2025 Quality Pool Methodology

(Reference Instructions)

Contents

Background

The Oregon Health Authority (OHA) has established a Quality Incentive Program to provide financial incentives to reward exceptional CCO performance and continuous quality improvement on a set of access, quality, and outcome metrics (“incentive metrics”) selected annually by the Metrics & Scoring Committee. Through this program, CCOs achieve financial rewards if they meet specific performance

benchmarks or improvement targets. The funding for the program is from the Quality Pool.

This model rewards CCOs for outcomes, rather than utilization of services. This stimulus is one of several health system transformation mechanisms for achieving Oregon's vision for better health, better care, and lower costs, and eliminating health inequities.

Per CCO contracts, this document provides further instructions about the methodology for distributing the Quality Pool.

Quality Pool Funding

The total funding available for the 2025 CCO Quality Incentive Program "Quality Pool" is calculated as **3.00**% of aggregate capitation and maternity case rate payments made to all CCOs for calendar year 2025 services paid through March 31, 2026. A 2.0% MCO tax gross up was applied to the Quality Pool payment estimate, which was in turn based on capitation payments net of the MCO tax.

CCO Eligibility for 2025 Quality Pool Funds

Each CCO will be eligible for a maximum amount of CCO Quality Incentive Program Quality Pool funds totaling up to 3.00% of the actual paid amounts to the CCO for calendar year 2025 as stipulated above.

In November 2025, OHA will publish initial **estimates** of the 2025 funds CCOs would receive if they earn the full 3.00% of calendar year 2025 payments (**note these are estimates and subject to change**). Final estimates of 2025 amounts will be posted online no later than April 30, 2026.

The estimates will be available online at:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Actual payments disbursed for 2025 performance will vary, as they will be based on CCO performance and final amount available in the Quality Incentive Program Quality Pool.

If a CCO's maximum amount of Quality Pool funds is less than one million dollars, OHA will set a floor so that each CCO shall be eligible to potentially earn at least one million dollars from the Quality Pool if they achieve the necessary benchmarks and improvement targets according to the methodology outlined below. In addition to these funds, CCOs may share in any remaining Challenge Pool funds as described below.

Quality Pool Timing

Funds from the Quality Pool will be distributed on an annual basis with the calendar year 2025 payment made by June 30, 2026.

Quality Pool Distribution

CCO Quality Incentive Program Quality Pool award amounts will be determined through a two-stage process. In stage one, the maximum amount of dollars for which a CCO is eligible will be allocated based upon the CCO achieving the thirteen 2025 CCO incentive measures and targets identified by the Metrics & Scoring Committee available here.

In stage two, any remaining CCO Quality Incentive Program Quality Pool funds that were not disbursed in stage one based on performance on the full incentive measure set will be distributed to CCOs that meet criteria on a subset of four Challenge Pool measures selected by the Metrics & Scoring Committee

Stage One: Distribution Based on Performance on all 13 Quality Incentive Measures

The portion of available funds that a CCO receives is based on the number of measures on which it achieves either an absolute benchmark or its improvement target as identified by the Metrics & Scoring Committee. The benchmarks are the same for all CCOs, regardless of geographic region and patient mix.

The 2025 benchmarks and improvement targets are online.

CCO performance on these measures is treated on a pass/fail basis and all measures are independent from one another.

Payment Calculation – Stage 1

As a CCO achieves more benchmarks or improvement targets on the 13 measures, it receives a higher payment (up to 100% of its Quality Pool - see Quality Pool Distribution table below).

To receive 100 percent of the Quality Pool funds for which it is eligible, a CCO must meet or exceed the benchmark or the improvement target on at least 75 percent of the incentive measures (10 of 13 measures).

CCOs earn a lesser amount if they do not achieve at least 75 percent of the measures, as outlined in Table 1 below:

Table 1. Quality Pool Distribution

Number of Measures Achieved	Quality Pool Amount
At least 10	100%
At least 9	90%
At least 8	80%
At least 7	70%
At least 6	60%
At least 5	50%
At least 4	40%
At least 3	30%
At least 2	20%
At least 1	10%
0	No quality pool payment

Stage Two: Challenge Pool Distribution

In the second stage, OHA has elected to create the Challenge Pool, funds for which consist of any remaining CCO Quality Incentive Program Quality Pool funds that have not been allocated to CCOs in stage one. These Challenge Pool funds will be distributed to CCOs that qualify based on a subset of four incentive measures selected by the Metrics & Scoring Committee:

1. Child and Adolescent Well-care Visits: Ages 3-6
2. Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
3. Prenatal and Postpartum Care: Postpartum Care Rate
4. Preventive Dental or Oral Health Services: Ages 1-5 and 6-14 (must achieve target for both age ranges)

On completion of this Challenge Pool distribution stage all CCO Quality Incentive Program Quality Pool funds will be distributed; no funds will roll over into a subsequent year.

OHA will determine the number of instances in which CCOs have achieved each of the four Challenge Pool measures.

OHA will then calculate a "base payment" by dividing the Challenge Pool funds into equal portions equivalent to the total number of Challenge Pool measures met. For example, if 12 CCOs achieve the Diabetes HbA1c Poor Control measure, nine achieve the Preventive Dental Assessments measure, three achieve the Postpartum Care measure, and six achieve the Child and Adolescent Well-Care Visits measure, then the Challenge Pool will be divided into 30 (i.e., 12+9+3+6) equal portions (the "base payment").

Assume $1,000,000 is remaining after Phase One distribution. Using the example above, the Challenge Pool is divided into 30 equal portions, resulting in a base payment of $33,333.33. The base payments are then adjusted for average monthly enrollment.

OHA will then calculate the Challenge Pool payments for each CCO that achieved the measure by adjusting the base payment using the CCO's average member months in 2025 (see Table 2 for example). This calculation will be performed separately for each of the four measures.

Table 2. Example of Challenge Fund Distribution for Well-Care Visits Measure

CCO Name	Base Payment	CCO Member Months	Mean MM	CCO's ratio of MMs to Mean MM	Adjusted challenge pool payment. (Base payment multiplied by CCO ratio of MMs to Mean MMs)
CCO A	$33,333.33	29,588	20,275	1.459	$48,633.33
CCO B	$33,333.33	23,343		1.151	$38,366.66
CCO C	$33,333.33	22,788		1.124	$37,466.66
CCO D	$33,333.33	18,014		0.889	$29,633.33
CCO E	$33,333.33	16,394		0.808	$26,933.33
CCO F	$33,333.33	11,521		0.568	$18,933.33
Total	$200,000.00	121,648			$200,000.00

This calculation is repeated for the three remaining Challenge Pool measures.

For More Information

Quality Incentive Program documentation including 2025 measures, benchmarks and improvement targets, measure specifications, improvement target methodology, and more: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Metrics & Scoring Committee
http://www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx

Contact us at: metrics.questions@odhsoha.oregon.gov

Appendix A: Additional Program Operations

Improvement Target Adjustments for Unplanned, Significant Membership Increases

Background

- During Medicaid expansion in 2014, CCOs expanded between 45% to over 100% during a planned addition of many new members; no changes were made to improvement targets, benchmarks, or continuous enrollment criteria for measure calculations.
- In any single 12-month year, under normal fluctuation conditions, CCO membership goes up and down between 1 and 3% from month to month.
- In 2018, when members switched CCOs after FamilyCare CCO closed its Medicaid line-of-business, Health Share of Oregon had its membership increase by about 54%; Willamette Valley Community Health by about 6%; and Yamhill CCO increased by about 100 people.

Given the tremendous, previously unplanned increase in membership experienced by Health Share of Oregon in just one month, in July 2018 the Metrics & Scoring Committee voted to allow a CCO experiencing at least a 45% increase in membership (the lower extreme experienced under Medicaid expansion in 2014) to have a single year adjustment to its improvement targets. In such instances, the Committee decided the CCO's improvement targets from the previous year would be carried forward (holding expectations steady during the upheaval caused by such a significant membership increase).

Parameters

The unplanned 45% or greater increase must occur either within the same measurement year or over a twelve-month period that crosses over two consecutive measurement years as follows:

Any 45% or greater month-to-month increase within the measurement year will result in improvement target adjustments within that measurement year.

- E.g., Jan. 2025 – March 2025, 45% increase in enrollment = adjusted 2025 improvement targets.

- E.g., March 2025 – April 2025 45% increase in enrollment = adjusted 2025 improvement targets.

Any 45% or greater point-in-time increase over a twelve-month period that crosses two consecutive measurement years will result in improvement target adjustments for the latter measurement year.

- E.g., Feb. 2025 – Jan. 2025, 48% increase in enrollment = adjusted 2025 improvement targets.
- E.g., Nov. 2025 – Oct. 2025, 48% increase in enrollment = adjusted 2025 improvement targets.

Limitations

The improvement target adjustment described above will only occur in instances of **unplanned** membership increases for an **existing** CCO. For such adjustments, OHA considers an unplanned increase to occur if a CCO does not have at least 180 days' notice to plan for the increase. An existing CCO is a CCO that has been in operation and provided services for Oregon Health Plan members for at least six consecutive months within the same service area.

The improvement target adjustment described above will **not occur** for planned membership increases (meaning those about which a CCO has known for at least 180 days) or for new CCOs. This is because, by definition, membership increases are planned when a new CCO begins operations. If a CCO is established or takes a new service area at the conclusion of a procurement period (e.g., the new 2020 CCO contracts resulting from the CCO 2.0 procurement of 2019), the CCO has planned for new membership. In instances such as this, no adjustments are made to the improvement target methodology.

Operations

- As they are best placed to monitor membership changes and impacts on the ground, CCOs are responsible for alerting OHA of any 45%+ membership increases within a given 12-month period (whether within the same measurement year or across two consecutive measurement years) and for which the CCO would like improvement target adjustments.

- The source of data for membership increases will Page 1 of the Medicaid Enrollment Report published by OHA here.
- If a CCO seeks adjustments to improvement targets, adjustments will be made for all measures (i.e., a CCO may not choose to have adjustments to targets for only some measures).
- CCOs must alert OHA no later than February 1st following the measurement year by submitting the request via email to metrics.questions@odhsoha.oregon.gov.
- As decided by the Metrics & Scoring Committee, if the CCO meets the criteria for an adjustment to its improvement targets, OHA will carry forward the affected CCO's improvement targets from the previous year (holding expectations steady).

Additional Considerations

In March 2020 the Metrics & Scoring Committee also noted that CCOs can apply for additional, single-year improvement target reassessment on a case-by-case basis for other types of membership changes, for example, a significant *decrease* in membership that would have a deleterious impact on measure performance, etc. CCOs should contact OHA at metrics.questions@odhsoha.oregon.gov to take their concerns to the Committee.

Measures with Denominator of Zero

Background

There may be times when a CCO may find itself with a denominator of zero for a CCO incentive measure. As the unit of analysis for measures varies (members, visits, member months, etc.), a denominator of zero can occur for numerous reasons, including continuous enrollment criteria excluding some members from measure calculations. In such cases, it is not possible to assess CCO performance on the measure with adherence to the measure specifications.

The issue of small denominators was initially discussed by the Metrics & Scoring Committee in April and June 2013, at which time the Committee considered a recommendation from OHA and the CCO Metrics Technical Advisory Group to omit measures with small denominators (n<30) from the quality pool calculation (i.e., 75%

of X measures must be met to earn 100% of the quality pool; subtract measures with small denominators from X for a given CCO). See here for recommendation details and here for meeting minutes with the Committee decision.

The Committee did not approve this recommendation, instead directing OHA to continue including measures with small denominators in quality pool calculations. The rationale for the decision was that CCOs are expected to provide quality care for all members, and that the program is not based upon statistical representation. However, at that time the Committee did not weigh in on how to treat measures in which a CCO has a denominator of zero, specifically.

In March 2020, however, the Metrics & Scoring Committee discussed the specific instance in which a CCO has a denominator of zero for a measure. At this time, the Committee decided to allow a change to the payment calculation in such instances. In these instances, such measures will be excluded from the quality pool calculation (i.e., 75% of X measures must be met to earn 100% of the quality pool; subtract measures with denominators of zero from X for a given CCO).

At its March 2020 meeting the Committee also discussed how to set an improvement target for the year following a CCO having a denominator of zero for a measure. The Committee decided that in such instances the median of all CCO statewide performance would be used as the baseline for the following year's improvement target calculation.

Operations

Claims and Hybrid Measures

- As it calculates claims and hybrid measures, OHA will monitor whether a CCO is likely to have a denominator of zero for any incentive measures in a given measurement year.
- OHA will alert a CCO that it will have a measure excluded from calculations no later than April 30th following the measurement year, though CCOs can alert OHA to any concerns about this issue at any point in the measurement year by emailing metrics.questions@odhsoha.oregon.gov.

EHR-based Measures

- As they are best placed to monitor denominator qualifications for EHR-based measures, CCOs are responsible for alerting OHA of any EHR-based measures for which there is a denominator of zero.
- CCOs must alert OHA of any EHR-based measures with a denominator of zero with the data submission for EHR-based measures, generally on or around April 1st following the measurement year.

As decided by the Metrics & Scoring Committee, any measures with a denominator of zero after the formal validation period ends in May following the measurement year will be excluded from the program calculation when OHA calculates the proportion of quality pool funds a CCO earns (75% of X measures must be met to earn 100% of the quality pool; subtract measures with denominators of zero from X for a given CCO) – see Table 1 above.

In terms of improvement targets for the subsequent year, the median of all CCO statewide performance will be used as the baseline for the following year's improvement target calculation.

Measure Rebaselining

Background

When incentive measure specifications change significantly from one year to the next, OHA may recalculate the baseline year data and resulting improvement targets using the current measurement year specification. This process is intended to create a fair opportunity for CCOs to meet their improvement targets while maintaining the integrity of the benchmarks and improvement target methodology set by the Metrics & Scoring Committee.

Administrative (claims-based) measures

For claims-based CCO incentive measures, OHA has the discretion to recalculate the baseline year data using current measurement year specifications. In general, the following criteria will be used to determine when OHA will use the recalculated baseline (rebaselined) results to calculate all CCO improvement targets.

- Statewide CCO average results change by 1 percentage point or more
- Any CCO result changes by 3 percentage points or more

OHA will publish rebaselined results and CCO improvement targets in the quarterly CCO metrics dashboards.

Hybrid measures

For measures that use a hybrid methodology, OHA will review measure specifications for the following year prior to issuing the chart review sample for the current year. If OHA determines that specification change(s) substantially alters the measure logic, CCOs will be required to report two sets of data during chart review for the current year: one set of data using current measurement year specifications and another set of data using the following year's specifications. OHA will then use the data corresponding to the following year's specifications in order to set the baseline and improvement targets for the following year.

For example: For the 2025 measurement year, OHA will release samples for hybrid measures on January 30, 2026, and CCOs must complete chart review for sampled mesaures by March 31, 2026. If OHA has determined that specifications for the next measurement year (2026) are significantly different from 2025 specificatons and rebaselining is necessary, then CCOs will be required to report 2025 data using both 2025 *and* 2026 specifications duirng the chart review period. The version reported using using 2026 specifications would be used for measurement year 2026 baseline and improvement target setting only.

EHR-based measures

Please refer to Appendix C: Rebaselining Electronic Health Record (EHR) Measures Policy in the Year Thirteen (2025) EHR guidance documentation.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Email metrics.questions@odhsoha.oregon.gov.

Health Poliicy and Analytics Division
Quality Incentive Program
421 SW Oak Street
Portland, Oregon 97204

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics.aspx