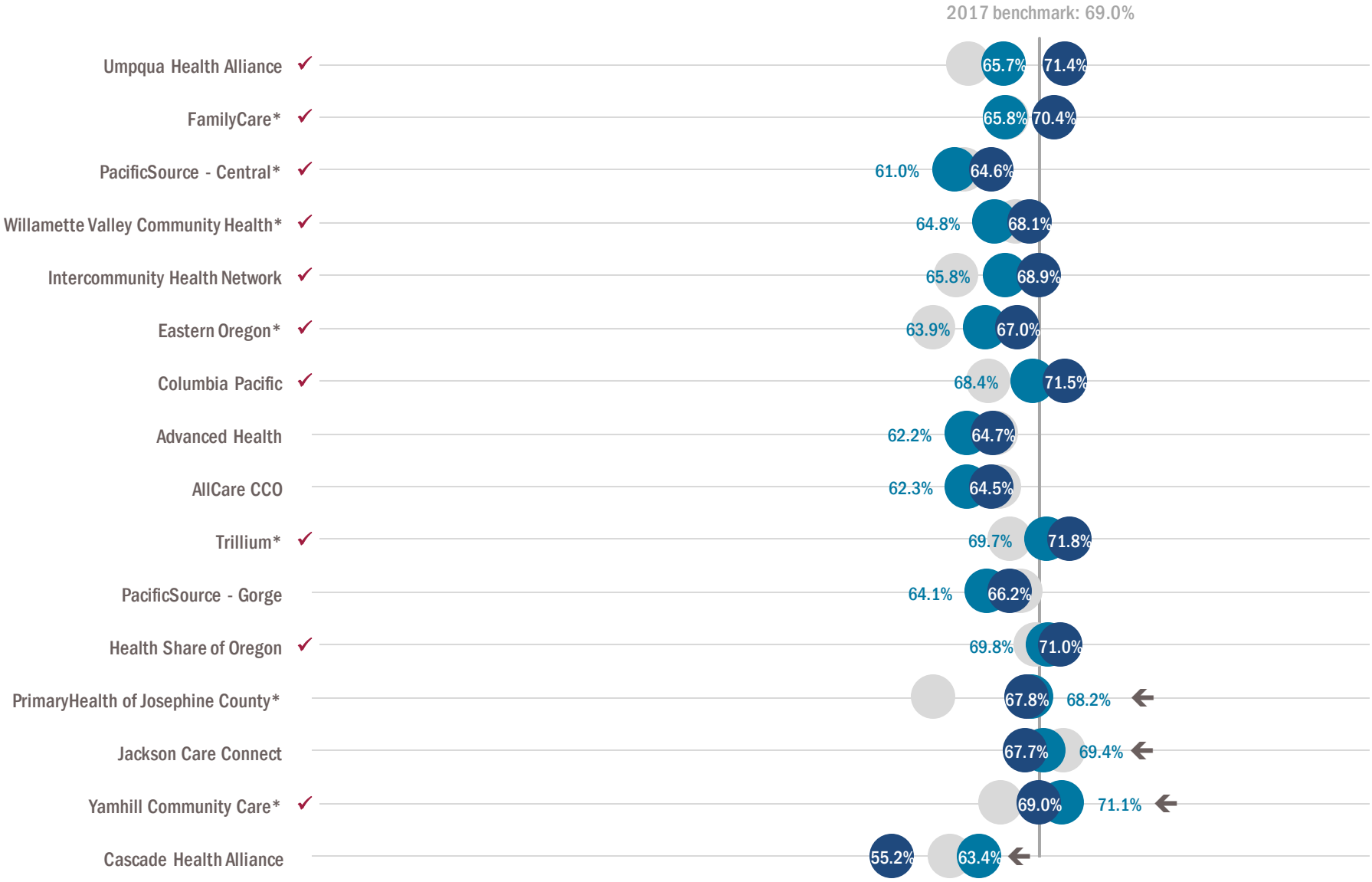
Race/ethnicity, and household language data are not available for this measure..

CONTROLLING HYPERTENSION

Controlling hypertension in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



*CCO's reporting includes some non-Medicaid data

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.

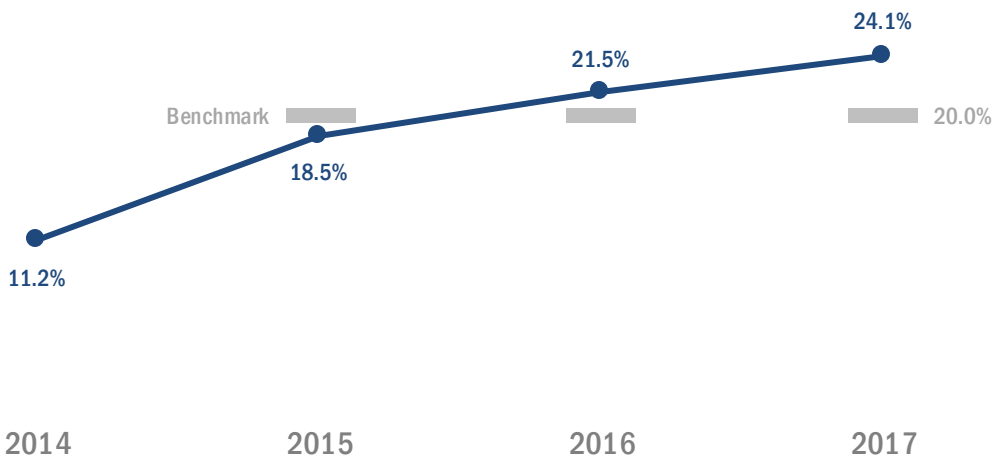
Data source:
Administrative (billing) claims

2017 benchmark source:
Committee consensus

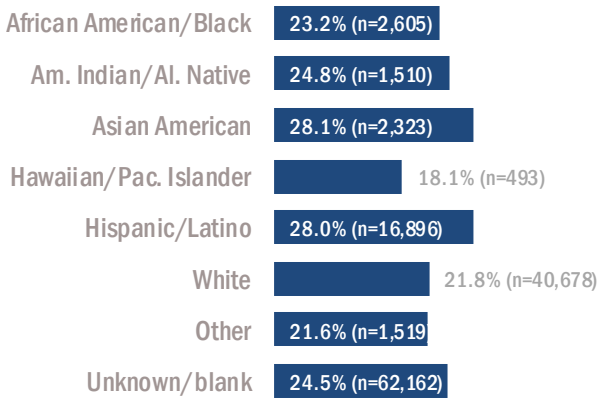
2017 data (N=128,186)

- Statewide percent change since 2016: **+12.1%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **all 16**

Statewide, dental sealants for children (all ages) continues to increase.

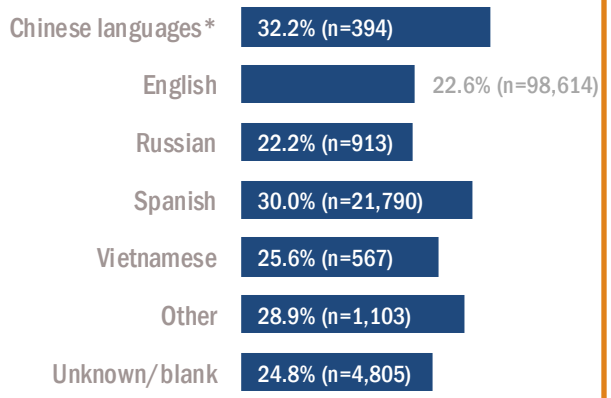


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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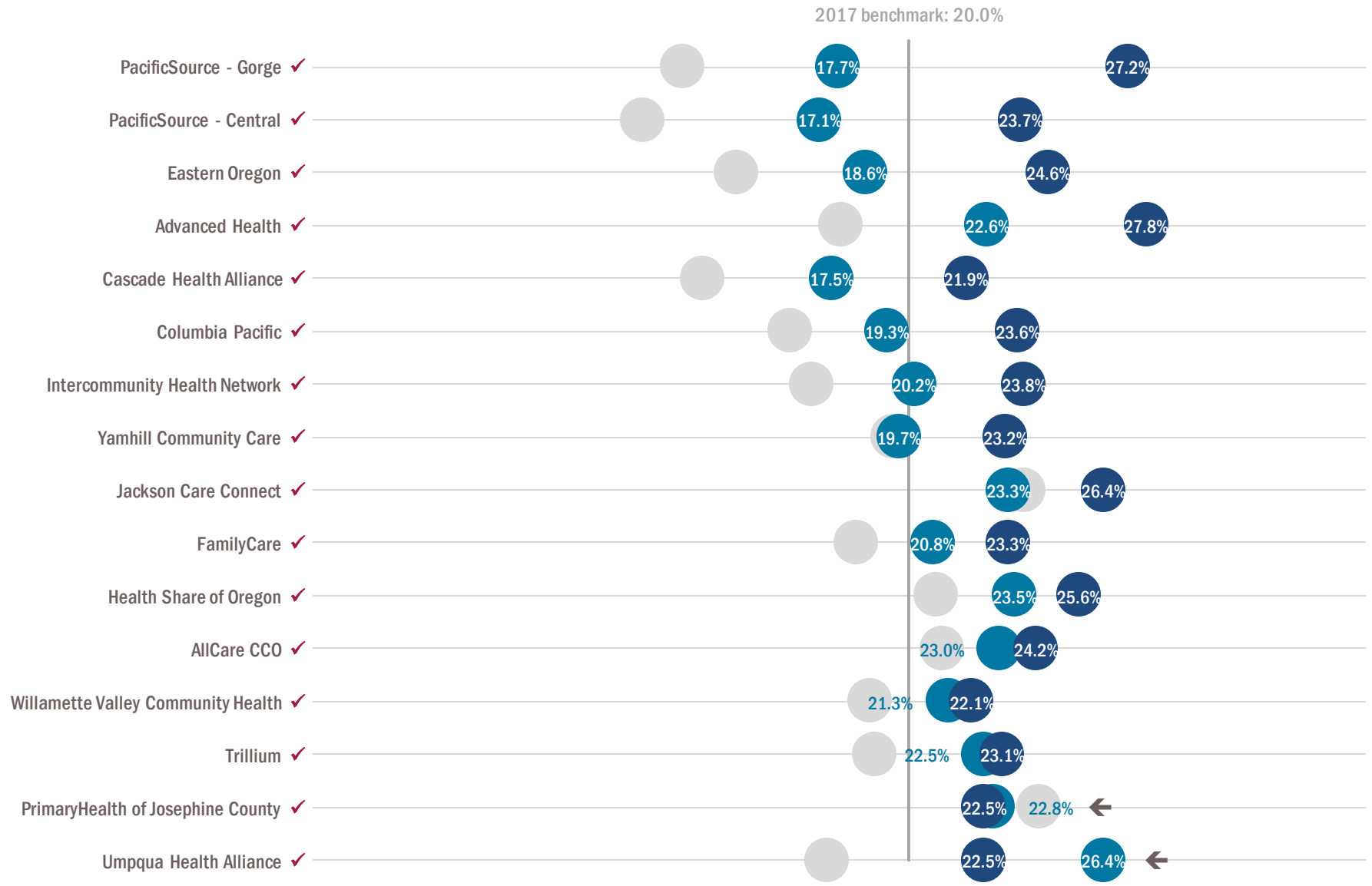
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages) in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



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

Dental sealants for children (ages 6-9)

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

Data source:
Administrative (billing) claims

2017 benchmark source:
Committee consensus

2017 data (N=59,004)

- Statewide percent change since 2016: **+9.9%**
- 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.

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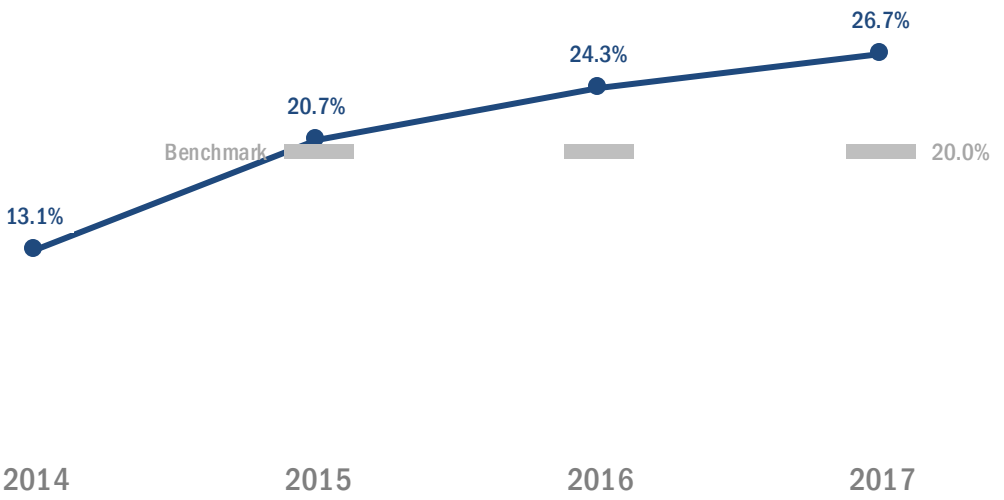
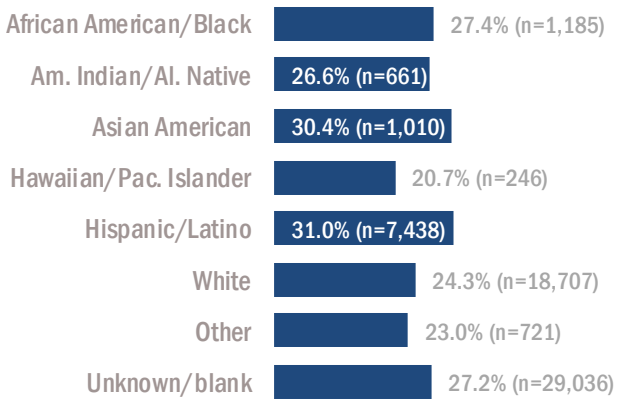
Statewide, dental sealants for children ages 6-9 continues to increase.

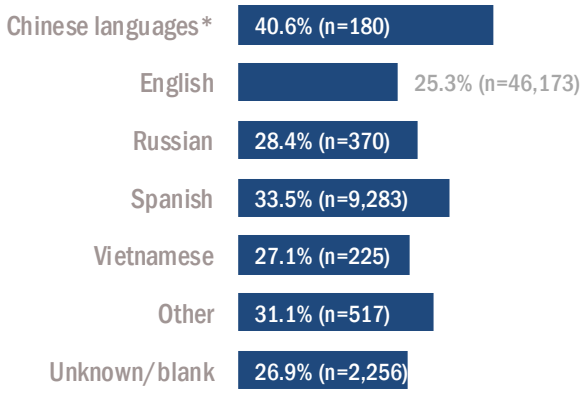


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

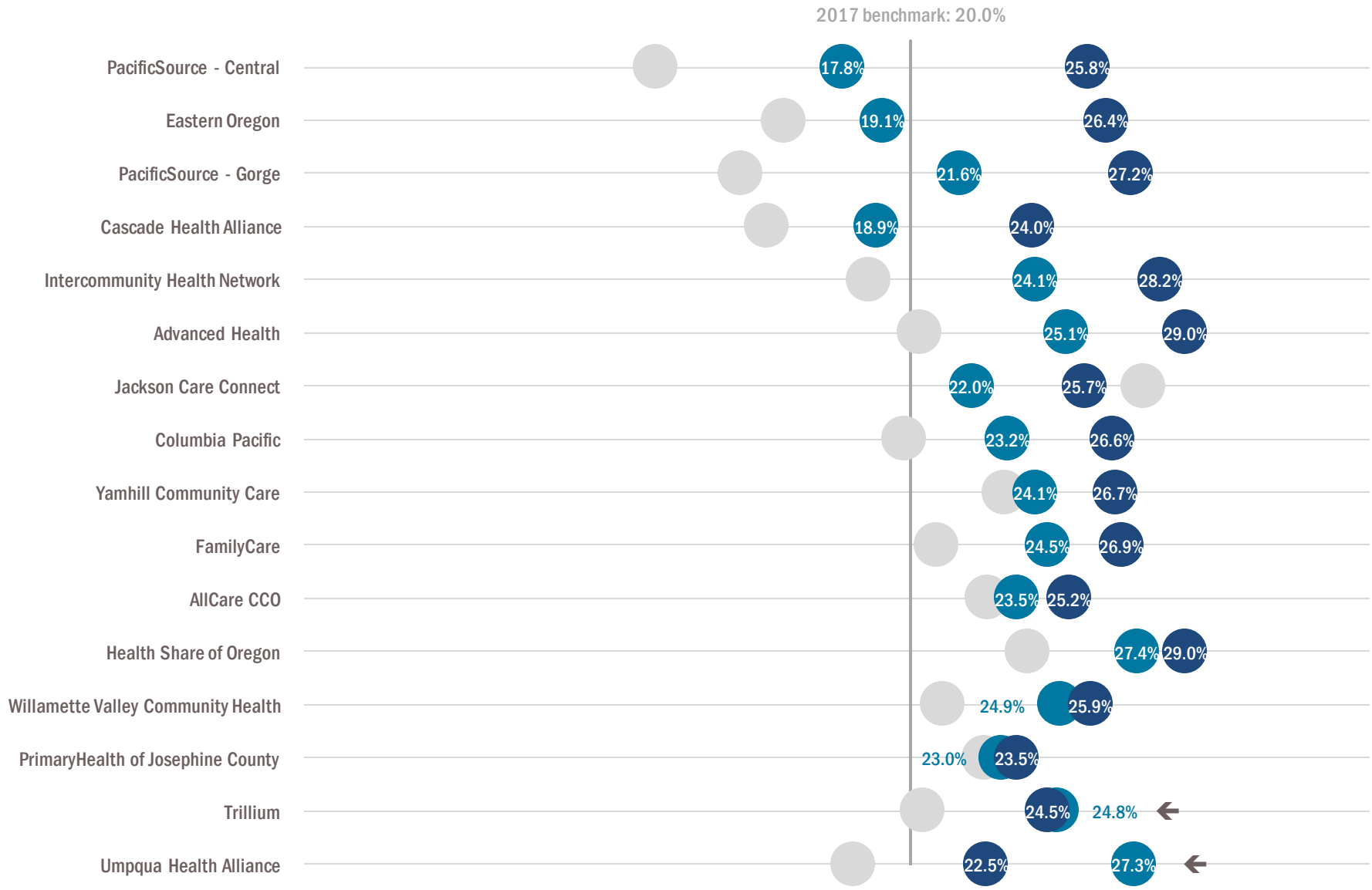


n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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

Dental sealants on permanent molars for children (ages 6-9) in 2016 and 2017, by CCO.

Grey dots represent 2015.



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

Dental sealants for children (ages 10-14)

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

Data source:
Administrative (billing) claims

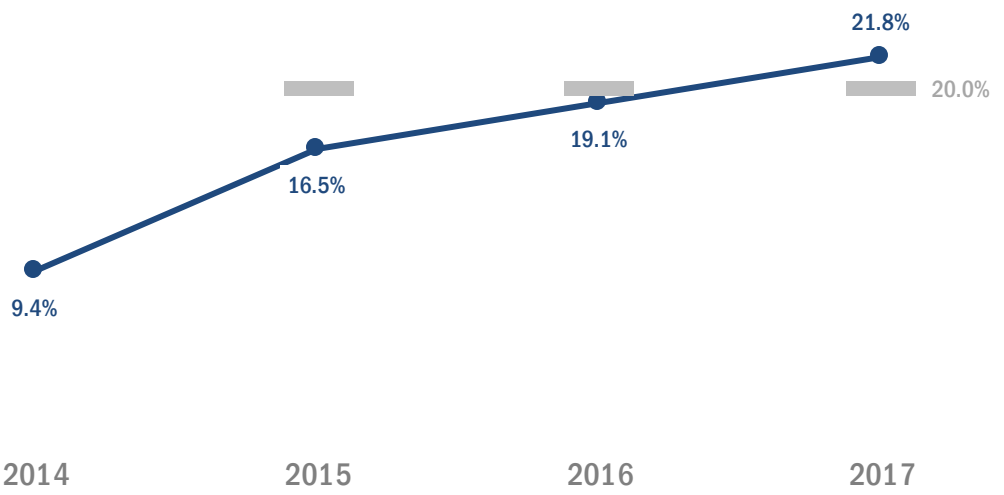
2017 benchmark source:
Committee consensus

2017 data (N=69,182)

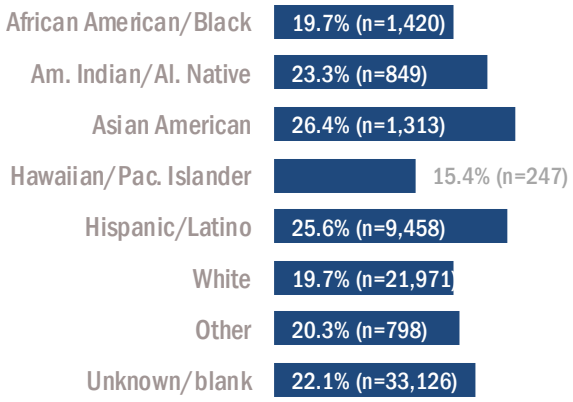
- Statewide change since 2016: **+14.1%**
- Number of CCOs that improved: **14**

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, dental sealants for children ages 10-14 continues to increase.

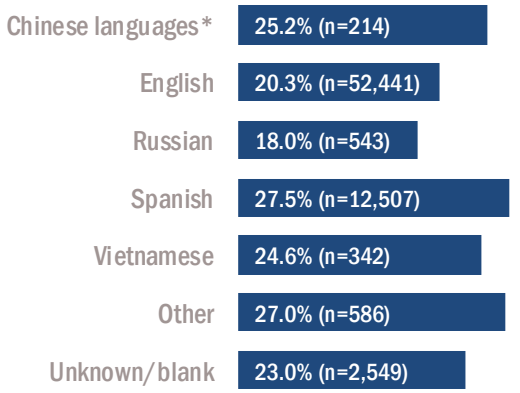


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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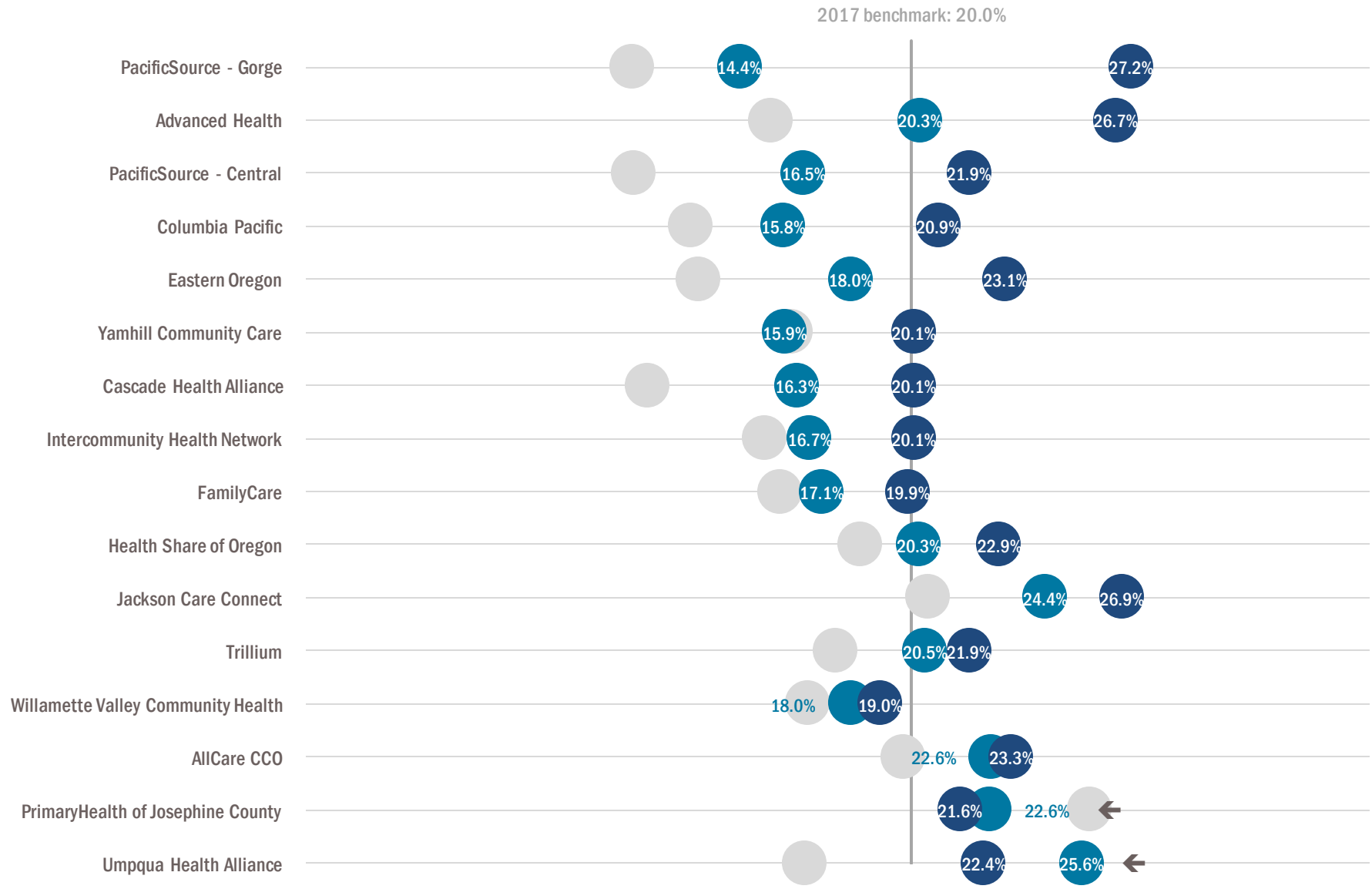
DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (ages 10-14)

Dental sealants on permanent molars for children (ages 10-14) in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up

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

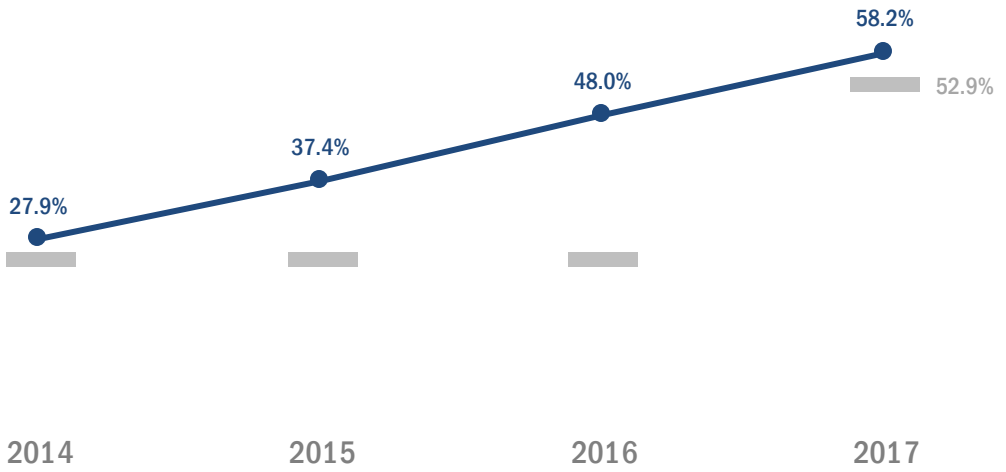
Data source:
Electronic Health Records

2017 benchmark source:
2015 CCO 75th percentile

2017 data (N=279,588)

- Statewide percent change since 2016: **+21.3%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **15**

Statewide, depression screening and follow-up plan continues to increase.



Race/ethnicity, and household language data are not available for this measure..

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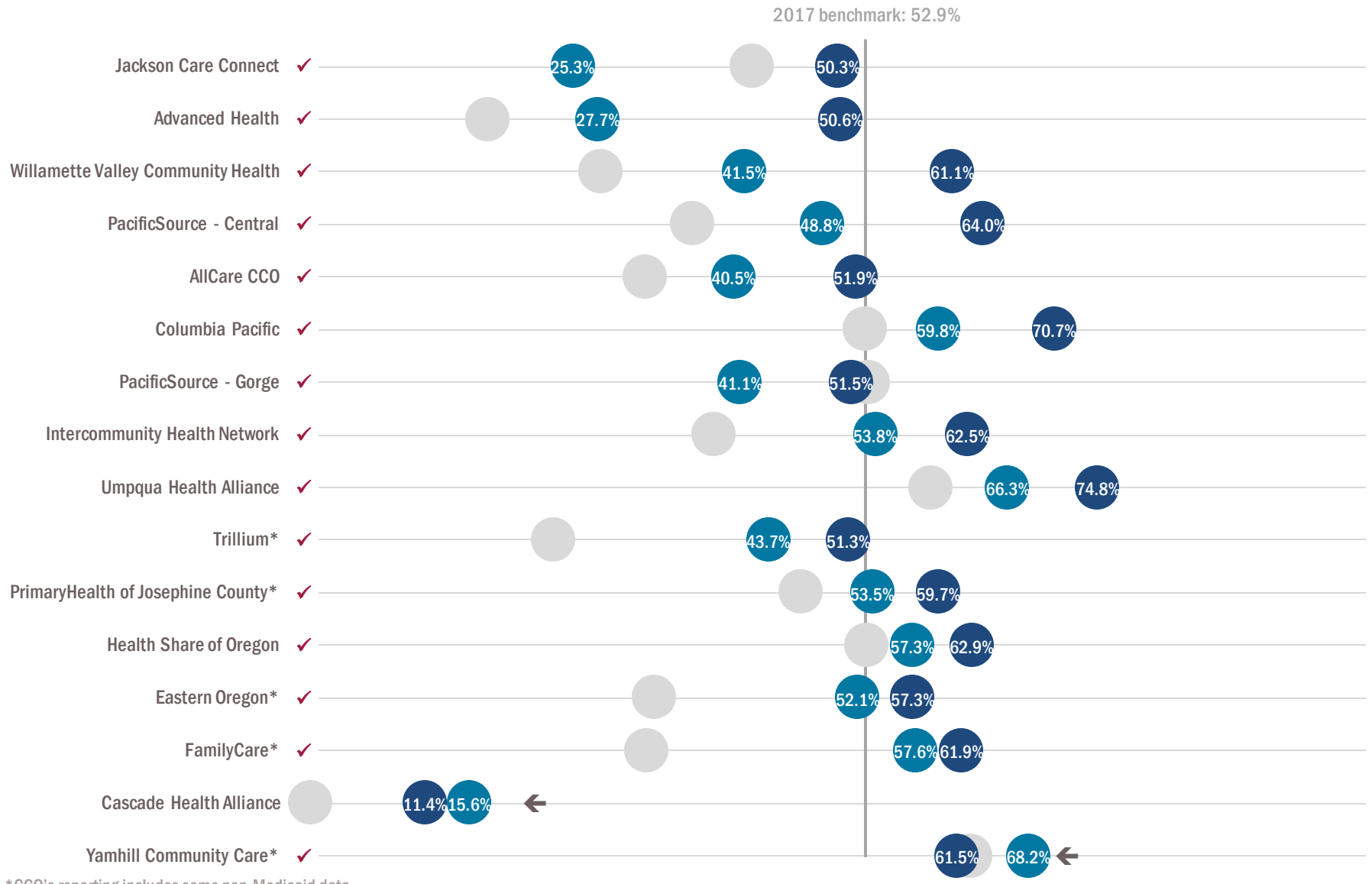
DEPRESSION SCREENING AND FOLLOW-UP PLAN

Depression screening and follow-up plan in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



*CCO's reporting includes some non-Medicaid data

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.

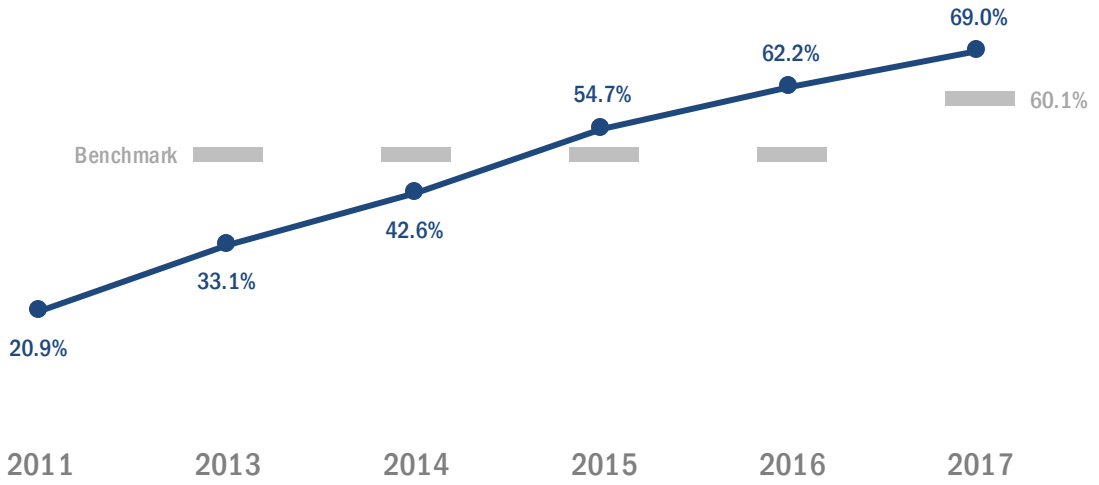
Data source:
Administrative (billing) claims

2017 benchmark source:
2015 CCO 75th percentile

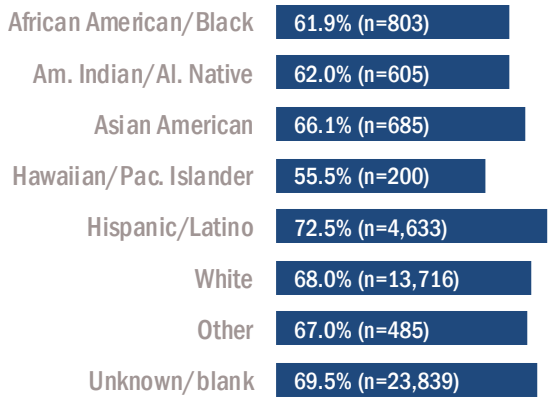
2017 data (N=44,966)

- Statewide percent change since 2016: **+10.9%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **all 16**

Statewide, developmental screenings continue to increase.

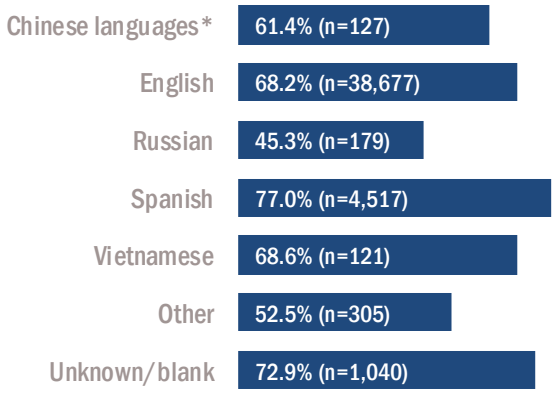


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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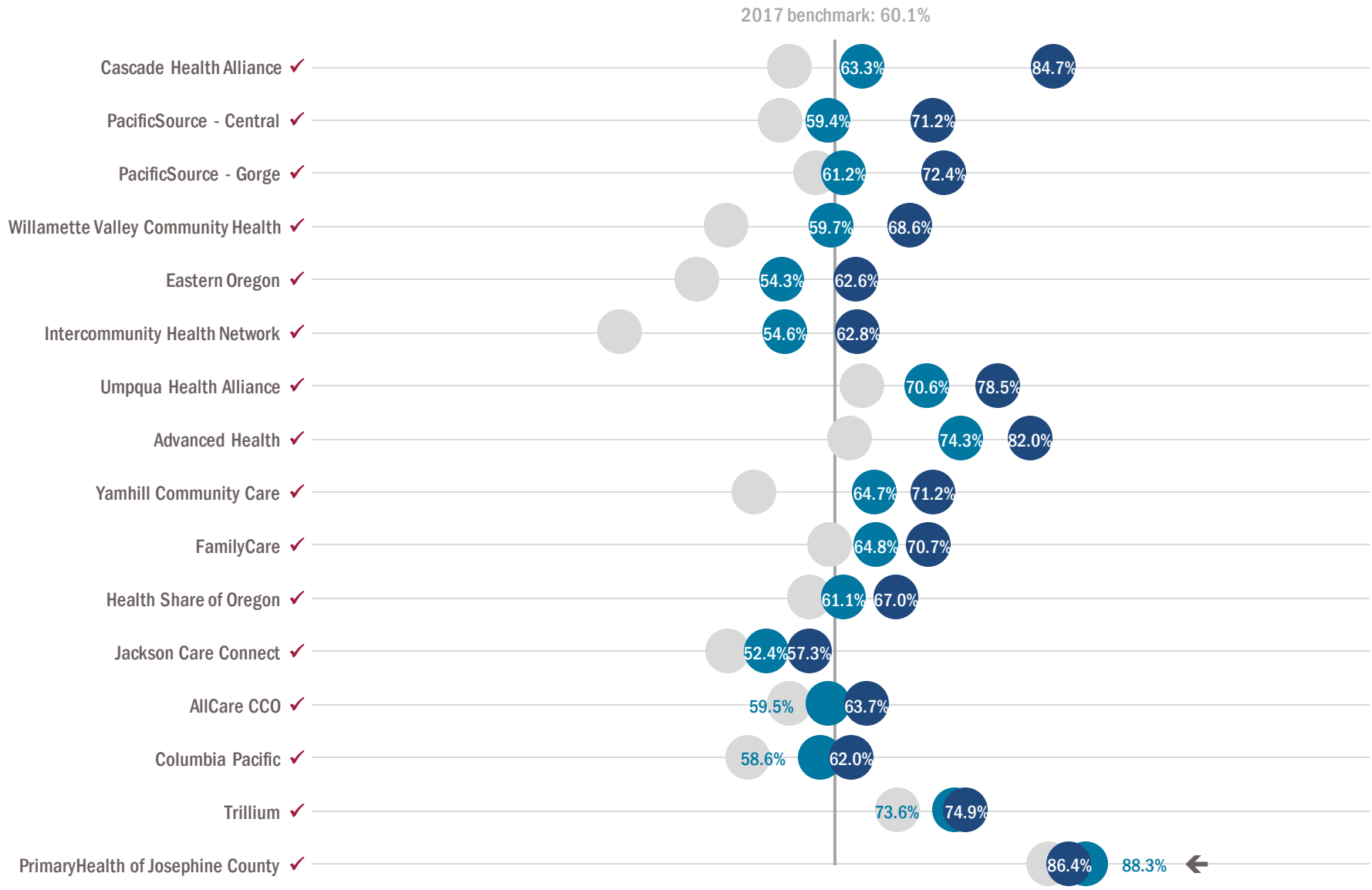
DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings and follow-up plan in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



DIABETES CARE: HbA1c POOR CONTROL

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.

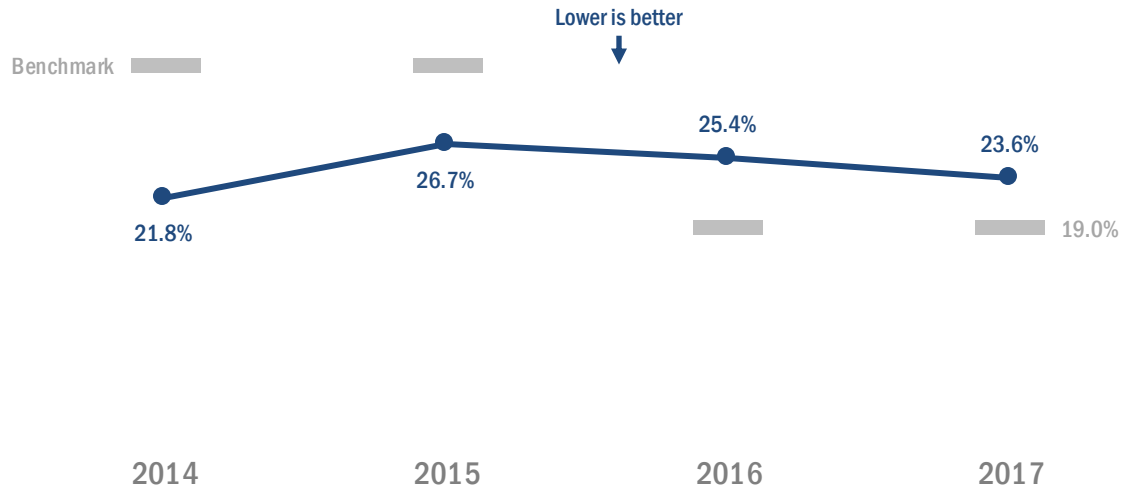
Data source:
Electronic Health Records

2017 benchmark source:
2015 national Commercial 90th percentile

2017 data (N=51,153)

- Statewide percent change since 2016: **-7.1%**
- Number of CCOs that improved: **10**
- Number of CCOs achieving target: **5**

Statewide, Hba1c poor control has declined.



Race/ethnicity, and household language data are not available for this measure..

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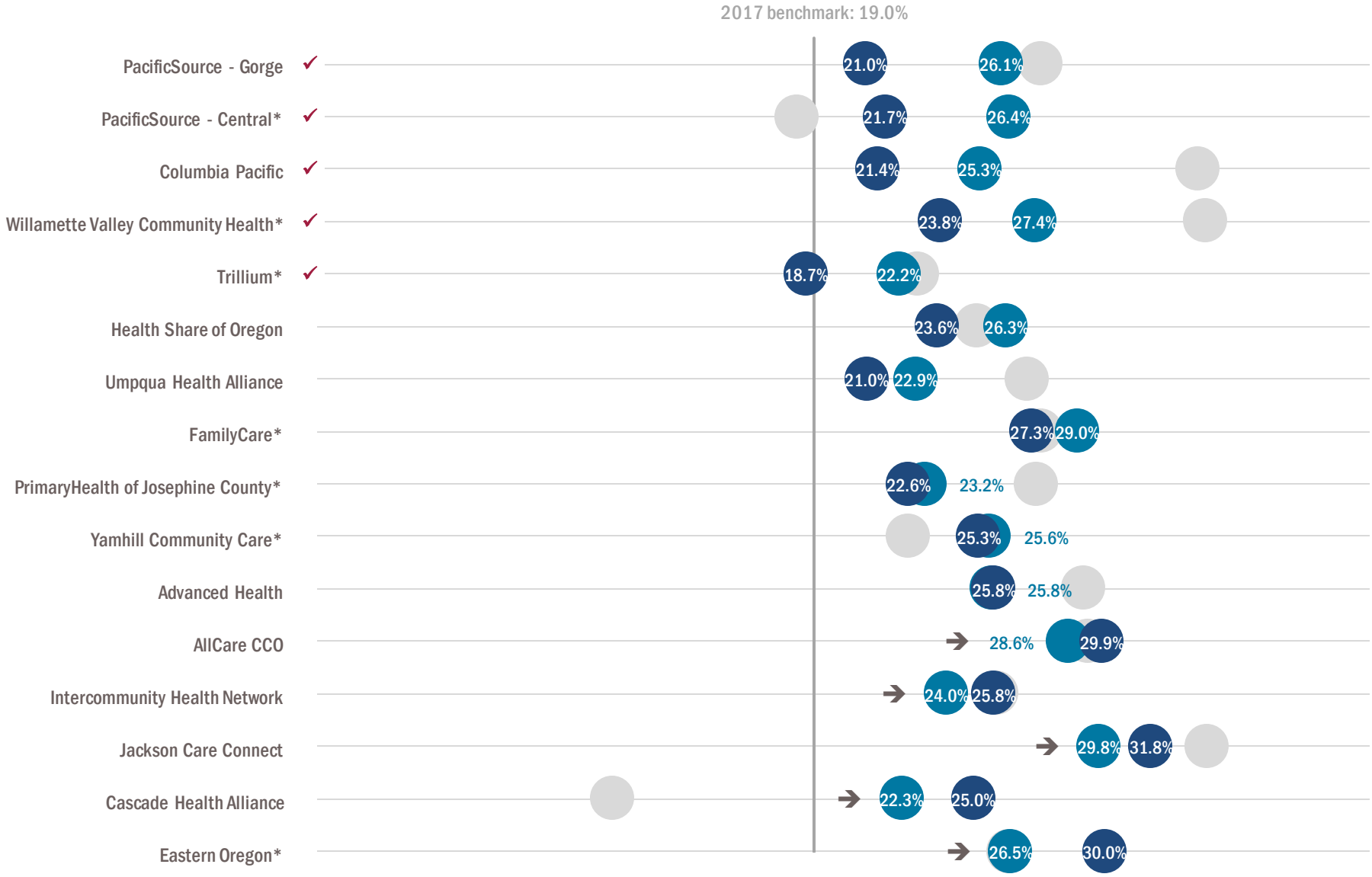
DIABETES CARE: HbA1c POOR CONTROL

Diabetes care, Hba1c poor control in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



*CCO's reporting includes some non-Medicaid data

EFFECTIVE CONTRACEPTIVE USE AMONG ADULT WOMEN AT RISK OF UNINTENDED PREGNANCY

Effective contraceptive use

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

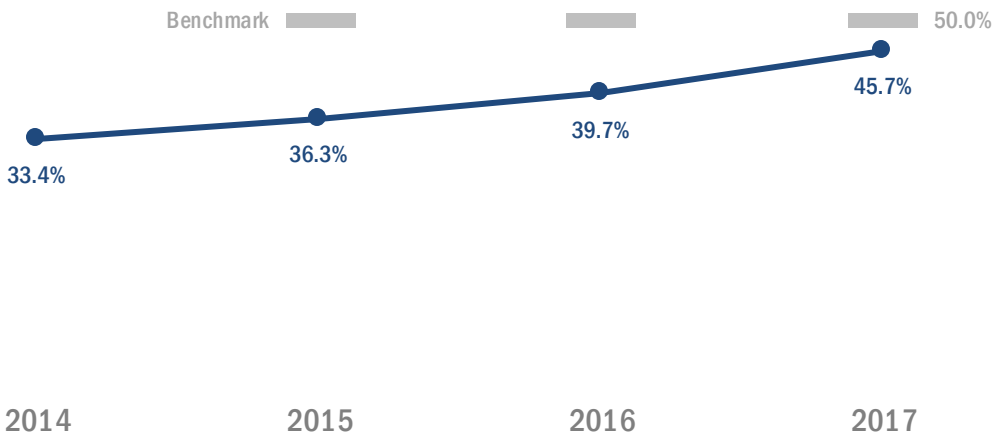
Data source:
Administrative (billing) claims

2017 benchmark source:
Metrics and Scoring Committee consensus

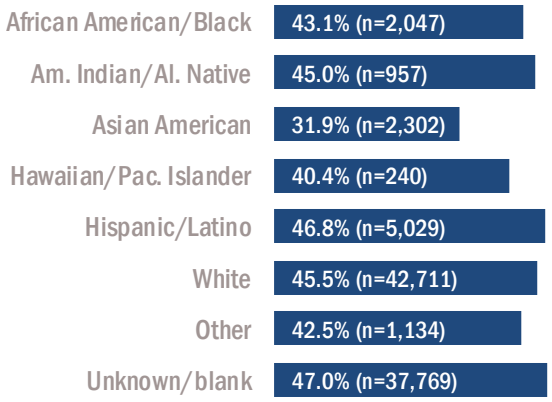
2017 data (N=92,189)

- Statewide change since 2016: **+15.1%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

Statewide, effective contraceptive use among adult women continues to increase.

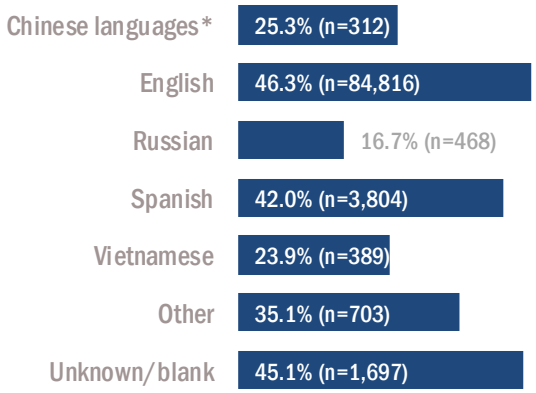


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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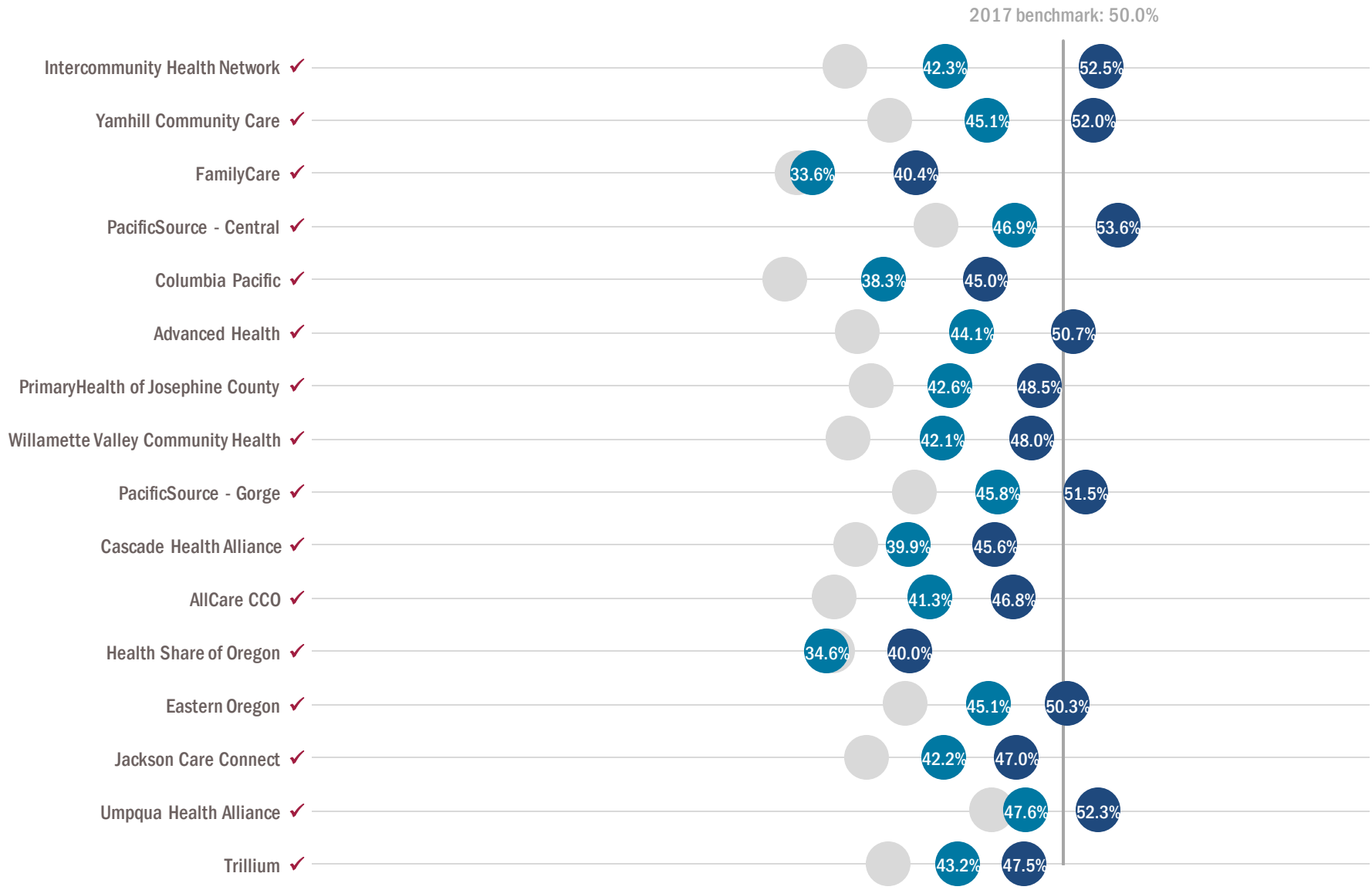
EFFECTIVE CONTRACEPTIVE USE AMONG ADULT WOMEN AT RISK OF UNINTENDED PREGNANCY

Effective contraceptive use among adult women at risk of unintended pregnancy in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



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

2017 benchmark source:
Metrics and Scoring Committee consensus

2017 data (N=17,354)

- Statewide percent change since 2016: **+2.0%**
- Number of CCOs that improved: **12**
- Number of CCOs achieving target: **all 16**

Results are stratified by age group (adolescents and all ages combined) for reporting and monitoring purposes only. Incentive payments are based on adults only3

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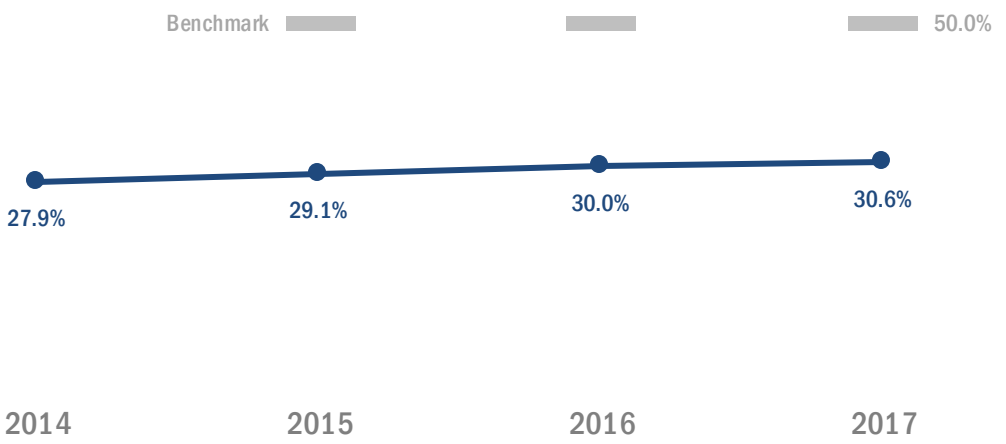
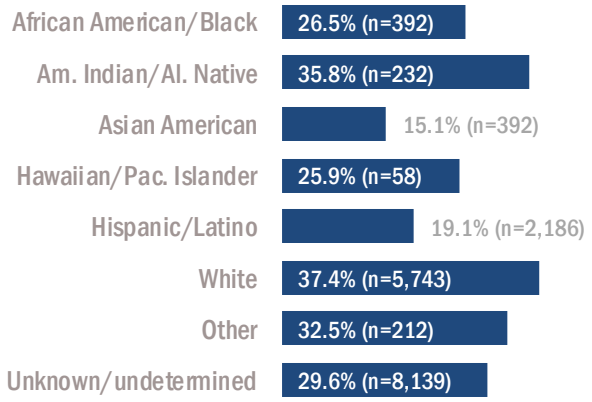
Statewide, effective contraceptive use among adolescents has remained steady.

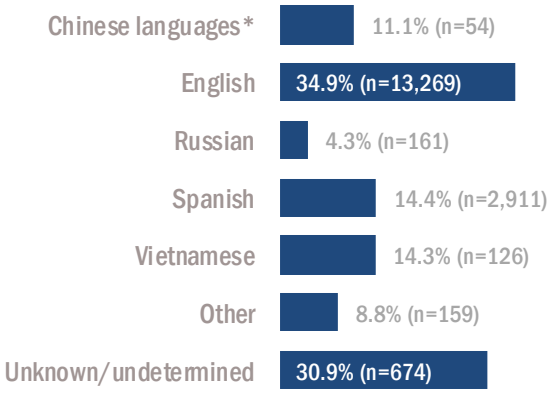


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

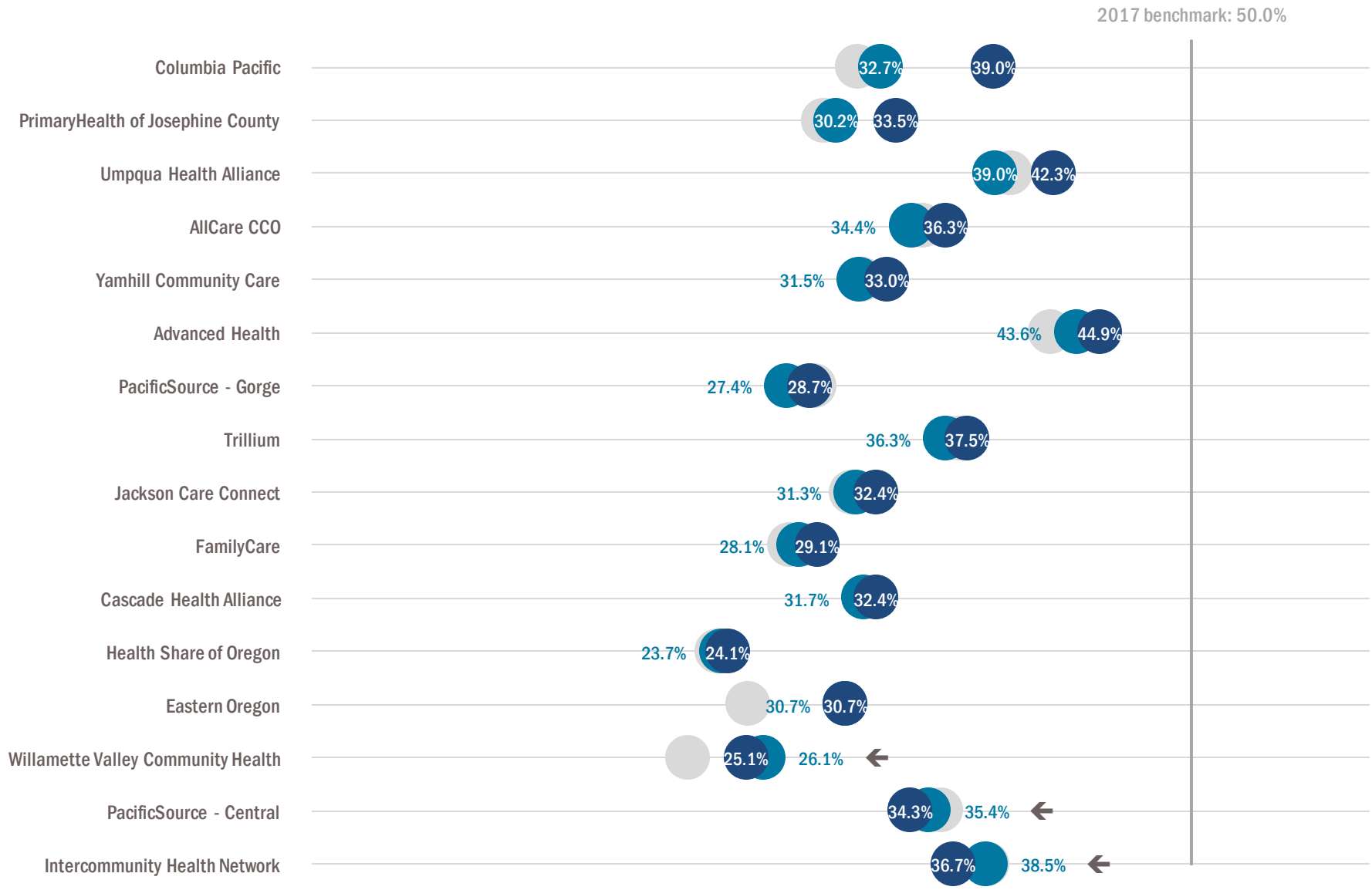


n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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 2016 and 2017, by CCO.

Grey dots represent 2015.



EFFECTIVE CONTRACEPTIVE USE AMONG WOMEN AT RISK OF UNINTENDED PREGNANCY (all 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

2017 benchmark source:
Metrics and Scoring Committee consensus

2017 data (N=109,543)

- Statewide percent change since 2016: **+12.5%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

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

Beginning in 2018, age range 15-50 will be the incentivized measure.

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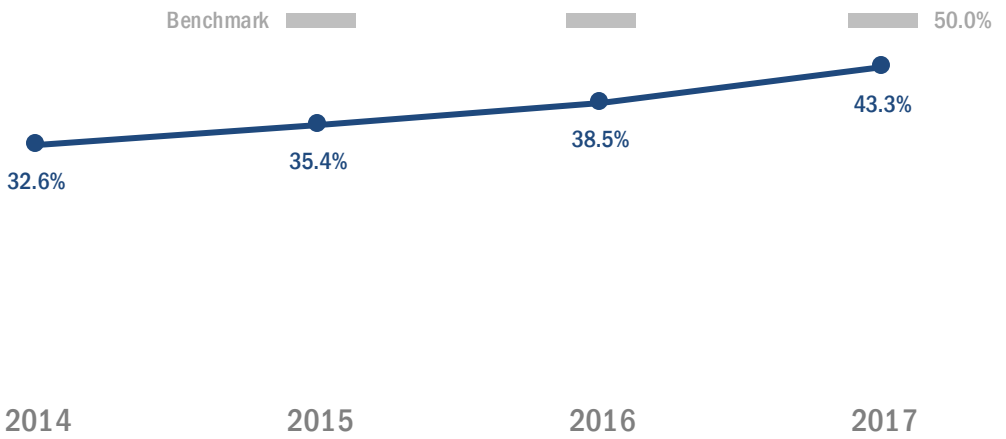
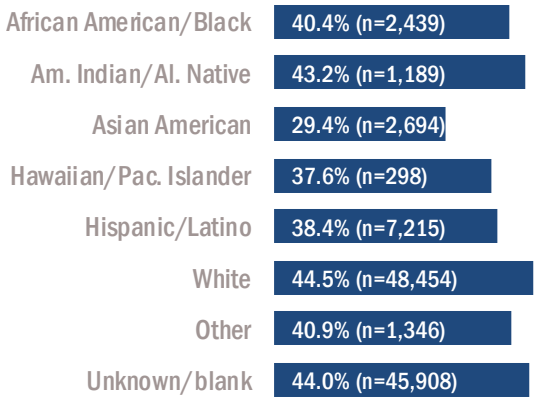
Statewide, effective contraceptive use among women ages 15-50 has increased.

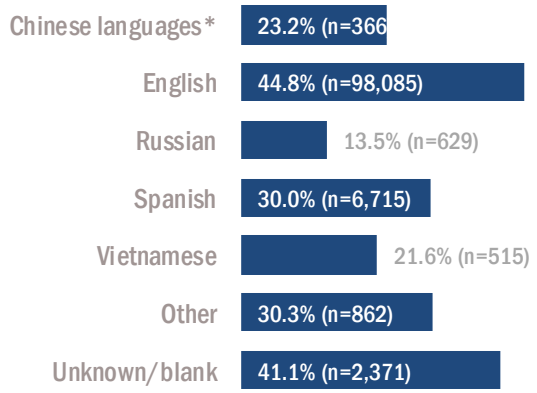


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

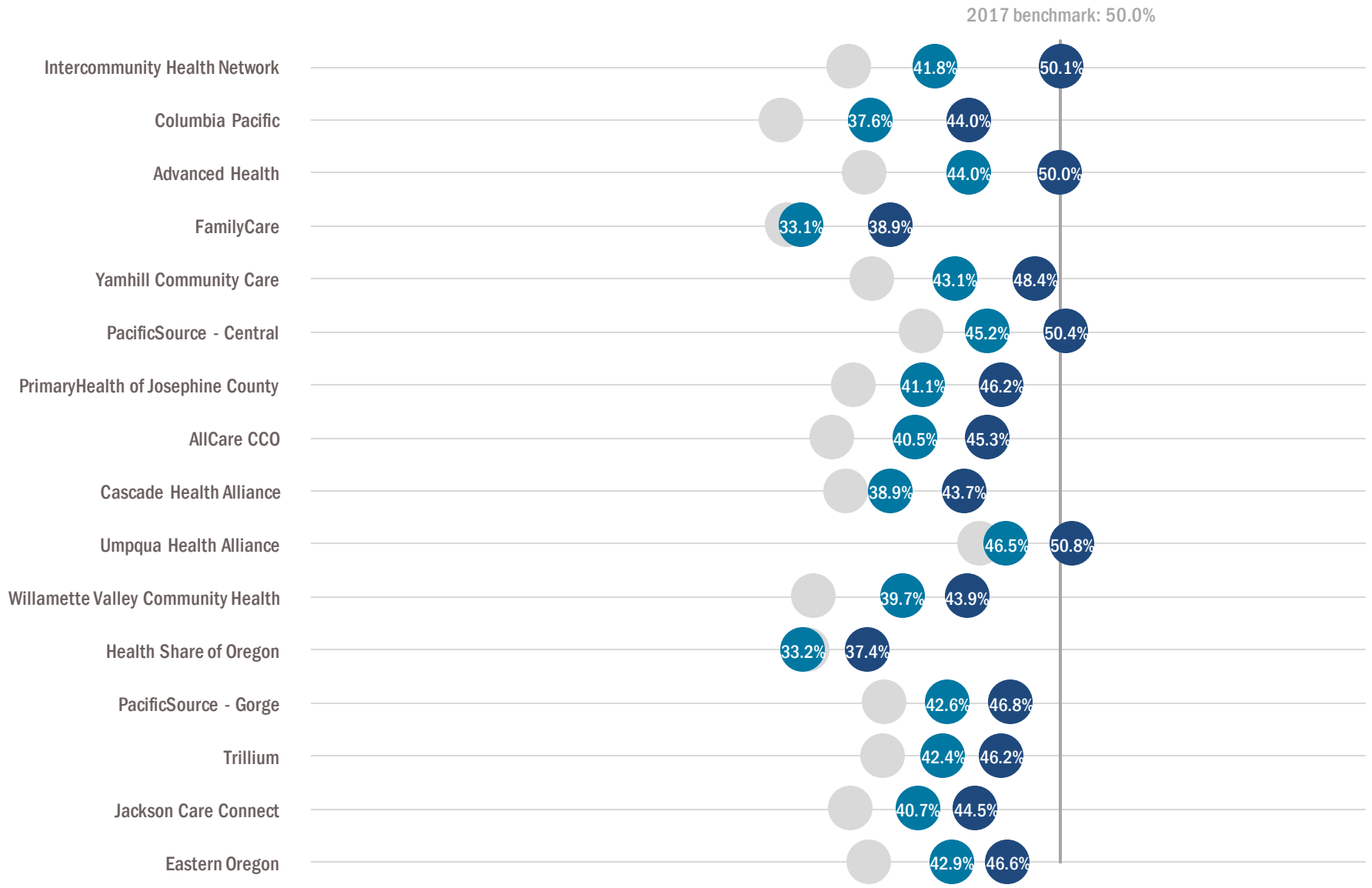


n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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

Effective contraceptive use among women ages 15-50 at risk of unintended pregnancy in 2016 and 2017, by CCO.

Grey dots represent 2015.



FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization

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

Data source:
Administrative (billing) claims

2017 benchmark source:
2015 CCO 75th percentile (rebased)

2017 data (N=2,952)

- Statewide percent change since 2016: **+7.6%**
- Number of CCOs that improved: **14**
- Number of CCOs achieving target: **15**

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).

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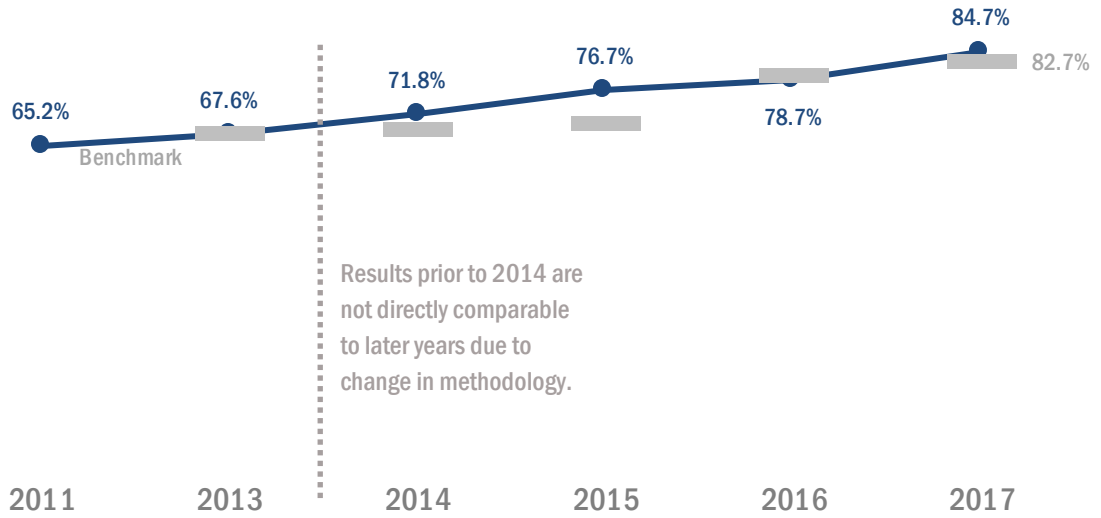
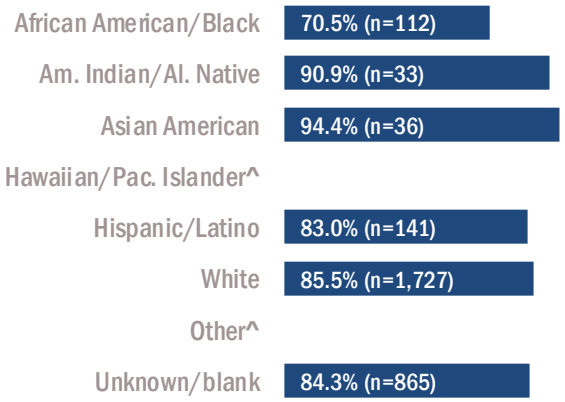
Statewide, follow-up after hospitalization for mental illness has increased.

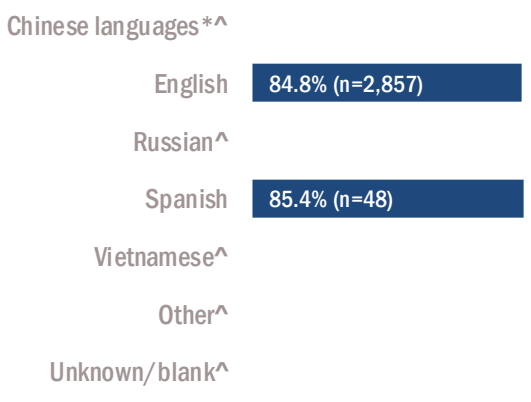


By race and ethnicity (2017)



^ data suppressed (n < 30)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

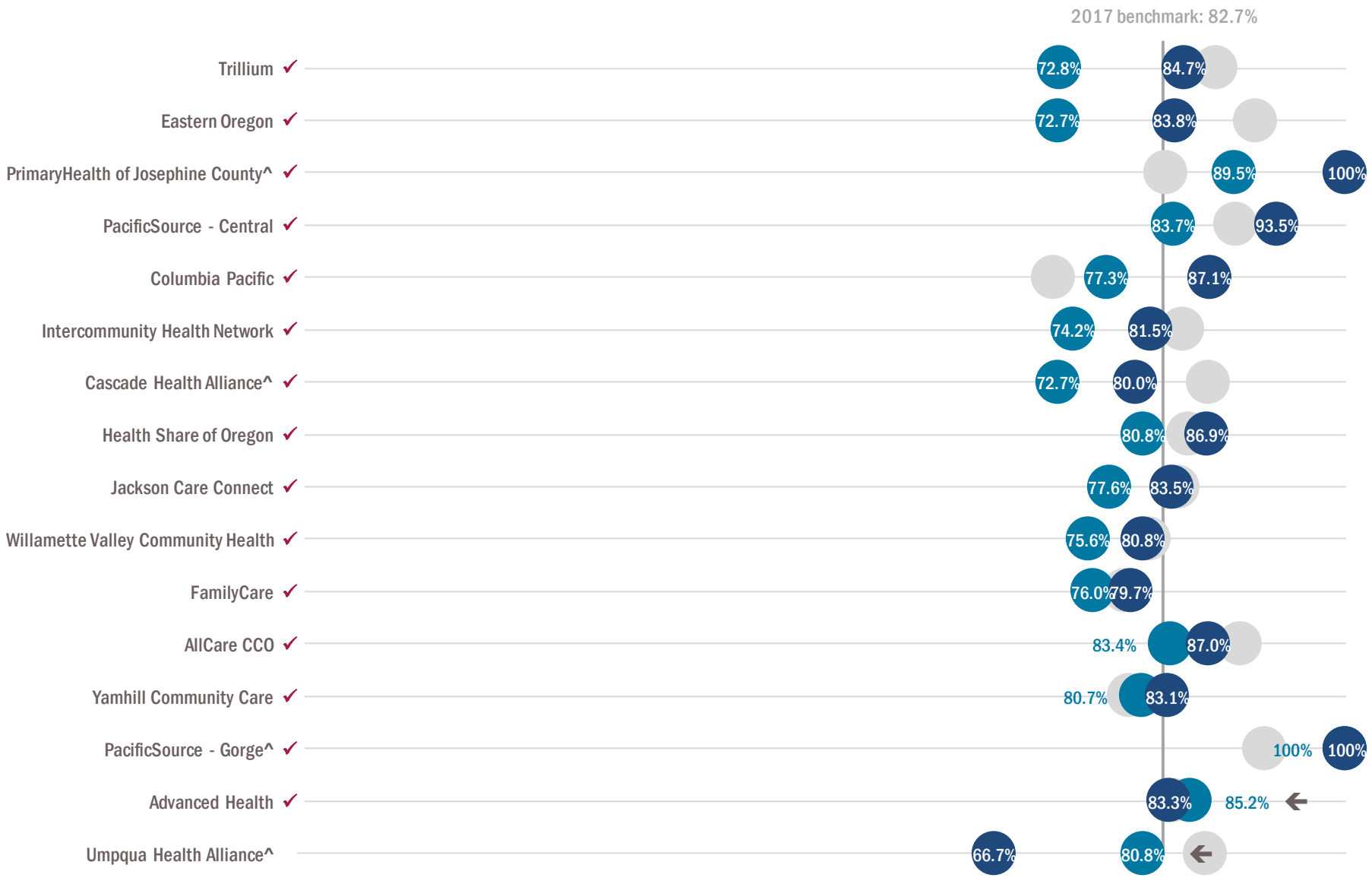


^ data suppressed (n < 30)
n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Follow-up after hospitalization for mental illness in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



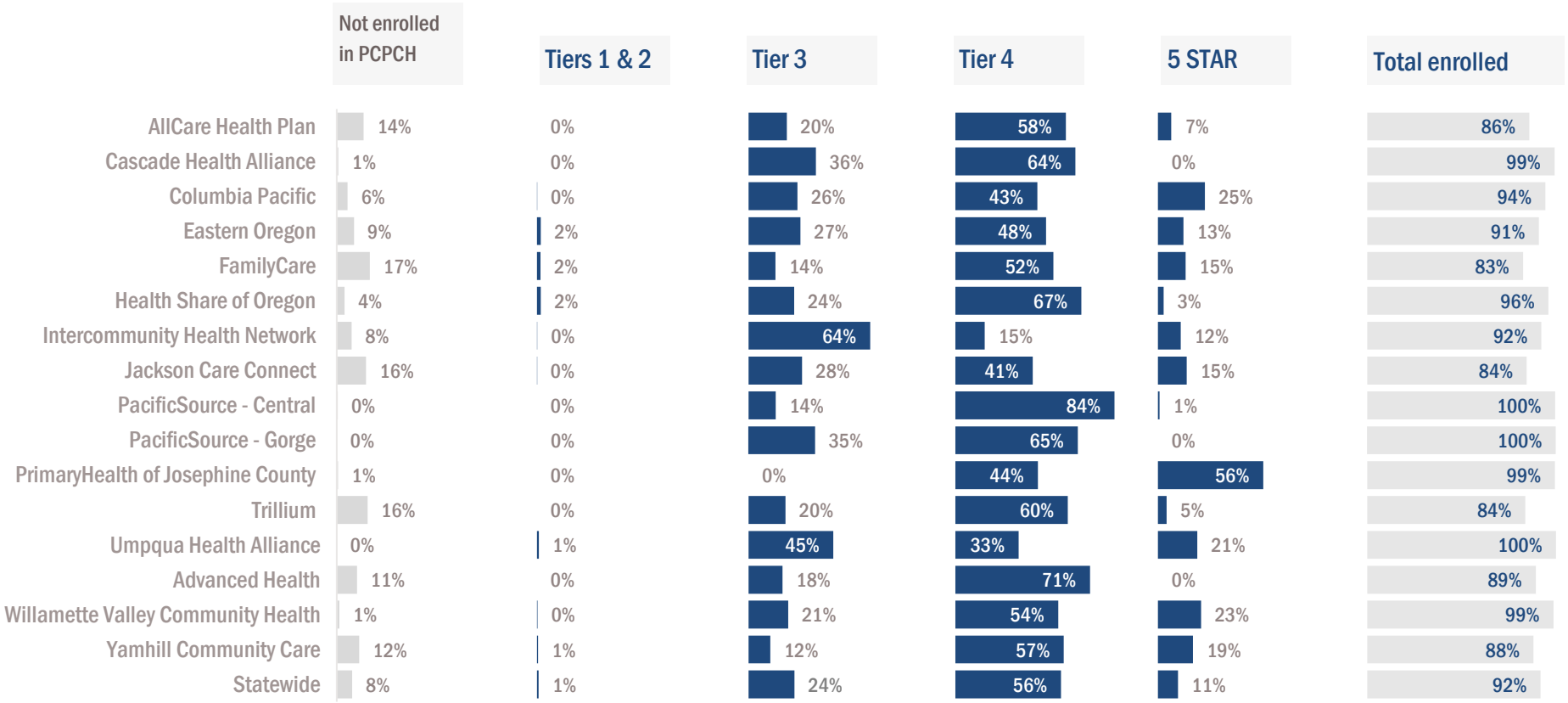
^ note small denominator (n<30)

PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Statewide in 2017, 92 percent of CCO members are enrolled in a PCPCH, resulting in a weighted score of 70.1 percent.

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

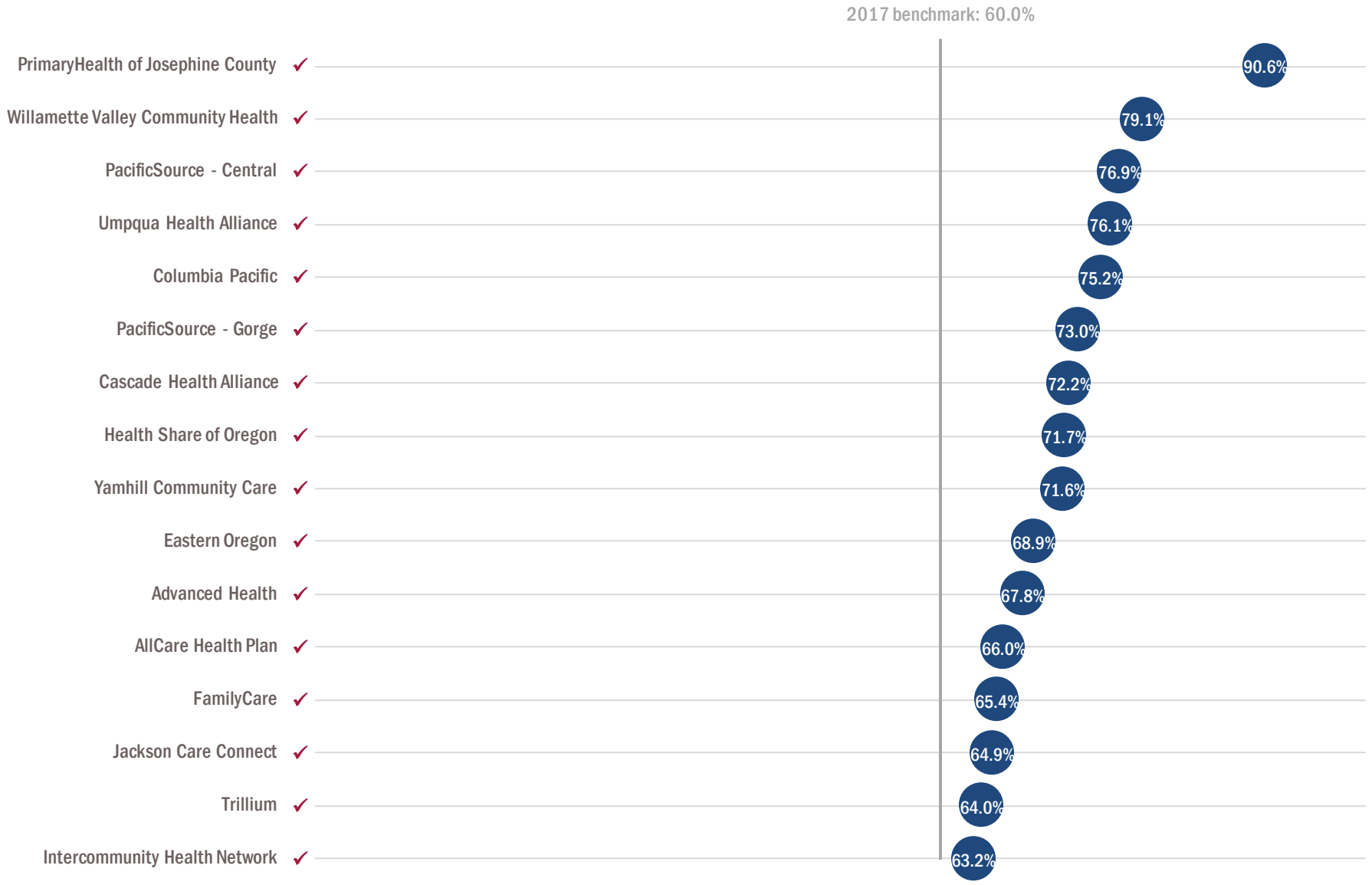
Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years. The graphs below show member enrollment by CCO across the PCPCH tiers. The next page shows each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



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

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

✓ indicates CCO met 60 percent threshold.



PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

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

Data source:
Administrative (billing) claims and medical record review

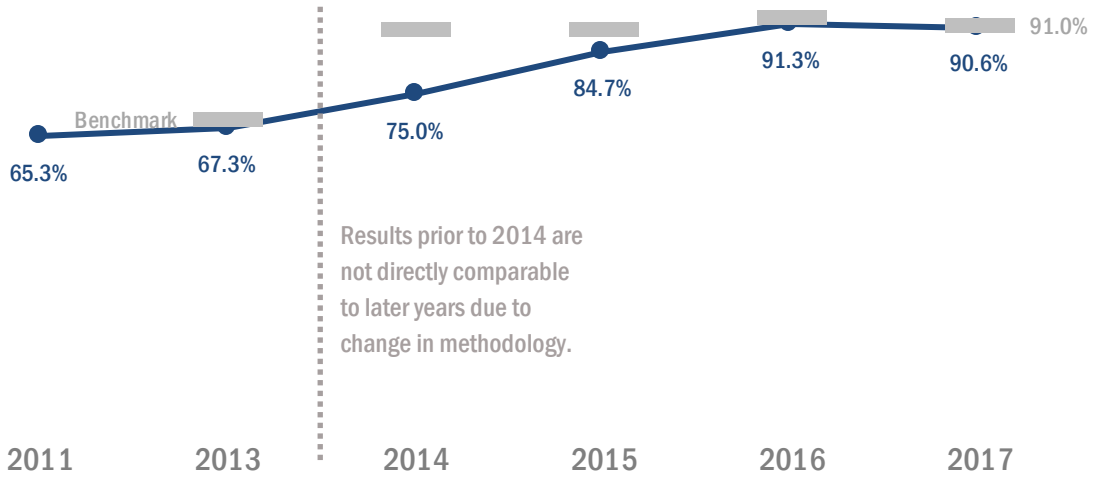
2017 benchmark source:
2016 national Medicaid 90th percentile

2017 data (N=5,702)

- Statewide percent change since 2016: **-0.8%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **11**

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

Statewide, timeliness of prenatal care remains near the benchmark in 2017.



n = subpopulation denominator
Each race category excludes Hispanic/Latino

n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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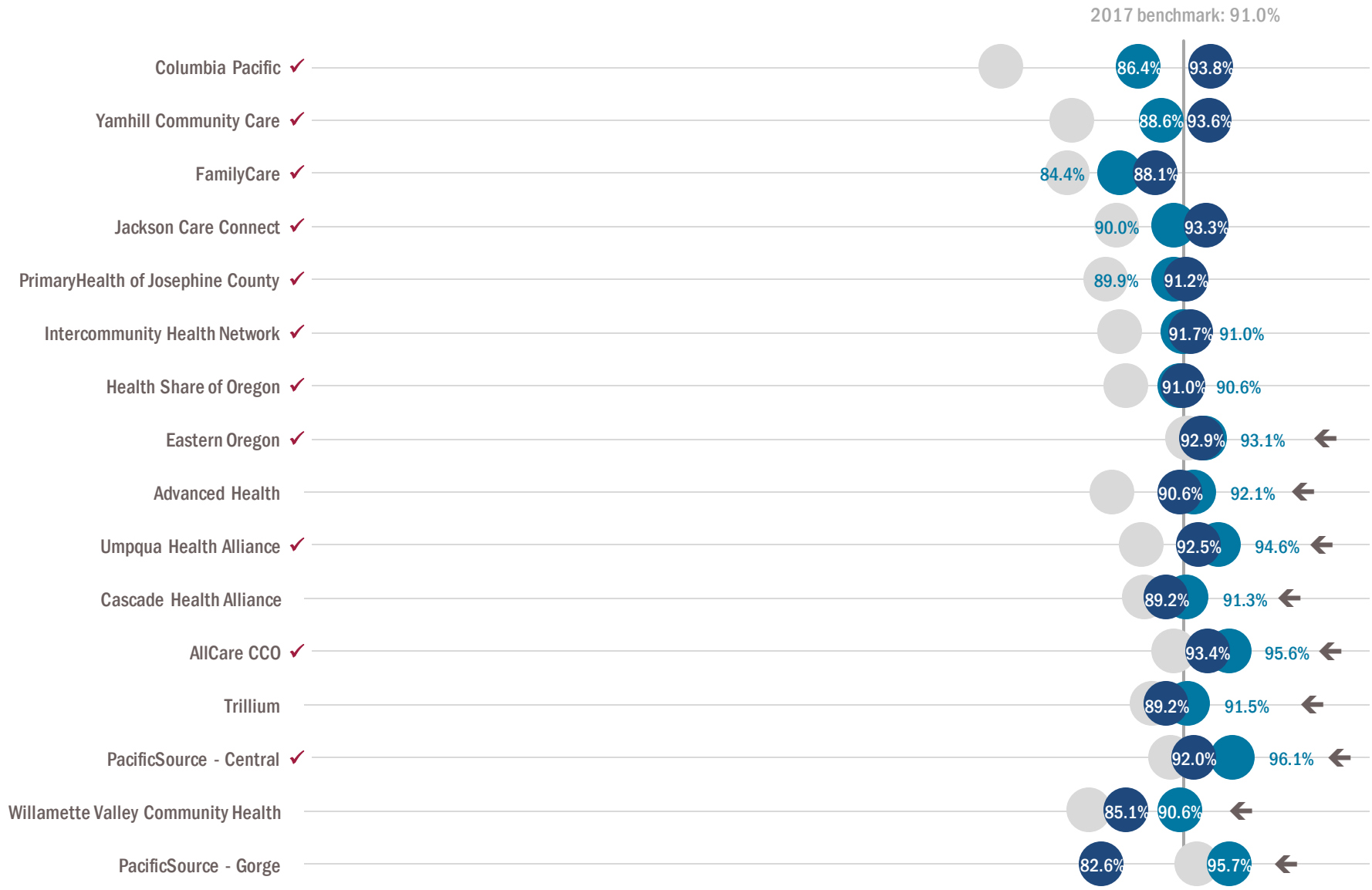
PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care (CAHPS)

Percentage of 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.

2017 benchmark source:
2016 national Medicaid 75th percentile; weighted average of adult and child rates

2017 data

- Statewide percent change since 2016: **+2.6%**
- Number of CCOs that improved: **13**
- Number of CCOs achieving target: **8**

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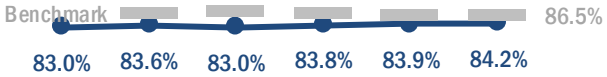
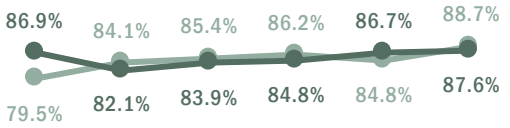
Statewide, satisfaction with care has remained steady over time.

All ages combined



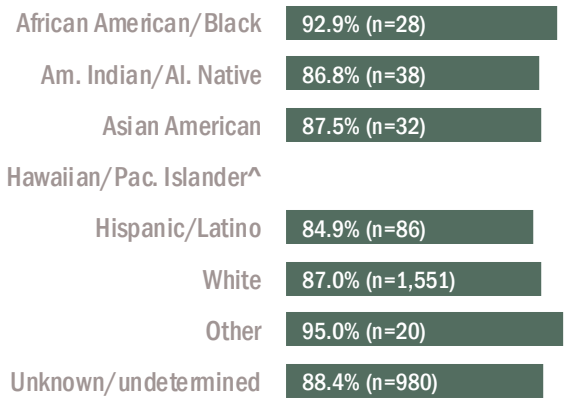
2011 '13 '14 '15 '16 2017

Adults and children



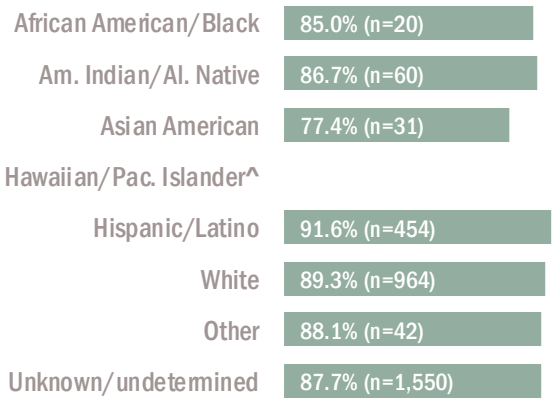
2011 2013 2014 2015 2016 2017

By race and ethnicity (adults) in 2017



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

By race and ethnicity (children) in 2017

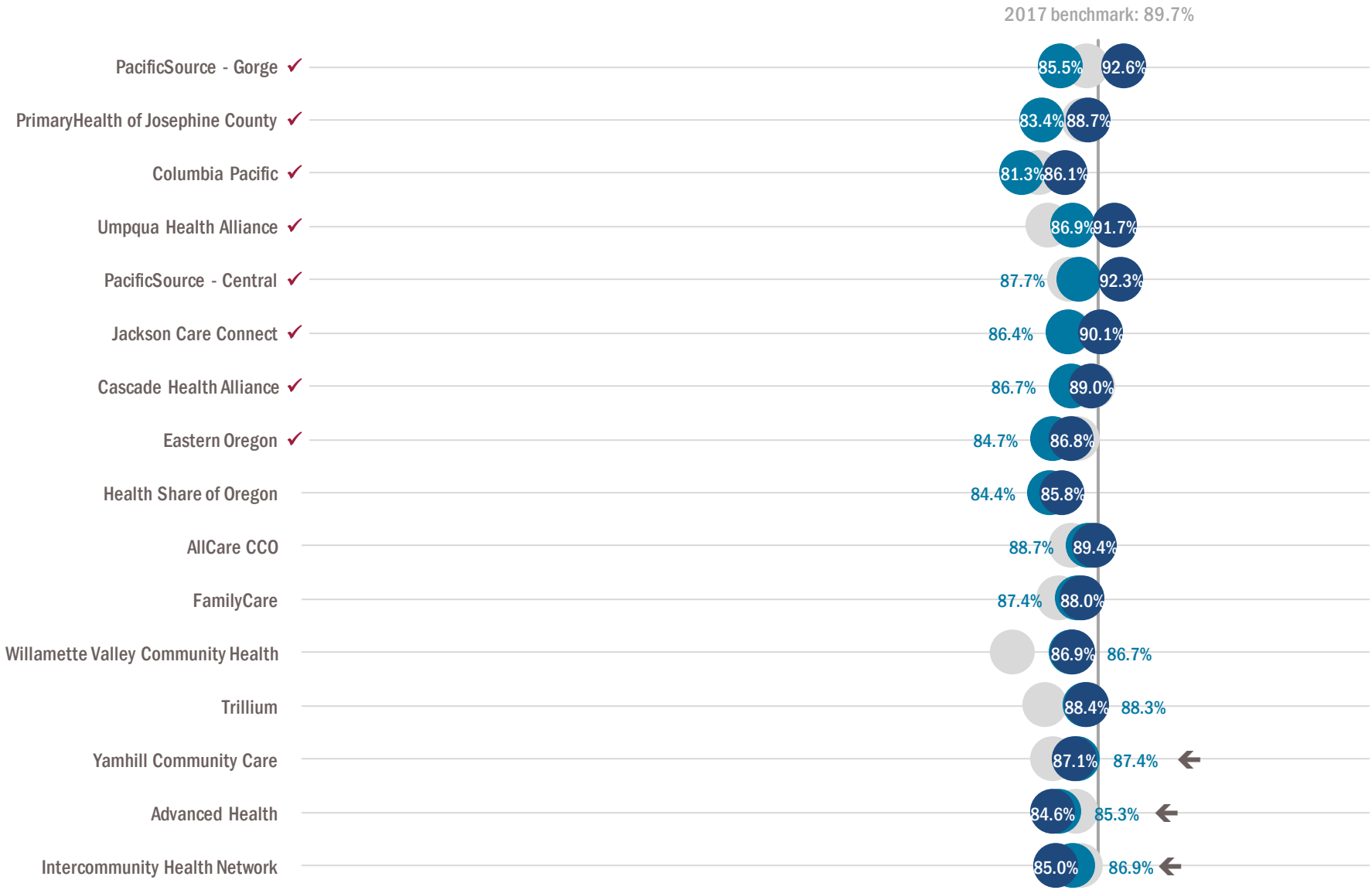


^ data suppressed (n<10)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

SATISFACTION WITH CARE (CAHPS SURVEY)

Satisfaction with care in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



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.

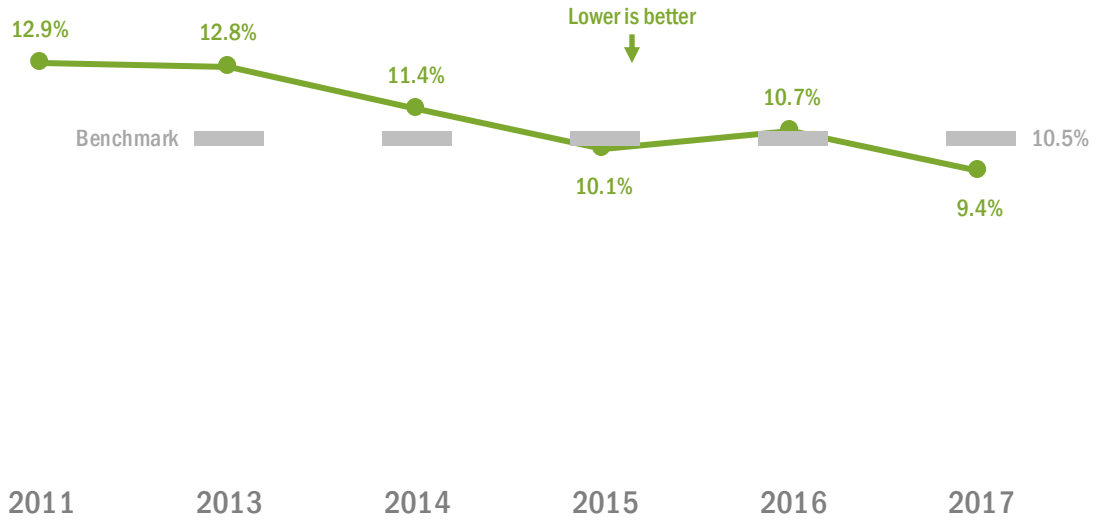
Data source:
Administrative (billing) claims

2017 benchmark source:
Average of 2013 commercial and Medicare 75th percentile

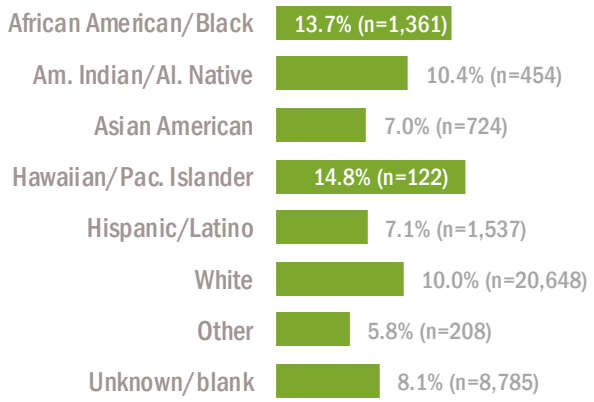
2017 data (N=33,839)

- Statewide percent change since 2016: **-12.1%** (lower is better)
- Number of CCOs that improved: **12**

Statewide, hospital readmissions declined in 2017.

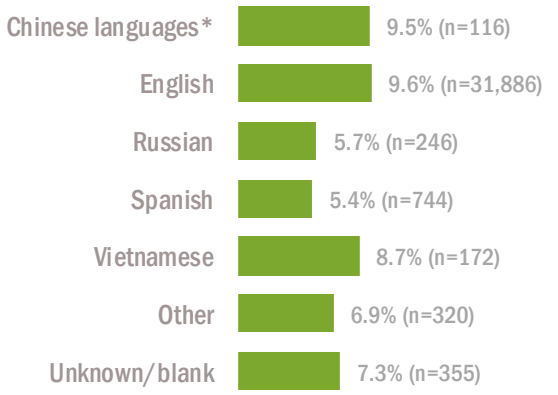


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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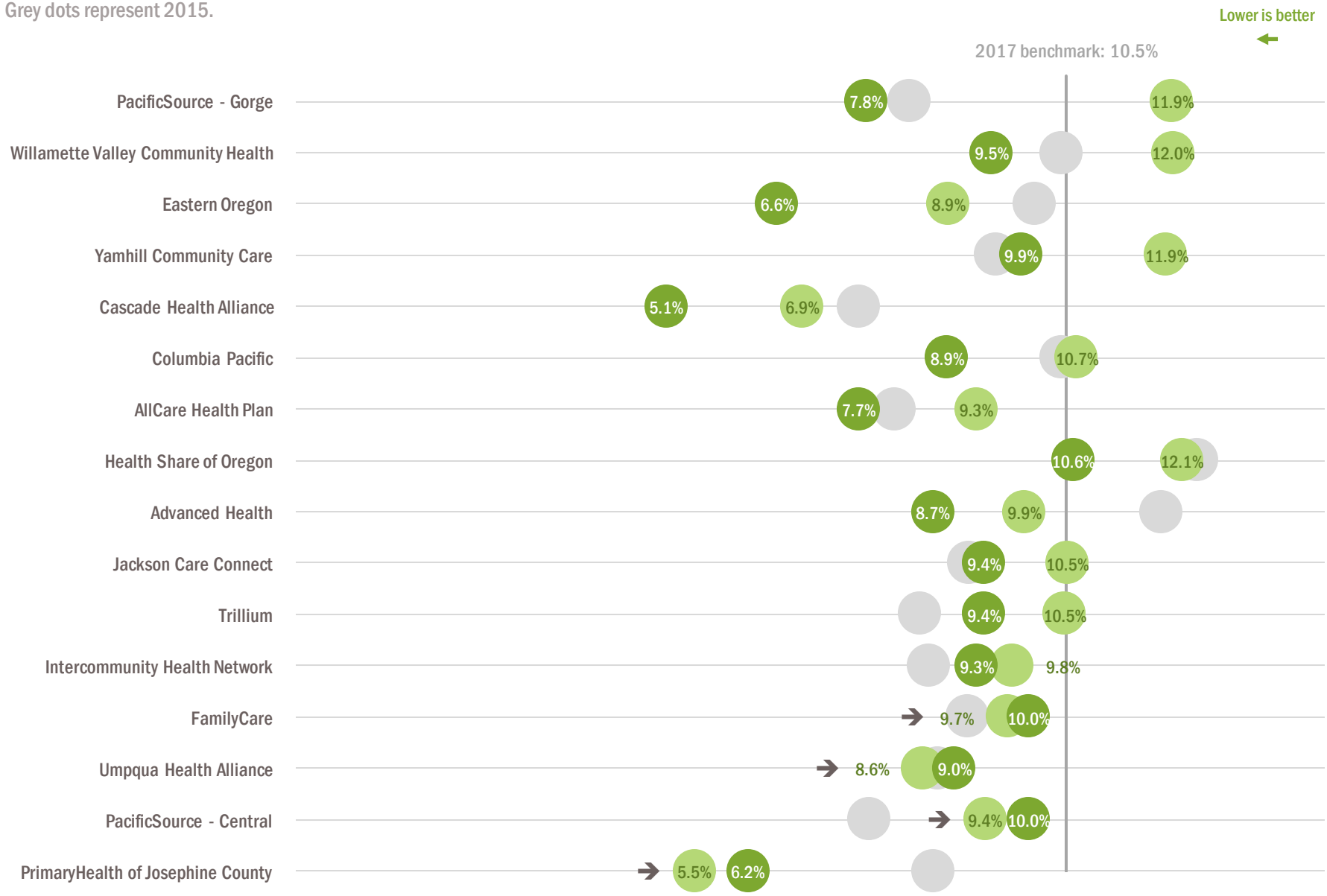
ALL-CAUSE READMISSIONS

Hospital all-cause readmissions in 2016 and 2017, by CCO.

Grey dots represent 2015.



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

2017 benchmark source:

n/a

2017 data (N=10,026,285 member months)

- Statewide percent change since 2016: **-1.4%** (lower is better)
- Number of CCOs that improved: **11**

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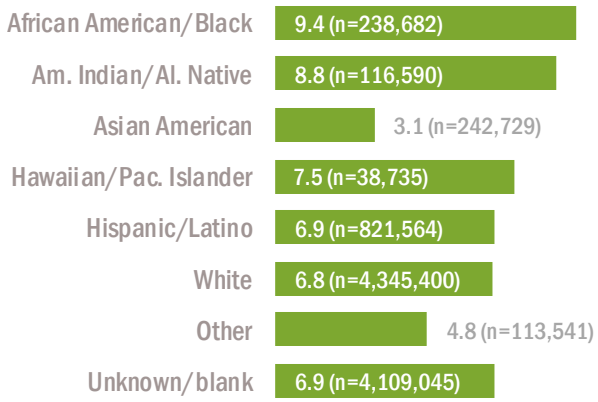
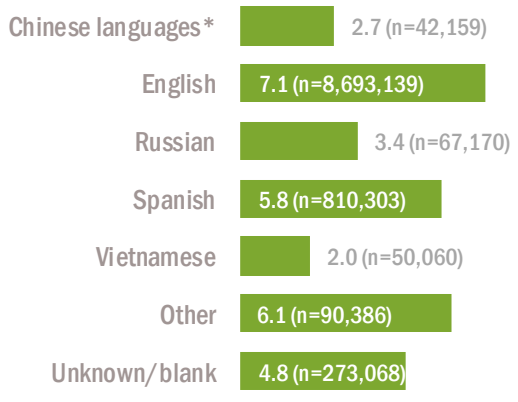
Statewide, avoidable ED utilization has leveled off.

By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)

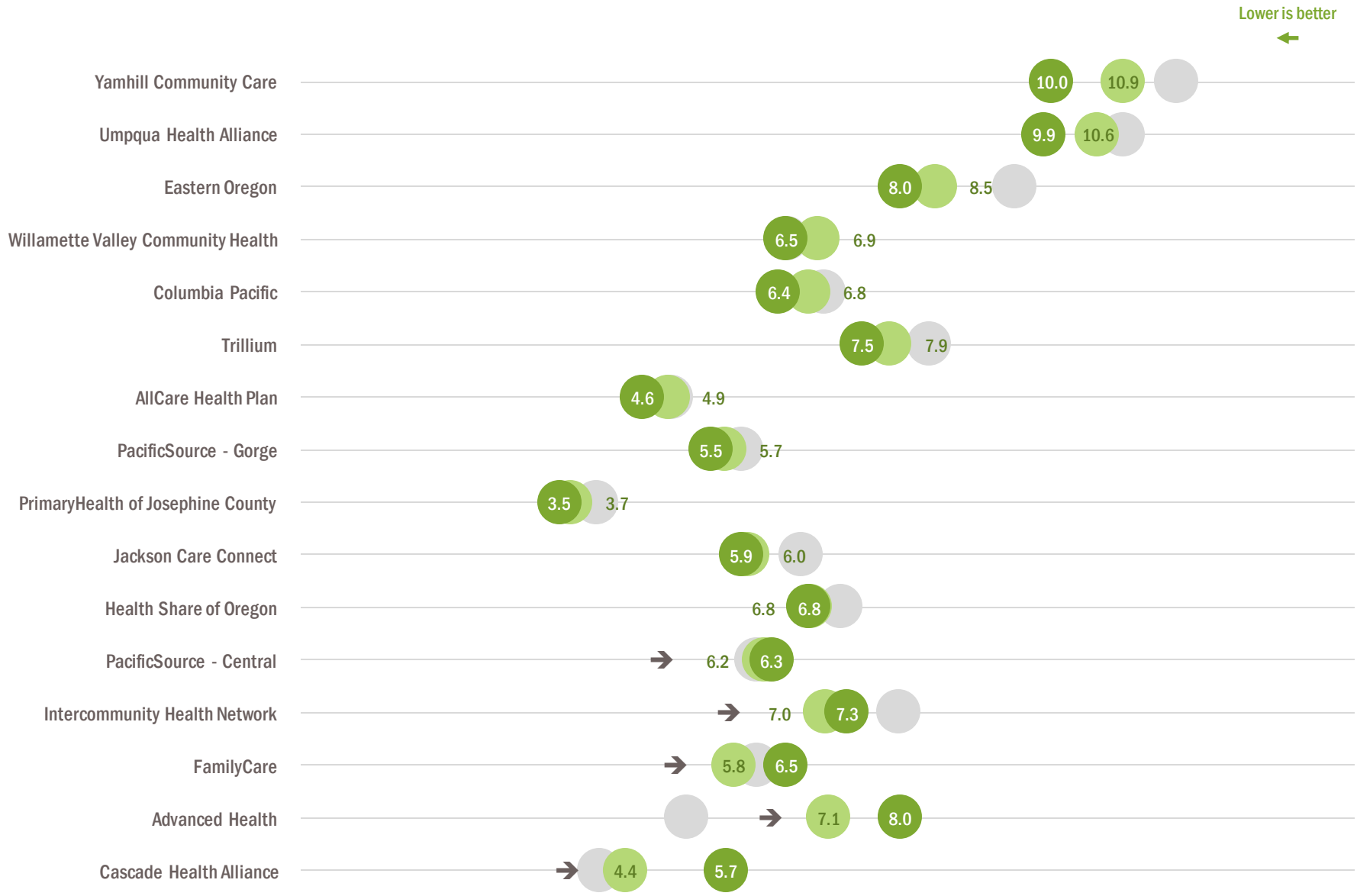


n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

AMBULATORY CARE: AVOIDABLE EMERGENCY DEPARTMENT UTILIZATION

Avoidable emergency department utilization in 2016 and 2017, by CCO.

Grey dots represent 2015.



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

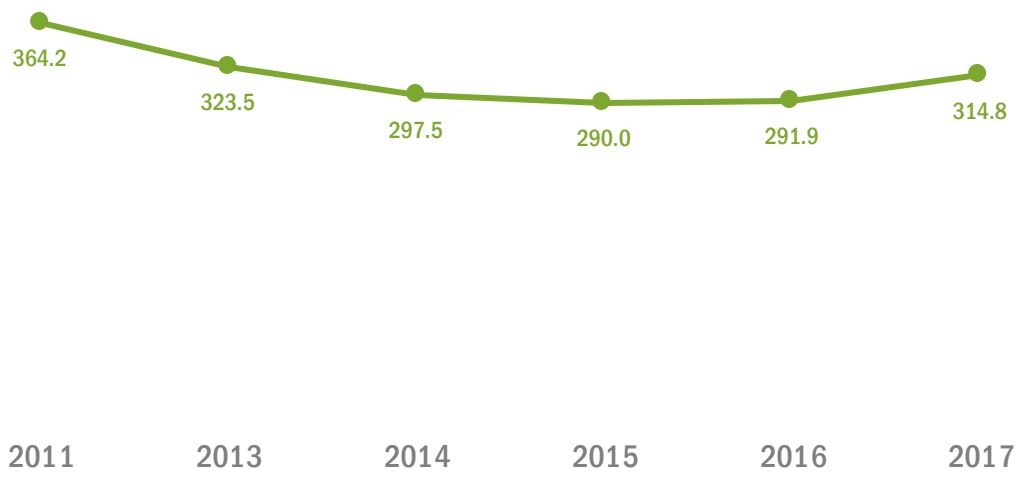
2017 benchmark source:
n/a

2017 data (N=10,026,285 member months)

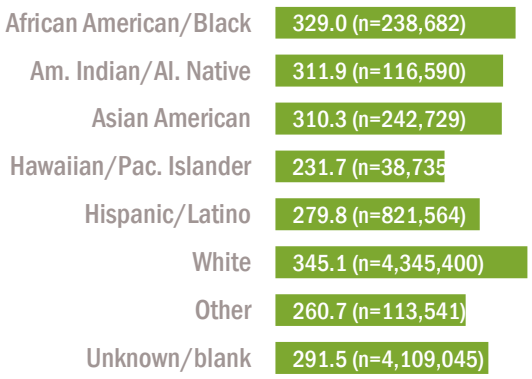
- Statewide percent change since 2016: **+7.8%**
- Number of CCOs that improved: **13**

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, outpatient utilization increased in 2017.

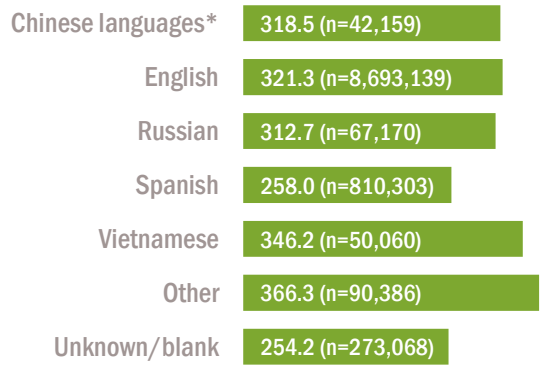


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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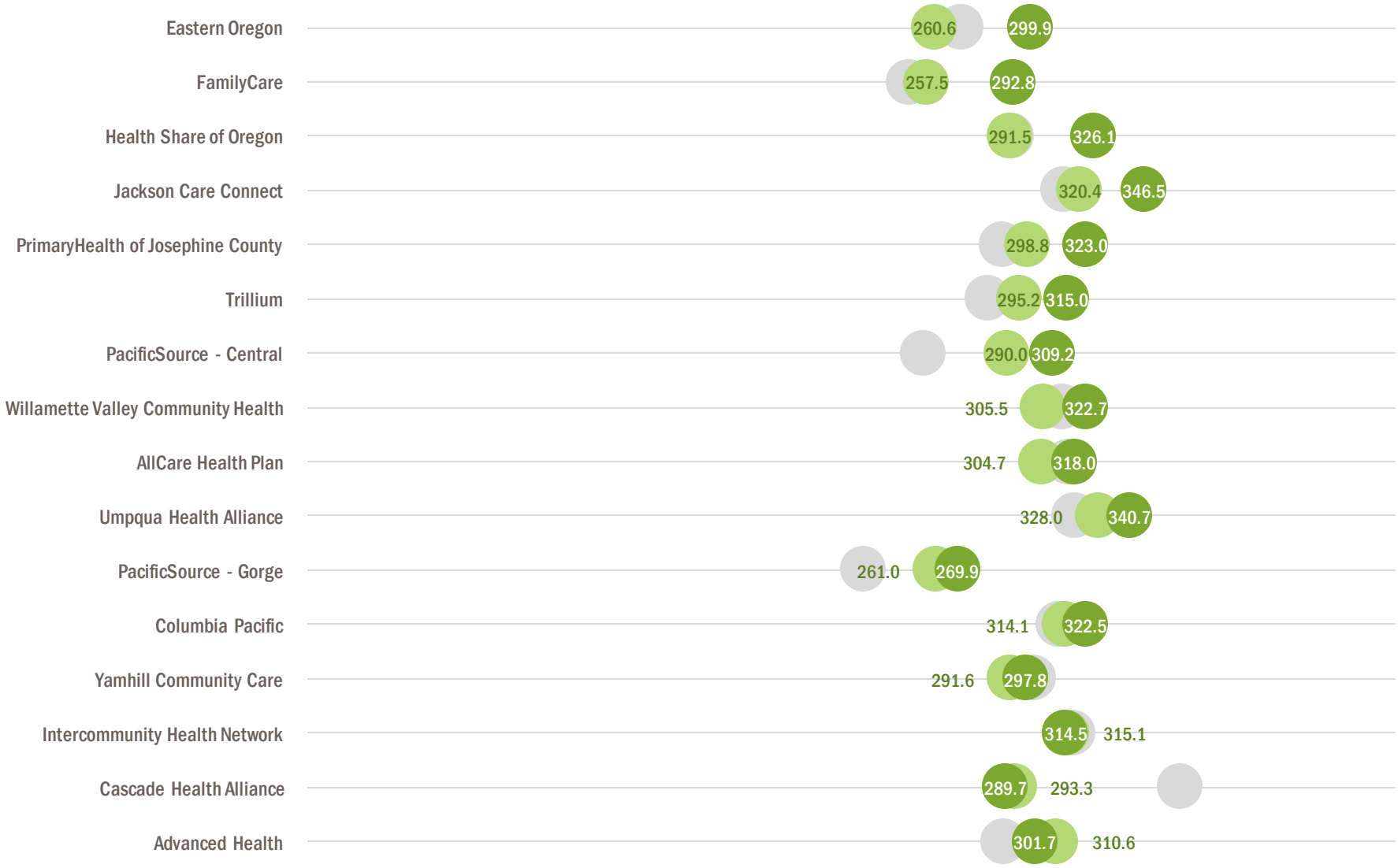
AMBULATORY CARE: OUTPATIENT UTILIZATION

Outpatient utilization in 2016 and 2017, by CCO.

Grey dots represent 2015.



CERVICAL CANCER SCREENING

Cervical cancer screening

Percentage of women (ages 21 to 64) who received one or more Pap tests for cervical cancer during the past three years.

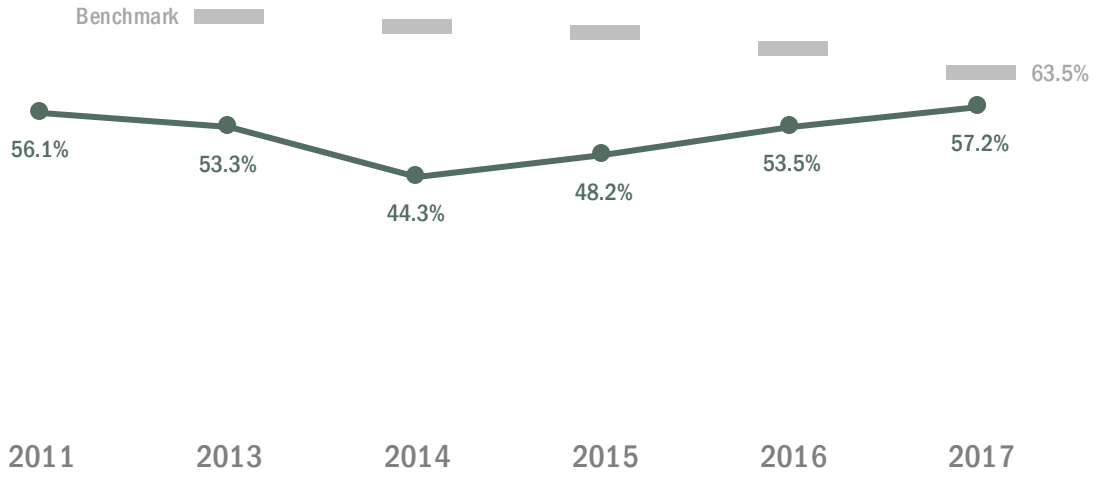
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 75th percentile

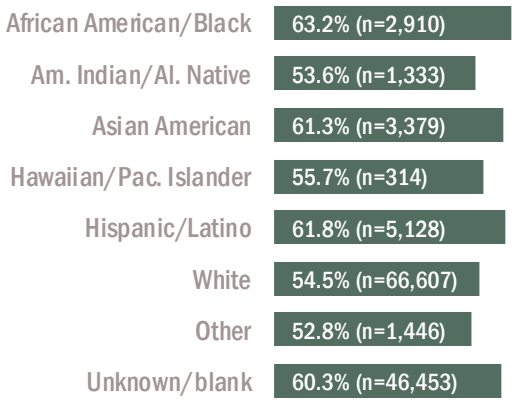
2017 data (N=127,570)

- Statewide percent change since 2016: **+6.9%**
- Number of CCOs that improved: **all 16**

Statewide, cervical cancer screening has increased.

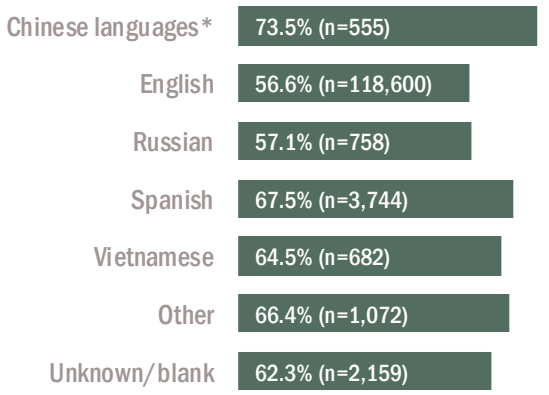


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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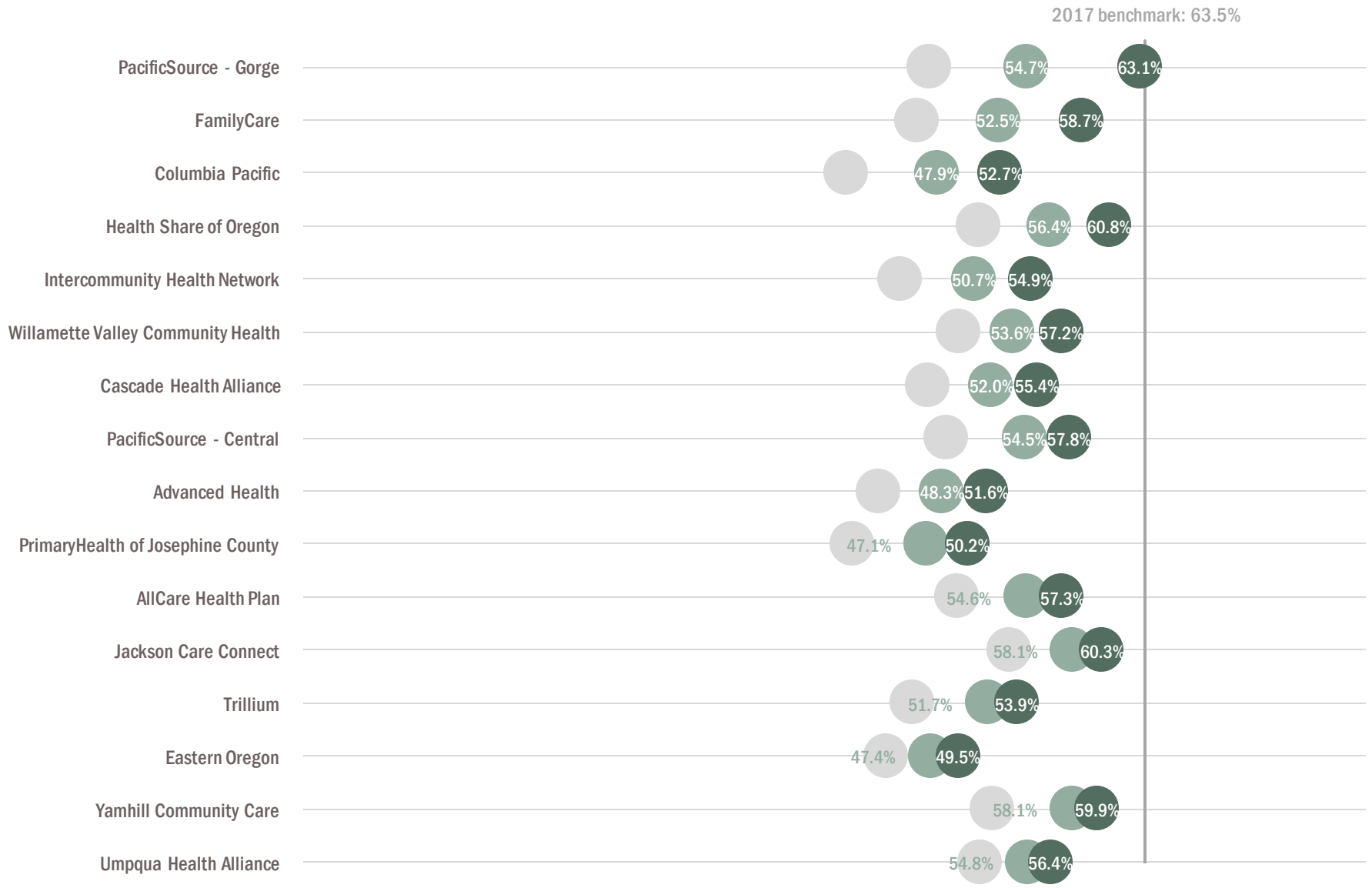
CERVICAL CANCER SCREENING

Cervical cancer screening in 2016 and 2017, by CCO.

Grey dots represent 2015.



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.

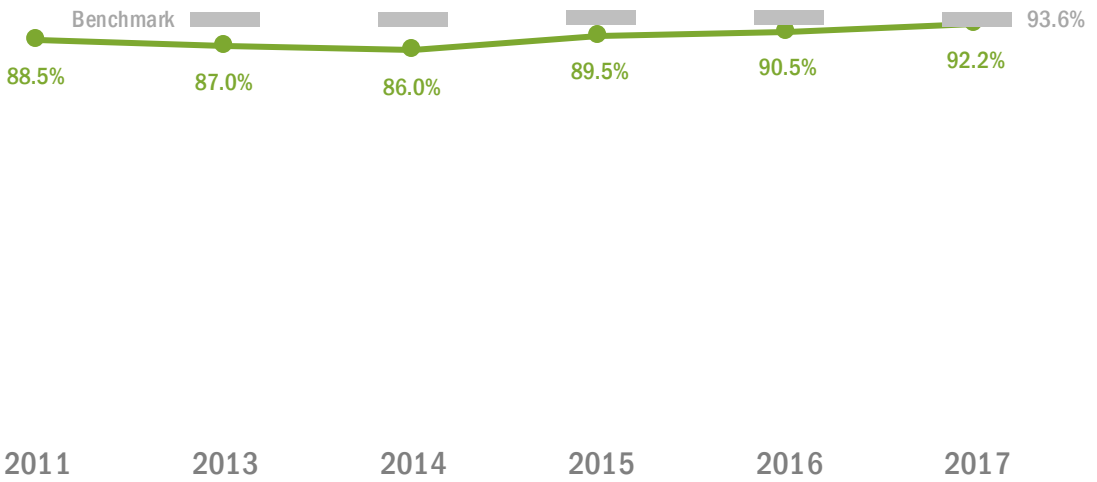
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 75th percentile

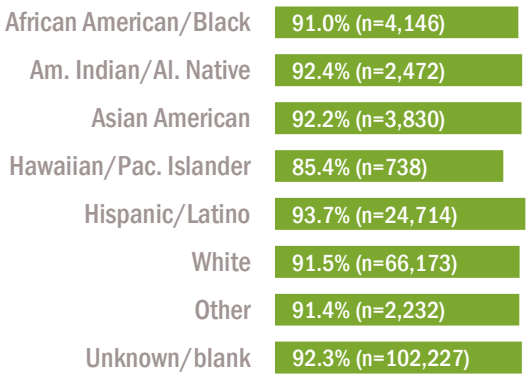
2017 data (N=206,532)

- Statewide percent change since 2016: **+1.9%**
- Number of CCOs that improved: **all 16**

Child and adolescent access to primary care, statewide.

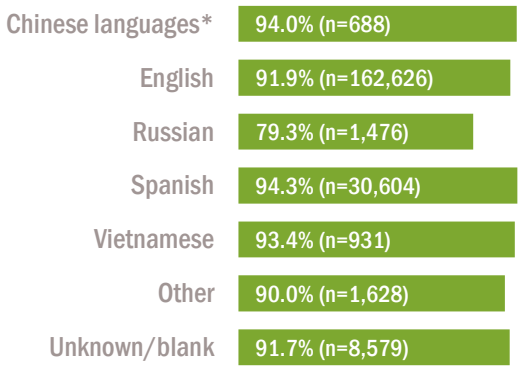


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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CHILDHOOD AND ADOLESCENT ACCESS TO PRIMARY CARE PROVIDERS

Childhood and adolescent access to primary care providers in 2016 and 2017, by CCO.

Grey dots represent 2015.

CHLAMYDIA SCREENING

Chlamydia screening

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

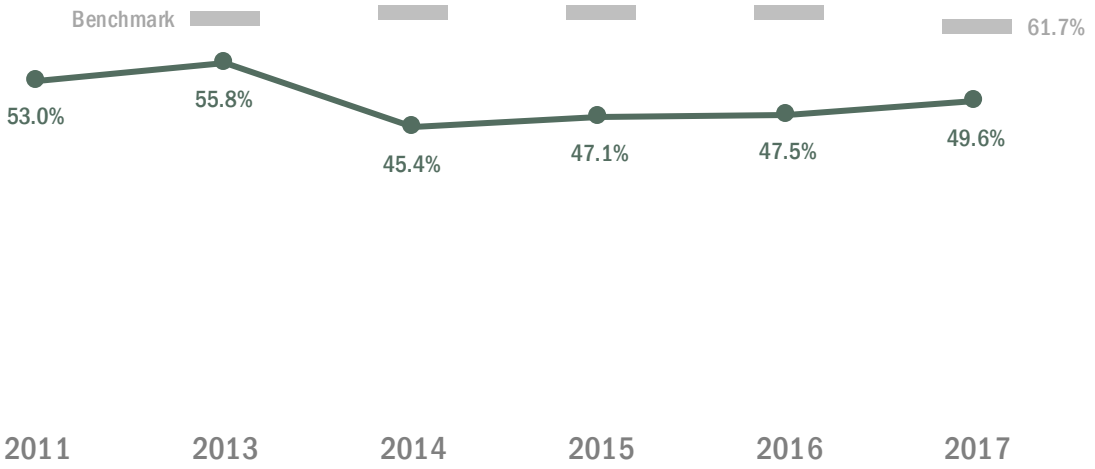
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 75th percentile

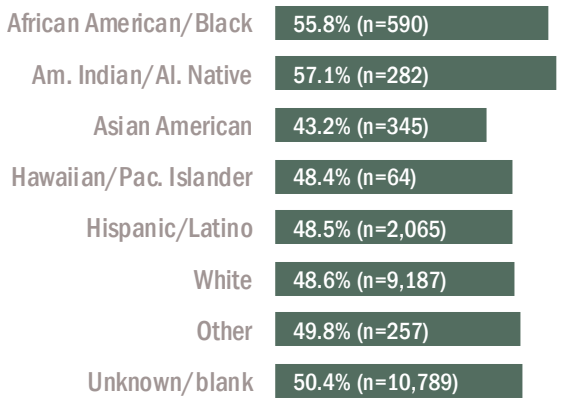
2017 data (N=25,579)

- Statewide percent change since 2016: **+4.4%**
- Number of CCOs that improved: **9**

Statewide, chlamydia screening increased in 2017.

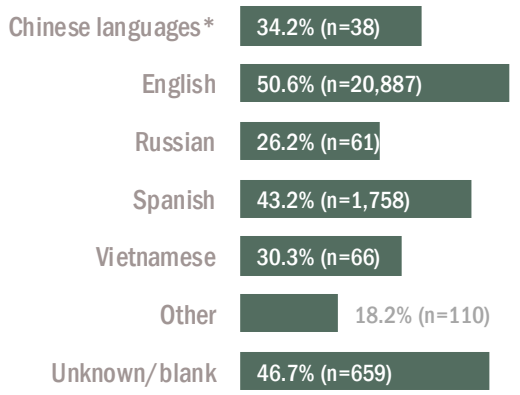


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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CHLAMYDIA SCREENING

Chlamydia screening in 2016 and 2017, by CCO.

Grey dots represent 2015.

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.

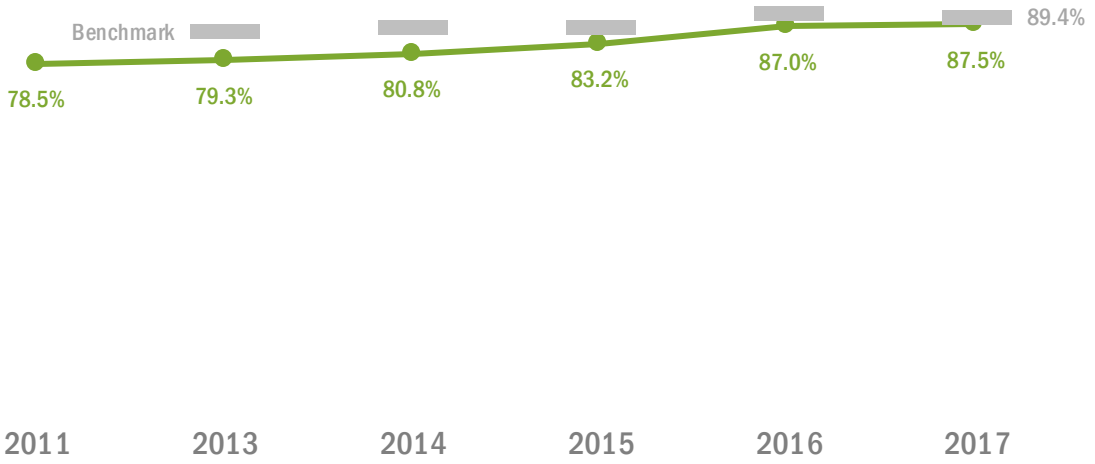
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 75th percentile

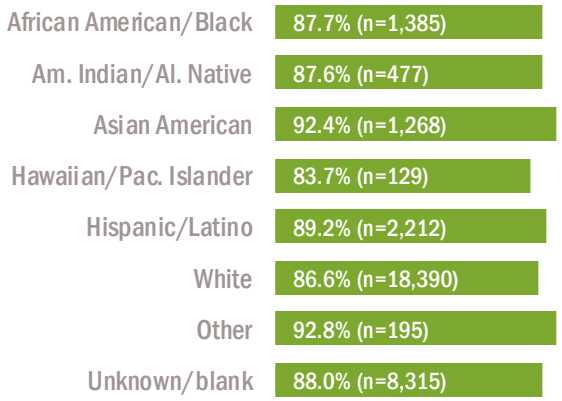
2017 data (N=32,371)

- Statewide percent change since 2016: **+0.6%**
- Number of CCOs that improved: **11**

Statewide, Hba1c testing for adults with diabetes remained steady in 2017.

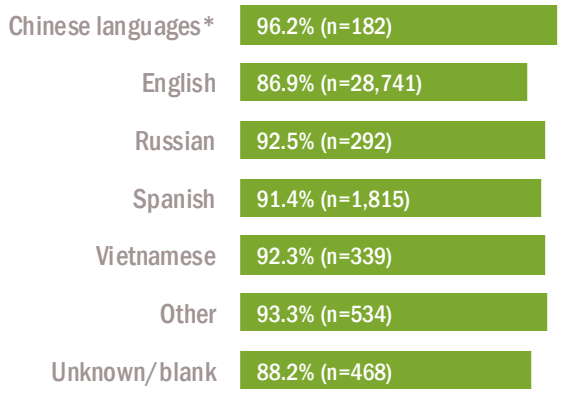


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1c TESTING

Hba1c testing for members with diabetes in 2016 and 2017, by CCO.

Grey dots represent 2015.

EARLY ELECTIVE DELIVERY

Early elective delivery

Percentage of women delivering a newborn who had an elective delivery between 37 and 39 weeks of gestation (lower score is better).

Data source:
Administrative (billing) claims, Vital Records, and hospitals

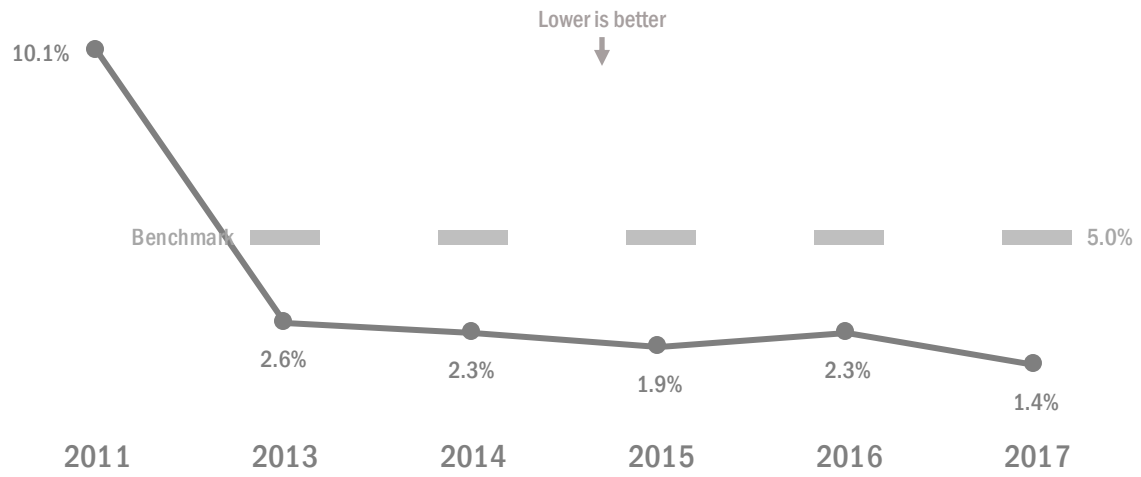
2017 benchmark source:
Metrics and Scoring Committee consensus

2017 data (N=3,524)

- Statewide percent change since 2016: **-39.1%** (lower is better)
- Number of CCOs that improved: **11**

Early elective delivery is a former CCO incentive measure; it was retired in 2015.

Statewide, early elective delivery continues to decline.



Race/ethnicity, and household language data are not available for this measure..

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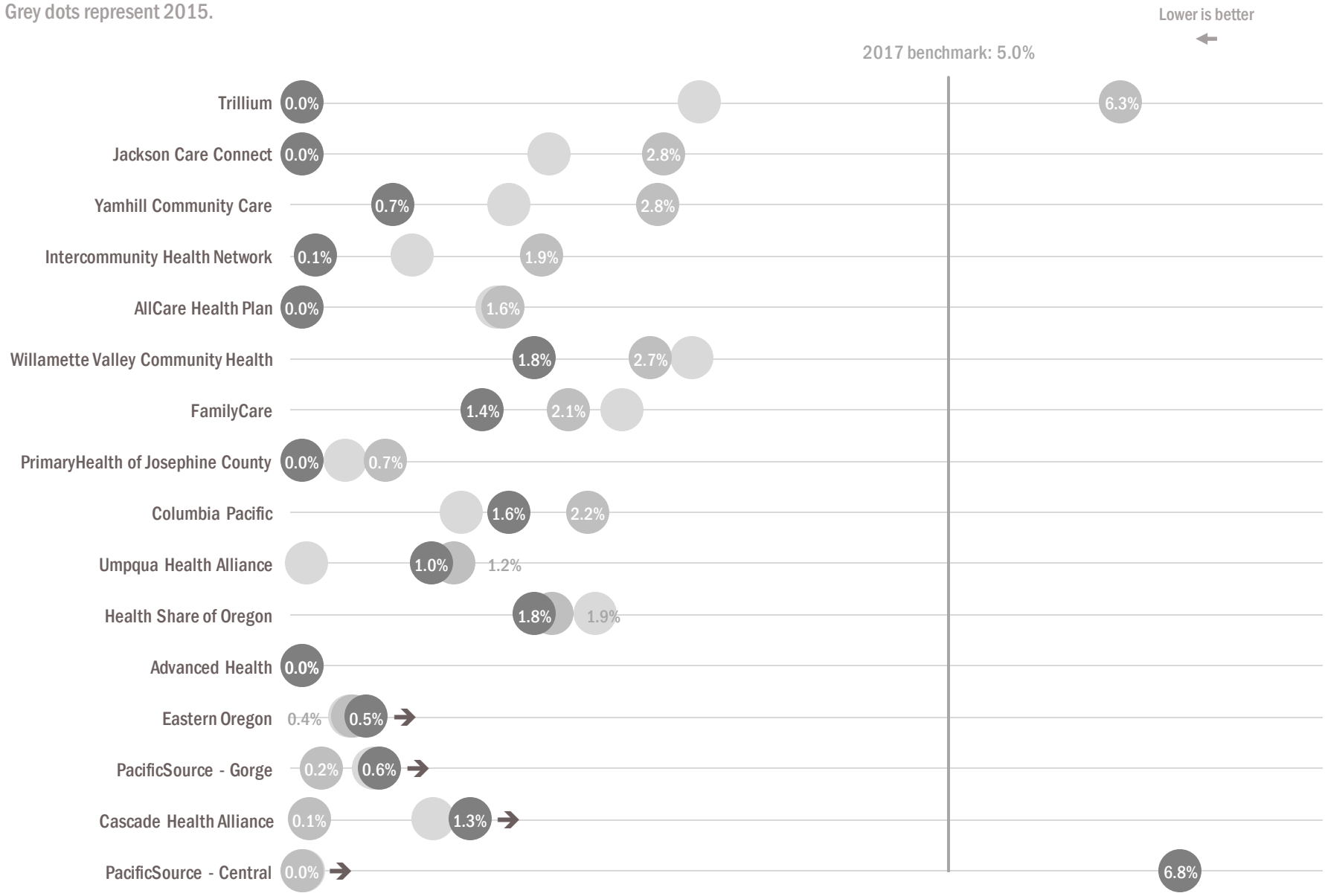
EARLY ELECTIVE DELIVERY



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

Measure description

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

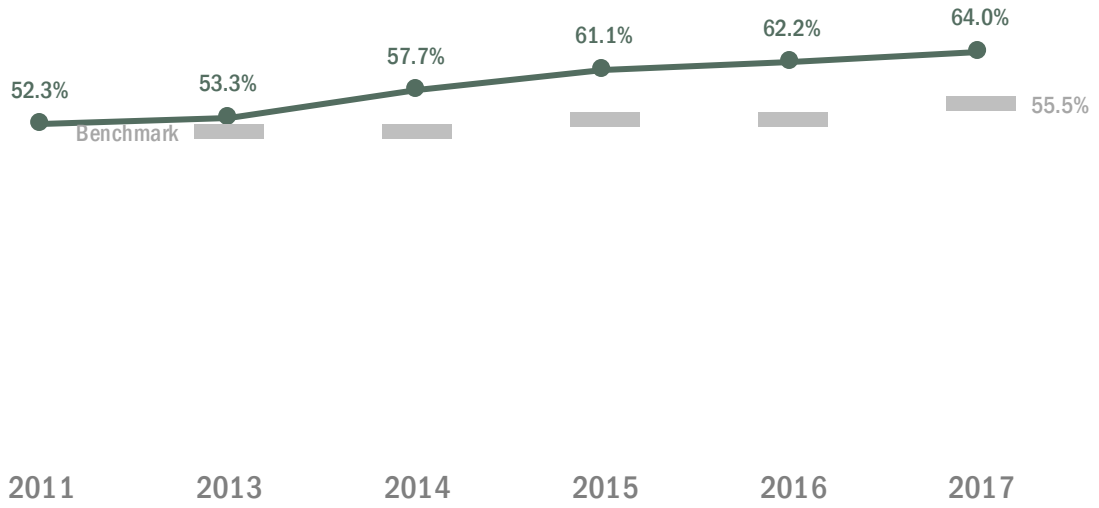
2017 benchmark source:
2016 national Medicaid 90th percentile

2017 data (N=1,963)

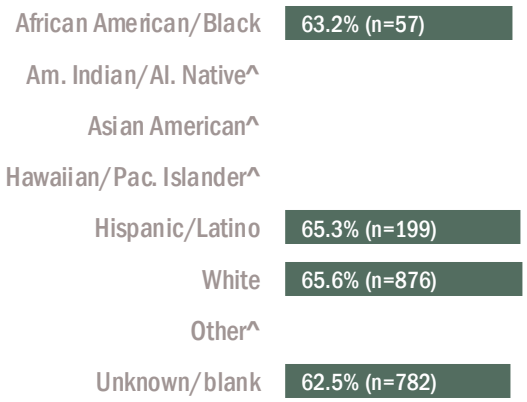
- Statewide percent change since 2016: **+2.9%**
- Number of CCOs that improved: **11**

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

Statewide, follow-up for children prescribed ADHD medication has increased.

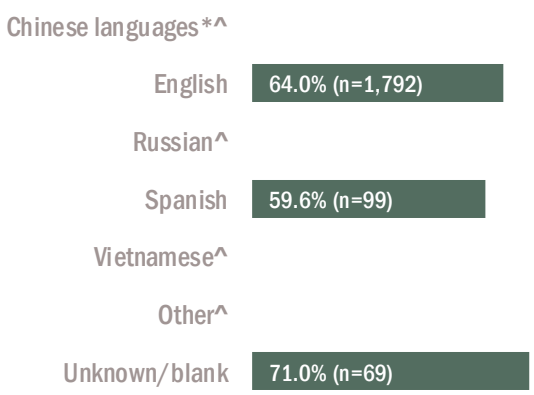


By race and ethnicity (2017)



^data suppressed (n<30)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



^data suppressed (n<30)
n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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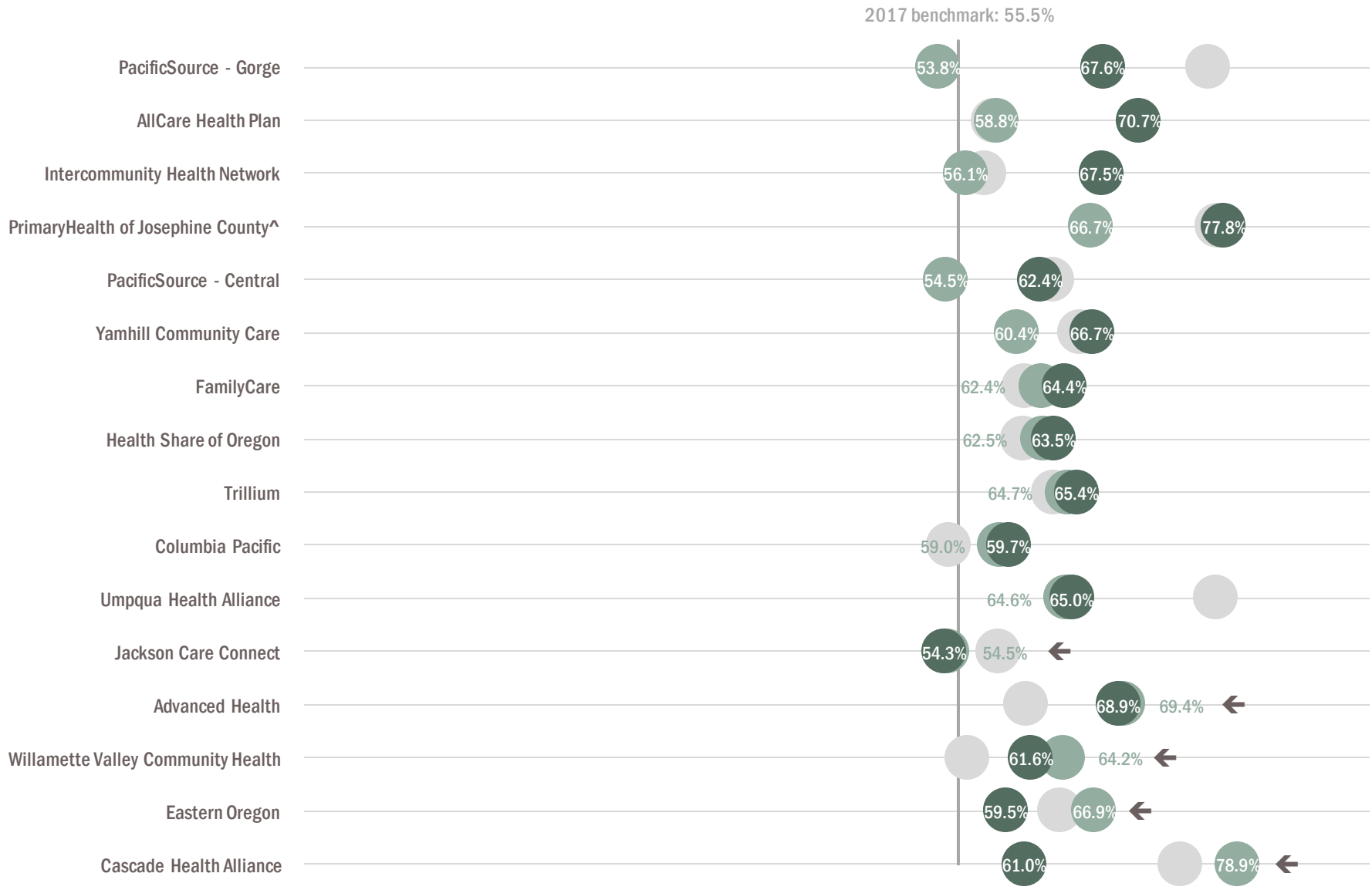
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (INITIATION PHASE)

Follow-up care for children prescribed ADHD medication in 2016 and 2017, by CCO.

Grey dots represent 2015.



^ note small denominator (n<30)

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

Measure description

Lorem 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.

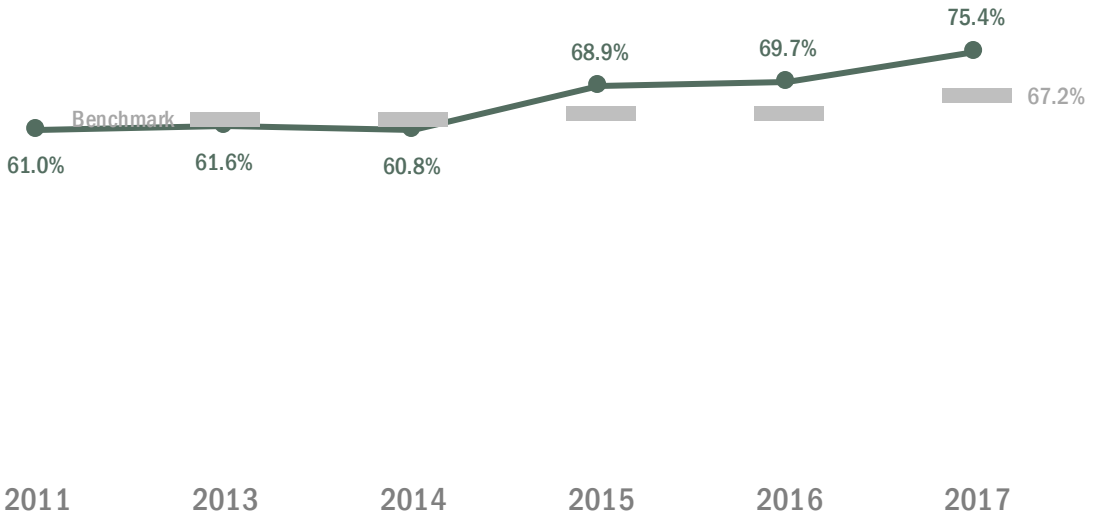
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid 90th percentile

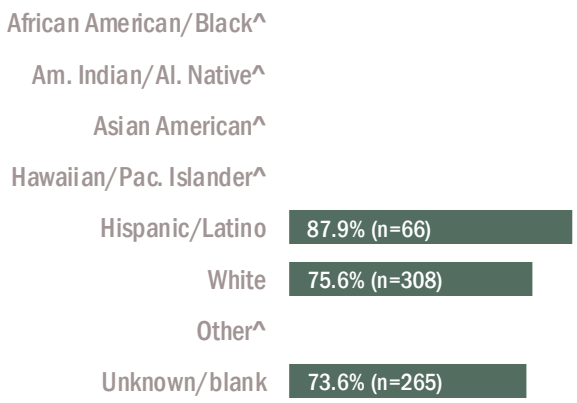
2017 data (N=666)

- Statewide percent change since 2016: **+8.2%**
- Number of CCOs that improved: **12**

Statewide, follow-up for children prescribed ADHD medication has increased.

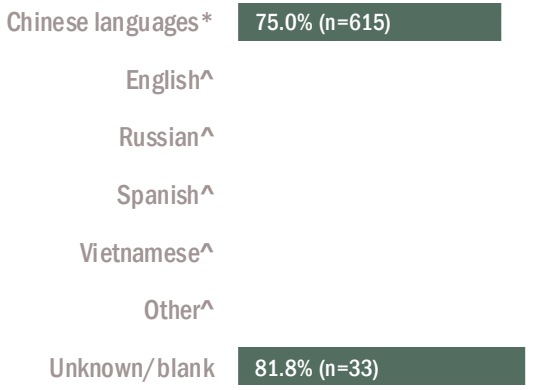


By race and ethnicity (2017)



^data suppressed (n<30)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



^data suppressed (n<30)
n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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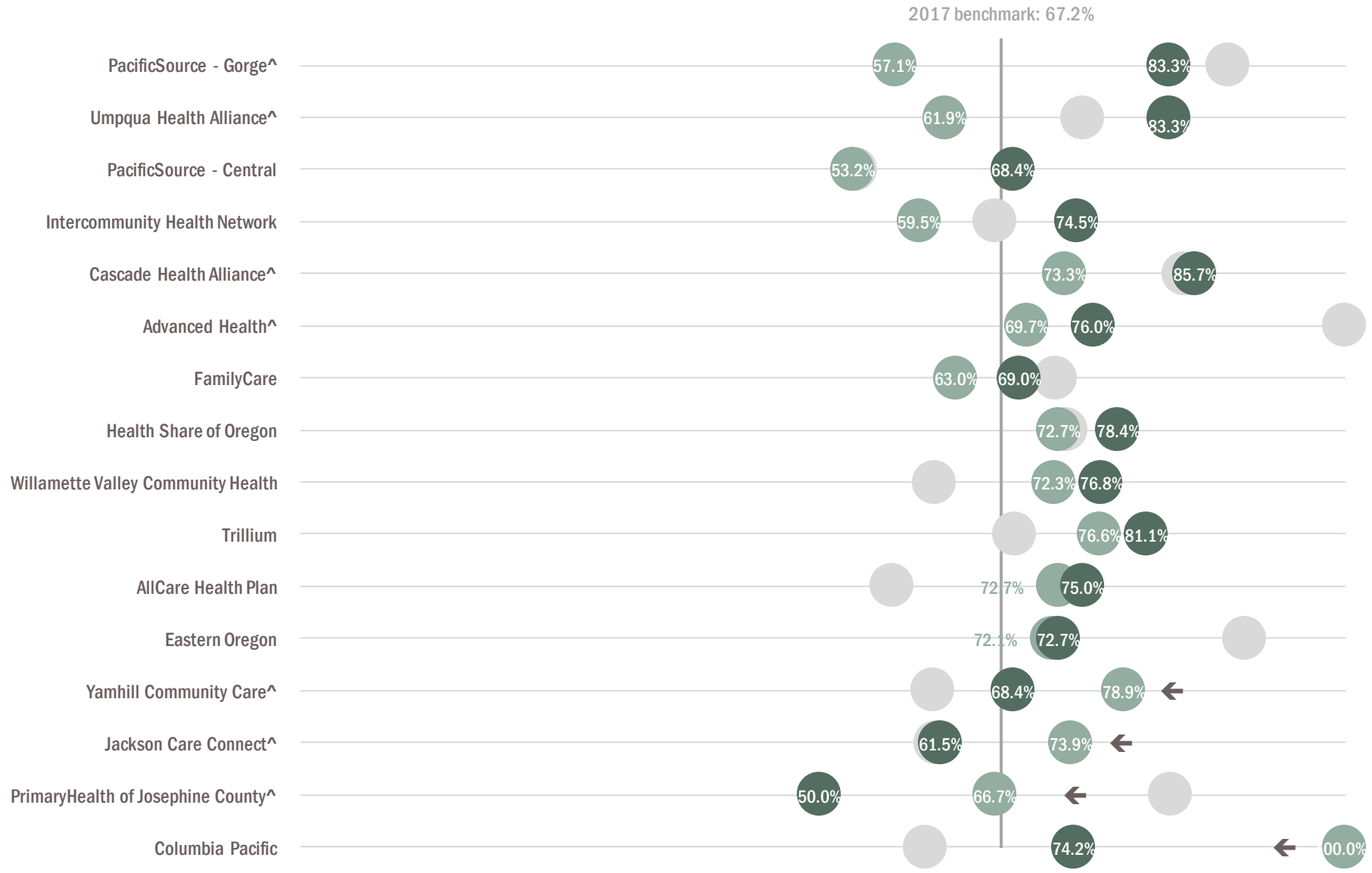
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (CONTINUATION AND MAINTENANCE PHASE)

Continuing follow-up for children prescribed ADHD medication in 2016 and 2017, by CCO.

Grey dots represent 2015.



^ note small denominator (n<30)

HEALTH STATUS - ADULTS (CAHPS SURVEY)

Health status (adults)

Percentage of adults who report 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.

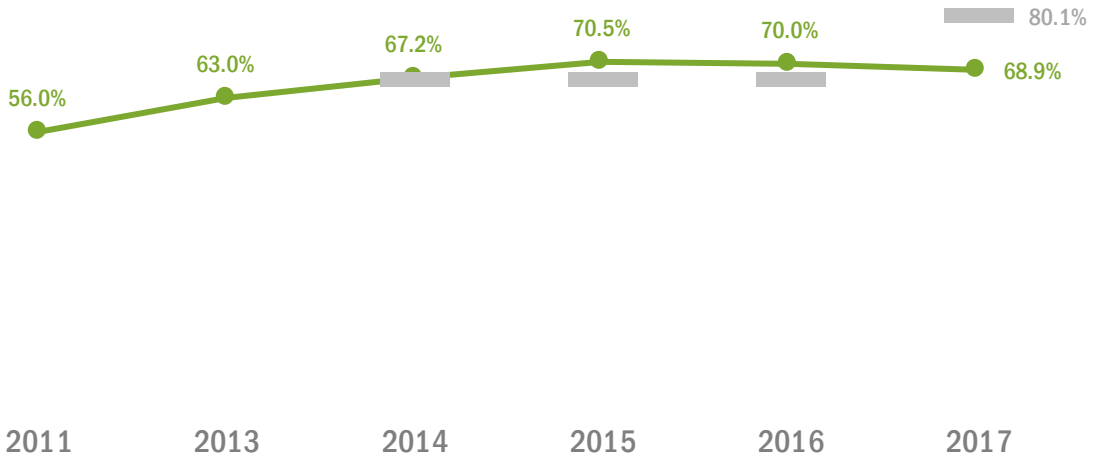
2017 benchmark source:

National CAHPS benchmark

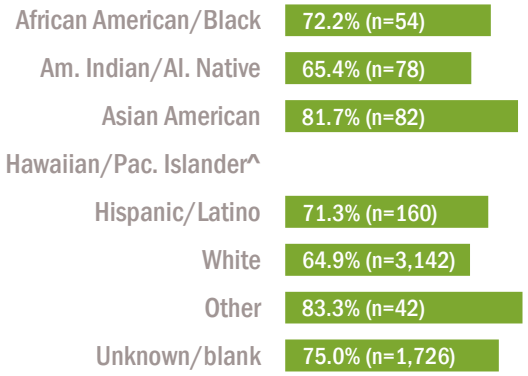
2017 data (N=5,291)

- Statewide percent change since 2016: **-1.6%**
- Number of CCOs that improved: **9**

Statewide, self-reported health status among adults declined slightly in 2017.



By race and ethnicity (2017)



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

Household language data are not available for this measure.

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HEALTH STATUS - ADULTS (CAHPS SURVEY)

Percentage of adults whose health status was good, very good, or excellent in 2016 and 2017, by CCO.

Grey dots represent 2015.

HEALTH STATUS - CHILDREN (CAHPS SURVEY)

Health status (children)

Percentage of children who report 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.

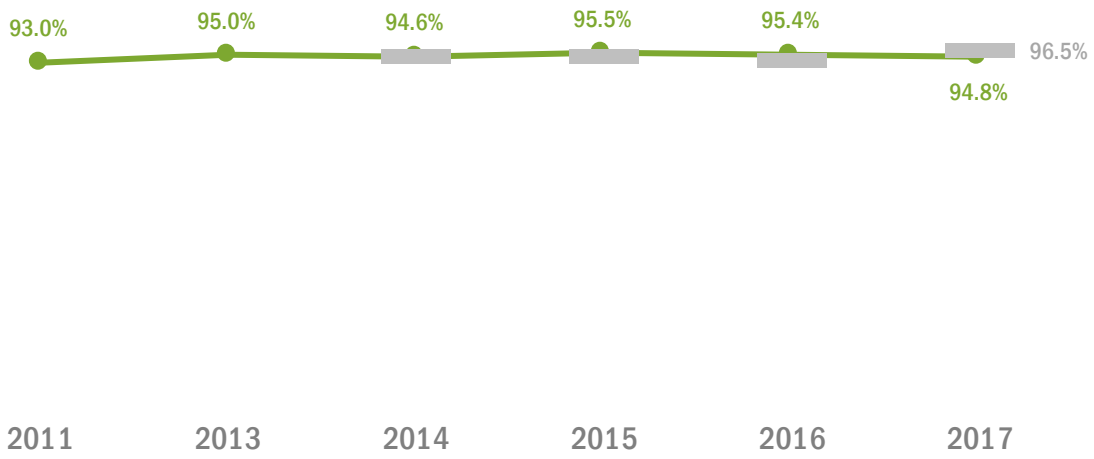
2017 benchmark source:

National CAHPS benchmark

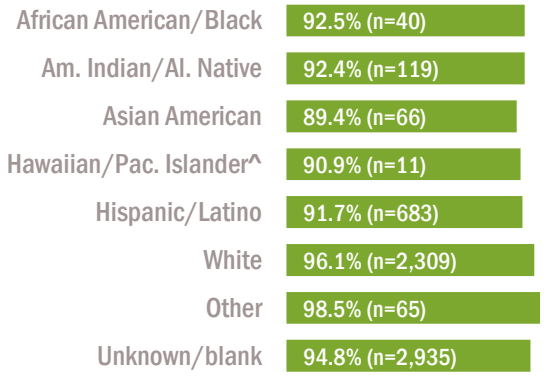
2017 data (N=6,228)

- Statewide percent change since 2016: **-0.6%**
- Number of CCOs that improved: **5**

Statewide, self-reported health status among children has been steady.



By race and ethnicity (2017)



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

Household language data are not available for this measure.

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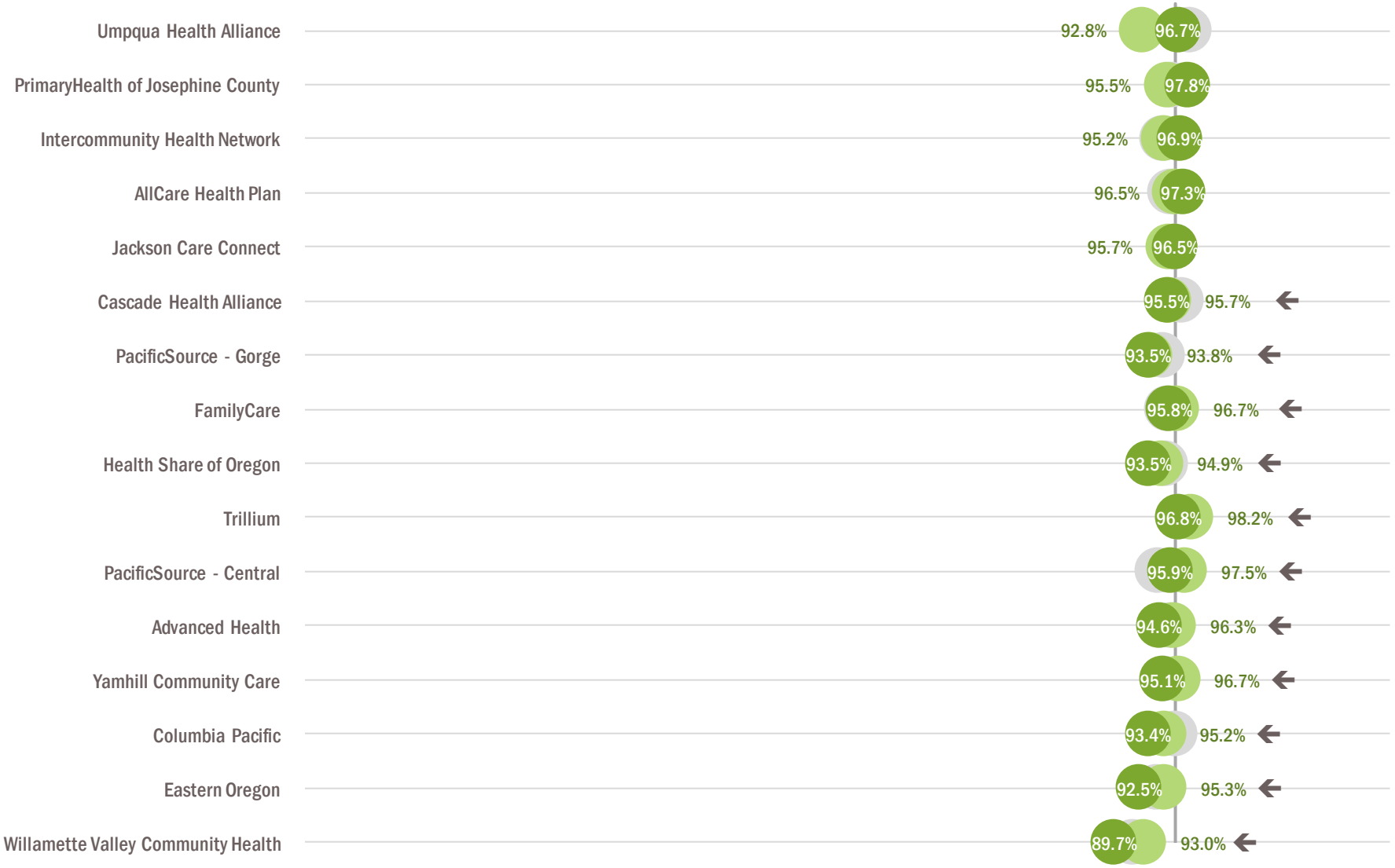
HEALTH STATUS - CHILDREN (CAHPS SURVEY)

Percentage of children whose health status was good, very good, or excellent in 2016 and 2017, by CCO.

Grey dots represent 2015.



IMMUNIZATIONS FOR ADOLESCENTS

Immunizations for adolescents

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

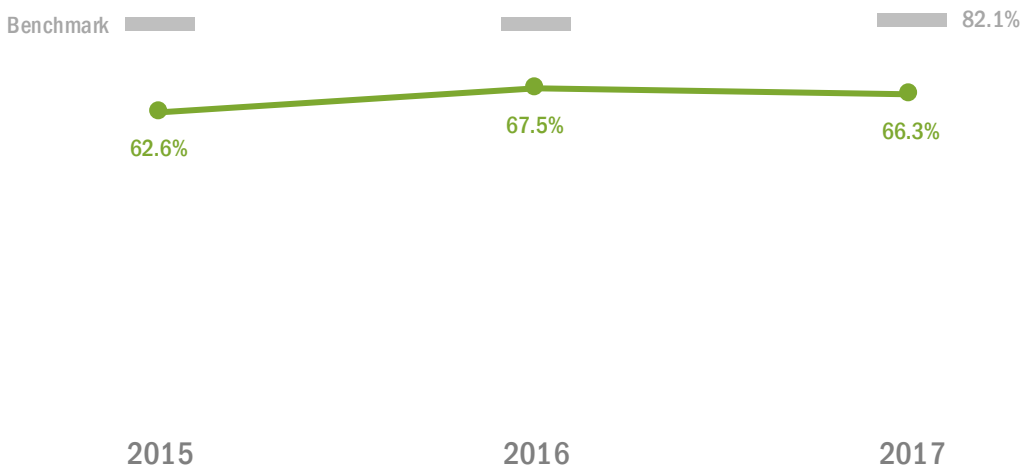
Data source:
Administrative (billing) claims and ALERT immunization data

2017 benchmark source:
2016 national Medicaid 75th percentile

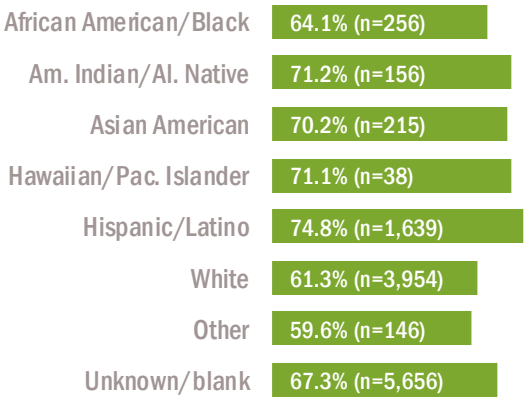
2017 data (N=12,060)

- Statewide percent change since 2016: **-1.7%**
- Number of CCOs that improved: **5**

Statewide, immunizations for adolescents decreased slightly in 2017.

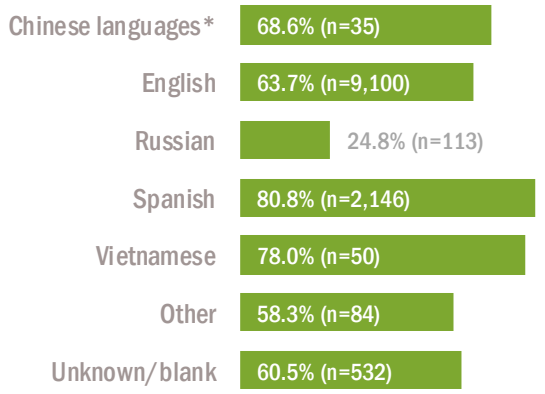


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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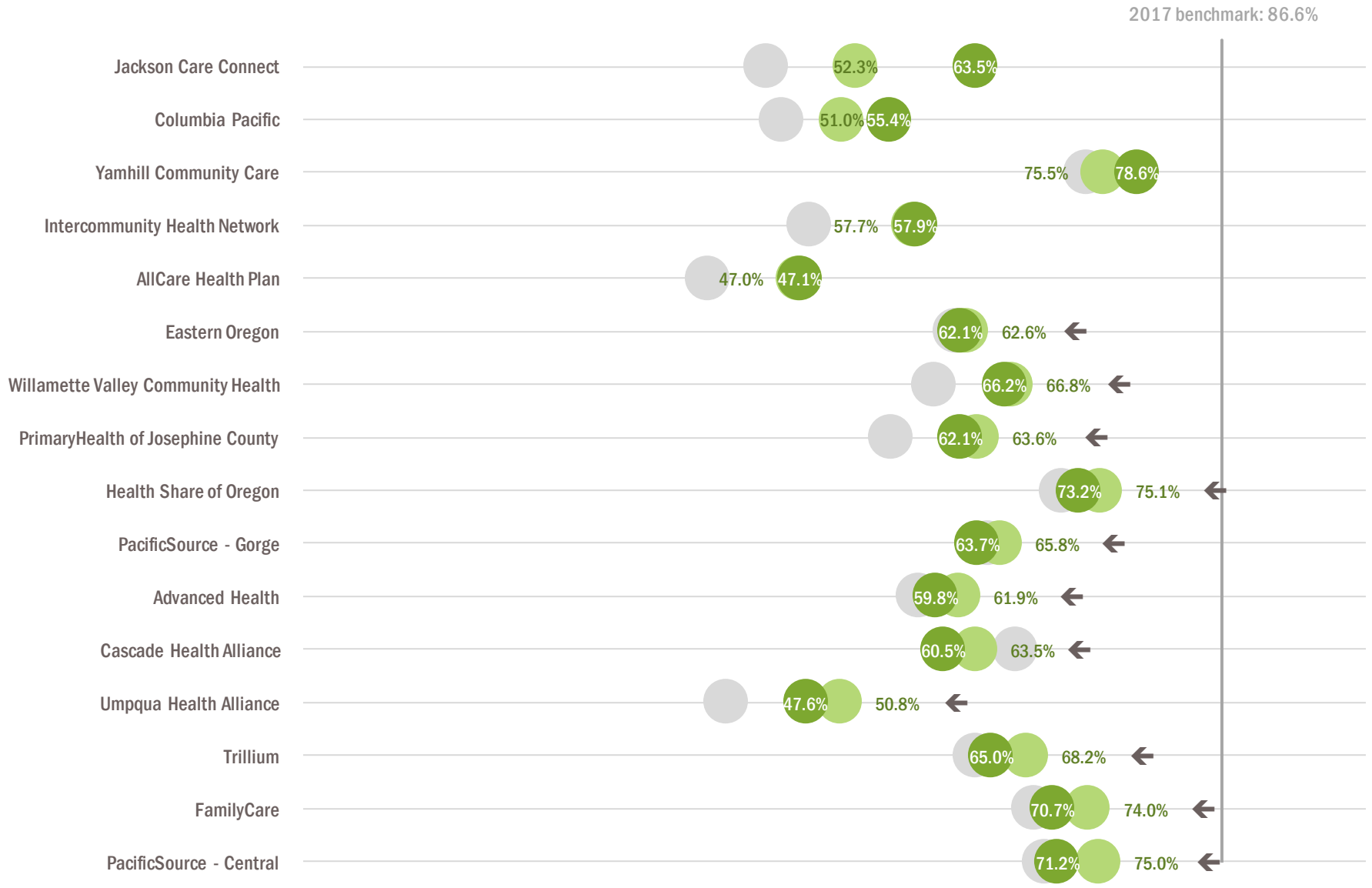
IMMUNIZATIONS FOR ADOLESCENTS

Immunizations for adolescents in 2016 and 2017, by CCO.

Grey dots represent 2015.



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

Measure description

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

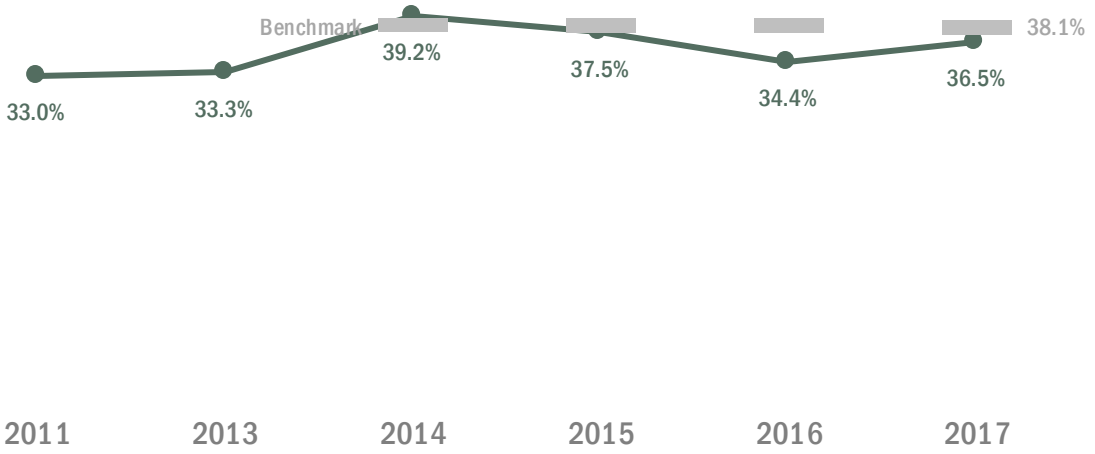
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid median

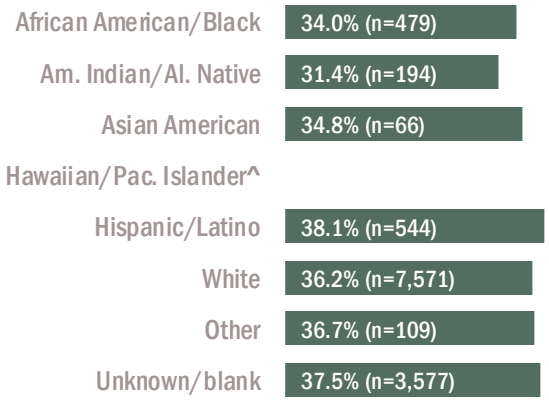
2017 data (N=12,564)

- Statewide percent change since 2016: **+6.1%**
- Number of CCOs that improved: **10**

Initiation of treatment for members with alcohol or drug dependence, statewide.



By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

Household language data are not available for this measure.

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

Initiation of treatment for members newly diagnosed with alcohol or drug dependence in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

Measure description

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

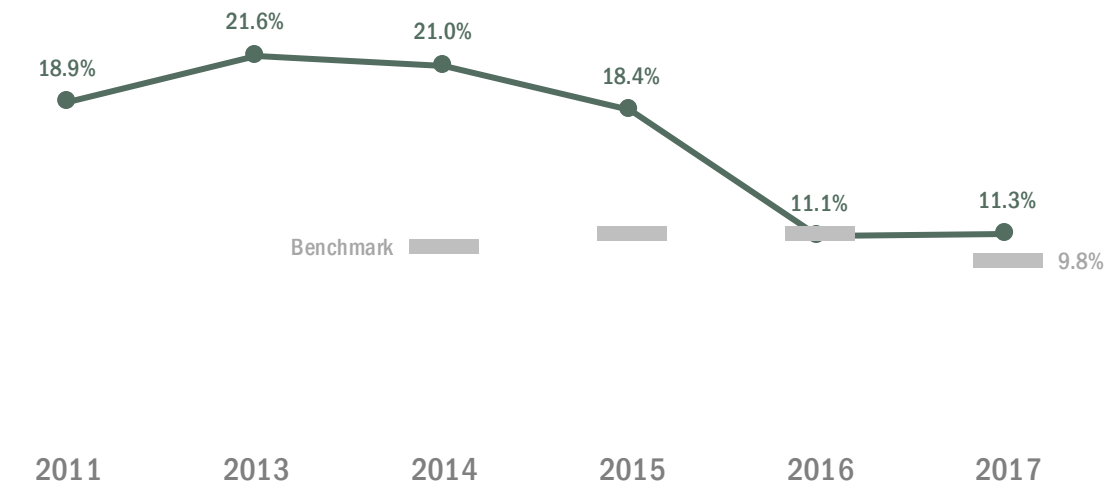
Data source:
Administrative (billing) claims

2017 benchmark source:
2016 national Medicaid median

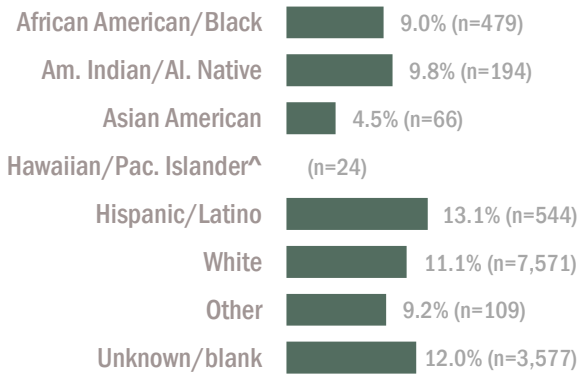
2017 data (N=12,564)

- Statewide percent change since 2016: **+1.8%**
- Number of CCOs that improved: **7**

Continuation of treatment for members with alcohol or drug dependence, statewide.



By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

Household language data are not available for this measure.

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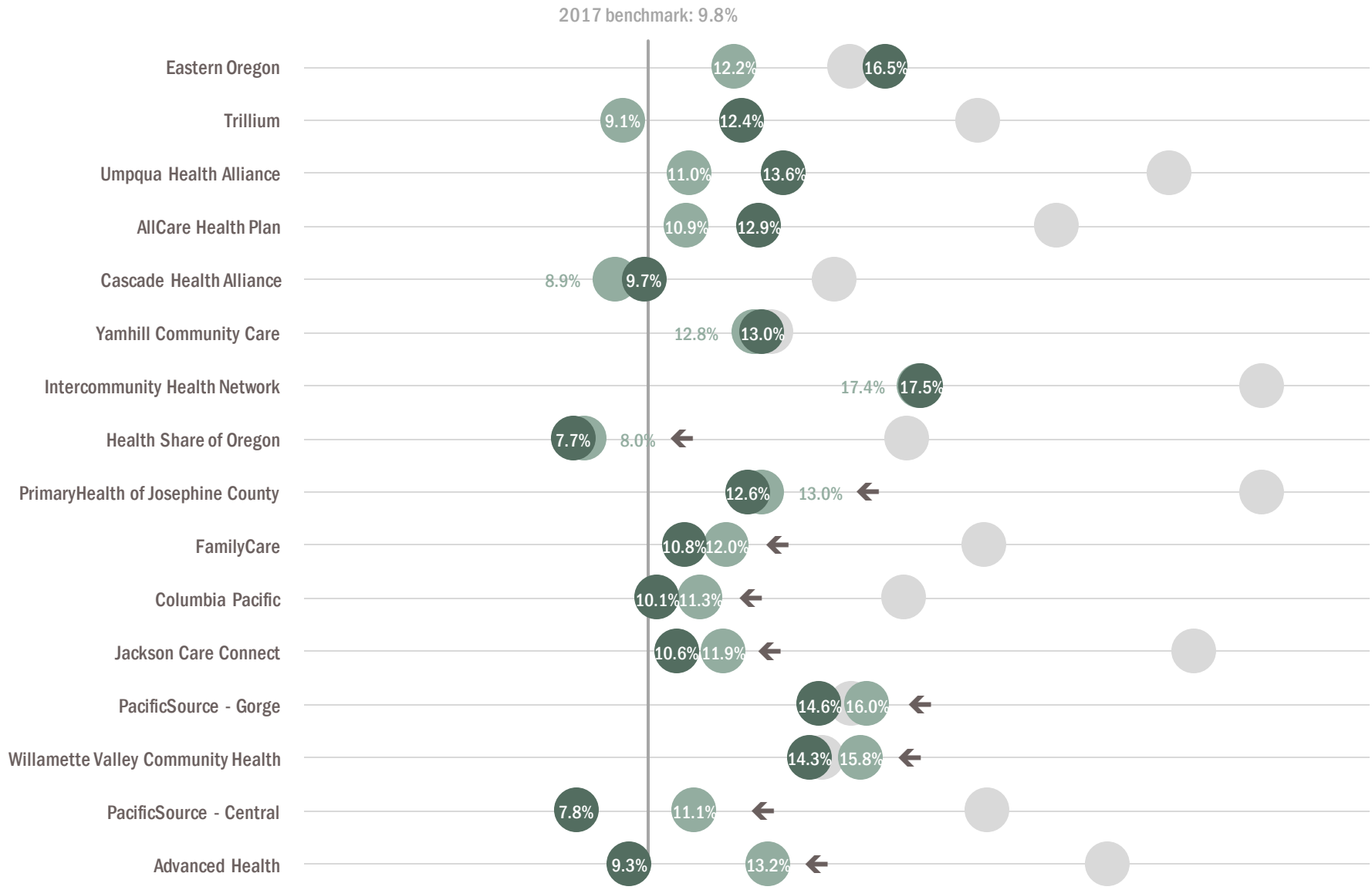
INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (ENGAGEMENT PHASE)

Continuation of treatment for members with alcohol or other drug dependence in 2016 and 2017, by CCO.

Grey dots represent 2015.



LOW BIRTH WEIGHT

Low birth weight

Percentage of live births that weighed less than 2,500 grams (5.5 pounds). A lower score is better.

Data source:
Oregon birth certificates, Vital Statistics, and Administrative (billing) claims

2016 benchmark source:
County Health Rankings 2016 90th percentile

2016 data (N=25,347)

- Statewide percent change since 2015: **-6.0%** (lower is better)

2017 data are not yet available for this measure. Results published in earlier reports should not be compared to those published here due to change in methodology.

This measure includes all Oregon Health Plan members; it is not limited to CCO members. Thus, results by CCO are not available.

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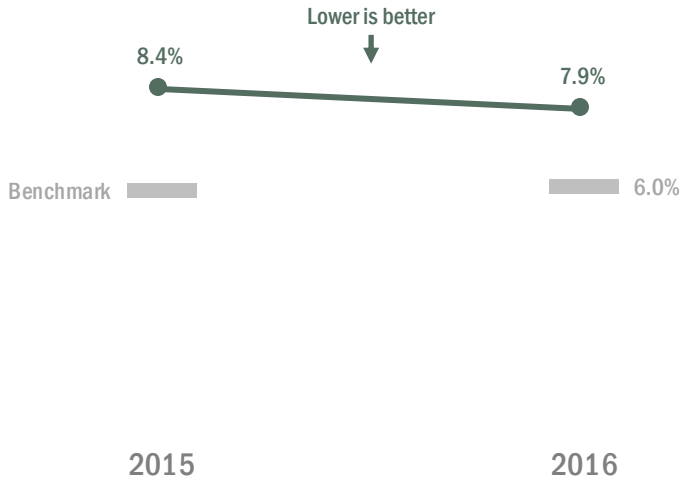
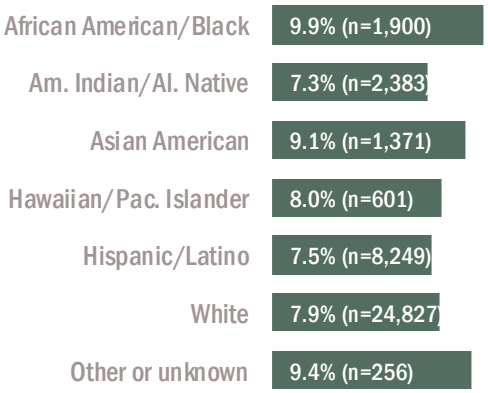
Low birth weights declined in 2016.



By race and ethnicity (2016)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

Household language data are not available for this measure.

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

Advised to quit

Percentage of adult tobacco users who were advised to quit by their doctor.

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.

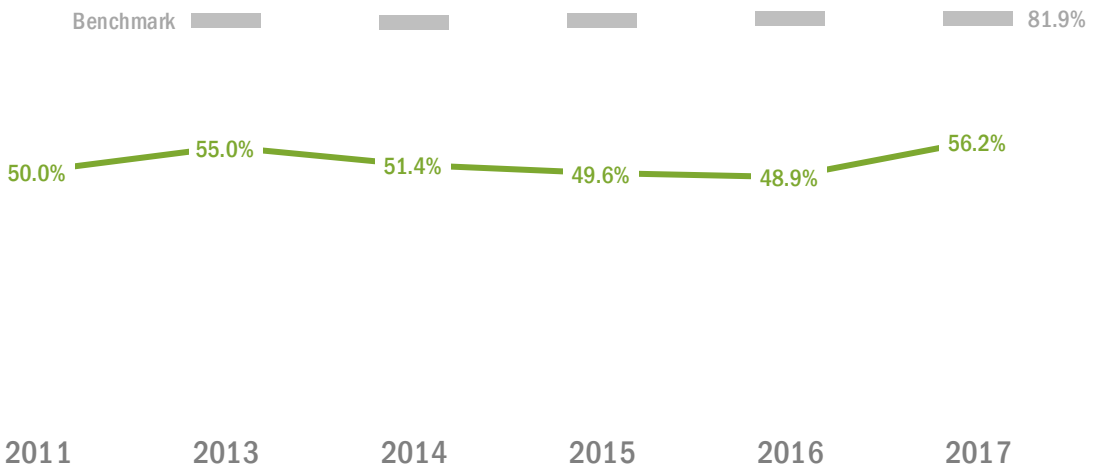
2017 benchmark source:

2016 national Medicaid 90th percentile

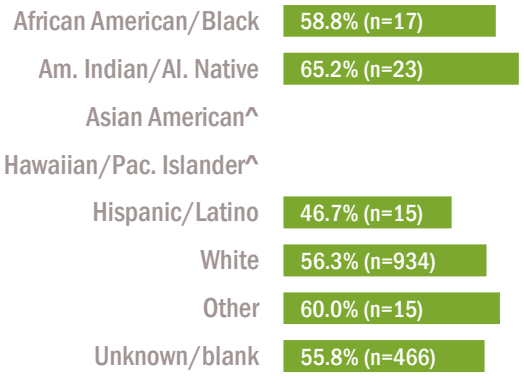
2017 data (N=1,478)

- Statewide percent change since 2016: **+14.9%**
- Number of CCOs that improved: **12**

Statewide, the percent of members whose doctor advised quitting tobacco increased.



By race and ethnicity (2017)



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

Household language data are not available for this measure.

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

Percent of members whose doctor advised quitting tobacco in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

Advised medication to quit

Percentage of adult tobacco users who were advised to medication to help them quit by their doctor.

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.

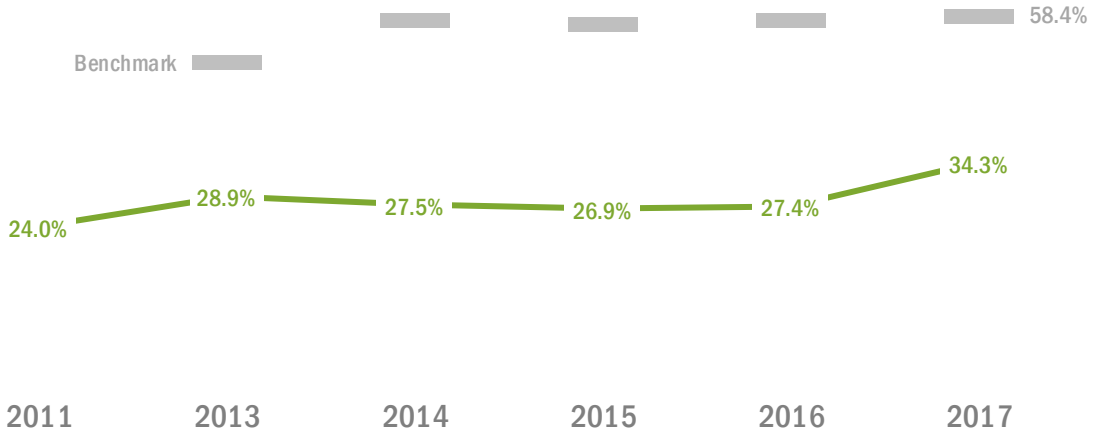
2017 benchmark source:

2016 national Medicaid 90th percentile

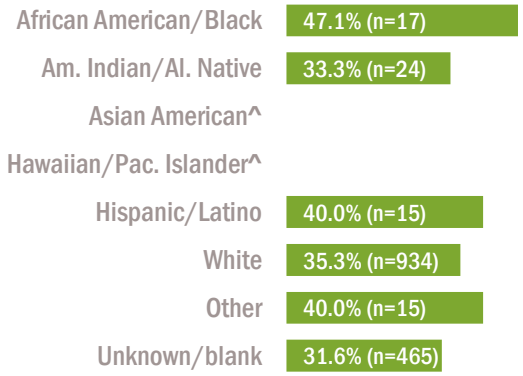
2017 data (N=1,477)

- Statewide percent change since 2016: **+25.2%**
- Number of CCOs that improved: **12**

Statewide, the percent of members whose doc advised medications to quit increased.



By race and ethnicity (2017)



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

Household language data are not available for this measure.

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

Percent of members whose doctor advised medication to help quit tobacco in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

Advised strategies to quit

Percentage of adult tobacco users who were advised other strategies to help them quit by their doctor.

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.

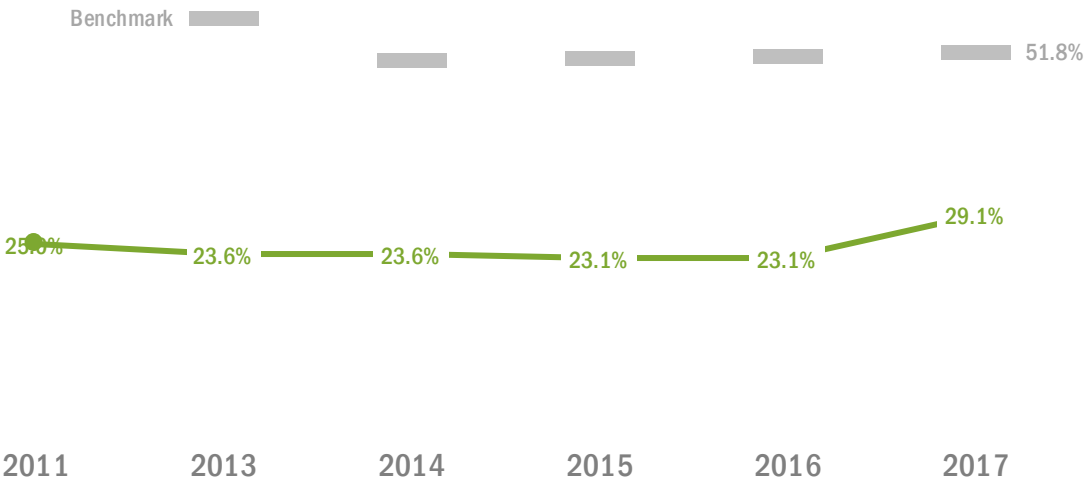
2017 benchmark source:

2016 national Medicaid 90th percentile

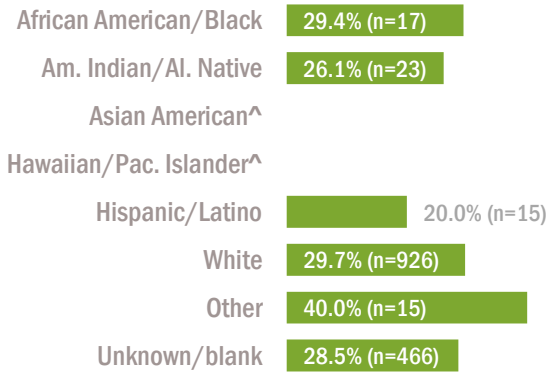
2017 data (N=1,469)

- Statewide percent change since 2016: **+26.0%**
- Number of CCOs that improved: **13**

Statewide, the percent of members whose doc advised strategies to quit increased.



By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

Household language data are not available for this measure.

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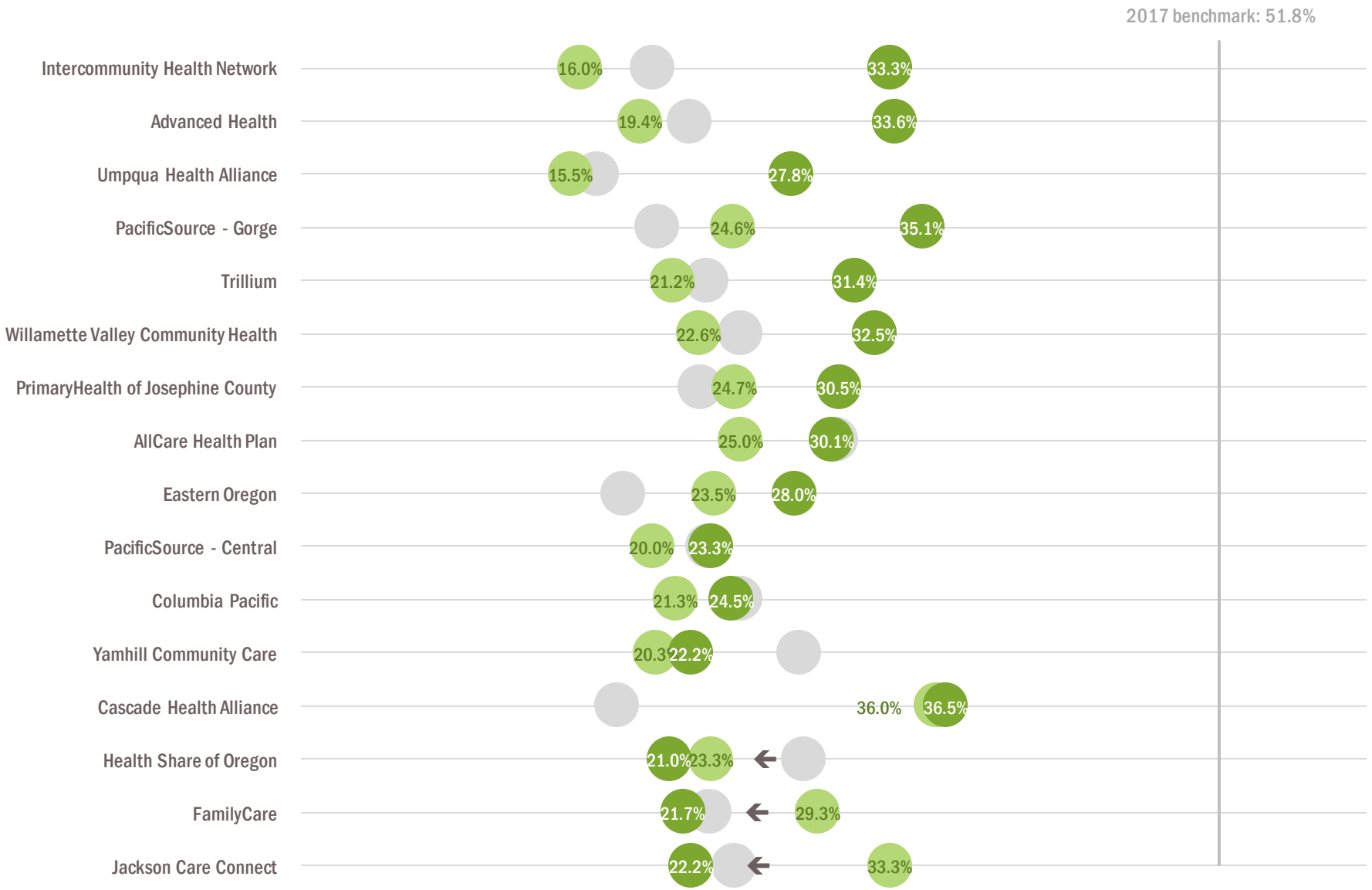
MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION: ADVISED STRATEGIES (CAHPS SURVEY)

Percent of members whose doctor advised strategies to help quit tobacco in 2016 and 2017, by CCO.

Grey dots represent 2015.



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

2017 benchmark source:
10 percent reduction from 2016

2017 data (N=5,92,061 member months)

- Statewide percent change since 2016: **+26.0** (lower is better)
- Number of CCOs that improved: **4**

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

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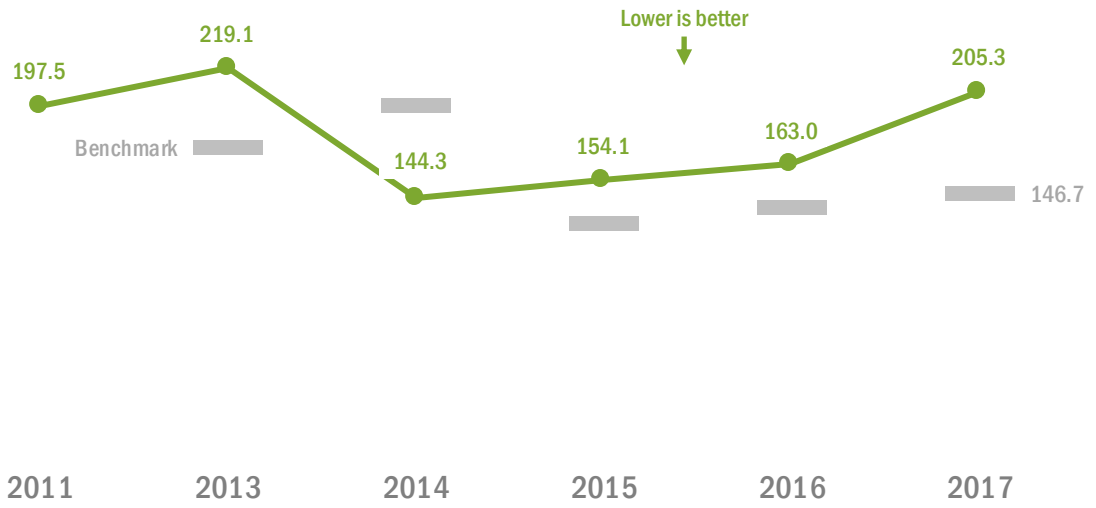
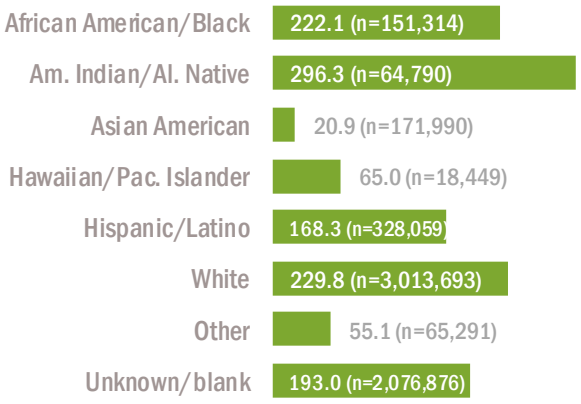
Statewide, admissions for short-term diabetes complications increased in 2017.

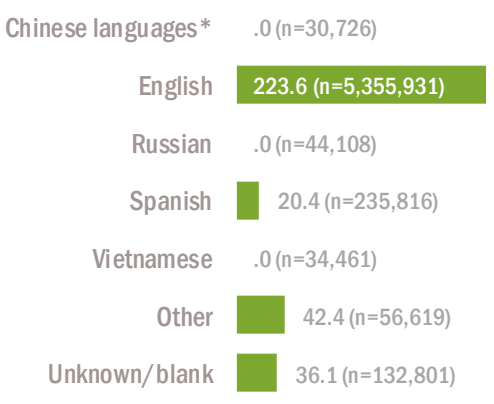


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

PQI 01: DIABETES SHORT-TERM COMPLICATION ADMISSION RATE

Hospital admissions for short-term diabetes complications in 2016 and 2017, by CCO.

Grey dots represent 2015.

PQI 05: COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE

PQI 5

Lorem 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
2017 benchmark source:
10 percent reduction from 2016

2017 data (N=5,92,061 member months)

- Statewide percent change since 2016: **+14.4** (lower is better)
- Number of CCOs that improved: **3**

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

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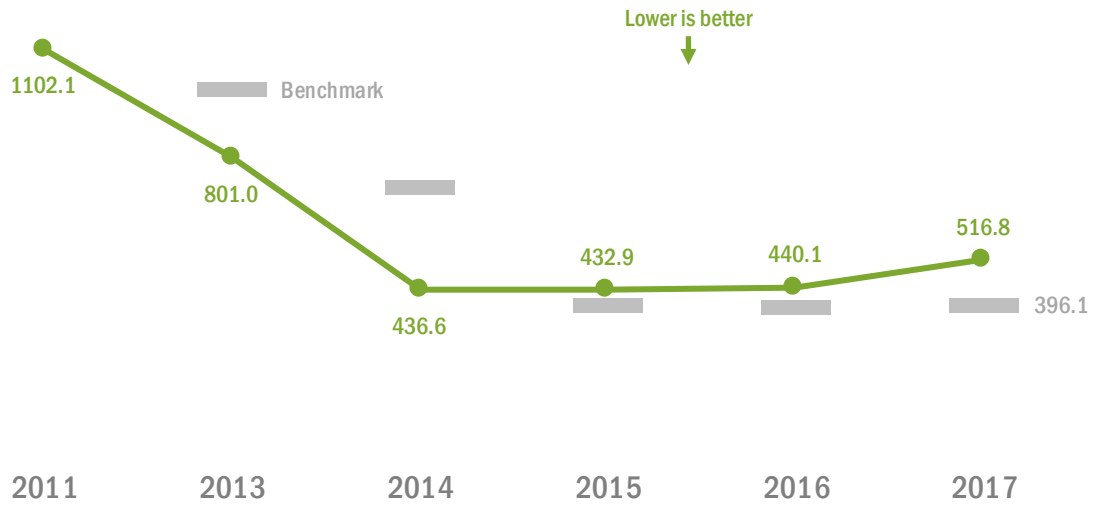
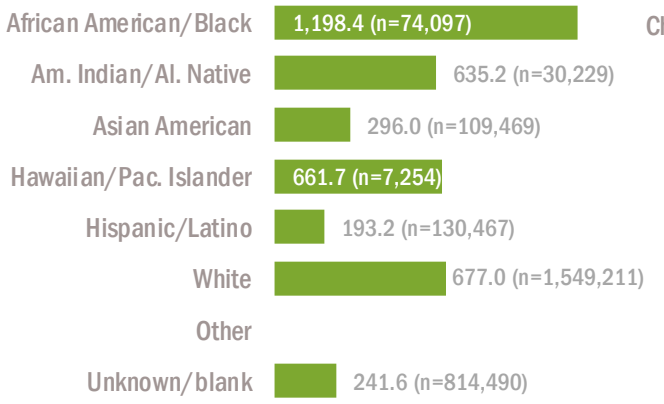
Statewide, hospital admissions for COPD or asthma increased in 2017.

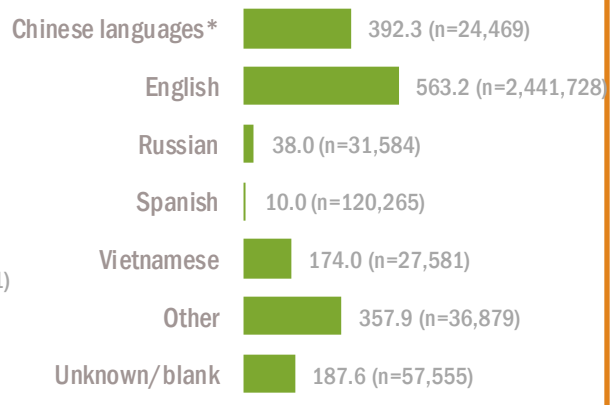


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

PQI 05: COPD OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Hospital admissions for COPD or asthma in older adults in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

2017 benchmark source:
10 percent reduction from 2016

2017 data (N=5,892,061 member years)

- Statewide percent change since 2016: **+19.0** (lower is better)
- Number of CCOs that improved: **4**

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

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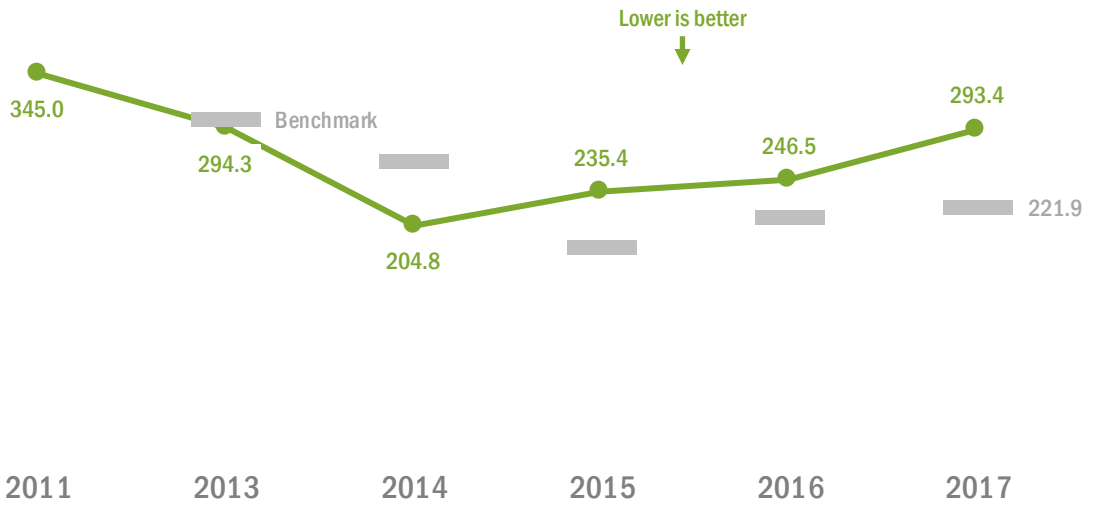
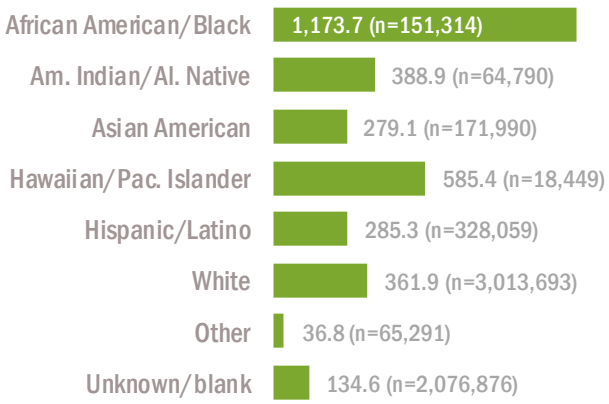
Statewide, admissions for congestive heart failure increased in 2017.

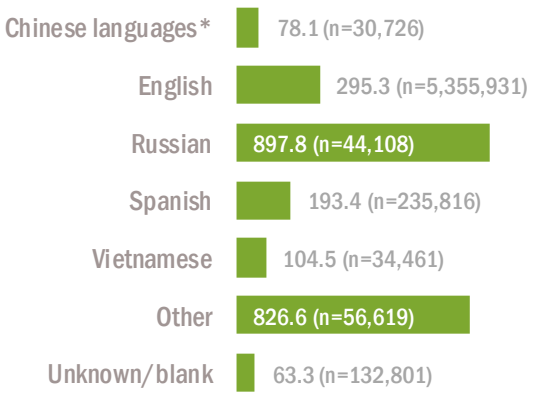


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

PQI 08: CONGESTIVE HEART FAILURE ADMISSION RATE

Hospital admissions for congestive heart failure in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

2017 benchmark source:
10 percent reduction from 2016

2017 data (N=3,150,315)

- Statewide percent change since 2016: **-9.4%** (lower is better)
- Number of CCOs that improved: **10**

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

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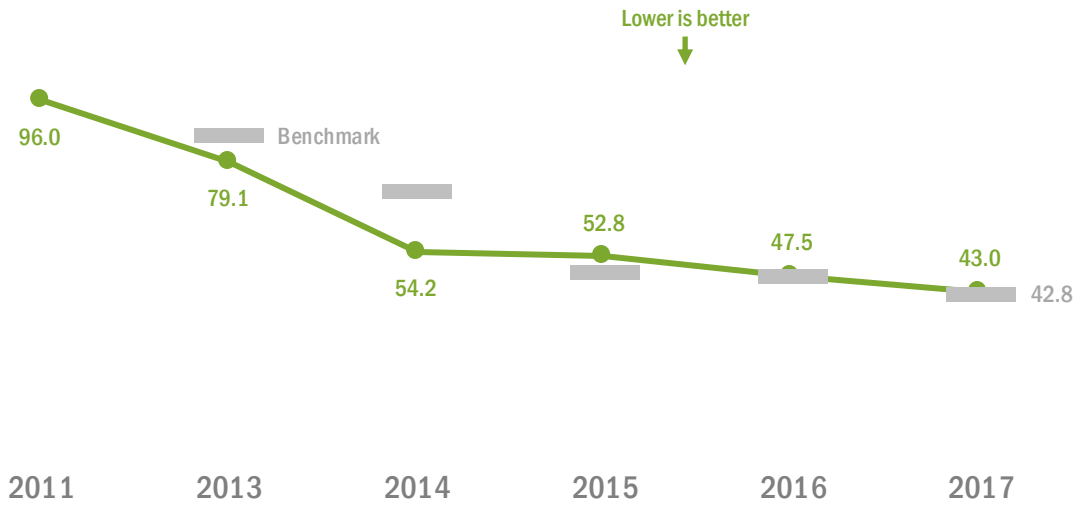
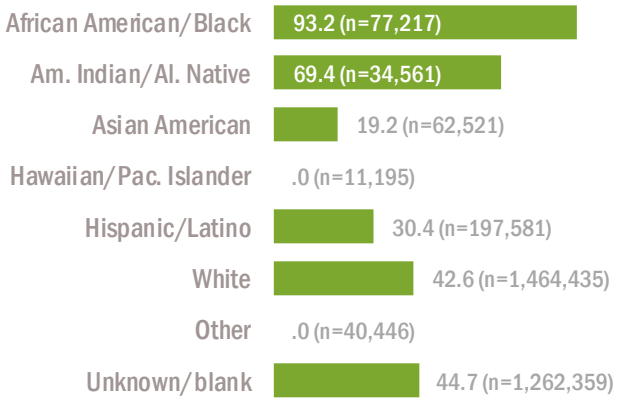
Statewide, admissions for asthma in younger adults decreased in 2017.

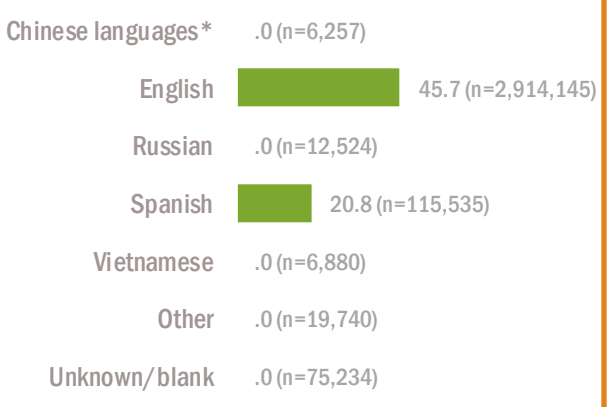


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Hospital admissions for asthma in younger adults in 2016 and 2017, by CCO.

Grey dots represent 2015.

PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Postpartum care rate

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

Data source:
Administrative (billing) claims and medical record review

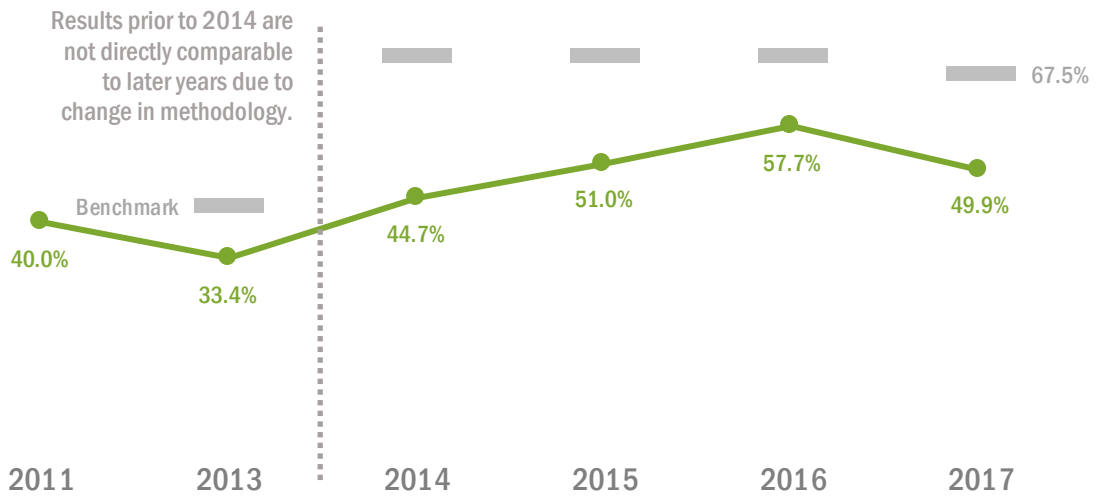
2017 benchmark source:
2016 national Medicaid 75th percentile

2017 data (N=5,702)

- Statewide percent change since 2016: **-13.5%**
- Number of CCOs that improved: **5**

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

Statewide, the percentage of women receiving postpartum care decreased in 2017



Race/ethnicity, and household language data are not available for this measure..

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PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE RATE

Percentage of women receiving postpartum care in 2016 and 2017, by CCO.

Grey dots represent 2015.

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

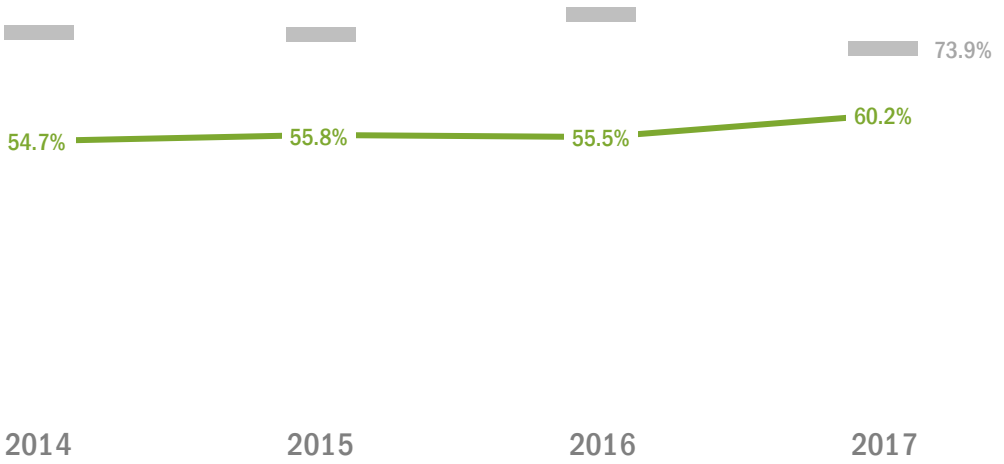
2017 benchmark source:
2016 national Medicaid 90th percentile

2017 data (N=16,260)

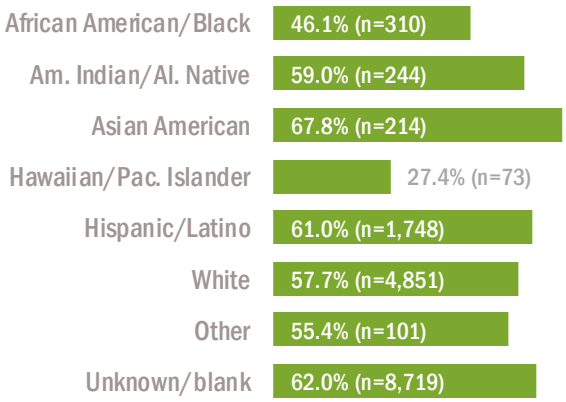
- Statewide percent change since 2016: **+8.5%**
- Number of CCOs that improved: **11**

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, well-child visits increased in 2017.

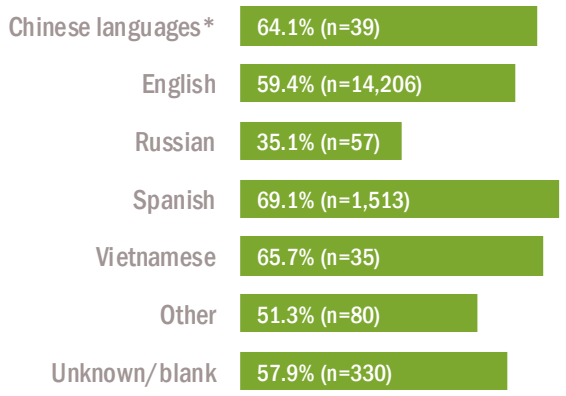


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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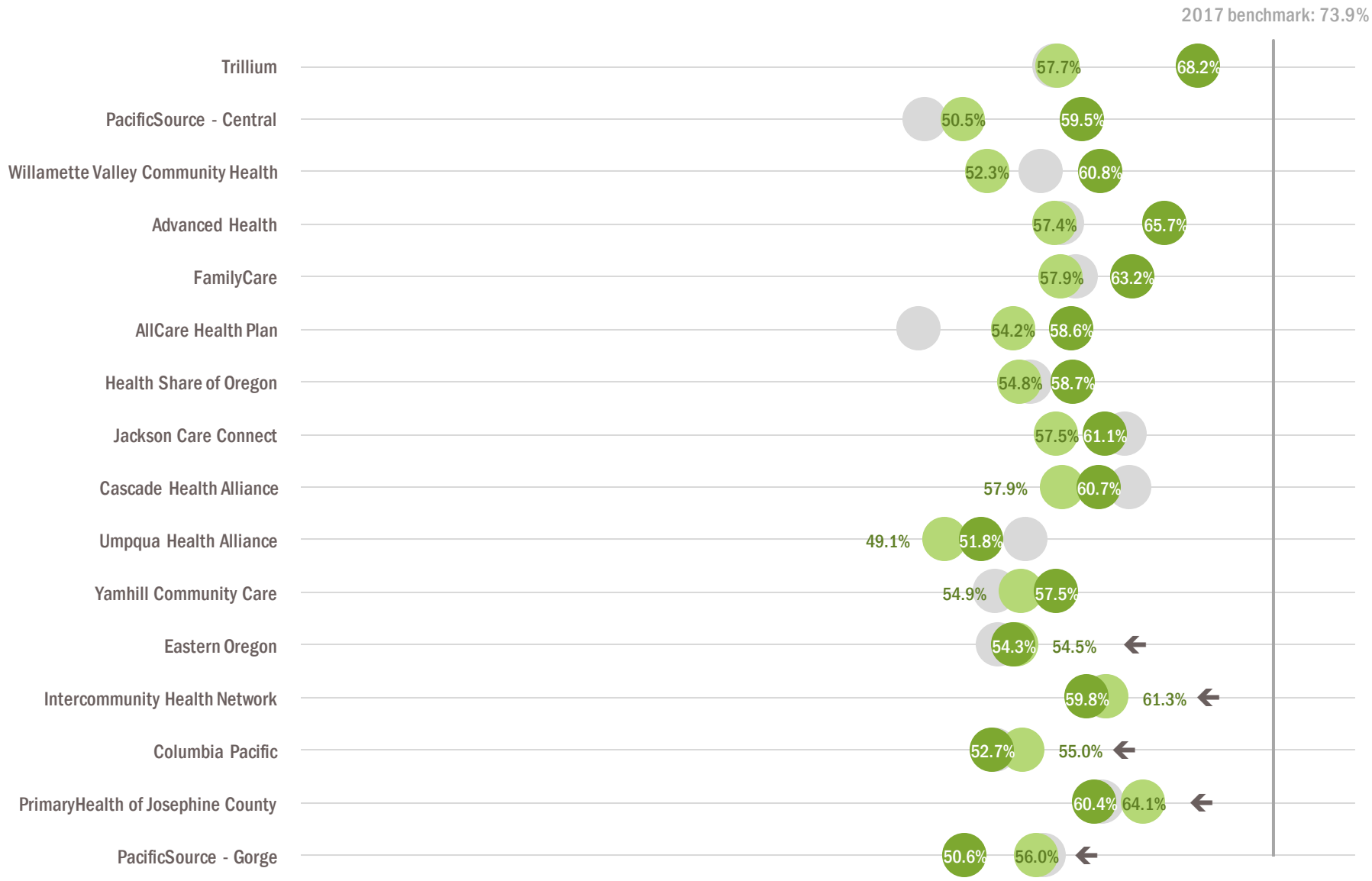
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

Well-child visits in the first 15 months of life in 2016 and 2017, by CCO.

Grey dots represent 2015.



APPENDIX: INCENTIVE MEASURE BENCHMARKS SINCE 2013

The tables below show the value and source for incentive benchmarks over time. Benchmarks are selected by the Metrics and Scoring Committee. Benchmarks for non-incentivized measures over time can also be found in the measure specifications, available online at: www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx.

Access to care (CAHPS)

2013	87.0%	Average of 2012 national Medicaid 75th percentiles for adults and children
2014	88.0%	Average of 2013 national Medicaid 75th percentiles for adults and children
2015	87.2%	Weighted average of 2014 national Medicaid 75th percentiles for adults and children
2016	86.7%	Weighted average of 2015 national Medicaid 75th percentiles for adults and children
2017	86.5%	Weighted average of 2016 national Medicaid 75th percentiles for adults and children

Adolescent well-care visits

2013	53.2%	2011 national Medicaid 75th percentile
2014	57.6%	2013 national Medicaid 75th percentile
2015	62.0%	2014 national Medicaid 75th percentile
2016	61.9%	2015 national Medicaid 75th percentile
2017	51.8%	2016 national Medicaid 75th percentile

Emergency department utilization

2013	44.4 /1,000 member months	2011 national Medicaid 90th percentile
2014	44.6 /1,000 member months	2013 national Medicaid 90th percentile
2015	39.4 /1,000 member months	2014 national Medicaid 90th percentile
2016	39.8 /1,000 member months	2015 national Medicaid 90th percentile
2017	42.9 /1,000 member months	2016 national Medicaid 90th percentile

APPENDIX: INCENTIVE MEASURE BENCHMARKS SINCE 2013

Assessments for children in DHS custody

2013	90.0%	Metrics and Scoring Committee consensus
2014	90.0%	Metrics and Scoring Committee consensus
2015	90.0%	Metrics and Scoring Committee consensus
2016	90.0%	Metrics and Scoring Committee consensus
2017	90.0%	Metrics and Scoring Committee consensus

Childhood immunization status

2016	82.0%	2015 national Medicaid 75th percentile
2017	78.6%	2016 national Medicaid 75th percentile

Cigarette smoking prevalence

2016	25.0%	2015 national Medicaid 75th percentile
2017	25.0%	2016 national Medicaid 75th percentile

Colorectal cancer screening

2013	n/a	Improvement target only
2014	47.0%	Metrics & Scoring Committee consensus
2015	47.0%	Metrics & Scoring Committee consensus
2016	47.0%	Metrics & Scoring Committee consensus
2017	50.8%	2015 CCO 90th percentile

APPENDIX: INCENTIVE MEASURE BENCHMARKS SINCE 2013

Controlling hypertension

2013	n/a	Reporting only
2014	n/a	Reporting only
2015	64.0%	2014 national Medicaid 90th percentile
2016	69.0%	2015 national Medicaid 90th percentile
2017	69.0%	2015 national Medicaid 90th percentile

Dental sealants

2015	20.0%	Metrics & Scoring Committee consensus
2016	20.0%	Metrics & Scoring Committee consensus
2017	20.0%	Metrics & Scoring Committee consensus

Depression screening and follow-up plan

2013	n/a	Reporting only
2014	25.0%	Metrics & Scoring Committee consensus (challenge pool only)
2015	25.0%	Metrics & Scoring Committee consensus
2016	25.0%	Metrics & Scoring Committee consensus
2017	52.9%	2015 national Medicaid 90th percentile

Developmental screenings

2013	50.0%	Metrics & Scoring Committee consensus
2014	50.0%	Metrics & Scoring Committee consensus
2015	50.0%	Metrics & Scoring Committee consensus
2016	50.0%	Metrics & Scoring Committee consensus
2017	60.1%	2015 CCO 75th percentile

APPENDIX: INCENTIVE MEASURE BENCHMARKS SINCE 2013

Diabetes Hba1c poor control

2013	n/a	Reporting only
2014	34.0%	2013 national Medicaid 75th percentile (challenge pool only)
2015	34.0%	2014 national Medicaid 75th percentile
2016	19.0%	2015 national commercial 90th percentile
2017	19.0%	2015 national Commercial 90th percentile

Effective contraceptive use

2015	50.0%	Metrics & Scoring Committee consensus
2016	50.0%	Metrics & Scoring Committee consensus
2017	50.0%	Metrics & Scoring Committee consensus

Follow-up after hospitalization for mental illness

2013	68.0%	2012 national Medicaid 90th percentile
2014	68.8%	2013 national Medicaid 90th percentile
2015	70.0%	2014 national Medicaid 90th percentile
2016	79.9%	2015 national Medicaid 90th percentile
2017	82.7%	2015 CCO 75th percentile

Patient-centered primary care home enrollment

Goal: 100%. Minimum threshold to earn 100 percent quality pool: 60% (Metrics and Scoring Committee consensus)

APPENDIX: INCENTIVE MEASURE BENCHMARKS SINCE 2013

Timeliness of prenatal care

2013	69.4%	2012 national Medicaid 75th percentile
2014	90.0%	2013 national Medicaid 75th percentile
2015	90.0%	2013 national Medicaid 75th percentile
2016	93.0%	2015 national Medicaid 90th percentile
2017	91.0%	2016 national Medicaid 90th percentile

Satisfaction with care (CAHPS)

2013	84.0%	Average of 2012 national Medicaid 75th percentiles for adults and children
2014	89.0%	Average of 2013 national Medicaid 75th percentiles for adults and children
2015	89.6%	Weighted average of 2014 national Medicaid 75th percentiles for adults and children
2016	89.2%	Weighted average of 2015 national Medicaid 75th percentiles for adults and children
2017	89.7%	Weighted average of 2016 national Medicaid 75th percentiles for adults and children

Oregon Health Authority

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