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Memo

To: Stacey Schubert and Chelsea Guest

Date: November 21, 2024

From: Mercer Health & Benefits, LLC

Subject: Quality Incentive Program (QIP) Restructure Opportunities

Dear Stacey and Chelsea:

Please find attached the technical report highlighting key opportunities to restructure the existing Oregon Health Authority's Quality Incentive Program (QIP) in alignment with the State's goals of eliminating health inequities by 2030.

As summarized in the report, Mercer recommends the following opportunities to restructure the QIP:

- Implement a withhold as part of the QIP to address downstream measures.
- Reserve the incentive payment part of the QIP for initiatives that advance health equity.
- Develop an equity-centered measure framework and methodology.

Mercer believes a phased-in implementation of this restructure, with input from community and other interested parties, will allow the QIP to be a highly impactful tool to narrow gaps in health equity and improve quality outcomes in the coming years.

We appreciate the opportunity to work with you on the QIP Restructure. Should you have any questions, please feel free to reach out.

Thank you,

Gretchen Horton-Dunbar, MBA, MPH, CPH
Mercer Specialty Sector Senior Associate

Mercer

Government Human Services Consulting

Quality Incentive Program Restructure Report

Review and Recommendations

Oregon Health Authority

November 21, 2024

Contents

Section 1
Introduction

In 2020, the Oregon Health Authority (OHA) set a goal of eliminating health inequities in the State by 2030.[1]

The Oregon Health Equity Committee (HEC) has noted that:

- "Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:
  - The equitable distribution or redistribution of resources and power; and,
  - Recognizing, reconciling and rectifying historical and contemporary injustices." [2]

Achieving OHA's health equity goal will require leveraging existing programs and initiatives. The OHA Quality Incentive Program (QIP), also known as the "quality pool," provides one such opportunity. The QIP has been an important OHA tool since its inception to incentivize Coordinated Care Organizations (CCOs) to work towards improving care for Medicaid members as it provides significant funding and reward to the CCOs to advance OHA's quality objectives. Looking to the future, re-evaluating the QIP within the context of the State's health equity goals is essential.

As the QIP has paid out hundreds of millions of dollars each year, enhanced CCO accountability for QIP payout dollar expenditures, along with more flexibility for OHA to ensure quality incentive funding is reaching community partners and providers, can re-tool the QIP to focus on health equity. At the same time, by utilizing stratified race, ethnicity, language, and disability (REALD) data already being collected via the QIP, the State has an important opportunity to harness QIP dollars that are already focused on improving health outcomes for low-income Oregonians to advance equity-focused healthcare.

QIP Restructure Project Overview

OHA contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to explore QIP financial levers that could (a) advance health equity; (b) provide additional accountability for how the funds CCOs earn through the QIP are distributed; and (c) allow for the use of QIP funds for upstream capacity building.

In response to OHA's request, Mercer performed a review of the QIP and developed several recommendations for restructure in discussion with OHA. This document provides an overview of the program, followed by Mercer's restructure recommendations.

[1] Oregon Health Authority Strategic Plan (state.or.us)

[2] https://www.oregon.gov/oha/EI/Pages/HEC%20Plan%20Definitions.aspx

Section 2

Executive Summary

In 2020, the OHA set a goal of eliminating health inequities in the State by 2030.[3]

The Oregon Health Equity Committee (HEC) has noted that for the State:

- "Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:
  - The equitable distribution or redistribution of resources and power; and,
  - Recognizing, reconciling and rectifying historical and contemporary injustices." [4]

Achieving OHA's health equity goal will require leveraging existing programs and initiatives. The OHA QIP, also known as the "quality pool," provides one such opportunity. After reviewing the program and discussions with OHA staff, Mercer recommends the following opportunities to better focus the QIP on health equity objectives, increase CCO accountability for incentive payment spending, and provide funding for upstream measure-related work:

- Implement a withhold as part of the QIP to address downstream measures.
- Reserve the incentive payment part of the QIP for initiatives that advance health equity. These may include upstream measures, select downstream measures with stratified benchmarks as data allows, and other future OHA-identified health equity goals. Furthermore, design the incentive payment portion of the QIP to enhance CCO accountability, promote CCO collaboration with community partners and providers, and advance visibility into CCO spending and related impact on metrics.
- Develop an equity-centered measure framework and methodology.

Mercer believes a phased-in implementation of this restructure, with input from community and other interested parties — from inside and outside of OHA — will allow the QIP to be a highly impactful tool to narrow gaps in health equity and improve quality outcomes in the coming years.

[3] Oregon Health Authority Strategic Plan (state.or.us)

[4] https://www.oregon.gov/oha/EI/Pages/HEC%20Plan%20Definitions.aspx

Section 3
Approach

Mercer reviewed an array of published studies, internal reports, and other OHA documents outlining the history of the QIP, program analyses, and potential strategic opportunities, including the following, as well as others cited throughout this report.

- Incentivizing Equitable Care
- Metrics and Scoring Committee Equity Impact Assessment
- Equity-Centered System of Health Concept Paper
- CCO Metrics Final Report for Years 2020, 2021, and 2022
- Equity-Centered Benchmarking — Data feasibility analysis
- Incentivizing Health Equity through Quality Measures (working paper)
- Calendar Year (CY) 2023 Exhibit L Reports

In addition, Mercer looked at quality programs in other states and how quality incentives are being used to address health inequities. Mercer also reviewed the design of the incentive program in Louisiana as a potential model for a redesign of the incentive payment program to enhance CCO accountability and collaboration with community partners and providers.

Mercer also convened a series of meetings with key staff from the Office of Health Analytics and the Office of Actuarial and Financial Analytics to review the best opportunities to restructure the QIP based on its current state as well as the potential impact of a restructure on the community, CCOs, and providers.

Based on the review of the program and other research, Mercer developed restructure opportunities for the QIP. In discussion with OHA staff, those opportunities were prioritized and are included in this report in the “Recommendations” Section of this report.

Section 4

Quality Incentive Program Review

QIP Overview

OHA launched the QIP in 2012. It is overseen by the Oregon Health Policy Board's (OHPB) Metrics and Scoring Committee. The program allows CCOs to earn bonus funds as incentives by improving access to a defined set of quality measures. The QIP represents an additional annual incentive payout in addition to the CCOs' yearly capitation rates. Over the years, the QIP has been an important tool in driving improvement in health outcomes for members. Looking to the future, OHA intends to use this powerful program more effectively with a focus on equitable outcomes for all Oregon Health Plan (OHP) members.

Financial Mechanism

Under the QIP, CCOs are paid for performance on a defined set of measures. The payment to CCOs under QIP is an incentive payment per 42 CFR § 438.6(b)(2). For each calendar year (CY), the program provides an incentive pool from which each CCO is eligible to receive a payout over and above the capitation revenue not to exceed 5%. Each CCO's potential payout depends on performance on the incentive metrics and its share of the members served in the program during the incentive year. CCOs can demonstrate performance on the quality metrics by either showing improvements on or achieving the benchmarks.

The incentive pool is paid out to CCOs in two steps — phase one distribution and the challenge pool. Under the phase one distribution, each CCO can earn 100% of their pool depending on their performance on the incentive metrics. Any unearned funds from CCOs that do not earn 100% of their incentive pool form the challenge pool. The funds in the challenge pool then get paid out to CCOs based on performance on select "challenge pool" metrics.

For calendar year (CY) 2021, the distribution to CCOs from the quality incentive pool was $235 million dollars (or 3.75% of capitation revenue).[5] For CY 2022, the distribution was $300 million dollars (or 4.25% capitation revenue).[6] For CY 2023, available quality pool funding is estimated at 4.25% of capitation revenue (or $326 million dollars) as of November 2023.[7]

Quality pool payouts to CCOs, as well as related CCO expenditures, are part of the global minimum medical loss ratio (MLR) calculation for remittance to OHA. Historically, CCOs have used a payout from the quality incentive pool to drive improvement on quality measures, primarily through incentive payments to providers. CCOs have also reinvested part of the payout back into their communities through spending on Health-Related Services (HRS). In recent years, the total CCO spend from the quality pool back into the OHP program has

[5] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021_CCO_metrics_report.pdf

[6] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2022-CCO-Metrics-Annual-Report.pdf

[7] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-Quality-Pool-Initial-Estimates.pdf

exceeded 80% across all CCOs in aggregate per Exhibit L reporting before considering all spending on HRS.[8]

In CY 2020, OHA redesigned the QIP such that the quality incentive payment was converted into a withhold as defined under 42 CFR § 438.6(b)(3). Under the withhold mechanism implemented in CY 2020, a portion of the capitation payment (4.25%)[9] was to be withheld by OHA during the calendar year, to be paid to CCOs depending on performance on the quality measures. This was accompanied by a 3.5% upward adjustment to the capitation rates.[10] CCOs were expected to earn back 90%–100% of this withhold. The upward adjustment to capitation rates along with the nearly full earn back expectation effectively held CCOs harmless in the implementation of the withhold. However, due to the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), the capitation payment withhold was suspended to ensure CCOs and providers had all the funding needed to weather the financial stresses resulting from the PHE.

Reporting on the CCO expenditures from the incentive pool payout is limited. The CCO Exhibit Ls include Report L17 and Report L17.1. Report L17 prompts narrative and totals from CCOs on non-HRS spending from the quality pool payout. Report L17.1 summarizes CCO QIP expenditure by payment and expenditure year. Any HRS-related spending using quality pool payout dollars is included in Report L6.21.

QIP Measures

Historically, CCOs have been required to meet 75% of measures to earn the full incentive payment each year, although OHA can adjust the incentive payment structure in future years. In CY 2024, the QIP is comprised of 15 measures[11] — 12 of which are considered “downstream” measures and three of which are considered “upstream.” Since 2013, CCOs will have been awarded an estimated total of more than $2 billion dollars in quality incentive funds (including the estimated payout for CY 2023).[12]

CY 2024 incentive measures are based on Senate Bill (SB) 966, which establishes data collection standards, requires a CCO QIP study be conducted in 2024 and shared with the legislature, and outlines new definitions for QIP measures.[13] QIP measure definitions include:

Upstream Measures

- Assessments for children in Oregon Department of Human Services custody
- System-level social emotional health (Kindergarten Readiness Measure)
- Meaningful language access
- Social Determinants of Health (SDOH) screening and referral

[8] Report L17.1 in CY 2023 Exhibit Ls provided by OHA

[9] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-Annual-Report_FINAL.pdf

[10] https://www.oregon.gov/oha/HPA/ANALYTICS/OHPRates/Oregon%20CY20%20Rate%20Certification%20-%20CCO%20Rates.pdf

[11] 2024 CCO Incentive Measures and Benchmarks_10.23.2023.pdf (oregon.gov)

[12] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6.-May-2024-Slides.pdf

[13] Ibid.

- Downstream Measures
  - Postpartum care
  - Depression screening and follow-up
  - Hemoglobin A1C poor control
  - Initiation and engagement with substance use disorder treatment
  - Childhood immunization (Combination 3)
  - Immunization for adolescents (Combination 2)
  - Child and adolescent well-care visits (ages 3 years–6 years — Kindergarten Readiness Measure)
  - Oral evaluation of adults with diabetes
- Measures that have not been defined as upstream or downstream during 2024 include those listed below. For 2025, the first two measures (cigarette smoking prevalence and screening, brief intervention, and referral to treatment) are retired, as they have not been adopted as upstream measures. Preventative dental or oral health services has been adopted as an upstream measure for 2025.
  - Cigarette smoking prevalence
  - Screening, brief intervention, and referral to treatment
  - Preventive dental or oral health services (ages 1 year–5 years and 6 years–14 years)

Section 5

Recommendations

After reviewing the OHA QIP and convening a series of QIP restructure discussions with OHA staff, Mercer recommends OHA prioritize the following recommendations using a phased approach. Mercer encourages the State to also align these recommendations as appropriate with the Portland State University (PSU) Coordinated Care QIP findings.

Mercer's recommendations are subject to a number of considerations, including:

- OHA implementation approach and timing
- Potential alignment with the upcoming procurement process
- Centers for Medicare & Medicaid Services (CMS) approval
- Input from other interested parties

Implementation of any of these recommendations will also present a number of potential challenges and barriers for OHA to navigate. However, Mercer strongly believes that over time, these recommendations will help OHA achieve its objectives of redesigning the QIP with a focus on health equity and upstream metrics, while bringing more accountability to CCO expenditures from QIP payouts.

Recommendation — Implement a QIP Withhold

Mercer recommends implementing a withhold of 2%–4% for downstream metrics as part of the QIP. These would be measures and benchmarks that are considered standard across Medicaid programs and focus on traditional medical care such as screenings, immunization, and chronic disease without necessarily focusing on outcomes for priority groups.

A withhold percentage in the low single digits would be consistent with the typical level in states that have withholds in their Medicaid managed care program. Furthermore, in recent years, the QIP payout to CCOs has ranged between 3.5% to 4.25% for downstream and upstream measures combined. A withhold between 2% to 4% would be in line with the historical QIP level, while also reflecting the fact that the withhold will only be covering a subset of the historical measures (i.e., downstream only).

Recommendation Benefits

Federal regulations allow Medicaid programs to develop withhold programs that are designed to drive managed care plan performance in ways distinct from the general operational requirements under the contract. Implementing a withhold for downstream metrics will allow OHA to focus the incentive payment portion on aspirational goals to address health inequities. The withhold percentage does not have a stated regulatory limit (i.e., a specific maximum percentage) but does need to be reasonable considering the CCOs' financial operating needs. Since incentive payments are limited to 5% of capitation payments, moving the downstream metrics and measures into the capitation rate will free up more room under the 5% incentive cap to be reserved for focus on health disparities.

Withhold being a part of the capitation rates brings more funding predictability for CCOs. Currently, the funding level for the incentive payment pool is subject to the annual budget process and is not known until well into the applicable calendar year. CCOs do not know with certainty the level of QIP incentive payout they can expect ahead of the start of the year. This in turn limits what the CCOs can commit to in the incentive payment arrangements with providers. Since withhold is the part of the capitation rates and capitation rates are developed ahead of the beginning of the rate calendar year, CCOs will know how much they can potentially earn in quality payments through the withhold.

A withhold is part of the capitation payment. Therefore, CCOs will be accountable for spending from the earned back withhold through risk mitigation mechanisms that cover the rates — such as the current 85% minimum MLR requirement. Additionally, spending related to the quality withhold will be part of future rate development and will be subject to more detailed cost reporting requirements than current QIP payout spending to support rate development.

Finally, the idea of a withhold is not new within the program since it was implemented in 2020. Lessons learned from this prior experience can help inform a future withhold implementation.

Potential Challenges

Several challenges can arise with the implementation of a new withhold. Introducing a withhold is a significant change to CCO payment structure. If the withhold is implemented without increasing capitation rates, CCO funding through the historical incentive payment (which is a significant amount) will be eliminated. Furthermore, CCOs will be at risk of potentially not earning a portion of the capitation payment that is subject to withhold.

If capitation rates are increased to reflect the conversion of a portion of the incentive payment into a withhold, the withhold would change the funding that CCOs are used to earning as something above and beyond the rates (a bonus) to an offset from their capitation revenue earned back based on their performance. If the withhold metrics targets become more challenging than they are currently, as CCOs have generally been earning high percentages of their QIP pool, having to earn back the incentive payment via a withhold earn back instead puts an otherwise reliable revenue stream at risk. Spending and reporting requirement changes around the QIP to support future rate development and other data needs after a withhold implementation will limit the flexibility that CCOs currently have in how they spend the funding. For example, CCOs can currently spend part of the incentive payment on HRS at their discretion. This may be more limited under the withhold arrangement.

Limited reporting detail about incentive pool dollar spending by the CCOs makes it difficult to assess how the quality dollars are being deployed to improve on quality goals. It is not possible to assess from the high-level aggregated cost reporting in the Exhibit Ls how expenditures align with specific populations or types of service provided — let alone the specific quality metrics targeted for improvement. This also means in the early years of the withhold, data to support the quality component of the capitation rate development will be limited.

Although a withhold brings more funding predictability to the CCOs, it limits the flexibility of the overall quality fund as a budget item for OHA, as the withhold will be part of capitation rates and not subject to budgetary flexibility after capitation rates are established for a calendar year.

As observed during the 2020 withhold implementation, many challenges and complications can arise with implementing withhold in the program. The differences between the financial and budgetary mechanics of a withhold payment versus an incentive payment and how a withhold interacts with the State budget and federal Medicaid funding may result in different processes and protocols around the withhold than what is currently in place for the incentive. As part of the 2020 implementation, OHA clarified timing around claiming federal match for a withhold arrangement versus an incentive payment arrangement. However, other issues may arise relating to the budget and accounting process that require discussion among various OHA divisions to resolve. Advance planning on implementation of a potential withhold will help ensure its success.

Considerations

Per 42 CFR § 438.6(b)(3), capitation rates minus any withhold not reasonably achievable must be actuarially sound. Mercer recommends that when a withhold is implemented, the withhold percentage and the metrics and benchmarks be designed such that the withhold revenue can be determined to be reasonably achievable. The rule does not prescribe a definition, measure, or threshold of the reasonably achievable standard. Therefore, the determination of reasonable achievability can be subjective. Fortunately, QIP has a long history and OHA has ample historical data on CCO performance on various benchmarks before and after the COVID-19 PHE. This data will be helpful to judge how challenging proposed metrics might be to the CCOs each rate year and how likely they are to achieve them fully. Mercer recommends a thorough review of each proposed withhold metrics each contract year within the context of historical performance to ensure that metrics overall are fully reasonably achievable.

At the same time, the capitation rate development should be aligned with the improvement demands on CCOs imposed by the withhold to ensure CCOs are provided enough funding to in turn incentivize providers to close quality gaps. Typically, when states implement a new withhold, the capitation rates would only be adjusted upwards to reflect increased financial risk to health plans if only a portion of the withhold is reasonably achievable rather than the full withhold. The adjustment may be made to the risk margin component of the underwriting gain. Actuarially sound capitation rates are developed to appropriately provide for the total projected medical and administrative costs to health plans to provide the covered services for the covered population, along with an underwriting gain to cover the costs of risk and risk capital. The unearned portion of the withhold potentially lowers the capitation payment, creating a risk to health plans; hence, the potential adjustment to the risk margin if the withhold is determined to be not fully reasonably achievable.

In the case of the QIP, if a withhold is implemented, an historical incentive payment is being partially converted into a withhold. Further, this incentive payment, rather than being a bonus the CCOs could keep in its entirety, is currently primarily being used by CCOs to pay providers or otherwise invest back into communities. If OHA judges that the incentive payment funding is critical to fund covered services or quality expectations from CCOs that are going to be part of the withhold and must continue to reach providers, the capitation rates can be adjusted to reflect this new withhold, similar to the 2020 withhold implementation.

In a given rate year, CCOs may not fully earn the withhold portion of the capitation rate revenue. An option for OHA is to add this unearned portion to the incentive payment pool to CCOs as long as the incentive payment to all CCOs remains under the 5% capitation. Alternately, OHA can use this unearned portion for other initiatives.

As part of implementing a withhold, OHA may also consider reviewing the payment structure based on CCO performance from the existing target. Currently, CCOs earn 100% of their incentive pool if they have met 75% of the metrics; changing the performance target to something different and possibly more challenging merits consideration, especially for metrics for which the current approach may not be set at a threshold to effectively push CCOs to perform on OHA's quality objectives.

Mercer also recommends modifications in CCO cost reporting to ensure there is data available with adequate detail to support capitation rate development, as well as analysis of the impact of withhold dollars on quality gaps. At a minimum, L17.1 can be modified to include a breakout of the provider incentive payments funded by QIP payouts at a similar level as L17.2, in which CCOs report other incentive payments that are funded by capitation rates at a population- and category of service-level detail.

Finally, Mercer recommends a thorough technical vetting of the potential implications of a withhold implementation with the relevant OHA divisions that will be impacted, such as budget, accounting, systems, metrics and scoring, and so forth.

Recommendation — Incentive Payment — Community Partnership Model

As a withhold is implemented to address CCO accountability on nationally standard measures, Mercer recommends reserving the incentive payment portion of QIP to focus on health equity. Mercer recommends the incentive payment be used to incentivize CCO performance on upstream metrics and select downstream metrics with stratified benchmarks (as data allows), as well as future health equity-focused measures that OHA identifies.

Further, Mercer recommends re-designing the incentive program such that it is available only to CCOs that can demonstrate formal collaborations with community partners and providers to achieve specific goals to address equity. Because managed care organization (MCO) incentive programs are in addition to actuarially certified capitation rates, there is more flexibility in meeting the federal regulatory parameters. OHA can define the incentive program as available only to CCOs that establish contractual relationships with community partners and providers to collaborate on specific incentive measures they select that are appropriate for their region and population within an OHA-specified framework. The CCOs, together with their partners, must then develop and implement a quality improvement plan that will be subject to review and approval by OHA. The plan can span multiple years, in which the first year is focused on formalizing partner relationships, developing strategy, selecting quality focus areas, and developing quality improvement approaches. A necessary component of the plan would include a strategy describing how the incentives, jointly earned by the CCOs and their partners, will be shared between the partners and could have a minimum incentive sharing requirement.

Mercer reviewed the Louisiana Managed Care Incentive Plan (MCIP)[14] with OHA staff as a model for a potential incentive payment design. The MCIP model is an incentive payment program consistent with the federal regulatory requirements. The Louisiana MCIP was established in 2018, and CMS has consistently approved the contract language included by Louisiana. Many of the specific program details, including the required elements of the MCO/hospital partnerships and quality metrics, are described in provider guidance documents that are in addition to what is included in the MCO contract. Although it was offered to the Louisiana MCOs for optional participation, all Louisiana MCOs are currently participating in the program. MCOs can contract with one or more third parties "to assist in the achievement of incentive arrangement activities, targets, performance measures, or quality-based outcomes." MCOs can choose to participate in one or more incentive arrangements.

The incentive arrangements are determined and offered to the MCOs by the Louisiana Department of Health in conjunction with partner input. Although the MCIP was developed focused on MCO/hospital partnerships, within the context of the OHP, it can be designed to promote CCO partnership with community organizations, as well as providers, depending on the measure. This can especially be helpful to strengthen and build upon CCO collaboration with community-based organizations (CBOs) and providers, such as Traditional Health Workers, who are working actively in communities to address upstream needs and health inequities. Such design can also be an important way to ensure funding is reaching such organizations and providers to support their work on the ground.

Recommendation Benefits

Focusing the incentive payment on upstream measures and health equity priorities will allow OHA more flexibility to design the incentive program to address health disparities. It will also focus the QIP and CCO effort on truly aspirational measures that require sustained effort over a long period of time to narrow or close health gaps.

Requiring CCOs to partner with entities actively working within the community to address the health equity-focused measures as part of the incentive program will build upon existing CCO relationships with CBOs and partners. Strengthening CCO relationships with such partners will also help inform CCO direction with community input on an ongoing basis. Further, contracted partnerships with minimum spending requirements will ensure funding is reaching entities working on the ground to alleviate health disparities.

This approach can also provide OHA input and review oversight into how the CCOs design the quality improvement plans in collaboration with their partners. Importantly, it will also allow OHA to track how funding is being targeted by CCOs at specific measures — whether through direct CCO spending or through partners — and how effectively the funding is impacting gaps on health equity measures. This can support return-on-investment type of analysis on quality dollars to inform future decisions about quality pool funding and metrics and incentive payouts. Under the current program, there is limited visibility on CCO spending on quality and how the spending is impacting specific gaps.

[14] https://www.lsuhsc.edu/admin/vcaf/docs/MCIP%20Brief.pdf

Potential Challenges

Although such a re-design of the incentive payment program addresses many of OHA's objectives in the QIP restructure, it will create additional administrative burden to CCOs, as well as to OHA.

CCOs will have to enter into contractual partnerships focused on quality improvement that may be different from how they are currently approaching quality improvement, especially in relation to health equity-focused measures. In addition, CCOs may resist any increased oversight from OHA in how they should spend the quality incentive dollars relative to the current structure where they have a lot of autonomy.

Redesigning the incentive payment framework will add to the administrative burden at OHA. A framework for CCOs to work with partners on quality will have to be developed, including guidance documents and collaboration with community partners and CCOs to develop and agree on a process. OHA review of the contractual relationships and quality improvement plans will also create an administrative burden to OHA staff that does not exist in the current program. OHA will need to develop and staff an evaluation structure.

If CCOs are allowed to select focus areas from a menu of measures, they may selectively choose to focus on easy to achieve measures and metrics that do not necessarily represent an aspirational goal or directly address a health equity gap for the members.

Over time, downstream measures with stratified benchmarks and metrics focused on closing gaps for priority groups can be covered through the incentive program. However, depending on the measure, it may take time before reliable data is available to develop stratified benchmarks and region and CCO specific goals.

Considerations

If the incentive payment is to be effectively focused on advancing health equity, community input to prioritize the areas of greatest importance to members served is critical. The incentive measures and metrics, as well as the associated incentive payment level, should be developed with community input. Additionally, input and guidance from the Division of Equity and Inclusion (E&I) on the program structure and measure selection for the incentive payment program is recommended to ensure that the design is consistent with overall health equity objectives.

A consideration for the incentive payment program is a phased-in implementation in which the incentive goals in the first year of the program are focused on CCOs establishing the partnership relationships, selecting a focus area, developing the quality improvement plans with partners, and getting approval from OHA. In the years following, CCOs can work with their partners on their selected metrics, and incentive payments will be based on their performance in closing gaps on selected metrics.

Recommendation — Develop QIP Health Equity REALD-Stratified Benchmarks

Based on Mercer's quality improvement program review above, OHA has prioritized developing a QIP health equity measure selection framework. Mercer recommendations in this Section are meant to build toward a State measure definition and ultimately serve as the building block for QIP Health Equity REALD-stratified benchmarking.

In the March 2024, OHA "Data feasibility analysis"[15] identified two goals that must be met before the State could implement "equity-centered benchmarking — Identifying a framework for selecting equity measures and identifying a methodology for selecting equity-centered benchmarks" (page 18).

The feasibility study noted that data feasibility is a key barrier to developing equity-centered benchmarks for QIP measures and identified the following issues[16]: Missing data, data validity, the potential for coercion, and the ongoing development of the REALD and Sexual Orientation and Gender Identity (SOGI) Repository. The report also strongly emphasized the importance of engaging the community in developing equity-centered benchmarks and stated that equity-centered benchmarks cannot be based on REALD-stratified data alone. Instead, equity-centered benchmarks must be developed using clearly defined principles of equity to develop a framework for decision-making and an equity-centered methodology for selecting health equity measures for benchmarking.

Further, the OHPB Metrics and Steering Committee's 2024 working definition of "Transformation"[17] sets a clear mandate to help reach the OHA's goal of health inequity elimination by 2030 via the QIP. It states that "[m]easures, a measure set, and an incentive program which advance health equity by recognizing, reconciling, and rectifying historical and contemporary injustices," while also acknowledging that the QIP measure selection methodology must be dynamic and include a focus on:

- OHA Oregon Administrative Rules-defined priority populations
- Addressing healthcare inequities at the patient-provider and structural levels
- Addressing the entire healthcare delivery system — behavioral, physical, oral, and social health
- Addressing social disparities and inequities

In addition, OHA's 2024 equity-focused incentive working paper "Incentivizing Health Equity Through Quality Measures" assessed the incentive methodology domains that seven states in comparison to Oregon are utilizing to improve health equity.[18] It reviewed the use of reference points, benchmarks, and equity-related incentives specifically. The paper also included the measures that other states are currently incentivizing to address health inequities, which could be reviewed for future measure selection consideration. Mercer understands that as a working paper, findings from that study are still actively being

[15] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[16] Ibid.

[17] PowerPoint Presentation (oregon.gov)

[18] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/4.-Working-paper-Incentivizing-health-equity-in-other-states-(updated-04.11.2024).pdf

discussed and would be considered in any QIP restructure initiatives. Those findings are incorporated into the recommendations below.

Mercer recommends OHA engage in the following activities, which are in alignment with OHA's transformation and benchmarking visions, to reach their QIP equity-centered goals.

Develop a Framework and Methodology

To develop a QIP equity-centered framework and methodology, Mercer recommends considering a number of domains, including those that CMS identified as best practices for measuring health inequities as presented during the CMS 2024 Health Equity conference.[19] These include the following: A culture of equity, metric selection, population selection, stratification and benchmarking, reference/comparison points, data gaps characterizations, and a baseline for data confidence.[20] In addition, Mercer recommends the methodology include the development of quarterly QIP data dashboards that provide REALD-level measure data for CCOs and community consumption.

Culture of Equity

Mercer believes OHA is committed to creating and maintaining a culture of equity based on their equity strategic goals, numerous equity-centered programs, CCO health equity-oriented contract requirements, the Equity Impact Assessment,[21] and the recently published "Data feasibility analysis" [22] cited in this report. Ensuring community members are actively engaged in providing feedback and identifying solutions is also a known OHA priority.

To meet the related goals of developing a health equity measure framework and choosing a methodology for measuring health inequities and disparities to develop benchmarks for QIP measures within a culture of equity, Mercer recommends the OHA engage the community and CCOs early in the process. OHA should consider leveraging a number of existing organizations and entities in developing that equity-centered framework to guide the development of a methodology to determine health equity benchmarked measures. The HEC, which has representation from OHA-defined priority populations[23] and community member participants with health equity expertise is an ideal entity to begin discussions about developing the framework in the near term. OHA should also consider engaging other existing and active community-based programs and/or committees for feedback as part of their framework development process, including, but not limited to, the Regional Health Equity Coalitions, Community Partner Outreach Program, and Community Advisory Councils.

Ideally, additional direct community engagement would be integrated into the development process to ensure meaningful inclusion outside of committee roles. This could include developing a new governance structure as referenced in the 2024 Incentivizing Health Equity through Quality Measures paper.[24]and the OHA Quality Incentive Program Study Findings Report.[25]

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[19] https://cmshealthequityconference.com/1-agenda-slides/KAzar_et%20al_Gold%20Standard.pdf

[20] Ibid.

[21] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MSC-Equity-Impact-Assessment-Report.pdf

[22] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[23] https://www.oregon.gov/oha/HSD/RAC/2022%20RAC%20Invitation%20or%20Notification_KM%20122322%20(1).pdf

[24] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/4.-Working-paper-Incentivizing-health-equity-in-other-states-(updated-04.11.2024).pdf

[25] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/QIP-Evaluation-Report.pdf

Metric Selection

The CMS metric selection guidelines OHA should consider including prevalence, disparity size, evidence strength/data confidence, and the feasibility of improvement over time.[26] In addition, Mercer agrees with the OHA recommendation that a 10% missingness threshold criteria for equity-centered measure consideration is essential to build into the benchmarking methodology.[27]

Population Selection

OHA is already reporting QIP measure data by race, ethnicity, language, and disability (REALD), which aligns with CMS' 2024 stratified reporting requirements.[28] Oregon Regional Health Equity Coalitions [29] have identified State populations that have been codified in Oregon Administrative Rule 950-021-0010 (7) and include communities of color, tribal communities (including the nine federally recognized tribes of Oregon and other American Indian and Alaska Native persons), immigrants, refugees, migrant and seasonal farmworkers, low-income individuals and families, persons with disabilities, and individuals who are lesbian, gay, bisexual, transgender, or queer, or who question their sexual orientation or gender identity.[30] As the OHA Metrics and Scoring Committee has suggested in the Equity Impact Assessment,[31] Mercer recommends that priority populations currently captured in REALD data are used to set health equity benchmarks. CMS recommends considering that population standardization across metrics is not always possible when developing benchmarked measures. This could mean that different populations are identified for different measures based on community needs, rather than focusing on all priority populations for each measure.[32]

Stratification and Benchmarking

CMS recommends that data stratification should be conducted using a "periscope" approach in which race and ethnicity are stratified first, and then data is broken down further by additional elements such as language and disability.[33] This aligns with OHA's recommendation in the "Data feasibility analysis" (2024) that QIP stratified benchmarking is not based on aggregated data alone but focuses on disaggregated race and ethnicity data.[34] It is also considered a best practice.[35]

OHA is currently leading with race and ethnicity stratification and will consider disability stratification in the future. The State has also identified the need to disaggregate data whenever possible to ensure population inequities are not masked in data analysis.[36]

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[26] https://cmshealthequityconference.com/1-agenda-slides/KAzar_et%20al_Gold%20Standard.pdf

[27] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[28] https://www.cms.gov/priorities/health-equity/minority-health/research-data/stratified-reporting

[29] https://www.oregon.gov/oha/ei/pages/rhec.aspx

[30] https://www.oregon.gov/oha/HSD/RAC/2022%20RAC%20Invitation%20or%20Notification_KM%20122322%20(1).pdf

[31] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MSC-Equity-Impact-Assessment-Report.pdf

[32] https://cmshealthequityconference.com/1-agenda-slides/KAzar_et%20al_Gold%20Standard.pdf

[33] Ibid.

[34] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10599325/

[36] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

OHA further recommends adopting a 30-member denominator minimum to be included for REALD-stratified benchmarking as noted in OHA's 2024 "Data feasibility analysis," which aligns with current national standards[37, 38] for stratified data. However, this threshold could be reconsidered if there is a compelling reason within the measure to do so, such as to not erase priority populations or where communities may be impacted by structural barriers.[39]

Data availability is also called out in stratification considerations, which the REALD and SOGI Repository is working to solve by creating one source of data truth for OHA to draw on for programs like QIP. In the "Data feasibility analysis," OHA recommended that an additional data study be conducted to identify which racial and ethnic groups are most impacted by data missingness, which includes declined, unknown, and blank data.[40]

Mercer also agrees with the 2024 feasibility analysis in recommending that an equity measure reporting threshold be required to be considered met, or that a standard percentage be set for measuring member race and ethnicity data. Any thresholds developed by the OHA would not include data where members did not want to answer (declined) the race and ethnicity questions and those who selected "Don't know" (unknown).

A number of states are currently using incentives to advance health equity improvements in specific race and ethnic groups.[41] Michigan quality measures with incentives under a withhold are benchmarked for Hispanic and African American (Black) population health improvements; North Carolina has one quality incentive measure under a withhold focused on improving health outcomes for Black Medicaid members and weights that measure payout higher than other quality incentive measures; Pennsylvania incentivizes two Healthcare Effectiveness Data and Information Set (HEDIS®) measures and a maternal care incentive specifically for Black member health outcome improvements; and California expects to add specific health equity measures for all race and ethnic categories by 2027.

Reference/Comparison Points

OHA's 2024 "Data feasibility analysis"[42] aligns with CMS' recommendation not to use Caucasian (White) populations for comparison in identifying health disparities and inequities or in benchmarking.[43] Numerous states use other comparison groups to stratify measures including but not limited to Medicaid percentiles.[44] Mercer recommends OHA's methodology consider following CMS in utilizing the best performing groups where they are outperforming national benchmarks like HEDIS. CMS also recommends considering incremental target setting between population groups that are lagging and leading and adjusting over time-based CMS considerations.

[37] https://res.ncqa.org/wp-content/uploads/NCQA-RE-Summary-Report.pdf#page=6

[38] https://www.medicaid.gov/sites/default/files/2023-07/QMR-stratification-resource-july-2023.pdf#page=2

[39] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[40] Ibid.

[41] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/4.-Working-paper-Incentivizing-health-equity-in-other-states-(updated-04.11.2024).pdf

[42] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

[43] https://cmshealthequityconference.com/1-agenda-slides/KAzar_et%20al_Gold%20Standard.pdf

[44] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/4.-Working-paper-Incentivizing-health-equity-in-other-states-(updated-04.11.2024).pdf

OHA's "Incentivizing Health Equity through Quality Measures" working paper highlights reference points other states are currently using in stratifying non-incentivized measures by race and/or ethnicity.[45] California uses the national Medicaid fiftieth percentile, Minnesota uses the White Non-Hispanic population, and Michigan uses both comparison groups.

Data Gap Characterization

OHA can leverage the HEC definitions of health disparities/health inequalities and health inequities,[46] in which inequities are differences in health that are not only "unnecessary and avoidable but, in addition, are considered unfair and unjust" to characterize access gaps. In addition, Mercer recommends defining "significance" for benchmarking measures beyond statistical significance by considering whether gaps represent community-identified needs, clinic access issues, or other emerging priorities.

When identifying data gaps, Mercer recommends the State leverage information already being collected and utilized by CCOs and the State, wherever possible, to aid in the identification of gaps in each CCO award region. These include, but are not limited to, the following reports: CCO Community Health Needs Assessments and Community Health Improvement Plans, annual CCO Delivery Service Network (DSN) Narrative and quarterly CCO DSN reports, annual Health Equity Plans, and annual Traditional Health Worker Implementation and Utilization reports.

Mercer also recommends the OHA review and consider national health disparities and inequity data sets in developing an equity-centered methodology. These could include but are not limited to; Oregon State Health Assessment,[47] Kaiser Family Foundation June 2024 Key Health Disparity Data report,[48] Robert Wood Johnson Foundation County Health Rankings and Roadmaps,[49] Health Opportunity and Equity Initiative data sets,[50] State Health Equity Measure Set,[51] and Centers for Disease Control and Prevention Chronic Disease Data and Surveillance reports.[52]

Data Confidence

CMS notes that data confidence should include flexibility for small population samples and should not be limited to clinical or statistical significance alone. Mercer also recommends engaging the community in measure benchmarking prioritization to ensure that community priorities influence the measure selection, regardless of population size. In addition, healthcare coercion is an OHA priority area that should be considered in developing confidence considerations and rationales.[53]

[45] Ibid.

[46] https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Health-Equity-Definition-October-2019-HEC-Presentation-to-OHPB.pdf

[47] Oregon Health Authority: State Health Assessment and Indicators: About the Public Health Division: State of Oregon

[48] https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=executive-summary-introduction

[49] https://www.countyhealthrankings.org/

[50] https://www.hopeinitiative.org/

[51] https://www.rwjf.org/en/insights/our-research/2023/06/measuring-health-equity-a-state-measure-set-to-assess-and-improve-equity.html

[52] https://www.cdc.gov/chronic-disease/data-surveillance/index.html

[53] 3.-Equity-centered-benchmarking_Data-feasibility-analysis.pdf (oregon.gov)

Data Dashboards

In alignment with identified OHA priorities, Mercer recommends OHA work with a vendor to develop quarterly QIP dashboards that display REALD-stratified QIP measures per CCO.[54] This would be accomplished using the existing REALD and SOGI Repository, which is managed by the OHA E&I Division. OHA recommended in the "Data feasibility analysis" that dashboards be produced and shared quarterly with CCOs.[55] In addition, Mercer recommends OHA also provide summary analysis and learning collaborative sessions with the CCOs to help refine and build REALD QIP data and dashboard knowledge.

Although OHA shared with Mercer that the majority of existing QIP measures can be analyzed using member-level data, OHA has noted that not all measures contain member-level data, which is a barrier to stratifying Electronic Health Record measures. Mercer recommends the State continue to explore the opportunity to develop this functionality in order to maximize the number of measures which may be considered for future QIP REALD-stratified benchmarking. Mercer also recommends that OHA consider integrating community-level data, such as information from Connect Oregon, into the Repository to enhance data completeness.

In addition, Mercer recommends that policies and procedures be developed regarding the data needed to build dashboards, which is provided by the E&I Division. This would include developing a process for when and how the data is shared and managed from E&I, determining the data fields, who has access to the quarterly data, and how dashboards are managed by metrics and scoring. Producing QIP REALD data summaries that can be shared with CCOs along with the dashboards is also recommended to support CCOs in utilizing the data to drive change and build toward stratified benchmarks.

Recommendation Benefits

Developing an equity-centered measure framework and methodology will create the foundation essential for REALD-stratified benchmarking and is aligned with Metrics and Scoring Committee recommendations.[56] In addition to the framework and methodology elements OHA has already identified and prioritized, considering CMS' data best practices and national data sets in the methodology design will allow OHA to align with national recommendations and contribute to advancing emerging best practices.

Mercer believes that engaging the community and integrating community-level feedback will help ensure measure selection is reflective of direct community experience and member priorities, which will improve QIP measure impacts over time. It will also set the stage for community engagement, ideally via a revised governance model, in developing REALD-stratified benchmarking future-state.

[54] Ibid.

[55] Ibid.

[56] https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MSC-Equity-Impact-Assessment-Report.pdf#page=7

QIP Dashboards would allow CCOs and the Metrics and Scoring Committee to become more familiar with the REALD-stratified QIP data. They would ultimately be utilized for identifying health equity benchmarks. Dashboards can also help facilitate community engagement and feedback. Although OHA encourages CCOs to share access data with contracted providers and Community Advisory Committees, Mercer understands that annual, but not quarterly, QIP REALD data is only visible to the community at this time.

Potential Challenges

There are potential challenges associated with OHA engaging in the strategies recommended above that should be considered when prioritizing next steps and timing. Challenges include measuring disparities and inequities across 16 CCO regions with significant population differences, ongoing OHP churn, the lack of an ultimate health inequity data set nationally or statewide, overall methodological challenges in measuring health disparities [57] and inequities, and the dynamic nature of data completeness in any given time period. Small data sets, including priority population missingness, could also be a barrier to developing REALD-stratified QIP benchmarks.

There may be challenges in collecting community-level feedback in ways that are meaningful to community members and that will be experienced as authentic given the complex nature of the QIP measures, the current committee process, and the ongoing reliance on community members for other types of OHA program feedback that may not be immediately incorporated or be able to be fully considered. OHA's internal capacity to engage the community as they are currently staffed and resourced is also a potential concern, as is the overall capacity at OHA to restructure the program as recommended.

Additional complications could include federal changes given the pending 2024 presidential election, shifting State legislative priorities and/or political will, and the upcoming CCO procurement cycle.

Recommendation — Adopt a Phased Approach to QIP Restructure Recommendations

Mercer recommends OHA consider adopting a phased approach to QIP restructuring per the table below. Doing so would allow time to develop the processes, engage community members for feedback, build on and enhance existing programs, and create building blocks for a new withhold, incentive investment accountability, and REALD-stratified benchmarks.

Recommendation	Current State	Phase I	Phase II	Ultimate State
Implement a Withhold	Incentive payment for downstream and upstream measures	Modified Exhibit L reporting for increased transparency around CCO quality incentive pool expenditure	Withhold (2%–4%) for downstream metrics Modified Exhibit L reporting for increased transparency	Withhold (2%–4%) for downstream metrics Modified Exhibit L reporting for increased transparency

[57] https://pubmed.ncbi.nlm.nih.gov/16032956/

Recommendation	Current State	Phase I	Phase II	Ultimate State
			around CCO quality incentive pool expenditure	around CCO quality incentive pool expenditure
Incentive Redesign	CCOs decide how to spend the incentive payment (provider incentives, HRS spending, etc.) Limited visibility into how the spend drives improvement on quality benchmarks Downstream and upstream incentive payout and spending are aggregated Incentives are based on overall population, and are not focused on addressing health disparities	CCOs establish contractual relationships with CBOs, medical providers, non-medical providers, and so forth to work on addressing gaps on specific metrics Develop partnership terms, plan, budget, and so forth Work with OHA to obtain approval and assure operational feasibility Modified Exhibit L reporting for increased transparency around CCO quality incentive pool expenditure	CCOs execute on the quality improvement plans and commitments with CBOs and providers Modified Exhibit L reporting for increased transparency around CCO quality incentive pool expenditure	CCOs execute on the quality improvement plans and commitments with CBOs and providers Modified Exhibit L reporting for increased transparency around CCO quality incentive pool expenditure
QIP Health Equity: REALD-Stratified Benchmarks	Upstream measures have been statutorily defined to target SDOH Equity-centered measures are not defined — no framework to select such measures or	Develop equity-centered measure framework based on equity principles to guide the development of an equity-centered methodology	Select equity-centered measures and benchmarks using framework and methodology that includes a meaningful community engagement process	Use equity-centered measures for REALD-stratified benchmarking

Recommendation	Current State	Phase I	Phase II	Ultimate State
	methodology for benchmarking Lack ability to share quarterly QIP data by REALD stratifications in an easy to access format; data is not analyzed quarterly and trends are not shared No community engagement is built into the current QIP measure selection and benchmarking processes	Develop equity-centered methodology for REALD-stratified benchmarking; review against limitations in data, such as missingness and small populations Methodology includes easily accessible and usable data dashboards that can be filtered and sorted to meet equity-centered methodology Identify community engagement process for measure and benchmark selection feedback; consider governance changes Test dashboard with CCOs and community partners to identify design opportunities	Quarterly dashboards that are standardized and can be filtered for analysis are utilized to drive measure decision making in collaboration with CCOs and community	

Section 6

Summary

Oregon has a unique opportunity to restructure the QIP to concretely address health inequities. QIP restructure recommendations outlined in this paper are in alignment with the OHA's existing analysis and vision. Mercer has also identified additional opportunities to support the State's strategic goal of eradicating health inequities by 2030. The key recommendations include:

- Implementing a withhold as part of the QIP to address downstream measures.
- Reserving the incentive payment part of the QIP for initiatives that advance health equity. These may include upstream measures, select downstream measures with stratified benchmarks as data allows, and other future OHA-identified health equity goals. Further, design the incentive payment portion of the QIP to enhance CCO accountability, promote CCO collaboration with community partners and providers, and advance visibility into CCO spending and related impact on metrics.
- Developing REALD-stratified QIP benchmarks using an OHA- and community-defined equity-centered measure framework and methodology.

Mercer recommends that QIP restructure activities be phased-in over time with robust input from community members and other OHA-identified individuals and organizations. The timeline for a phased approach would be determined by OHA subject to rate setting, CCO contract amendments, CMS approval, and the upcoming procurement process, among other considerations.

Appendix A

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