Oregon Health Authority
Improvement Targets

In order to be awarded funds from the quality pool, Oregon's Coordinated Care Organizations (CCOs) will be measured against a specified benchmark for each of the 17 CCO incentive measures[1]. CCOs that do not meet the benchmark for a given measure will be assessed against their improvement from their own baseline target ("improvement target"). If CCOs meet their improvement target on a given measure, they will be awarded the quality pool funds associated with that measure.

The improvement targets were selected by the Metrics & Scoring Committee, with input from their technical advisory workgroup (TAG). Improvement targets for the first measurement year (CY 2013) for each of the CCO incentive measures are documented below in Appendix A.

Improvement Target Calculations

The improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System ("Minnesota method" or "basic formula").[2] This method requires at least a 10 percent reduction in the gap between baseline and the benchmark to qualify for incentive payments.

Or, stated as a formula:

$$\frac{[\text{State Benchmark}] - [\text{CCO Baseline}]}{10} = x \qquad [\text{CCO Baseline}] + [x] = \text{Improvement Target}$$

For example: a CCO's baseline for the timeliness of prenatal care measure may be 50 percent. Oregon has set the benchmark at 69.4 percent.

$$\frac{[69.4] - [50]}{10} = 1.94 \qquad 50 + 1.94 = 51.9$$

The CCO must reduce the gap between its baseline and the benchmark by 10 percent; therefore, the CCO must improvement its rate on the timeliness of prenatal care measure by 1.9 percentage points, resulting in an improvement target of 51.9 percent.

The CCO must meet either the benchmark of 69.4 percent or the improvement target of 51.9 percent to be awarded quality pool funds for this measure.

[1] Benchmarks for each of the 17 CCO incentive measures are documented in the measure specification sheets and in the state baseline data summaries, online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

[2] Additional details about this methodology are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Improvement Target with Floor Calculations

In some cases, depending on the difference between the state benchmark and the CCO baseline, the Minnesota method may result in very small improvements that may not represent statistically significant change.

For example: a CCO's baseline for the follow up care for children prescribed ADHD medications may be 49.8 percent . Oregon has set the benchmark at 51.0 percent.

$$\frac{[51.0] - [49.8]}{10} = 0.12 \qquad 49.8 + 0.12 = 49.92$$

This is especially a consideration for CCOs that have small denominators (n<30) for some of the incentive measures where just one or two members may affect their measurement results.

Where the Minnesota method results in small improvement targets, the Metrics & Scoring Committee has established a "floor" or a minimum level of required improvement before a CCO would meet the improvement target and be awarded the quality pool funds associated with that measure. The floor ranges from one to three percentage points, depending on the measure.

For measures where a floor has been established, if the improvement target calculation for a CCO results in a percent improvement that is less than the floor, the floor takes precedence and is applied instead of the improvement target calculation.

For example, the timeliness of prenatal care measure used above has a 3 percentage point floor. As the improvement target calculation results in only a 1.9 percentage point increase in the rate, the 3 percentage point floor is used instead.

Initial calculation	*Improvement target*	*New improvement target with floor applied.*
$\frac{[69.4] - [50]}{10} = 1.94$	50 + 1.94 = 51.9	50 + 3 = 53

However, if a second CCO's baseline was only 35 percent on this measure, its improvement target would be greater than the 3 percentage point floor, and the floor would not be applied. Its improvement target would remain the initial calculation.

Initial calculation	*Improvement target*	*New improvement target with floor applied.*
$\frac{[69.4] - [35]}{10} = 3.44$	35 + 3.44 = 38.4	Not applicable. No floor applied.

In some instances, the improvement target calculation for a measure could equal the benchmark. For example, with the timeliness of prenatal care measure, if a CCO's baseline was 66.4:

Initial calculation	*Improvement target*	*New improvement target with floor applied.*
$\frac{[69.4] - [66.4]}{10} = 0.3$	66.4 + 0.3 = 66.7	66.4 + 3 = 69.4

In this case, the CCO must reach the same rate (via the benchmark or the improvement target calculation) to be awarded the quality pool funds for that measure.

And finally, in some instances, the improvement target calculation for a measure could exceed the established benchmark. In this case, the CCO must only meet the benchmark to be awarded the quality pool funds for that measure.

For example, with the follow up after hospitalization for mental illness measure, the state benchmark is set at 68.0 percent. Several CCOs have baselines ranging from 65 – 67 percent. Using the formula:

Initial calculation	*Improvement target*	*New improvement target with floor applied.*
$\frac{[68.0] - [66.7]}{10} = 0.13$	66.7 + 0.13 = 66.8	66.7 + 3 = 69.7

The calculated improvement target (69.7 percent) is higher than the established benchmark (68.0 percent). The CCO must only meet the benchmark of 68.0 percent to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the benchmark to qualify.

Exceptions

The only exception to the Minnesota method for improvement target calculations is for the colorectal cancer screening measure. As the measure has been modified from HEDIS specifications and is now reporting only the unique number of members who have received colorectal cancer screenings in a 12 month period, the Metrics & Scoring Committee did not set a new benchmark for the revised measure.

A CCO must demonstrate 3 percent improvement on this measure to be awarded quality pool funds. Note this is 3 percent improvement, not 3 percentage points.

For example: If a CCO's baseline is 15 / 1,000 member months, it must raise its rate to 15.45/1,000 member months to meet the target.

15 * 3% = .45
15 + .45 = 15.45

Questions

➔ *If a CCO does not have an improvement target because it has met or exceeded the benchmark, does that mean that any rate is acceptable and it will be awarded funds from the quality pool?*

No. If a CCO does not have an improvement target because it met or exceeded the benchmark in its baseline data, or because its improvement target calculation resulted in a score that meets or exceeds the benchmark (see above for scenarios), the CCO will still need to meet or exceed the benchmark in the measurement year to be awarded quality pool funds. If the CCO's rate slips down below the benchmark for the measurement year, it will not be awarded quality pool funds associated with that measure.

➔ *Does a CCO have to demonstrate certain improvements on the incentive measures for racial and ethnic groups to be awarded funds from the quality pool?*

No. Race and ethnicity data is not tied to the incentive measures and there are no financial implications for CCOs related to race/ethnicity data. There are no improvement targets related to race/ethnicity or reducing disparities in the first measurement year.

OHA has committed to reporting all of the measures by race and ethnicity and looking at disparities at the state level, not at the CCO level. OHA is also committed to improving the collection of race, ethnicity, and language data.

➔ *Why is the "floor" set at 2 percentage points for the two CAHPS measures when it is 3 percentage points for most other measures?*

The statewide baseline and general CCO performance is relatively close to the benchmark. In many cases, the improvement target calculation with a 3 percentage point floor applied would result in an improvement target that exceeds the benchmark. However, the Metrics & Scoring Committee wanted to ensure that CCOs still demonstrate meaningful improvement, so it selected a lower floor.

➔ *Why is there not an improvement target for the Patient Centered Primary Care Home (PCPCH) Enrollment measure? It is listed as n/a.*

The PCPCH Enrollment measure does not have an improvement target as this measure is the only measure of the 17 incentive measures not treated on a pass/fail basis. Instead, performance is measured using the tiered formula (see footnote on page one above). The tiered formula provides a sense of where the CCO is relative to the goal of having all CCO members enrolled in a Tier 3 PCPCH. The results of the formula will be reported on a sliding scale (from 0 to 100 percent).

Details on the tiered formula and how the PCPCH Enrollment measure factors into the quality pool distribution are available online at:
http://www.oregon.gov/oha/CCOData/Quality%20Pool%20Methodology.pdf

Appendix A: Existing Improvement Targets

This document has been updated to reflect decisions made by the Metrics & Scoring Committee on August 16, 2013.

See pages one-two above for a description of the basic formula and percentage point floors for the improvement target calculations.

CCO Incentive Measures	Improvement Target for CY 2013	Benchmark
Access to Care: Getting Care Quickly (CAHPS survey composites for adult and child)	Basic formula with 2 percentage point floor	87% *Average of the 2012 National Medicaid 75th percentiles for adult and child rates*
Adolescent well-care visits	Basic formula with 3 percentage point floor	53.2% *2011 National Medicaid 75th percentile, administrative data only*
Alcohol and drug misuse (SBIRT)	Basic formula with 3 percentage point floor	13% *Metric & Scoring Committee consensus*
Ambulatory care: outpatient and emergency department utilization *****The emergency department component will be used to determine the quality pool payment	Basic formula	ED utilization: 44.4/1,000 member months Outpatient utilization: 439/1,000 member months *2011 National Medicaid 90th percentile.*
Colorectal cancer screening	3 percent improvement only	n/a
Controlling high blood pressure	n/a *reporting only for year one (CY 2013)*	n/a *reporting only for year one (CY 2013)*
Developmental screening in the first 36 months of life	Basic formula	50% *Metrics & Scoring Committee consensus, based on 2007 National Survey of Children's Health*
Diabetes: HbA1c poor control	n/a *reporting only for year one (CY 2013)*	n/a *reporting only for year one (CY 2013)*

CCO Incentive Measures	Improvement Target for CY 2013	Benchmark
Early elective delivery	Basic formula with 1 percentage point floor	5% or below *Metrics & Scoring Committee consensus*
Electronic Health Record (EHR) Adoption	Basic formula with 3 percentage point floor	49.2% *Federal benchmark for EHR adoption by 2014.*
Follow up after hospitalization for mental illness	Basic formula with 3 percentage point floor	68% *2012 National Medicaid 90th percentile*
Follow up care for children prescribed ADHD medications *The initiation component will be used to determine the quality pool payment.	Basic formula	Initiation: 51% Continuation & Maintenance: 63% *2012 National Medicaid 90th percentile*
Mental and physical health assessments within 60 days for children in DHS custody	Basic formula with 3 percentage point floor	90% *Metric & Scoring Committee consensus*
Patient Centered Primary Care Home (PCPCH) enrollment *The dollars available to CCOs for this measure are tied to the percentage of enrollees in PCPCHs, based on the measure formula[3]	n/a	Goal: 100% of members enrolled in Tier 3 PCPCHs
Satisfaction with Care: Health Plan Information and Customer Service (CAHPS survey composites for adult and child)	Basic formula with 2 percentage point floor	84% *Average of the 2012 National Medicaid 75th percentiles for adult and child rates*
Screening for clinical depression and follow up plan	n/a *reporting only for year one (CY 2013)*	n/a *reporting only for year one (CY 2013)*
Timeliness of prenatal care	Basic formula	69.4% *2012 National Medicaid 75th percentile, administrative data only*

[3] The PCPCH enrollment measure is calculated as: [(# of members in Tier 1)*1 + (# of members in Tier 2)*2 +(# of members in Tier 3)*3] / (the total number of members enrolled in the CCO * 3)