

Equity-centered benchmarking

Data feasibility analysis

March 2024



About this report

[Metrics and Scoring Committee](#) has expressed strong interest in exploring different benchmarking options for coordinated care organization (CCO) performance, including stratifying by race and ethnicity groups. The aim of this benchmarking is to advance health equity within the [CCO Quality Incentive Program](#).

This report is divided into two sections. The first section provides an in-depth history of the program's exploration of equity measure selection and benchmarking conversations. This information is important framing for the second section, which explores data feasibility of stratified benchmarking.

Findings and recommendations were informed by the [Equity Impact Assessment](#), which identified opportunities for the CCO Quality Incentive Program to address health care inequities. This report is accompanied by a [Data feasibility analysis tool](#) demonstrating race and ethnicity data availability as of May 2023.

Acknowledgments

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Executive summary

The Metrics and Scoring Committee first began exploring equity measurement and benchmarking proposals in 2015. At the Committee's request, OHA convened an informal workgroup to explore options, including stratified benchmarking by race and ethnicity groups. Stratified benchmarking is when we apply benchmarks across different demographic groups. From these efforts, we found that data feasibility was a major barrier to stratified benchmarking.

In May 2021, OHA staff presented the [Equity Impact Assessment](#) to the Committee, which provided recommendations on how the Quality Incentive Program could address health care inequities. We have made significant progress on some recommendations, such as monitoring incentive measures by granular race, ethnicity, language and disability (REALD) groups. This is possible due to the new REALD and Sexual Orientation Gender Identity (SOGI) Repository (called the Repository in this report), which was launched in 2023. The Repository links together many different data sources and is our most complete source of REALD data. However, there are other known equity gaps in the Quality Incentive Program that have not yet been addressed.

Stratified does not mean equitable. Equity principles must be used when developing and implementing stratified benchmarking (see [Appendix B: Equity principles definition](#)). These include recognizing the role of historical and contemporary oppression in health care quality measures. Equity principles also shift resources and power to communities that have been excluded and marginalized. Without equity principles, stratified benchmarking is **not** equity-centered benchmarking.

This analysis only focuses on data feasibility of stratified benchmarking. Our recommendations consider limitations within the current program requirements, data sources, measures and capacity. We look at data feasibility for downstream measures reported by stratified REALD groups in measurement year 2022. This is **not** an analysis of a measure's ability to promote health equity, nor of different benchmarking models.

Decisions about equity-centered benchmarking cannot be made on data feasibility alone. Measurement and program constraints can lead to unintended, negative consequences on health equity, so the Committee needs to exercise caution.

Our analysis is framed by the guiding question: **How do we ensure that bonus dollars** are awarded in a way that **improves the equity and quality of care?** We explore three topic areas in this analysis, informed by barriers identified during previous equity initiatives:

- **Missing data:** How complete must data be to confidently measure CCO performance by stratified race and ethnicity groups?
- **Group sizes:** With small race and ethnicity groups, can we attribute year-over-year change to CCO performance? How can we reduce potential coercion in the Quality Incentive Program?
- **Operations:** What agreements and processes do we need to operationalize REALD data in the Quality Incentive Program?

Key findings

There is no gold standard for an acceptable rate of missing data. In practice, missing rates at or below 5% are considered inconsequential and above 10% are considered likely to be biased. However, why data are missing (missing at random or missing not at random) may have a greater impact than the amount that is missing.

Missingness varies greatly by CCO and by measure. Rates of missingness may also change over time. Missingness has continued to decrease as the REALD and SOGI Repository gets more established. However, missingness could increase in the future due to political climate and institutional distrust.

OHA sometimes applies a reporting threshold. For some measures in the program, OHA requires CCOs to report a minimum percentage of data. Reporting thresholds ensure that data are valid and representative of CCO members.

Restricting group sizes erases priority groups. We use disaggregated REALD data because it reveals inequities that are masked when we roll up groups into broader aggregate categories. Nationally, groups with fewer than 30 members are suppressed to ensure data are valid and reliable. Denominator minimums restrict the number of priority groups that we can report.

Incentive measures may promote coercion. CCOs have raised concerns about incentive measures promoting provider and institutional coercion. The U.S. has a long history of health care providers and systems coercing marginalized racial and ethnic groups when making health care decisions. The Committee needs to consider measures' social and historical context when making decisions about incentives.

More time is needed to operationalize REALD and SOGI Repository data. CCOs began receiving Repository data in September 2023 but will need time to integrate these data into workflows. Additionally, OHA provides CCOs a quarterly dashboard to help them see if they are on track to meet incentive measures. At this time, OHA cannot ingest and calculate incentive measure results stratified by race and ethnicity groups on a quarterly basis.

Data feasibility recommendations

- **Recommendation 1:** Further analysis is needed to assess impacts of blank, unknown and declined (missingness) data on race and ethnicity groups. As staffing capacity allows, trends in missingness for race and ethnicity data should be monitored at a CCO and measure level on an ongoing basis.
- **Tentative recommendation 2:** Based on projected decreases in Repository missingness, the Committee should select equity measures with median CCO missingness (blank, unknown and declined) no greater than 10%.

However, if further analysis can demonstrate that patterns in missingness do not negatively impact priority race and ethnicity groups, the Committee could select equity measures with higher median CCO missingness.

- **Recommendation 3a:** To meet an equity measure, CCOs should be required to meet a reporting threshold, or report a set percentage of race and ethnicity data for their members within the measure. Reporting thresholds would exclude unknowns (“Don’t know”) and declines (“Don’t want to answer”).

- **Tentative recommendation 3b:** Based on projected decreases of blanks in the Repository, the Committee should set reporting thresholds no lower than 90%. The Committee may also consider an incremental approach to increasing the reporting threshold over time.
- **Recommendation 4:** Stratified benchmarking must include disaggregated race and ethnicity data. Aggregate categories may be considered as an additional element but cannot be the only data used as it masks inequities.
- **Recommendation 5:** Coercion is a universal concern in all aspects of incentive measures and cannot be solely addressed by denominator minimums. The Committee should explore other practices, for example, considering potential coercion during equity measure selection and implementation.
- **Recommendation 6a:** The Committee should **select equity measures** that have sufficient denominator sizes unless a measure demonstrates a compelling reason not to follow this standard.

Denominator minimums must be set at a level that does not further erase priority populations. Current national reporting standards align with this requirement (30 members) but may change in the future.^a

- **Recommendation 6b:** Equity benchmarks should **only apply to groups** with at least 30 members unless a measure demonstrates a compelling reason not to follow this standard.

Denominator minimums must be set at a level that does not further erase priority populations. Current national reporting standards align with this requirement (30 members) but may change in the future.^a

- **Recommendation 7:** Do not implement stratified benchmarking until a HEDIS-certified vendor (or other staffing resources) can produce stratified race and ethnicity data in CCO-facing quarterly dashboards.
- **Recommendation 8:** The Committee should communicate early with CCOs about equity measures and benchmarking models selected for stratified benchmarking.

Next steps

The CCO Quality Incentive Program must engage community partners to move forward with equity initiatives. This includes developing partnerships with Medicaid members and groups most harmed by health inequities, as well as health care providers and other health system representatives, to:

- Develop new measure selection criteria to identify measures advancing health equity
- Select methods for measuring disparities and benchmarking models

^a Our primary measure steward, [National Committee for Quality Assurance \(NCQA\)](#), and Centers for Medicare & Medicaid Services (CMS) suppress groups with less than 30 members in stratified race and ethnicity reporting.

Further, this report's recommendations are meant to align with Senate Bill 966. [Senate Bill 966](#) directs OHA to conduct a study with community partners on how to center equity in the Quality Incentive Program. In addition to the study, Senate Bill 966 provided the following funding for advancing equity initiatives in the Quality Incentive Program.

- First, we have an ongoing contract to continue community engagement initiated by the Senate Bill 966 study. This contract could be used to **engage community on how to identify measures that advance health equity.**
- Second, we have funds for a limited duration contract to **explore methods for measuring disparities and benchmarking models, continuing the work started with this report.** This is a one-time contract for a consultant to facilitate discussions with OHA staff, the Committee, community members and others.

History of the program

Background

While stratified benchmarking is a new endeavor for the [Quality Incentive Program](#), it is built off of previous equity initiatives and learnings. Below is a summary of equity initiatives tested within and related to the CCO Quality Incentive Program. Barriers during these initiatives informed the key data feasibility questions we attempt to answer in this report.

The Committee first considered a health equity “meta-measure” or index

In May 2015, former Committee member Bob Dannenhoffer recommended the Committee adopt a health equity “meta-measure.” This is also known as an index, which provides an aggregate score of the variation among demographic groups across multiple measures. The index was intended to use existing measures to “incentivize CCOs to have similar performance for the historically underserved populations as they do for their overall population.” At that time, no measure within the program was specifically designed to measure or address health inequities.

The Committee expressed interest in this concept as a future Challenge Pool measure and asked OHA staff to begin measure development. OHA staff convened an informal workgroup of internal stakeholders (including Office of Equity & Inclusion and Transformation Center), Oregon Health & Sciences University Center for Health Systems Effectiveness (OHSU CHSE), Oregon Health Care Quality Corporation (Q Corp) and CCOs.

After reviewing national health equity indices and CCO data, the workgroup expressed concern that an [index may not meaningfully measure nor advance health equity](#). For example, CCOs could improve their index score by worsening performance for some populations. Further, the program’s timeline means an aggregate score may not be engaging nor actionable for CCOs (e.g., can we expect CCOs to move an aggregate score within a 12-month period?). An index can also be confusing and may not be meaningful to the communities being measured.

The workgroup explored different incentive models

In May 2016, the workgroup provided [two alternatives to an index](#). First, the Committee could select a disparity-sensitive measure as a “must pass” requirement for CCOs to be eligible for 100% of their incentive funds. This “must pass” model had been used previously for some incentive measures, such as electronic health record (EHR) adoption. Second, the Committee could adopt a subset of disparity-sensitive measures and stratify them by population groups. Incentive funds would then be tied to each group in a measure that met the benchmark or improvement target.

The Committee agreed that with either approach, they needed to first identify disparity-sensitive measures before defining the incentive model. Additionally, the Committee contemplated whether the intention of an equity measure was to a) reduce variations among groups or b) improve performance of all groups, called an “all boats rise” approach.

The Committee endorsed an “all boats rise” approach

In [August 2016](#) the Health Equity Index Workgroup brought forward a new proposal for equity measurement. At that time, the workgroup and Committee endorsed the “all boats rise” approach, where all demographic groups would need to meet a measure’s benchmark or improvement target.

The new proposal would use existing incentive measures. The Committee would select one core measure that would be the same for all CCOs. Then each CCO would select a menu measure based on their own population's unique needs. For each measure, CCOs would select at least two groups experiencing a disparity. Potential groups included age, race and ethnicity (using [federal data standards](#)), language spoken at home, geography, gender and populations with disabilities and/or mental health diagnoses. CCOs would only meet the measures and earn the incentive if each selected group met the benchmark or improvement target.

CCOs were hesitant about the proposal, especially with race and ethnicity

The Committee requested [CCOs provide feedback on equity measure options](#) presented by the workgroup in August. First, CCOs expressed hesitancy with a core measure, since each CCO region is different, and communities may experience disparities in different ways. CCOs added that it was difficult to find two disparate populations for the same metric. CCOs suggested that focusing on one population per metric might be more effective.

When asked if they should be required to pick at least one racial or ethnic group for an equity measure, CCOs answered no. CCOs cited variations in populations and poor demographic data. At that time, 13% of race and ethnicity data (using [federal data standards](#)) was missing for CCO members statewide. Despite these concerns, most CCOs identified at least one racial or ethnic group as a group of interest. However, four CCOs chose white members as their group of interest.

Following feedback from CCOs, the Committee stated that race and ethnicity should be a required component of an equity measure. Additionally, a selected group should be one that faces extra barriers or is historically disadvantaged, not just one experiencing lower CCO performance. However, the Committee struggled with how to define these groups in practice. The Committee did not come to a consensus on whether CCOs could select white members as a group of interest.

CCOs shared ideas on how to engage community and tailor care

When gathering feedback on this model, OHA asked CCOs to discuss what [community involvement](#) informed their selection from menu measures. If no community engagement occurred, CCOs were asked what that may look like the following year. Given the short timeframe for feedback, only a few CCOs had the opportunity to gather community input. For future engagement, CCOs referenced working with Community Advisory Councils (CACs), local public health agencies, community health centers and culturally-specific community groups or advocacy organizations.

OHA also asked CCOs to share how they may implement equity measures in a [culturally appropriate and responsive way](#). CCOs referenced a range of ways to tailor care including:

- Working with marketing department to create advertising targeting region and age group.
- Partnering with community groups to improve outreach to selected populations.
- Working closely with clinics to improve workflows; incorporating diversity trainings to providers.
- Providing and disseminating culturally competent materials in multiple languages.
- Increasing health literacy and cultural competence trainings.

- Providing easily accessible interpreter services to members who need them.
- Ensuring clinics that work heavily with the selected population(s) receive appropriate training and resources to serve the population.
- Working with Care Coordination and Population Health teams to apply an equity lens to CCO's programming.
- Engaging with members of the selected population through community organizations to have an inclusive conversation about the needs of members.
- Developing a survey to ask members of the selected population about the barriers they face.
- Hiring a full-time employee dedicated to improving on the selected measure.

The proposal for an equity measure shifted due to data feasibility

Throughout these discussions, data availability was cited as a challenge. For example, race and ethnicity data are not available for all CCO measures (e.g., those sourced from electronic health records). Even for measures with available race and ethnicity data, some CCOs could only report performance among white groups due to small denominator sizes.

In January 2017, OHA staff presented a new [equity measure proposal](#) with two options that would align across all CCOs. The Committee decided to focus on a single measure: Emergency department (ED) utilization. This measure was selected since ED utilization is a high impact measure. It also has a sufficiently large denominator for all CCOs and shows large disparities across different demographic groups. The Committee also decided to focus on a single group. In 2016, CCO members with severe and persistent mental illness had much higher rates of ED utilization compared with CCO members overall. Ultimately, the Committee chose to adopt a new incentive measure, [Disparity measure: ED utilization among members with mental illness](#) for measurement year 2018. This was not a unanimous vote and there were lingering concerns that the measure did not address racial or ethnic inequities. The measure was incentivized from 2018 to 2021.

Initial discussions highlighted the need for a shared equity definition

The discussions leading to the [Disparity measure: ED utilization among members with mental illness measure](#) highlighted areas where the Committee, CCOs and OHA staff needed further learnings on health equity. For example, disparities and inequities were used interchangeably throughout these discussions. Additionally, some CCOs selected white members as their group of interest for racial and ethnic health inequities.

In October 2019, OHA and the Oregon Health Policy Board (OHPB) adopted the [health equity definition](#), which was presented to Metrics and Scoring Committee in [January 2020](#). The definition was developed with feedback from the Nine Federally Recognized Tribes of Oregon, community-based organizations, OHPB committees, CCOs and Community Advisory Councils.

Health equity definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

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.

OHA and partners have developed new upstream measures

Since these initial discussions, the Quality Incentive Program has focused on developing new upstream measures. Upstream measures are concentrated on improving the social determinants of health, defined in statute as “[nonmedical factors that influence health outcomes](#).”^b These are primarily “homegrown” measures stewarded by Oregon agencies. As such, they require intensive engagement and resources. Upstream measures take years to develop and ongoing maintenance. The most recently developed upstream measures are:

Meaningful language access: From October 2018 to May 2019, the [Health Equity Measurement Workgroup](#) convened to develop recommendations on equity measurement on a health plan level. These recommendations led to creating the [Meaningful language access](#) measure. This measure began on a glide path in 2021, where new requirements were gradually added each year.

Social determinants of health: Work on a measure related to the social determinants of health, specifically food insecurity, began in 2015. The Committee ultimately chose not to adopt the measure, as there were concerns about the ability to report at a health plan level. However, interest in addressing the social determinants of health continued. Partners from the Oregon Food Bank, the Oregon Primary Care Association and OHA proposed that the measure be refined and broadened to include other social determinants of health. In 2019, the Metrics and Scoring Committee endorsed the development of a broader social determinants of health (SDOH) measure. From late 2020 to early 2021, the [SDOH Measurement Workgroup](#) convened to develop the [SDOH: Social Needs Screening and Referral](#) measure, which launched in 2023.

Kindergarten readiness: In 2017, the Committee sponsored the [Health Aspects of Kindergarten Readiness](#) workgroup to develop recommendations for one or more measures on the health system’s role in preparing children for kindergarten. The workgroup was supported by a partnership between OHA and Children’s Institute (CI), with technical support from the Oregon Pediatric Improvement Partnership (OPIP). The workgroup proposed a multi-year, multi-measure approach to jointly focus on children’s physical, oral, developmental and social-emotional health. In November 2018, the Committee unanimously endorsed the strategy proposed by the workgroup. In 2019, the Committee added two of these measures to the

^b The statutory definition also includes the following: “The conditions in which individuals are born, grow, work, live and age” and “The forces and systems that shape the conditions of daily life, such as economic policies and systems, development agendas, social norms, social policies, racism, climate change and political systems.”

incentive measure set (Preventive dental visits for children ages 1-5 and Well-child visits for children ages 3-6). In 2022 the [System-level social emotional health measure](#), developed and stewarded by CI and OPIP, was added to the Quality Incentive Program.

COVID vaccinations tested stratified race and ethnicity benchmarking

With the development of upstream measures, the Quality Incentive Program paused pursuing benchmarking by stratified race and ethnicity groups. However, in 2021 this benchmarking model was first tested with the [Emergency Outcome Tracking Program CCO COVID-19 vaccination \(EOT\) measure](#). The EOT program rewarded CCOs for making progress in vaccinating their members using an “all boats rise” approach. The program required CCOs meet an improvement target for a) their entire membership and b) across all race and ethnicity groups with at least 50 members. Funds from the Quality Incentive Program were redirected to the EOT program.

OHA was requested to develop a COVID incentive metric by the state's leadership at the height of the COVID pandemic. It became apparent from race and ethnicity data (using [federal data standards](#)) that people of color were dying at higher rates from COVID. Those disparities persisted into vaccine rollout, with people of color less likely than the white population to be vaccinated in Oregon. Given the public health emergency, EOT program incentives were [developed outside of the usual Committee processes](#) and timelines required by the CCO Quality Incentive Program. Measure development did not include community engagement or input.

We have made great strides in monitoring measures by race and ethnicity

A barrier to stratified benchmarking has been adequate and accurate demographic data. There have been substantial changes in state data systems since the start of the Quality Incentive Program. In 2018, OHA began collecting race, ethnicity, language and disability (REALD) data for Oregon Health Plan members during enrollment. REALD is a set of demographic standards specific to the state of Oregon. Not only are these standards highly local, but they were determined by communities most impacted by health inequities. As such, REALD standards are more detailed than any other demographic data we have. This level of detail is necessary because disaggregated demographic data can help us unmask inequities.

Starting in 2022, we began reporting CCO performance measures stratified by race and ethnicity groups going back to 2018. This reporting is done at an aggregate level (nine parent categories) and disaggregate level (40 granular groups). Our reporting is possible due to the new REALD and Sexual Orientation Gender Identity (SOGI) Repository (called the Repository in this report). Launched in 2023, the Repository is the first effort by any state government to develop a relational database containing the most complete demographic information possible.

OHA does not have demographic data for electronic health record (EHR) measures.

EHRs are records kept by clinics during a health care visit. Currently, CCOs report EHR metrics at a population level only, without providing patient-level information.

Oregon leads the nation in disaggregated race and ethnicity reporting

Nationally, stratified race and ethnicity reporting for Medicaid measures is just starting to take shape. Starting in 2024, Centers for Medicare & Medicaid Services (CMS) will require all states to report race and ethnicity data (using [federal data standards](#)) for the [Adult Behavioral and Child Core Set](#) measures. Starting in summer 2024, [California](#) will require health plans to report race and ethnicity data, with annual stratified reporting beginning in 2025. In September 2022,

[North Carolina](#) directed managed care plans to report stratified race and ethnicity data, but has not yet announced a plan for making those results publicly available. [Michigan](#) last publicly reported measure performance among race and ethnicity groups in 2020. In all of these efforts, states use [federal data standards](#) for race and ethnicity, which only includes six aggregated groups (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander and white) and one ethnicity group (Hispanic or Latino).

Currently no other state reports disaggregated race and ethnicity data. With our granular REALD reporting, we can make more data-informed decisions about stratified benchmarking. For example, when considering benchmarking by race and ethnicity, the [California Health Equity and Quality Committee](#) discussed a study published by Torre et al. (2016) that found that the incidence of cervical cancer appears lower for Asian Americans when compared to non-Hispanic white Americans. However, when disaggregated by race and ethnicity, rates are much higher in Vietnamese and Cambodian but lower in Chinese and Asian Indian sub-populations.¹ The Committee recommended the Department of Managed Health Care (DMHC) require California health plans to collect and use disaggregated data, if and when it is possible.

Previous equity recommendations

This analysis was informed by previous findings and recommendations in the [Equity Impact Assessment](#), which OHA staff presented to the Committee in May 2021. The purpose of this assessment was to identify opportunities for the CCO Quality Incentive Program to address health care inequities. The report provided case studies of four incentive measures.

The assessment found equity concerns in the Quality Incentive Program. To address these concerns, OHA recommended the following:

- **Update measure selection and retirement criteria** to formally integrate equity principles.
- Explore changes to the program structure to **focus on priority populations**. In the current structure, setting targets across the entire membership can mask inequities.
- **Increase input from Medicaid members and priority populations** impacted by measures.
- **Educate about inequities** and use consistent language to address the problem.
- Once a measure is incentivized, **emphasize opportunities for health equity principles in implementation**.
- **Committee and OHA staff need to do more work** on identifying additional solutions and process changes to address historical and contemporary injustices.

The Committee needs to use equity principles for selecting measures

Measurement and program constraints can have unintended, negative consequences on health equity. As such, the Committee needs to exercise caution with what measures are included in the CCO Quality Incentive Program. The Committee needs to consider [how measures are framed](#), and if that framing aligns with equity principles. Framing refers to how we identify something as a problem, what problems are worth solving and how they should be solved. Framing can differentially affect priority groups, especially when communities most impacted by an issue are not consulted.

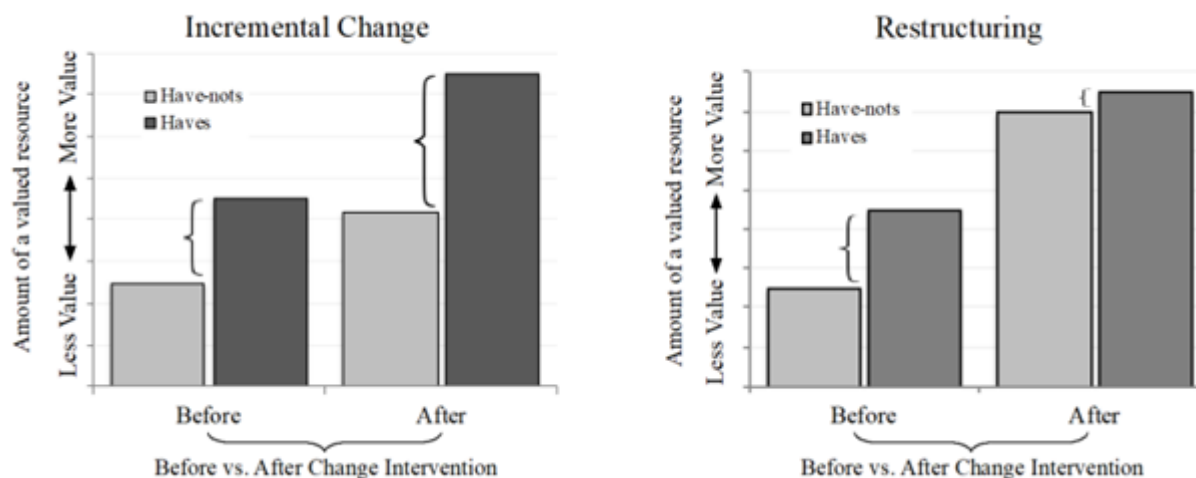
When exploring different proposals for an equity measure in 2016, the Committee agreed that they needed to first select disparity-sensitive measures before defining the incentive model. The measure selection criteria have not been updated since 2014 and do not include equity as a criterion.

An “all boats rise” approach is ineffective at addressing inequities

A major finding in the [Equity Impact Assessment](#) was that “setting targets across the entire membership can mask inequitable outcomes.” This finding was related to the [Disparity measure: ED utilization among members with mental illness measure](#), where inequities remained among priority groups. Despite existing evidence about inequities in mental health care, the measure focused on integration of physical and mental health care for all eligible members. Universal approaches for improving access have been proven to be ineffective at reducing disparities in behavioral health care.² Instead, tailoring care based on social needs and engaging racial and ethnic minority groups are likely to be more effective in decreasing the gap.

In his presentation at the National Academies of Science’s workshop on the [Ecosystem of Health Equity Measures](#), Speer described the difference between these approaches.³ In an “all boats rise” approach, which he calls incremental change, groups experiencing a disparity see an improvement. However, groups with social advantage also see an improvement. As such, the gap between groups does not diminish. In a tailored approach, which he calls restructuring, resources are equitably redistributed and the gap decreases. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.⁴

Figure 1: Incremental change vs. restructuring impacts on disparities³



OHA and the Committee need input from priority groups and to explore new solutions

A central recommendation of the Equity Impact Assessment is that we need to [use diverse knowledge and expertise](#), particularly from Medicaid members and priority groups impacted by measures. Unfortunately, the Quality Incentive Program was not designed to meaningfully engage Medicaid members and priority groups impacted by measures. To be meaningful, engagement must be at all levels of the program, including measure selection, implementation, evaluation and retirement.⁵ Meaningful engagement also means sharing decision-making power and addressing imbalances in power.⁶ These processes take time and relationship building. If engagement is not meaningful, it will lead to community fatigue and distrust.

The current program structure does not allow for the time nor processes needed to meaningfully engage community. Passed in 2023, [Senate Bill 966](#) directs OHA to conduct a study with community partners and explore new solutions on how to center equity in the Quality Incentive Program. [Senate Bill 966](#) also provides ongoing funds to continue this community engagement (see [Upcoming work](#)).

More supports are needed for equity-centered implementation

Supporting CCO implementation of incentive measures is outside of the scope of the CCO Quality Incentive Program. However, the Committee may consider what supports CCOs need to implement measures with equity principles when considering different benchmarking models. This could look like sharing learnings with other OHA teams supporting CCO implementation

(e.g., Transformation Center). It could also include providing CCOs adequate notice of new benchmarking models and time to establish needed partnerships and systems.

The Equity Impact Assessment was foundational to this analysis

While our understanding and efforts around equity have grown, there remain known gaps in the CCO Quality Incentive Program. These gaps need to be addressed to advance health equity in the CCO Quality Incentive Program. Based on the Equity Impact Assessment, **the following consideration is foundational to the recommendations made in this report.**

The Quality Incentive Program must engage community to move forward with equity initiatives. Equity-centered benchmarking must be developed in partnership with Medicaid members and groups most harmed by health inequities, as well as health care providers and other health system representatives. This includes, but is not limited to:

- Developing new measure selection criteria to identify measures advancing health equity, and
- Selecting methods for measuring disparities and benchmarking models.

Equity principles must be used when developing and implementing stratified benchmarking (see [Appendix B: Equity principles definition](#)). Without equity principles, stratified benchmarking is **not** equity-centered benchmarking.

Analysis

Scope of this analysis

To implement equity-centered benchmarking, we have identified two primary, longer-term goals. Both goals require community engagement and consultation with equity and inclusion experts. We are also assessing other states' processes and practices with equity measures and benchmarks.

Goal 1: Identify a framework for selecting equity measures.

Goal 2: Identify a methodology for choosing equity-centered benchmarks.

Within these goals, we need to determine feasibility based on data availability. As described in the [Background](#), data feasibility has been identified as a barrier to equity-centered benchmarking. **This analysis is one part of the work needed to support these goals.**

This analysis only focuses on data feasibility

This analysis will help guide discussions about stratified benchmarking within our **current** program requirements, data sources, measures and capacity. This report is **not** an analysis of a measure's ability to promote health equity, nor different benchmarking models.

Decisions about equity-centered benchmarking cannot be made on data feasibility alone. Meaningful community engagement is essential to developing and implementing equity-centered benchmarking. Further analysis is also needed for identifying measures that advance health equity. As stated above, stratified benchmarking is **not** equity-centered benchmarking if done without equity principles (see [Appendix B: Equity principles definition](#)).

We analyze downstream, or CMS Core Set, measures

With [Senate Bill 966](#), the CCO Quality Incentive Program is now split into two sets of measures: upstream and downstream. As described in [Background](#), upstream measures are focused on improving the social determinants of health (e.g., Meaningful language access). Downstream measures focus more on traditional medical care (e.g., Cervical cancer screening). As outlined by [Senate Bill 966](#), downstream measures must come from the CMS [Adult Core Set](#) and [Child Core Set](#). Downstream measures align with national reporting requirements.

For stratified benchmarking, the Quality Incentive Program has focused downstream, to reduce disparities within existing measures. Therefore, this analysis focuses on measures in the CMS Core Sets that we reported by stratified REALD groups in measurement year 2022. In measurement year 2022, we did not report all CMS Core Sets measures. Additionally, EHR measures are not included in this analysis, as we are unable to report their REALD data at this time.

Key data feasibility questions

Through reviewing previous meeting materials, workgroup findings and current CCO performance data, we have defined three major data feasibility topics. This analysis is laid out by these topics with examples and explanations.

While these feasibility questions may look familiar, we have a guiding question to frame our discussions: **How do we ensure that bonus dollars** are awarded in a way that **improves the**

equity and quality of care? This framing is intended to drive forward OHA's goal of eliminating health inequities by 2030. Here is an outline of the feasibility questions as they pertain to the CCO Quality Incentive Program.

- **Missing data:** How complete must data be to confidently measure CCO performance by stratified race and ethnicity groups?
- **Group sizes:** With small race and ethnicity groups, can we attribute year-over-year change to CCO performance? How can we reduce potential coercion in the CCO Quality Incentive Program?
- **Operations:** What agreements and processes do we need to operationalize REALD data in the CCO Quality Incentive Program?

Not all questions related to stratified benchmarking will be answered in this analysis. We call out these limitations throughout the report and highlight areas for future exploration. Learnings from this assessment will be shared with other OHA programs working on Medicaid quality.

This report is accompanied by a Data feasibility analysis tool

To help explore the questions above, we have developed a Data feasibility analysis tool. The tool includes CMS Core Set measures we reported by stratified REALD groups in measurement year 2022. This tool focuses on the following questions:

- **Missing data:** How does data missingness vary by measure? By CCO?
- **Group sizes:** How do denominator minimums impact priority race and ethnicity groups?

Missing data

With the newly launched Repository, we have made great strides in reporting CCO performance by stratified race and ethnicity groups. We also anticipate data quality and completeness will improve as the Repository gets more established.

However, missing data remain a challenge for rewarding bonus payments. In the CCO Quality Incentive Program, we reward CCOs annually for providing exceptional care to members. **How complete must data be to confidently measure CCO performance by stratified race and ethnicity groups?**

High rates of missing race and ethnicity data are a structural inequity

The systemic undercounting and erasure of communities of color is an example of structural racism built into government and public health databases.⁷ Researchers at the Urban Indian Health Institute and other organizations have used the term [data genocide](#) to describe the systemic and repeated erasures of American Indians and Alaska Natives in health surveillance systems. Lack of quality race and ethnicity data not only misrepresents and obscures the burden of disease among communities of color, but can also result in misinformed policies and inadequate resource allocation.⁸

The COVID-19 pandemic highlights the problems missing data can lead to. In July 2020, 56% of confirmed COVID-19 cases nationwide were missing race and ethnicity data. Even as government agencies worked to reduce missingness, between 2020 and 2022 race and ethnicity data were missing from 34% of all reported cases.⁹ Despite these high missing rates, inequities were identified nationwide.

The large amount of missing race and ethnicity data likely led to underestimates in the size of these inequities. For example, a study in Georgia found that even conservative adjustments for statistical biases associated with missing race and ethnicity data increased the incidence of COVID-19 by 130% for Black people, 170% for Hispanic people, and 160% for “other” (including Indigenous, Native Hawaiian and Pacific Islander) people.¹⁰ **Missing data led to significant underestimates of the health inequities experienced by different racial and ethnic groups during the COVID-19 pandemic.**

There is no gold standard for rates of missing data

As with all quantitative data, some level of missing data is expected. In statistics and epidemiology, there is no established cutoff for an acceptable rate of missing data that is considered valid. Statisticians have argued that a missing rate of 5% or less is inconsequential, and that statistical analysis is likely to be biased when more than 10% of data are missing.¹¹ However, the percentage of missing data cannot be the only basis for assessing data quality. In fact, the types of missing data may have greater impact than the amount of data missing.

Types of missing data can impact representation

With race and ethnicity, there are two types of missing data we are most concerned with. First is **missing at random**, which means that missing data can be explained or predicted by other fields in a dataset. For example, a member who does not speak English well may be less likely to respond to race and ethnicity questions because of language barriers. When data are missing

at random, imputation methods can be used. Imputation is when you replace missing data with substitute values based on other related fields in the dataset. The Repository uses imputation methods to fill gaps in race and ethnicity data. For details, please see the [REALD Implementation Guide](#) or the CCO Performance Metrics [Race and Ethnicity Reporting Methodology](#).

Second, we need to consider **missing not at random**, which means that missing data are only explained by the missing values themselves. In these cases, imputations from the same dataset are often not appropriate. There is some evidence that, in general, race and ethnicity data are missing not at random. For example, Branham et al. (2022) looked at trends in missing race and ethnicity data in HealthCare.Gov enrollment data after imputing with other data sources.¹² Imputed results indicated non-reporters were disproportionately Black or Hispanic, suggesting that these data are missing not at random. In another study, those who identify as Black, Hispanic, and Asian American and Pacific Islander were more likely than white-identifying individuals to skip race and ethnicity questions.¹³

Further analysis is needed to determine impacts of missing data on CCO members. We have not yet determined if there are patterns in missing race and ethnicity data for CCO members. As such, we do not yet know which groups are most impacted by missing data.

In this analysis, we combine blank, unknown and decline categories

In this analysis, we **report missingness** which includes three categories: blank, unknown and decline (see table below for definitions).

Missingness	Blank	Member does not have recorded responses to race and ethnicity questions or is not currently in the Repository.
	Unknown	Member responded “Don’t know” to race and ethnicity questions.
	Declined	Member responded “Don’t want to answer” to race and ethnicity questions.

Missingness rates in this analysis are higher than current Repository data

Data for this analysis came from the Repository in May 2023, when the Repository was still in early development. These are the same data used in the 2022 CCO Performance Metrics Dashboard. Since then, updates and improved imputation methods have been applied. In November 2023, missingness of race and ethnicity data was down to 12.6% for CCO members statewide (previously 22.8%). This analysis will be updated in summer 2024, after we receive refreshed Repository data.

For some measures, missingness rates vary greatly by CCO

As seen in the [tool accompanying this report](#), missingness among CCOs can vary greatly. For example, the Colorectal cancer screening measure is in the [NCQA health equity measurement framework](#) and [National Quality Forum \(NQF\) disparity-sensitive measure](#). At the maximum,

one CCO's missingness was 39.9% of their members. At the minimum, another CCO's missingness was 13.1%. Among primary care measures, Colorectal cancer screening has the largest range in missingness across CCOs (39.9%-13.1%=26.8%).

For each measure, we report the median missingness across CCOs. We use the median, instead of the average, because it is not affected by outliers. Median is a better measure of central tendencies among skewed data. For Colorectal cancer screening, the median CCO missingness was 28.2% as of May 2023.

Missingness rates also vary across downstream measures

The [tool](#) also shows how median CCO missingness varies across downstream measures. Variations are likely due to differences in measure specifications, specifically who is eligible for and counted in a measure. In general, CAHPS survey measures had the lowest median CCO missingness (8% to 11.8%), followed by maternal and perinatal health measures (9.6%). These measures use samples, not full count data like most measures. Measures using samples look at smaller groups, likely leading to their lower missingness. Among other topic areas, median CCO missingness ranged from 14.9% to 29.1% as of May 2023.

Measures with high missingness may signal underlying structural inequities. For example, differences in screening have led to higher incidences of colorectal cancer and mortality among non-Hispanic Black and African American populations compared with non-Hispanic white populations.¹⁴ High rates of missingness for Colorectal cancer screening may mask this and other inequities.

Missingness may change over time

Overall, we expect missingness to decline as REALD data collection becomes more established and part of the cultural norm in Oregon. However, there may be reasons that missingness would increase. For example, from 2014 to 2017, missingness of race and ethnicity data (using [federal data standards](#)) grew from 12% to 39% among CCO members. Political climate during the 2016 presidential election may have made members fearful of reporting their race or ethnicity to government entities. Increases in missingness, especially declines, may be an indicator of institutional distrust. As such, it would be valuable to monitor missingness at a CCO level on an ongoing basis. This assessment could examine what categories are driving missingness (missing, unknown or declines) and what race and ethnicity groups are most impacted.

OHA sometimes applies a reporting threshold to incentive measures

For some incentive measures, OHA requires CCOs to report on a minimum percentage of their members or data, called a reporting threshold. Reporting thresholds ensure that data are valid and representative of CCO members. In 2022, CCOs began collecting quantitative data for the [Meaningful language access measure](#). In the first year of this measure, OHA provided a hybrid sample to CCOs for reporting. CCOs were required to collect at least 80% of interpreter service data among this sample. One CCO did not meet this reporting requirement and, therefore, did not meet the measure.

[Minimum population thresholds](#) are also used for EHR measures. For EHR measures, the threshold is based on the total CCO membership, not a subset of CCO members eligible for the measure. OHA uses an incremental approach to increase the population thresholds for EHR

measures. This approach is intended to help CCOs build capacity for EHR reporting. Currently, most of our EHR measures are CMS electronic clinical quality measures (eCQMs). In recent years, OHA has set minimum population thresholds for eCQMs at 70% of all members.

Reporting thresholds should exclude declines or unknowns

REALD questions are voluntary, and OHA aims to respect members' responses. As such, declines ("Don't want to answer") and unknowns ("Don't know") are considered active member responses and should be considered separately from blanks. As stated in Oregon Administrative Rule ([OAR 950-030-0020](#)), responses to REALD questions must be self-reported and cannot be completed by a provider. Reporting thresholds for race and ethnicity data should not include declines or unknowns, so as not to pressure members into changing their responses. In November 2023, only 3.9% of CCO members statewide declined to answer race and ethnicity questions and 0.1% responded "Don't know." 8.6% of race and ethnicity data were blank for CCO members and is an opportunity to engage members.

Low missingness cannot be the only criterion for equity measures

Among primary care measures, the Chlamydia screening measure had the lowest median CCO missingness (18%) and the second-lowest range in missingness across CCOs (10.8%). However, the Chlamydia screening measure has known equity concerns. There is evidence that Black and Hispanic women are screened at higher rates than white women.¹⁵ Due to injustices like racism, misogyny and homophobia, testing for sexually transmitted infections has a long history of stigma and discrimination. This is a reminder that decisions about equity-centered benchmarking cannot be made based on data feasibility alone. The Committee needs community engagement and criteria for selecting measures that advance health equity.

Recommendations on missing data

For the following recommendations, we would expect race and ethnicity data to come from the REALD and SOGI Repository. CCOs could encourage collection of REALD data through written policies, provider trainings and sharing resources with patients. As new Repository data systems are implemented to collect REALD data (e.g., patient-facing registry), we anticipate data quality and completeness to continue improving for CCO members (see [Operations](#)).

Recommendation 1: Further analysis is needed to assess impacts of blank, unknown and declined (missingness) data on race and ethnicity groups. As staffing capacity allows, trends in missingness for race and ethnicity data should be monitored at a CCO and measure level on an ongoing basis.

Tentative recommendation 2: Based on projected decreases in Repository missingness, the Committee should select equity measures with median CCO missingness (blank, unknown and declined) no greater than 10%.^{c,d,e}

However, if further analysis can demonstrate that patterns in missingness do not negatively impact priority race and ethnicity groups, the Committee could select equity measures with higher median CCO missingness.

Recommendation 3a: To meet an equity measure, CCOs should be required to meet a reporting threshold, or report a set percentage of race and ethnicity data for their members within the measure. Reporting thresholds would exclude unknowns (“Don’t know”) and declines (“Don’t want to answer”).

Tentative recommendation 3b: Based on projected decreases of blanks in the Repository, the Committee should set reporting thresholds no lower than 90%.^f The Committee may also consider an incremental approach to increasing the reporting threshold over time.^g

^c We use the median, instead of the average, because it is not affected by outliers and is a better measure of central tendencies among skewed data.

^d As of November 2023, missingness statewide was 12.6%. We expect some measures to have median CCO missingness above and below this rate.

^e The Committee may also consider an incremental approach to decreasing the median CCO missingness used for selecting equity measures. For example, median CCO missingness could be 10% in the first year, then 8% in the second year and so on.

^f As of November 2023, 8.6% of race and ethnicity data were blank for CCO members statewide. We expect some measures and CCOs to have blanks above and below this rate.

^g For example, the reporting threshold could be 90% in the first year, then 92% in the second year and so on.

Group sizes

Restricting group sizes in demographic data has been used to systematically erase racial and ethnic groups.¹⁶ With the Repository, we have made great strides in increasing visibility of race and ethnicity groups in our reporting, while protecting confidentiality.

However, small group sizes remain a challenge for benchmarking. In our current program structure, we must reward CCOs annually for improving performance year-over-year. When measures have small eligible populations, changes can fluctuate dramatically year-over-year. These changes may be based on a handful of members or changes to the population. **With small race and ethnicity groups, can we attribute year-over-year change to CCO performance?**

Additionally, concerns about potential provider and institutional coercion have been raised for some incentive measures. The U.S. has a long history of health care providers and systems coercing marginalized racial and ethnic groups when making health care decisions. **How can we reduce potential coercion in the CCO Quality Incentive Program?**

We prioritize disaggregated data because it unmask inequities

Disaggregated data is a core principle of REALD legislation ([House Bill 2134](#)). We mask inequities when we report race and ethnicity groups in broader aggregate categories. Disaggregated data better prepares us to address the root causes of inequities and meet the unique needs of our communities.

Oregon is one of the first states to collect and publish data on Pacific Islanders from countries affected by the Compact of Free Association (COFA) treaty. The COFA treaty is the result of U.S. military occupation, atomic bomb testing and ballistic military exercises that contaminated much of the environment and impacted the health of generations.

The treaty went into effect in 1986 and promised access to Medicaid coverage. However, COFA citizens lost their Medicaid access in 1996 due to a drafting error in a welfare reform package.¹⁷ This has contributed to high rates of uninsurance, poor health outcomes and untreated chronic disease.¹⁸ Medicaid coverage was not reinstated for these communities until December 2020. It took nearly 25 years and more than 20 attempts in Congress to reinstate this coverage.

Disparities among COFA citizens are minimized when they are rolled up into the broader Native Hawaiian and Pacific Islander data. Additionally, using aggregate Native Hawaiian and Pacific Islander data does not allow us to recognize, reconcile and rectify the historical and contemporary injustices COFA citizens face.

Priority groups are those who face contemporary and historical injustices

We report race and ethnicity data as proxies for exposure to systemic racism. In this analysis, we use the [Equity Impact Assessment's](#) definition of priority race and ethnicity groups: Black, Indigenous, People of Color (Asian, Pacific Islander and Latino/a/x) and American Indian and Alaska Native people.

Nationally, groups with fewer than 30 members are suppressed

The [National Committee for Quality Assurance \(NCQA\)](#), the steward for most of our downstream measures, considers denominators less than 30 too small to report a valid rate. As such, [NCQA excludes groups with fewer than 30 members](#) from health plan-level and stratified race and ethnicity reporting. [CMS also suppresses rates](#) for race and ethnicity groups with less than 30 members due to reliability concerns.

Some measures have very few eligible members

Maternal health measures have well-known and well-documented racial inequities. As stated in the [Missing data](#) section above, maternal health measures have some of the lowest median CCO missingness among downstream measures (9.6%). This is likely because maternal health measures only report on a hybrid sample of pregnant members. This means that OHA identifies live birth deliveries from claims data and provides CCOs with a random sample of members for chart review. CCOs are only required to report on this random sample, which can only have [up to 411 members per CCO](#). Services for maternity care are bundled. Because of this, some services would be missed if we only reviewed claims. Chart review of a sample allows us to capture maternity care services that would otherwise be missed within claims data for the entire population.

In 2022, only eight CCOs had a priority group with 30 or more members for maternal health measures. These priority groups were:

- African American (Health Share only)
- American Indian (AllCare and Health Share only)
- Mexican

As with all CMS Core Set measures, specifications and sampling methods are determined by national measure stewards and cannot be altered. OHA cannot increase the sample size nor oversample priority groups for the maternal health measures in the CMS core sets.

The Committee does not require denominator minimums

Metrics and Scoring Committee has twice decided to [not omit measures with small denominators](#) (i.e., measures with fewer than 30 members) in the incentive program. The Committee stated that CCOs are expected to provide quality care for all members, and that the program is not based on statistical representation. Sufficient denominator size is a potential criterion within the [Metrics and Scoring Committee's current measure selection criteria](#), but it is not a requirement.

An example of an incentive measure with a small eligible population is the Assessment of children in ODHS custody. This is an upstream measure focused on providing coordinated care quickly to children and youth in foster care. This measure has been incentivized in all years of the CCO Quality Incentive Program and denominators vary greatly across CCOs. In 2022, CCOs ranged from having 10 to 283 eligible youth for this measure. In 2021, the range was five to 295 eligible youth. Even though there are few eligible members for this measure, it has a major impact on the health and well-being of a vulnerable population.

Incentive measures may promote coercion

In the past, CCOs have raised concerns about incentive measures promoting provider and institutional coercion. For the [Emergency Outcome Tracking Program CCO COVID-19](#)

[vaccination \(EOT\) measure](#), CCOs advocated to only set improvement targets for groups with at least 50 continuously enrolled members. CCOs stated this was to prevent harassing individuals in smaller race and ethnicity groups.

Effective contraceptive use is another example of a measure where CCOs raised [concerns about incentivizing contraceptive coercion by health care providers](#). This concern was first brought to Metrics and Scoring Committee in August 2016. In 2017, Metrics and Scoring Committee expanded the measure to include young women ages 15-17 years. Effective contraceptive use was dropped as an incentive measure in 2020, based on the measure's inclusion of women not at risk of unintended pregnancy and equity concerns.

Social and historical context are especially important when considering coercion.

Both examples above highlight measures with contemporary and historical injustices. Vaccine hesitancy is in part contributed to by long-standing and earned distrust in government and medical institutions.^{19,20} In the U.S., we have a well-documented history of forced sterilization and contraceptive coercion by providers among women of color.^{21,22}

Recommendations on group sizes

For the following recommendations to be successful, **the Committee must first work with community** to:

- Develop new measure selection criteria that identify measures advancing health equity
- Select methods for measuring disparities and benchmarking models.

In the [Upcoming work](#) section, we highlight supports for engaging community on these topics.

Recommendation 4: Stratified benchmarking must include disaggregated race and ethnicity data. Aggregate categories may be considered as an additional element but cannot be the only data used as it masks inequities.

Recommendation 5: Coercion is a universal concern in all aspects of incentive measures and cannot be solely addressed by denominator minimums. The Committee should explore other practices, for example, considering potential coercion during equity measure selection and implementation.

Recommendation 6a: The Committee should **select equity measures** that have sufficient denominator sizes unless a measure demonstrates a compelling reason not to follow this standard.

Denominator minimums must be set at a level that does not further erase priority populations. Current national reporting standards align with this requirement (30 members) but may change in the future.

Recommendation 6b: Equity benchmarks should **only apply to groups** with at least 30 members unless a measure demonstrates a compelling reason not to follow this standard.

Denominator minimums must be set at a level that does not further erase priority populations. Current national reporting standards align with this requirement (30 members) but may change in the future.

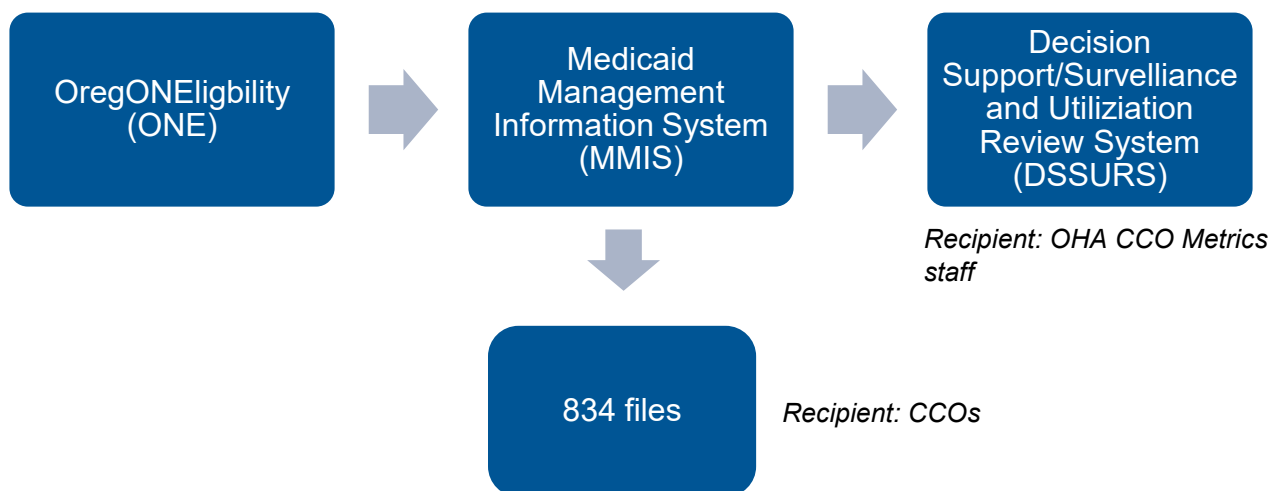
Operations

Currently, the Quality Incentive Program is a pilot for using Repository data. As part of this pilot, REALD data are only provided for annual reporting purposes. This means that agreements and processes are not currently in place to use Repository data for incentive payments. Stratified benchmarking would require the program to receive Repository data on a more regular and ongoing basis. It would also require program staff to produce stratified data on a regular and ongoing basis, so that CCOs could see if they are on track to meet equity measures. **What agreements and processes do we need to operationalize REALD data in the Quality Incentive Program?**

Previously, demographic data only came from eligibility and enrollment systems

Historically, CCOs have received demographic data from OHA through eligibility and enrollment processing. These demographic data originate in OregONEligibility (ONE), the state's system to enroll in Oregon Health Plan and other public benefits. ONE data are then passed to the [Medicaid Management Information System \(MMIS\)](#), which processes claims, eligibility and enrollment data. MMIS eligibility and enrollment data are passed directly to CCOs through 834 files. 834 data are identical to MMIS data. Eligibility and enrollment data in MMIS are then passed to the Decision Support/Surveillance and Utilization Review System (DSSURS) through overnight batch processing. DSSURS is the data source OHA staff uses to produce and analyze CCO performance measures. MMIS, 834 and DSSURS are catch and replace systems, only receiving updates when a change has occurred. The latest updates override old records in these systems, even if the demographic information is changed from a reported category to an unknown, missing or declined category.

Figure 2: Historical flow of demographic data to CCOs and OHA CCO Metrics staff



The Repository links together many different data sources

In 2023, OHA launched the REALD and SOGI Repository, as directed by [House Bill 3159](#). The Repository is the first effort by any state government to develop a relational database containing

the most complete demographic information possible. Below is a summary of the different data sources ingested into the Repository.

Figure 3: Data sources in the REALD and SOGI Repository



As of May 2023, the Repository contained around 19.4 million unique records. Roughly 90% of those records came from ONE, with 10% of records coming from data sources in OHA’s Acute and Communicable Disease Prevention (ACDP) Section. OHA is working to ingest additional data sources, as well as build other systems for data collection. This includes a new patient-facing registry, which will collect REALD and SOGI data directly from members. OHA is prioritizing data streams that would improve completeness of demographic data for Medicaid members.

Providers and payers are now required to submit REALD data annually

In addition to the Repository, [House Bill 3159](#) ushered in new requirements for providers and payers to submit REALD and SOGI data at least annually. Providers first began collecting

REALD data in 2020 for COVID-19 encounters, as directed by [House Bill 4212](#). This was a temporary directive that expired at the end of 2022. [House Bill 3159](#) was passed in 2021, continuing and expanding these data collection requirements.

CCOs now receive Repository data, but may need time to operationalize

Starting in September 2023, CCOs now receive flat files twice a month from the Repository. Repository data are received separately from 834 files. CCOs have integrated 834 files into their workflows and security protocols. CCOs have requested that Repository data be funneled through the 834 files. Currently, that request is outside the scope and capacity of the Repository.

In November 2023, CCOs participated in a REALD and SOGI Data Analytic Institute hosted by OHA. This institute gave an overview of Repository data sources and cleaning processes. It also gave an overview of how to work with Repository data by topic area (e.g., race and ethnicity). CCOs expressed the need for ongoing learnings on how to best use REALD and SOGI data. They also expressed the need for time to incorporate Repository data into their existing workflows.

For incentive measures, CCOs receive quarterly updates on their progress

To help CCOs see if they are on track to meet incentive measures, OHA provides CCOs a quarterly data dashboard. Currently, OHA has an agreement with NCQA to produce their Healthcare Effective Data and Information Set (HEDIS) measures, many of which are in the CMS Core Sets. Moving forward, any data vendor for the CCO Quality Incentive Program must be HEDIS-certified, meaning they have met NCQA standards for measure production.

In future years, OHA has plans to contract with a HEDIS-certified vendor to calculate and produce CCO-facing quarterly dashboards. OHA intends to include ingesting and calculating stratified race and ethnicity results in this new vendor contract.

At this time, OHA cannot ingest and calculate results stratified by race and ethnicity groups on a quarterly basis. OHA currently does not have the staff nor resources to do this data processing. As such, CCOs would have to track their own progress on stratified benchmarks. This would be an additional reporting burden, especially during annual validation with OHA staff.

OHA and measure stewards notify CCOs of upstream measure changes in advance

In general, OHA and partnering measure stewards notify CCOs of upcoming changes to upstream measures at least one year in advance. This process is based on CCO feedback stating they need adequate time to operationalize changes. This may include updating data systems and/or workflows, as well as establishing the partnerships necessary for successfully implementing a measure.

Recommendations on operations

Meaningful change can take time to implement, especially when data systems are involved. Therefore, we recommend:

Recommendation 7: Do not implement stratified benchmarking until a HEDIS-certified vendor (or other staffing resources) can produce stratified race and ethnicity data in CCO-facing quarterly dashboards.

Recommendation 8: The Committee should communicate early with CCOs about equity measures and benchmarking models selected for stratified benchmarking.

Upcoming work

In 2023, the Oregon Legislature passed [Senate Bill 966](#). Senate Bill 966 represents a shift in the CCO Quality Incentive Program to center equity. This shift is in alignment with OHA's goal of eliminating health inequities by 2030. Recommendations in this report are expected to be in coordination with upcoming work for Senate Bill 966.

2024 study will focus on centering equity in the Quality Incentive Program

[Senate Bill 966](#) directs OHA to conduct a study on program changes and committee structures so that the Quality Incentive Program is primarily focused on health equity. The study will engage community partners, CCOs and providers. This study is due to the Legislature in September 2024 and will focus on three topic areas:

- **Governance structure:** How can communities experiencing health inequities be centered in the program so that it advances health equity?
- **Measure and benchmark selection practices:** What changes could be made in selection practices, so that the program is primarily focused on addressing health inequities?
- **Program operations:** What changes could be made to payment structure and program timeline, so that the program is primarily focused on addressing health inequities?

These topics will be explored broadly and in relation to how they intersect in furthering or hindering health equity. Following the study, there will likely be areas that need more in-depth exploration. For example, this study will not provide specific recommendations on methods for measuring disparities nor benchmarking models.

We have two contracts that can assist with stratified benchmarking

In addition to the study, [Senate Bill 966](#) provided additional funding for the CCO Quality Incentive Program to advance equity initiatives. First, we will have an ongoing contract for community engagement. This includes culturally specific outreach efforts, such as developing and translating materials, conducting focus groups in multiple languages and more. This contract could be used to engage community on how to identify measures that advance health equity. Second, we have funds for a limited duration contract to explore methods for measuring disparities and benchmarking models. This is a one-time contract for a consultant to work with OHA staff and the Committee.

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Appendix B: Equity principles definition

It is important to have a shared understanding of equity principles, which may mean different things to different people. OHA's goal of eliminating health inequities by 2030 is driven by our [agency's health equity definition](#). Equity principles are the practices we use to realize this goal. Equity is a practice and a discipline, not a one-time outcome. How we do equity work matters.

For the purposes of this report, we define equity principles as below. This is **not** a comprehensive list of practices for achieving health equity, but a jumping-off point.

Our understanding of equity principles may change in the future, and after engagement with community. We expect to change and refine our practices as we learn more about the health inequities our communities face.

When identifying and implementing equity solutions, we will:

- Focus on power and structural dynamics that determine policy and underlying social determinants of health.
- Shift resources and power to communities that have been excluded and marginalized.
- Recognize the role of historical and contemporary oppression and structural barriers that communities in Oregon face.
- Engage a wide range of partners representing diverse constituencies and viewpoints.
- Involve affected communities as partners and leaders in change efforts.
- Engage partners in a continuous process at all levels of program development and implementation.
- Engage in critical self-reflection to continually examine one's identity and relationship to systems of oppression and privilege.
- Dedicate time and resources to build capacity and infrastructure required to advance health equity.

Appendix C: Previous meeting materials

June 2015 Metrics and Scoring Committee	<p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/June-19-2015-Draft-Minutes.pdf#page=2</p>
April 2016 Metrics and Scoring Committee	<p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/MS%20April%202016%20Notes_v2.pdf#page=2</p>
April 2016 CCO Technical Advisory Group	<p>Slides: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsTAGMeetingDocuments/April%2028,%202016%20Presentation.pdf#page=21</p> <p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsTAGMeetingDocuments/April%2028,%202016%20Minutes.pdf#page=4</p>
May 2016 Metrics and Scoring Committee	<p>Slides: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/May-20-2016-Presentation.pdf#page=8</p> <p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/May%2020,%202016%20Draft%20Minutes.pdf</p>
June 2016 Metrics and Scoring Committee	<p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/June-17-2016-Minutes.pdf</p>
August 2016 Metrics and Scoring Committee	<p>Slides: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/August-19-2016-Presentation.pdf#page=17</p> <p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/August-19-2016-Minutes.pdf#page=3</p>
January 2017 Metrics and Scoring Committee	<p>Equity measure proposal: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Equity-proposal-Jan-2017.pdf</p> <p>Minutes: http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Minutes%20-%20January%2020,%202017.pdf#page=2</p>