Health Policy and Analytics Division

CCO Quality Incentive Program

CCO Metrics 2024 Final Report

Executive summary

For 2024, Oregon's Coordinated Care Organizations (CCOs) collectively earned over $325 million through the CCO Quality Incentive Program, a pay-for-performance program that rewards quality of care.

The goal of the CCO Quality Incentive Program is to improve the quality of care for Oregon Health Plan (OHP) members. To earn bonuses from the CCO Quality Incentive Program, CCOs must provide better and better care each year. Bonuses are on top of monthly payments that cover the cost of care, called per-member per-month (PMPM). In 2024, the total CCO Quality Incentive Pool was set at 4.25% of that year's aggregate PMPM to CCOs.

The size of the Quality Pool has grown significantly over the past decade as CCO capitation payments and Medicaid membership have increased. In 2015 the total Quality Pool was approximately $168 million and by 2024 it was $325 million. This reflects Oregon's long-standing commitment to tying payment to performance.

On average, CCOs slightly improved on most incentive measures from 2023 to 2024.

CCOs showed the most improvement on Behavioral Health measures from electronic health records (EHR), particularly Screening, Brief Intervention and Referral to Treatment (SBIRT) and Cigarette Smoking Prevalence. However, individual CCOs also had the greatest increases and decreases with EHR measures from 2023 to 2024. On average, CCOs also slightly improved on measures related to Dental and Oral Health, Kindergarten Readiness and diabetes.

CCOs have continued room for improvement on two measures.

First is Initiation and Engagement of Substance Use Disorder Treatment, which is supported by the Statewide Performance Improvement Project. Second is Childhood Immunization Status (Combo 3), in which the 2024 results include services going back to 2022. Disruptions in care during the COVID-19 pandemic likely still affected 2024 child immunization rates. For both of these measures, CCO statewide performance held steady from 2023 to 2024.

In 2024, benchmarks rose to more aspirational levels than prior years, but CCO-specific improvement targets remained less challenging.

Incentive measures and their goals are selected by the Metrics and Scoring Committee. The COVID-19 pandemic upended the committee's usual approach, resulting in less challenging goals from 2021 through 2023. For many measures, the Metrics and Scoring Committee selected more aspirational benchmarks in 2024 compared with 2023. However, the Metrics and Scoring Committee continued to keep CCO-specific improvement targets low. For nearly all measures, CCOs only had to improve by 1 to 2 percentage points from the prior year.

Upstream measures addressing the social determinants of health build toward quantitative reporting for more members.

CCOs continued capacity-building for the Social Determinants of Health (SDOH): Social Needs Screening and Referral measure. Starting in 2025, CCOs will report screening and referral activities for housing insecurity, food insecurity and transportation needs on a sample of members. Additionally, this was the final year of System-Level Social-Emotional Health for Young Children before being replaced by a measure tracking the percentage of children (ages 1-5) receiving a social-emotional issue-focused intervention or treatment service.

In 2024, Meaningful Language Access (Health Equity) moved from reporting on visits for a sample of members, to all members who self-identified as needing an interpreter. In 2024, CCOs statewide reported providing qualified and certified interpreters for 14.6% of visits. To account for continued data collection difficulties, OHA recalculated CCO-specific improvement targets using lower baselines. This recalculation led to five CCOs meeting the measure that otherwise would not have.

Table of Contents

Published September 23, 2025

About this report

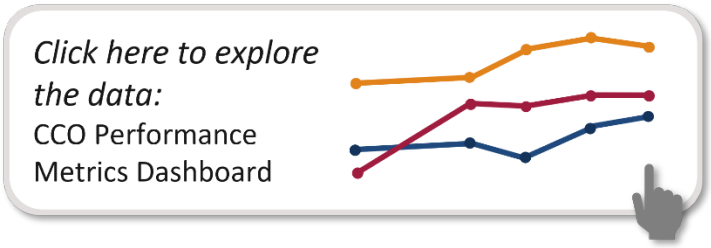
Measuring quality and access to care, and holding CCOs accountable to key metrics, is a cornerstone of Oregon's health system transformation. The CCO Quality Incentive Program rewards exceptional care and continuous quality improvement by CCOs, which serve over one million Oregonians on the Oregon Health Plan (Medicaid).

This report is a summary of performance by Oregon's coordinated care organizations (CCOs) in 2024. It includes highlights of statewide performance and snapshots of CCOs' performance and payments for incentive metrics. It also highlights program changes and events in 2024.

As OHA continues to steward public resources in the face of evolving federal policy and state budgetary pressures, the agency remains committed to preserving the core values of the quality program—namely, rewarding meaningful outcomes, advancing health equity, and ensuring local flexibility. In the coming year, OHA will work with partners to examine how best to sustain and strengthen these goals while maintaining program solvency and system-wide accountability.

Explore the CCO Performance Metrics Dashboard

The CCO Performance Metrics Dashboard expands on this Final Report, describing in more detail the progress of Oregon's CCOs on quality measures. Viewers can quickly find their metric of interest and see individual CCO trends over time. The dashboard also has the option to explore breakouts of many measures by Race, Ethnicity, Language and Disability (REALD) standards. **2024 CCO performance will be added to the dashboard by the end of 2025.**



Acknowledgements

This publication was prepared by the Oregon Health Authority's Office of Health Analytics. For questions about this report, please contact metrics.questions@odhsoha.oregon.gov.

Suggested citation

Oregon Health Authority. Oregon CCO Quality Incentive Program: CCO Metrics 2024 Final Report. Portland, Oregon. August 2025.
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2024-CCO-Metrics-Annual-Report.pdf

Program highlights

Senate Bill 966 study recommends program changes to eliminate health inequities.

In 2023, the Oregon Legislature passed Senate Bill 966. The bill directed OHA to conduct a study on how the Quality Incentive Program could address health inequities. This study aligns with OHA's goal of eliminating health inequities by 2030.

OHA partnered with Portland State University's (PSU) Regional Research Institute to gather feedback and make recommendations. From May to June 2024, PSU surveyed over 700 Oregon Health Plan (OHP) members and interviewed 60 health system representatives (CCOs, community-based organizations, providers and committee members).

The study was delivered to the Oregon Legislature in September 2024. The study recommended that OHA:

- Increase OHP member representation and support in program decision-making
- Communicate more clearly and openly about the program
- Improve the Metrics and Scoring Committee public comment process
- Create opportunities for OHP member and community feedback
- Adjust the measure selection process, including extending the timeline to two or more years

Read the full report here.

Final year Cigarette Smoking Prevalence and Screening, Brief Intervention and Referral to Treatment (SBIRT) measures were in CCO Quality Incentive Program.

In addition to the study, Senate Bill 966 changed eligible incentive measures starting in 2025. The CCO Quality Incentive Program will have two types of measures: upstream and downstream. Upstream measures are focused on improving the social determinants of health (for example, SDOH: Social Needs Screening and Referral). These are primarily "homegrown" measures stewarded by Oregon entities. Downstream measures focus more on traditional medical care (for example, Immunizations for Adolescents).

As outlined in Senate Bill 966, downstream measures must come from the Centers for Medicare & Medicaid Services (CMS) Adult Core Set and Child Core Set. Downstream measures must align with national reporting requirements. Two downstream measures in the program do not follow these requirements: Cigarette Smoking Prevalence and SBIRT. As such, 2024 was the last year these measures could be in the CCO Quality Incentive Program.

Final year of the System-Level Social-Emotional Health for Young Children measure before transition to child-level measurement.

In 2022, the Metrics and Scoring Committee first selected the System-Level Social-Emotional Health for Young Children measure, an upstream measure part of the broader Health Aspects of Kindergarten Readiness strategy. This measure was developed by the Oregon Pediatric Improvement Partnership (OPIP) and Children's Institute (CI) with support from OHA.

From 2022 to 2024, this system-level measure focused on developing resources and provider networks to better identify and treat children with social-emotional health needs. The goal of the system-level measure was to ensure that CCOs were ready to implement the Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services measure starting in 2025. This new measure will track the percentage of children (ages 1-5) who received a social-emotional issue-focused intervention or treatment service.

In 2024, the system-level measure required CCOs to complete a self-assessment, asset map and action plan. These tracked CCOs' progress on four components:

1) Social-emotional health reach metric data review and assessment
2) Asset map of existing social-emotional health services and resources
3) CCO-led cross-sector community engagement
4) Action plan to improve social-emotional health service capacity and access

By 2024, CCOs were required to demonstrate contracted social-emotional health services with behavioral health therapists and integrated behavioral health within Patient Centered Primary Care Homes (PCPCH). CCOs were also required to explore contracting with community-based social-emotional health services. CCOs had to complete all must-pass items in 2024, with no option for partial credit.

New must-pass requirements for SDOH: Social Needs Screening and Referral build off last year's efforts.

2024 was the second year for the upstream Social Determinants of Health (SDOH): Social Needs Screening and Referral measure. This measure is on a glide path, with new requirements added each year. In the first three years of the measure (2023 to 2025), CCOs must set up the infrastructure and systems needed for screening and referrals. These include meeting requirements on:

- **Screening practices:** Preparing equitable, trauma-informed and culturally responsive screening practices
- **Referral practices and resources:** Working with community-based organizations to build capacity for referrals and meeting social needs
- **Data collection and sharing:** Supporting data sharing between CCOs, providers and community-based organizations

In 2024, CCOs had to complete all must-pass items, with no option for partial credit.

Starting in 2025, CCOs will report screening and referral activities for housing insecurity, food insecurity and transportation needs on a sample of CCO members. OHA has recommended benchmarks and CCO-specific improvement targets for this measure start in 2027.

Since 2023, OHA's Transformation Center and the Oregon Rural Practice-Based Research Network (ORPRN) have provided ongoing technical assistance to CCOs on the SDOH: Social Needs Screening and Referral measure. Technical assistance has included training resources, learning collaboratives and guidance on aligning with Health Related Social Needs (HRSN) benefits.

Meaningful Language Access (Health Equity) moves from hybrid to full population reporting, improvement targets recalculated.

The Meaningful Language Access (Health Equity) upstream measure promotes high quality language services for CCO members with self-identified language access needs. Language access is a primary social determinant of health. Creating a health care system that provides language access for persons who use a language other than spoken English improves patient well-being and decreases cost overall.

This upstream measure began in 2021 and has two components:

- **Component 1:** CCOs must attest to building a higher quality and more robust language services infrastructure over time.
- **Component 2:** Beginning in 2022, CCOs report the percentage of visits with high quality language services for members with interpreter needs.

In 2022 and 2023, CCOs were only required to report on 80% of visits for a sample of up to 411 members (called hybrid reporting). In these years, CCOs were also contractually required to report on visits for all CCO members with self-identified language access needs (called full population reporting). OHA used hybrid reporting in 2022 and 2023 to give CCOs time to implement full population reporting in 2024.

When setting improvement targets, OHA uses CCOs' service rate from the prior year. This is called their baseline. Historically when moving to full population reporting, OHA would use the prior year's hybrid rate as the baseline. However, OHA recommended recalculating 2024 improvement targets using lower baselines. This accounted for continued data collection difficulties for this measure.

For the baseline, OHA proposed using the 2023 full population rate if it was lower than the 2023 hybrid rate. This was the case for ten CCOs. For these CCOs, their 2024 improvement target was lowered by 0.1 to 16.6 percentage points. The Metrics and Scoring Committee approved of this plan in February 2025.

OHP eligibility redetermined and coverage expanded after the COVID Public Health Emergency.

During the COVID Public Health Emergency, the Family First Coronavirus Recovery Act provided continuous Medicaid coverage. This meant that members were able to enroll and keep Medicaid benefits regardless of income during the federal Public Health Emergency. In Oregon, federally funded Medicaid is delivered through OHP. In addition to Medicaid, OHP includes state-funded coverage for those who do not qualify under federal requirements.

After the federal Public Health Emergency ended on May 11, 2023, OHA had to redetermine eligibility for all OHP members. Adults with annual incomes above 138% of the federal poverty level (FPL) are generally not eligible for Medicaid. Before the pandemic, adults in Oregon with incomes just above this limit were more likely to be uninsured than other groups.

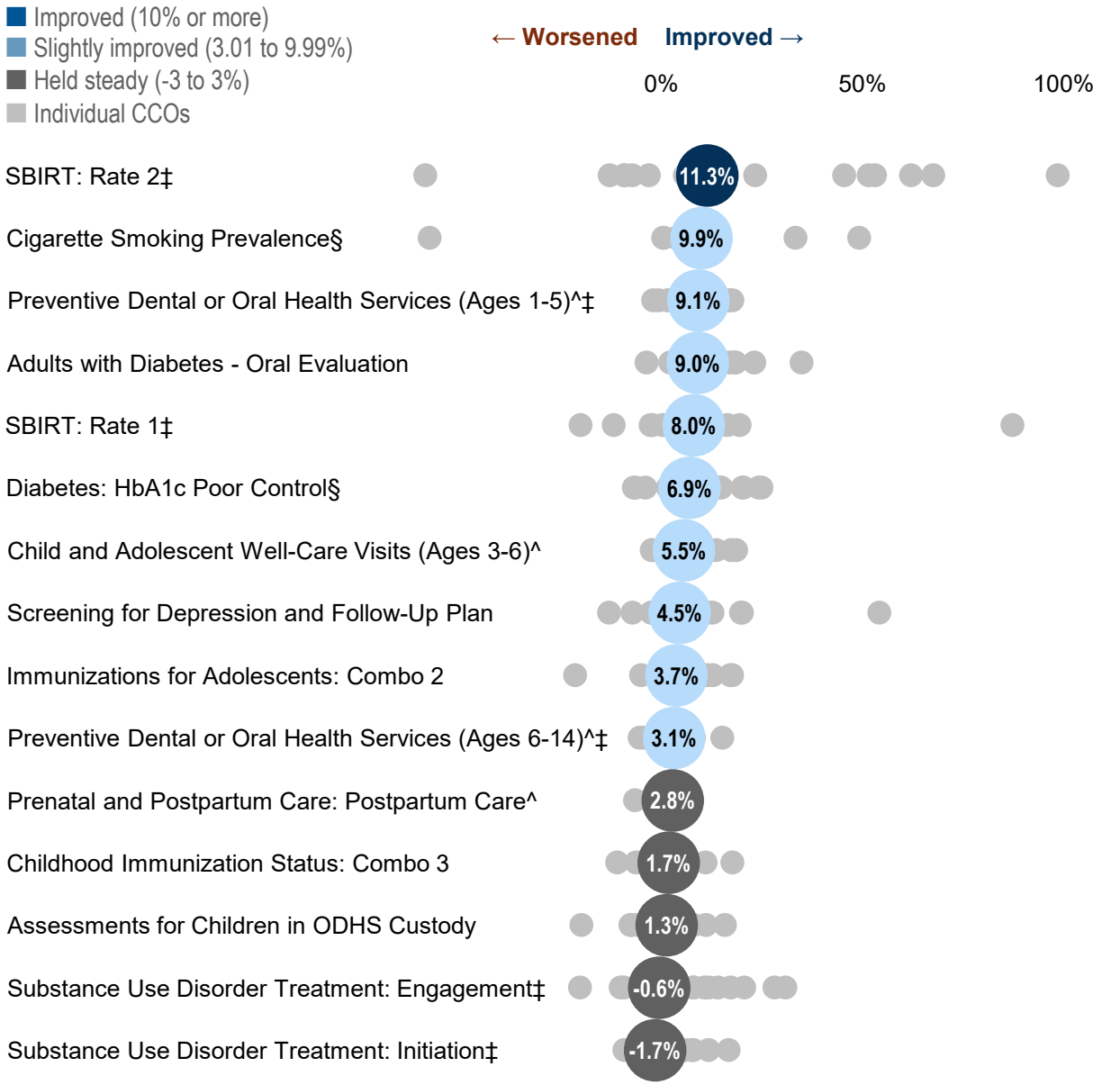
Following the federal Public Health Emergency, Oregon worked to continue OHP benefits for adults with annual incomes between 138-200% FPL. Temporary Medicaid Expansion (TME) provided OHP coverage for adults in this income range through June 30, 2024.

On July 1, 2024, OHA launched the OHP Bridge Basic Health Program. OHP Bridge is available for those who both make more than 138% of the federal poverty level on a monthly basis and 133-200% of the federal poverty level on an annual basis. OHP Bridge provides no-cost OHP benefits, excluding Long Term Services and Supports (LTSS) and Health Related Social Needs (HRSN). In this income range, Medicaid provides federal funds for adult OHP Bridge Basic members who are Native American/Alaska Native. For all other members, OHP Bridge Basic is paid for with state funding.

In 2024, the CCO Quality Incentive Program only included OHP members funded by Medicaid. It did not include members who received OHP benefits through state funding (that is, TME or non-Native American/Alaska Native OHP Bridge Basic members). All OHP members should receive high quality care, regardless of inclusion in the CCO Quality Incentive Program.

At a glance: CCO performance from 2023 to 2024

This chart shows **percent change**, or the **relative rate of change**. For example, a 100% increase means that CCO performance doubled from 2022 to 2023. For absolute change in percentage points, see Appendix D.



^ Challenge Pool measure

§ A lower rate is better. For comparison, positive values are measures that improved and negatives are those that worsened. For example, 9.9% for Cigarette Smoking Prevalence means the rate improved (or decreased) by 9.9%.

Meaningful Language Access (Health Equity) is not included in this chart. Percent changes are exaggerated due to low performance, in part due to poor data collection.

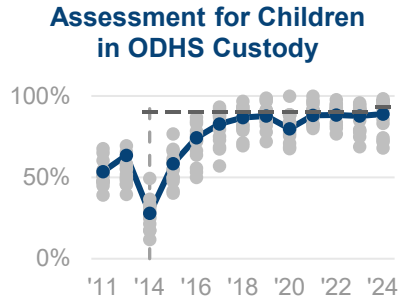
Measure highlights

Below we describe CCO performance on individual measures and their change over time. We also describe the range in CCO performance, which is the gap between the top and bottom performing CCOs.

Measures are grouped by topic area from the upstream set or in the downstream CMS Core Sets. Topic areas include Upstream, Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, and Dental and Oral Health Services. For measures that are not defined in Senate Bill 966, we assigned them to topic areas that most closely aligned. We also include a summary of measures that are part of the broader Kindergarten Readiness strategy.

Upstream

Upstream measures are focused on improving the social determinants of health. These are primarily "homegrown" measures stewarded by Oregon entities. Going beyond medical services, they aim to improve coordination across sectors that impact social needs.



Assessments for Children in ODHS Custody helps ensure children entering foster care get the age-appropriate physical, mental, and dental health care they need.

From 2014 to 2019, CCO statewide performance more than tripled.[a] After falling somewhat in 2020, CCO statewide performance quickly recovered and mirrored pre-pandemic performance. In 2024, the Metrics and Scoring Committee selected a slightly higher benchmark than prior years.

From 2023 to 2024, CCO statewide performance held steady. Twelve out of 16 CCOs met this measure, with nine reaching the benchmark. Eight CCOs improved or slightly improved from 2023 to 2024. The range in CCO performance widened from 2023 to 2024. This was primarily due to improvements by the top performing CCOs. One CCO's performance notably worsened from 2023 to 2024.

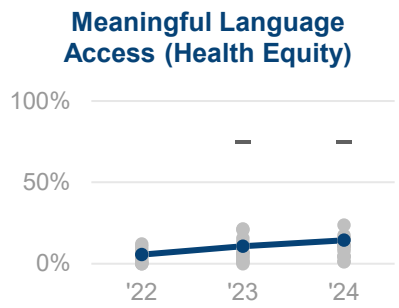
Meaningful Language Access (Health Equity) is intended to increase the use of high-quality language services for members with interpreter needs. People who communicate in languages other than English or are hard of hearing face barriers accessing health services. They receive lower quality care relative to patients whose preferred language is English,[b] and are at higher risk for medical errors.[c]

In 2024, CCOs had to meet both components to pass this measure:

[a] In 2014, this measure was expanded to include dental health assessments. Because of this, results before 2014 are not directly comparable to later years.
[b] https://pubmed.ncbi.nlm.nih.gov/19179539/
[c] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5111827/

- **Component 1:** Attest to activities that build a higher quality and more robust language services infrastructure over time.
- **Component 2:** The percentage of visits with either a) an Oregon-certified or qualified health care interpreter, or b) a provider[d] who speaks their preferred language among members who self-identified as needing an interpreter.[e]

Nine CCOs met both components in 2024. Three CCOs did not meet Component 1.



In 2024, CCOs transitioned from reporting on visits for a sample of up to 411 members (hybrid) to all members (full population) who self-identified needing an interpreter. During this transition, OHA recommended lower improvement targets for Component 2 to account for continued data collection difficulties. Five CCOs met Component 2 due to lowered improvement targets.

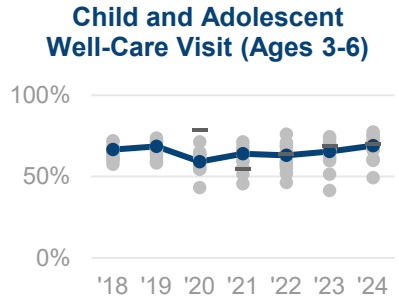
From 2023 to 2024, CCO statewide performance increased from 10.8% to 14.6%. CCO statewide performance remained well below the 75% benchmark.

The range in CCO performance slightly widened in 2024 compared with 2023. The top performing CCO provided qualified and certified interpreters for 23.7% of visits. The lowest performing CCO only reported them for 1.1% of visits.

CCOs, language service companies, and health care providers are required to use OHA certified and qualified health care interpreters (Oregon Administrative Rule [OAR] 950-505-0000).[e] OHA will continue to provide technical assistance to CCOs and health care providers to increase access and compliance.

Primary Care Access and Preventive Care

In 2024, Primary Care Access and Preventive Care measures in the CCO Quality Incentive Program focused on health care for children and adolescents.

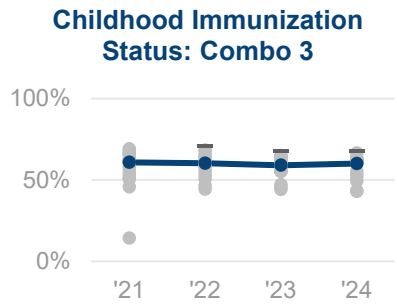


Child and Adolescent Well-Care Visits (Ages 3-6) looks at the percentage of children who had one or more well-care visits with a primary care provider or obstetrician gynecologist (OB/GYN). Well-care visits are a critical opportunity for screening and preventive care. This measure is part of the broader Kindergarten Readiness strategy.

From 2023 to 2024, CCO statewide performance slightly improved. After falling 14% in 2020, 2024 was the first year CCO statewide performance rose to pre-pandemic levels.

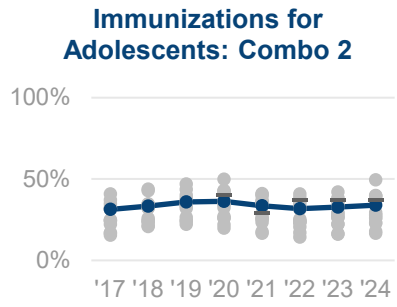
[d] Providers must be either a native speaker or have passed a proficiency test. Providers must be primarily responsible for services during the visit. Support or general clinic staff are not eligible.
[e] OAR 950-050-0160, 950-050-0170, and 950-050-0180

Eleven out of 16 CCOs met this measure, with seven reaching the benchmark. In 2024, the range in CCO performance narrowed from prior years. This change was primarily due to improvement by the lowest performing CCO. However, this CCO continued to have notably lower rates compared with other CCOs.



Childhood Immunization Status: Combo 3 assesses the percentage of children who received recommended vaccines in Combo 3[f] before their second birthday. 2024 measure results include services going back to 2022. Disruptions in care during the pandemic likely still affected 2024 rates. For this measure, the Metrics and Scoring Committee chose to keep the same benchmark as in 2023.

CCO statewide performance held steady from 2023 to 2024. Only six CCOs met their improvement target. Additionally, five CCOs performed worse or slightly worse in 2024 than in 2023. The range in CCO performance also widened from 2023 to 2024.



Immunizations for Adolescents: Combo 2 assesses the percentage of adolescents who received recommended vaccines in Combo 2[g] between their 9th and 13th birthday.

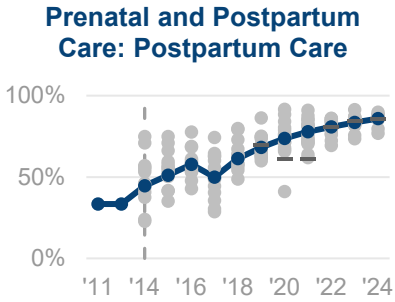
2024 measure results include services going back to 2020. Disruptions in care during the COVID-19 pandemic were likely still affecting this measure. For this measure, the Metrics and Scoring Committee chose to keep the same benchmark as in 2023.

From 2023 to 2024, CCO statewide performance slightly improved on Immunizations for Adolescents: Combo 2. Nine out of 16 CCOs met the measure, with six reaching the benchmark. Ten CCOs improved or slightly improved from 2023 to 2024. However, the range in CCO performance widened from 2023 to 2024. This change was primarily due to improvement by the highest performing CCO.

Maternal and Perinatal Health

In 2024, CCO Quality Incentive Program had one incentive measure on Maternal and Perinatal Care – **Prenatal and Postpartum Care: Postpartum Care**. This measure looks at the percentage of women who had a postpartum care visit on or between seven and 84 days after delivery. Postpartum Care supports the long-term health and well-being of both parent and child.

[f] Includes Diphtheria, Tetanus and acellular Pertussis (DTaP); Inactived Polio Vaccine (IPV); Measles, Mumps and Rubella (MMR); Haemophilus influenzae type b (Hib); Hepatitis B; Varicella-Zoster (Chickenpox) Vaccine (VZV); and Pneumococcal Conjugate Vaccines (PCV).
[g] Includes Meningococcal; Tetanus, Diphtheria, Acellular Pertussis (TDAP/TD); and the complete Human Papillomavirus for Adolescents (HPV) series.

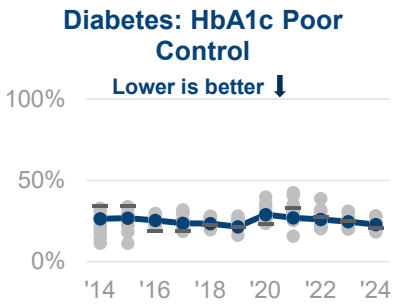


This measure reports chart reviews on a sample of live deliveries. Samples include no more than 411 deliveries per CCO. For smaller CCOs, this sample captures all deliveries in that year. We use chart reviews to capture bundled maternity care services that would otherwise be missed in administrative data.[h]

From 2023 to 2024, CCO statewide performance held steady. This is one of the few measures where CCO performance statewide continued to improve during the pandemic. Fifteen out of 16 CCOs met this measure in 2024, with 13 CCOs reaching the benchmark. The range in CCO performance also narrowed compared with prior years.

Care of Acute and Chronic Conditions

In 2024, the CCO Quality Incentive Program had one incentive measure on Care of Acute and Chronic Conditions – **Diabetes: HbA1c Poor Control**. Adequately monitoring and controlling blood sugars can prevent serious disease, including heart disease, kidney disease and vision loss.



This measure looks at the percentage of adult CCO members who have diabetes and whose blood sugars were poorly controlled or were not laboratory tested during the measurement year. As such, a lower rate is better for this measure.

This measure uses electronic health records (EHR) for reporting. EHR reporting includes aggregate service counts from health care organizations/practices or providers.

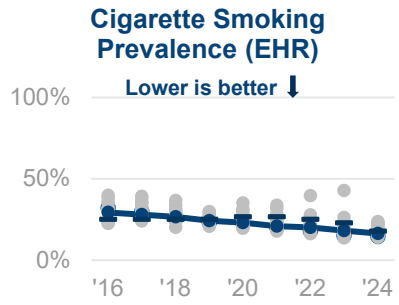
From 2023 to 2024, CCO statewide performance slightly improved, but remained slightly worse than the 2019 pre-pandemic rate. Twelve out of 16 CCOs met this measure, with seven reaching the benchmark. Eleven CCOs improved or slightly improved from 2023 to 2024, with six CCOs improving by 14% or more. The range in CCO performance also narrowed compared with prior years.

Behavioral Health Care

Behavioral health has been a major focus area for OHA, CCOs and community partners. In 2024, the CCO Quality Incentive Program primarily focused Behavioral Health Care measures on substance use. Additionally, OHA is supporting quality improvement for one of these

[h] Chart reviews were introduced in 2014. From 2011 to 2013, this measure used administrative claims data only for the full population. Because of this, results prior to 2014 are not directly comparable to later years.

measures, Initiation and Engagement of Substance Use Disorder (SUD) treatment, through the Statewide Performance Improvement Project.

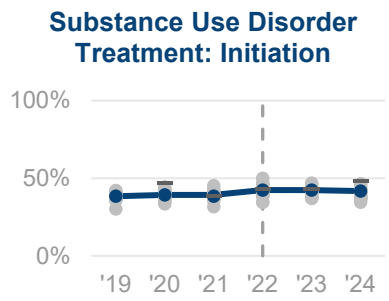


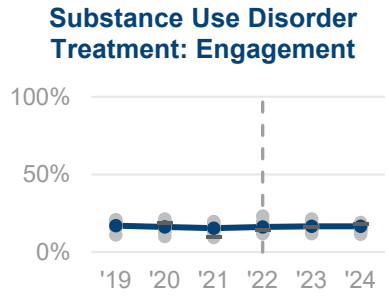
Cigarette Smoking Prevalence measures the percentage of members (age 13 and older) who were screened for smoking status and identified as current smokers. For this measure a lower rate is better. This measure uses EHR reporting, which includes aggregate service counts from health care organizations/practices or providers.

Tobacco continues to be the leading cause of preventable death for people in Oregon.[i] OHP members are twice as likely to smoke cigarettes compared with people not on OHP.[j]

From 2023 to 2024, CCO statewide performance slightly improved. From 2016 to 2024, cigarette smoking prevalence has decreased by 44% among CCO members statewide. Thirteen out of 16 CCOs met this measure, with ten reaching the benchmark. Thirteen CCOs improved or slightly improved from 2023 to 2024. However, one CCO reported a notably worse rate compared to 2023. The range in CCO performance also narrowed compared with prior years.

OHA developed this measure and it is not in the CMS Core Sets. Per Senate Bill 966, this measure will not be eligible for the CCO Quality Incentive Program starting in 2025.





Initiation and Engagement of SUD treatment has two components that CCOs must meet to pass the measure:

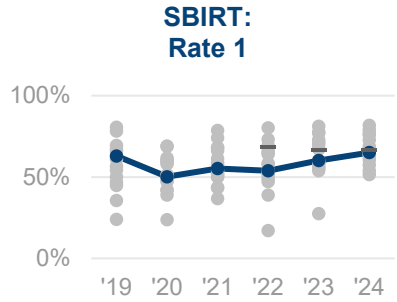
- **Initiation:** Among adults, percentage of new SUD diagnoses followed up by treatment within 14 days of initial diagnosis.
- **Engagement:** Among adults, percentage of new SUD diagnoses followed up by two engagement visits or medication treatments within 34 days of initial treatment.

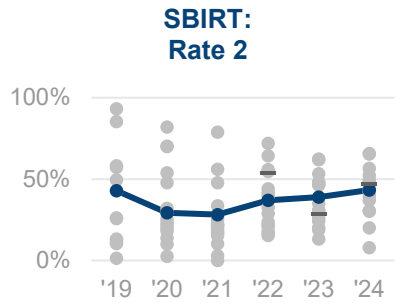
In 2024, only four CCOs met both components.

For Initiation, CCO statewide performance held steady from 2023 to 2024. Eleven CCOs met their improvement target. However, eight CCOs performed worse or slightly worse in 2024 compared with 2023. The range in CCO performance also widened from 2023 to 2024.

For Engagement, CCO statewide performance also held steady from 2023 to 2024. Five CCOs met this component, with two reaching the benchmark. Nine CCOs performed worse or slightly worse in 2024 than in 2023. The range in CCO performance narrowed from prior years.

[i] Oregon Center for Health Statistics, Death data (2021)
[j] Oregon Health Authority, Oregon Behavioral Risk Factor Surveillance System (2021)





Screening, Brief Intervention and Referral to Treatment (SBIRT) uses EHR reporting, which includes aggregate service counts from health care organizations/practices or providers. This measure also had two components that CCOs must meet to pass the measure:

- **Rate 1:** Percentage of members ages 12 and older who received an age-appropriate screening for alcohol or other substance use.
- **Rate 2:** Percentage of members ages 12 and older who screened positive for alcohol or other substance use and received a brief intervention or referral to treatment.

Ten CCOs met both components, with five reaching the benchmark for both. For Rate 1, the Metrics and Scoring Committee continued the benchmark from 2023, which was lower than in 2022. For Rate 2, the Metrics and Scoring Committee selected a higher benchmark in 2024 compared with 2023. However, the 2024 benchmark was still lower than in 2022.

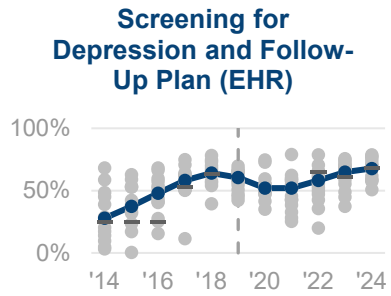
For **Rate 1**, CCO statewide performance slightly improved from 2023 to 2024. After falling 20% in 2020, this was the first year CCO statewide performance rose above the 2019 pre-pandemic rate. Fourteen of 16 CCOs met Rate 1, with seven reaching the benchmark. Ten CCOs improved or slightly improved from 2023 to 2024. The range in CCO performance also narrowed compared with prior years. This was due to major improvements by the lowest performing CCO in 2023, which moved from screening 27.5% of members in 2023 to 51.5% in 2024.

For **Rate 2**, CCO statewide performance improved by eight percentage points. On average, this measure had the greatest improvement in the incentive set. For individual CCOs, however, this measure had the greatest increases and decreases. From 2023 to 2024, ten CCOs improved by more than 10%, with six improving by more than 45%.

The range in CCO performance on Rate 2 also widened compared with 2023. Across the incentive set, Rate 2 had the widest spread in CCO performance. In 2024, the gap between the top and bottom performing CCOs was 57.9 percentage points. One CCO reported a notably lower rate than other CCOs. For this CCO, their performance dropped from 18.9% in 2023 to 7.8% in 2024.

OHA developed the SBIRT measure and it is not in the CMS Core Sets. Per Senate Bill 966, this measure will not be eligible for the CCO Quality Incentive Program starting in 2025.

Screening for Depression and Follow-Up Plan measures the percentage of members age 12 and older who had appropriate screening and follow-up planning for depression. This measure uses EHR reporting, which includes aggregate service counts from health care organizations/practices or providers.



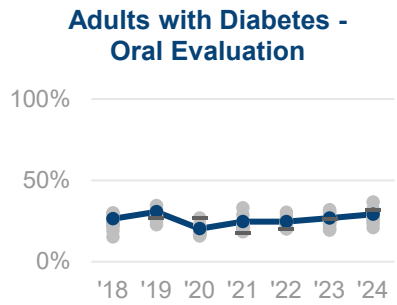
From 2023 to 2024, CCO statewide performance slightly improved, continuing to rise above the 2019 pre-pandemic rate.

Fourteen of 16 CCOs met this measure, with nine reaching the benchmark. Ten CCOs improved or slightly improved from 2023 to 2023. The range in CCO performance also narrowed compared to prior years. This was primarily due to major improvements by the lowest performing CCOs from 2023

.

Dental and Oral Health Services

Among the incentive set, Dental and Oral Health Services measures were some of the most negatively affected by the pandemic. Overall, CCO performance on these measures continued to slowly improve in 2024, with the largest gains on Preventive Dental or Oral Health Services for children ages 1-5.



Adults with Diabetes – Oral Evaluation measures the percentage of adults with diabetes who received at least one comprehensive, periodic or periodontal oral evaluation that year. People with diabetes have higher rates of periodontal disease. Annual oral evaluations can help providers catch and treat the disease early, resulting in better health outcomes.

From 2023 to 2024, CCO statewide performance slightly improved, but remaining slightly below the 2019 pre-pandemic rate. Fourteen of 16 CCOs met this measure, with two reaching the benchmark.

Additionally, ten CCOs improved performance by 10% or more on this measure. However, the range in CCO performance widened from 2023 to 2024. This change was primarily due to improvement by the highest performing CCO.

This is a Dental Quality Alliance measure and is not currently in the CMS Adult Core Set. Previously, the CMS Core Set did not have any adult dental measures. With the addition of adult oral health measures in the CMS Core Set, this measure will no longer be eligible for the CCO Quality Incentive Program starting in 2026, per Senate Bill 966.

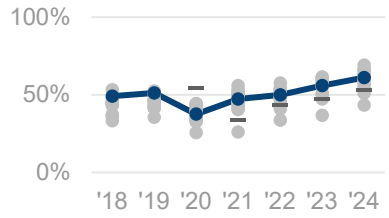
Preventive Dental or Oral Health Services help children avoid oral health problems that can impact their health and education.

This measure has two components, based on age groups:

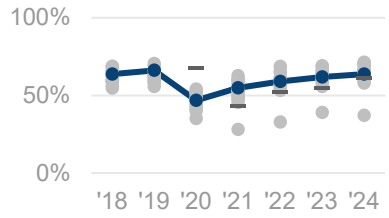
- Ages 1-5: Part of the broader Kindergarten Readiness strategy
- Ages 6-14.

In 2024, CCOs had to meet both components to pass the measure. Fourteen CCOs met both components, with eleven reaching the benchmark for both. One CCO reported notably lower performance on both components compared with other CCOs.

Preventive Dental or Oral Health Service (Age 1-5)



Preventive Dental or Oral Health Service (Age 6-14)



Ages 1-5: All CCOs met this component, with 14 reaching the benchmark. From 2023 to 2024, CCO statewide performance slightly improved and was well above the 2024 benchmark.

After falling 27% in 2020, 2023 was the first year CCO statewide performance rose above pre-pandemic levels. This rise continued in 2024. From 2020 to 2024, CCO statewide performance improved by 36%.

Ages 6-14: Fourteen out of 16 CCOs met this component, with 12 reaching the benchmark. From 2023 to 2024, CCO statewide performance slightly improved. After falling 29% in 2020, CCO statewide performance has remained slightly below the pre-pandemic 2019 level. The range in CCO performance also widened from 2023 to 2024. This change was primarily due to a worsening rate by the lowest performing CCO in both years.

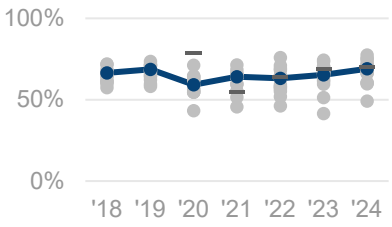
OHA developed the Preventive Dental or Oral Health Services measure and it is not in the CMS Core Sets. The Metrics and Scoring Committee adopted this as an upstream measure for 2025 so that it may remain in the CCO Quality Incentive Program.

Kindergarten Readiness

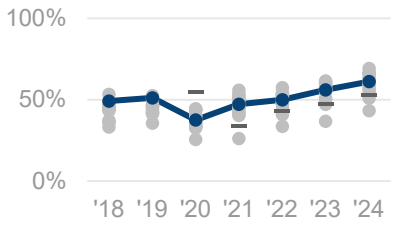
The Health Aspects of Kindergarten Readiness strategy aims for health system behavior change, investments and cross-sector efforts to improve kindergarten readiness. This multi-measure strategy was developed by the Health Aspects of Kindergarten Readiness Workgroup and was endorsed by the Metrics and Scoring Committee.

In 2024, the CCO Quality Incentive Program had three measures in the broader Kindergarten Readiness strategy: Child and Adolescent Well-Care Visits (Ages 3-6); Preventive Dental or Oral Health Services (Ages 1-5); and the upstream System-Level Social-Emotional Health for Young Children. Most CCOs met these measures in 2023, with many reaching the benchmark.

Child and Adolescent Well-Care Visit (Ages 3-6)



Preventive Dental or Oral Health Service (Age 1-5)



Incentive payment model

About benchmarks and improvement targets

CCOs earn incentive funds for meeting or making progress toward a measure's goal.

The Metrics and Scoring Committee is a public body that selects incentive measures. The committee also selects the goals CCOs must reach for each incentive measure. To encourage ongoing improvement, CCOs can meet a measure by achieving either the benchmark or a CCO-specific improvement target.

Benchmarks are the same for all CCOs. Benchmarks are meant to be aspirational goals, generally at the 75th or 90th percentile of national performance.

CCO-specific improvement targets are milestones specific to each CCO, between their current performance (baseline) and the benchmark. Specifically, CCO-specific improvement targets are a 10 percent reduction in the gap between baseline and the benchmark.

Additionally, minimum goals, or "**floors**," are used to prevent improvement targets from being too low. Historically, the committee typically set floors at three percentage points from the prior year. For an example, see Appendix B: How improvement targets are calculated.

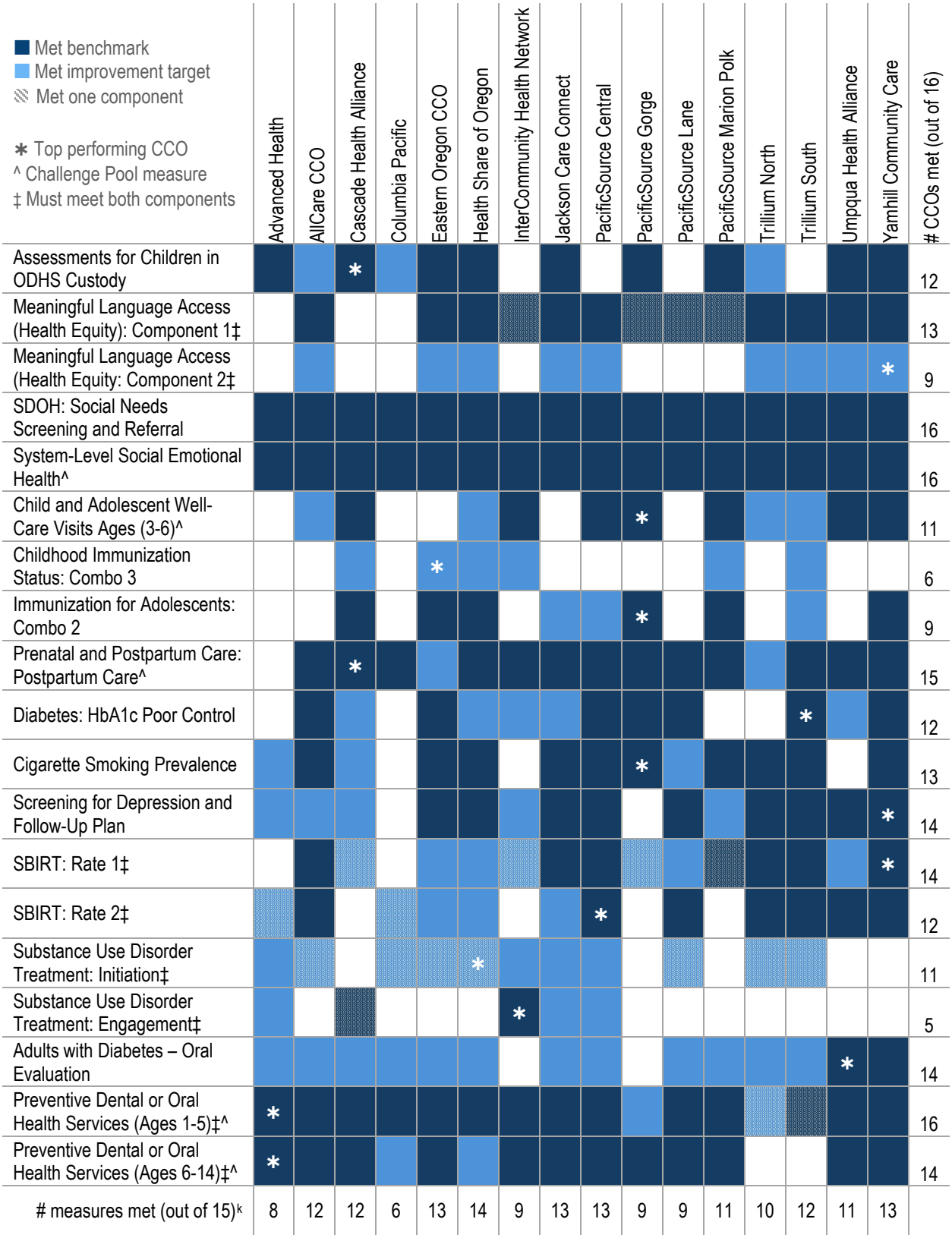
In 2024, benchmarks rose to more aspirational levels than prior years, but floors remained less challenging.

The COVID-19 pandemic upended the usual benchmarking and improvement target approach. In 2020, all performance benchmarks were suspended and the amount of funds in the program was greatly reduced. In 2021, the Metrics and Scoring Committee reintroduced benchmarks, though at significantly lower levels than before 2020. In 2022, the Metrics and Scoring Committee continued lower benchmarks for seven measures most impacted by the pandemic. In 2021 and 2022, CCOs did not have floors for improvement targets.

Even as health systems emerged from the pandemic, the Committee continued lower, less challenging benchmarks in 2023. The Committee reintroduced improvement target floors in 2023. However, floors were lower than pre-pandemic levels, with most measures having a one percentage point floor.

For many measures, the Metrics and Scoring Committee selected more aspirational benchmarks in 2024 compared with 2023. For three measures, the committee used the same benchmark from 2023: 1) Childhood Immunization Status: Combo 3; 2) Immunizations for Adolescents: Combo 2; and 3) SBIRT Rate 1. However, the Metrics and Scoring Committee continued to keep floors low. For nearly all measures, floors were between one and two percentage points.

2024 measures met summary (quilt chart)



[k] Measures that require meeting both components are counted as one measure

About bonus pools

The goal of the CCO Quality Incentive Program is to improve the quality of care for Oregon Health Plan (OHP) members. To earn bonuses from the CCO Quality Incentive Program, CCOs must provide better and better care each year.

Bonuses are on top of monthly payments that cover the cost of care.

These cost of care payments are called per-member per-month (PMPM) or capitation. The amount CCOs can earn from the Quality Pool is determined by:

a) CCO size and composition (number of enrolled members and their eligibility status)

b) Performance on incentive measures.

Because these are bonuses, **incentive funds are not guaranteed.** CCO Quality Incentive Program funds are paid out from two bonus pools.

In 2024, the Quality Pool was over $325 million.

Each year, OHA decides the size of the Quality Pool by considering budgetary and other factors. Per code of federal regulations (CFR), total CCO payments cannot be greater than 105% of total PMPM payments. This means each CCO's bonus is capped at 5% of their total PMPM payments. In 2024, the total Quality Pool was set at 4.25% of that year's aggregate PMPM (capitation) to CCOs. See table below for Quality Pool amounts and percentage of total PMPM payments for the past 10 years.

Measurement year	Quality Pool amount in millions	Percentage of total PMPM payments
2015	$168	4%
2016	$178.8	4.25%
2017	$178.3	4.25%
2018	$188	4.25%
2019	$166.7	3.5%
2020[I]	$52.8	4.25% (Quarter 1 only)
2021	$266.2	3.75%
2022	$300.8	4.25%
2023	$327	4.25%
2024	$325	4.25%

[I] Under the original 2020 CCO contract, OHA was to withhold 4.25% of each CCO's 2020 PMPM payments to fund the Quality Pool. Due to the COVID-19 pandemic, the withhold was suspended in April 2020 so that funds could be infused into the health care system to help CCO address critical needs.

Phase 1: Quality Pool

CCOs do not have to meet all incentive measures to earn 100% of Quality Pool funds.

CCOs earn 100% of their Quality Pool by meeting the benchmark or improvement target for 75% of the incentive metrics (12 of 15 metrics in 2024). For CCOs that meet less than 75% of incentive measures, Quality Pool payments are reduced by a set percentage (see table to the right).

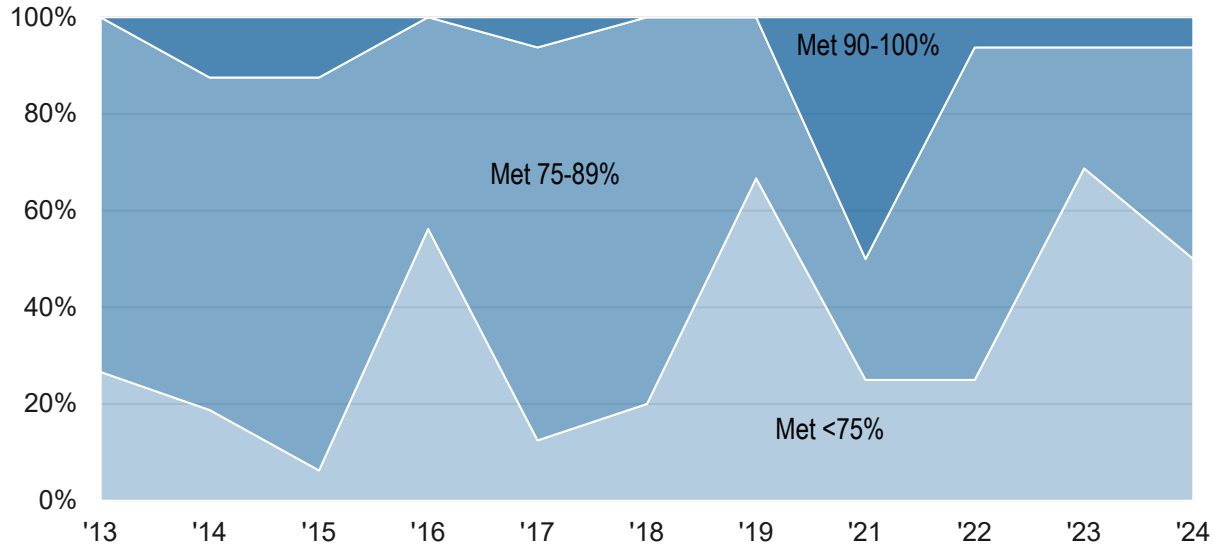
To see how well CCOs have met incentive measures compared with payments, see chart below and on page 21.

No “must pass” metrics were selected for the 2024 Quality Pool.

“Must pass” metrics have a benchmark or reporting requirement that CCOs must meet to be eligible to receive full Quality Pool payments. Historically, the Metrics and Scoring Committee has selected one to three “must pass” metrics in most years of the program.

Number of measures met (out of 15)	Quality Pool %
At least 12	100%
At least 11	90%
At least 10	80%
At least 9	70%
At least 8	60%
At least 6	50%
At least 5	40%
At least 4	30%
At least 3	20%
At least 2	10%
At least 1	5%

The proportion of CCOs that met 90-100%, 75-89% and less than 75% of measures by year[m]



[m] We did not include 2020 in this chart. In 2020, all benchmarks were changed to report only, which all CCOs met.

Phase 2: Challenge Pool

Unearned Quality Pool funds are funneled into the Challenge Pool. All CCOs can earn additional funds through the Challenge Pool. Even if a CCO did not earn 100% of Quality Pool funds in phase 1, they can earn funds through the Challenge Pool. To earn Challenge Pool funds, CCOs must meet performance expectations on a subset of incentive measures.

In 2024, the Challenge Pool focused on Kindergarten Readiness and Postpartum Care.

Challenge Pool funds were distributed to CCOs according to their performance on each of the four Challenge Pool metrics:

1. Child and Adolescent Well-Care Visits (Ages 3-6)
2. System-Level Social-Emotional Health for Young Children
3. Preventive Dental or Oral Health Services, Ages 1-5 and 6-14
4. Postpartum Care.

Challenge Pool funds are distributed in equal proportions based on the number of times Challenge Pool measures are met. For more information, see the 2024 Quality Pool Methodology (Reference Instructions).

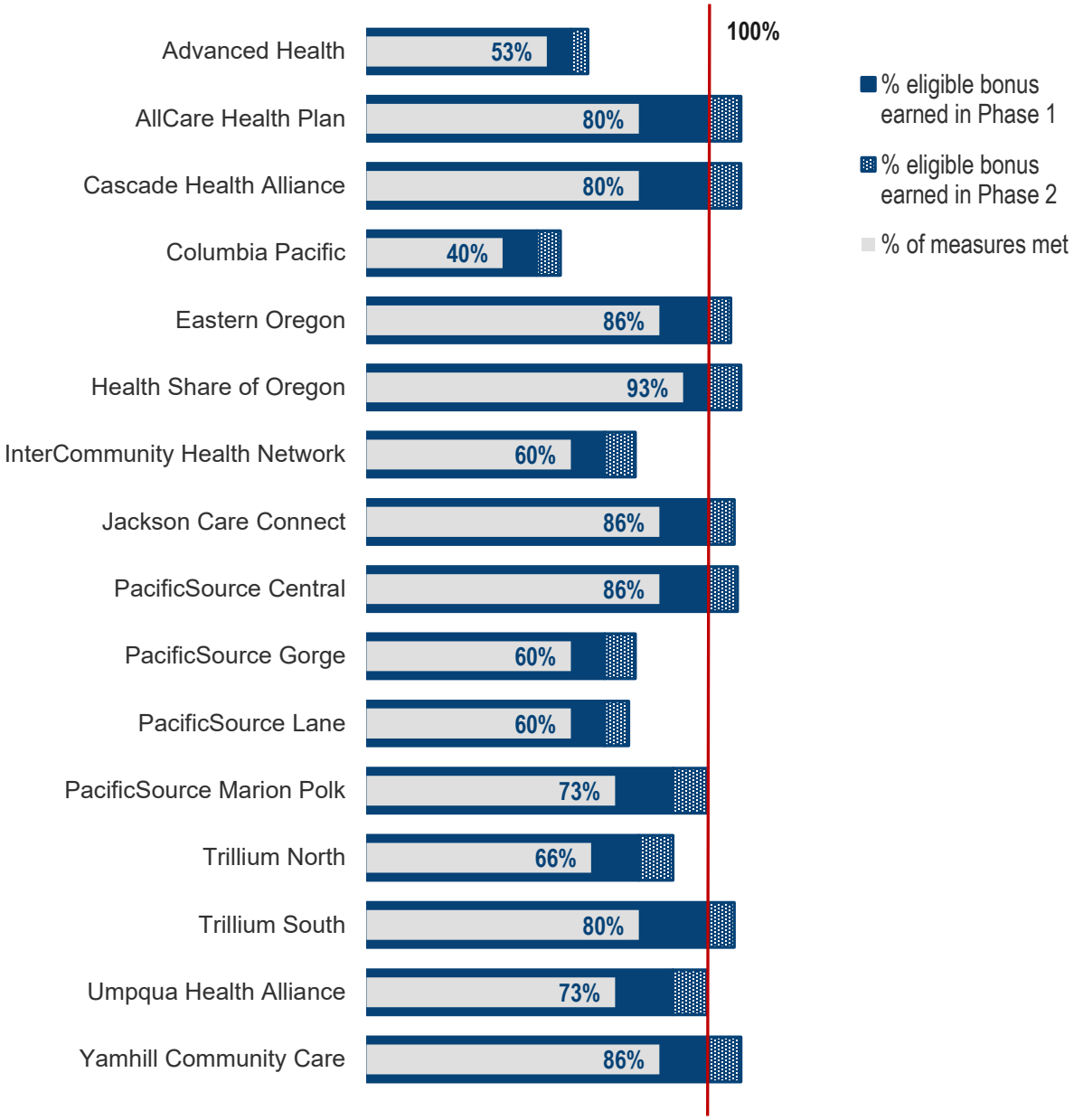
With the Challenge Pool, CCOs can earn more than 100% of eligible bonus funds.

All CCOs—even those that earned all their Quality Pool—can earn additional bonus money from the Challenge Pool. In all but one year of the program, the majority of CCOs earned more than 100% of their bonus by the addition of the Challenge Pool.

Regardless of CCO performance, **OHA pays all CCO Quality Incentive Program funds** each year to CCOs through the Challenge Pool. No bonus funds are saved or carried over to the next year.

In 2024, no CCOs met 100% of the quality incentive measures.

However, In Phase 1 eight CCOs were paid 100% of eligible Quality Pool funds by meeting at least 12 out of the 15 incentive measures



2024 Quality Pool distribution

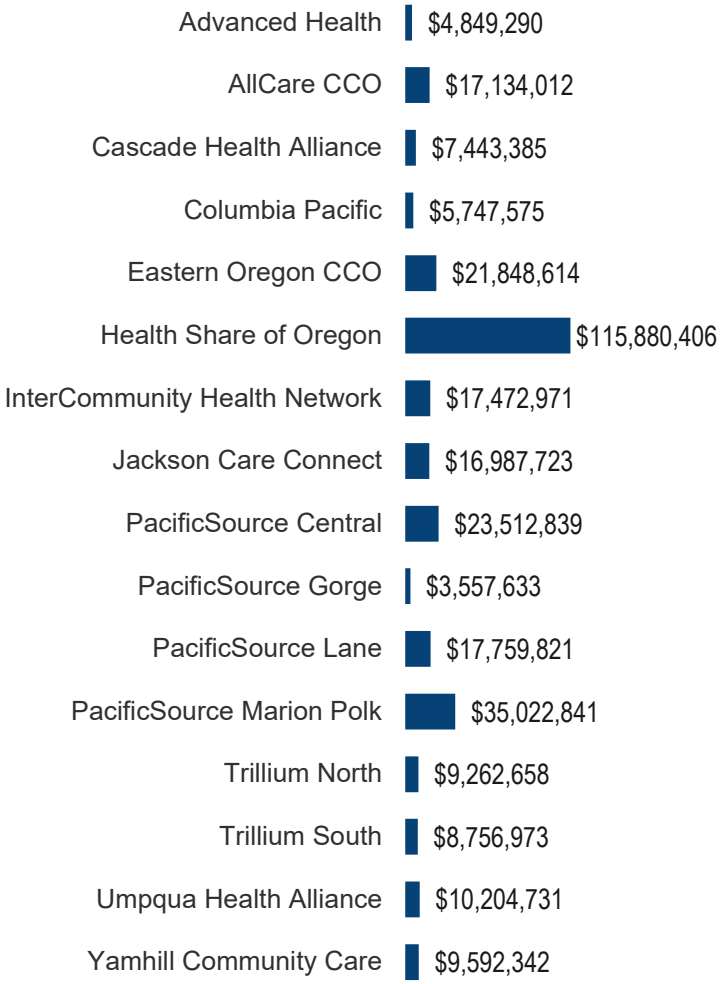
	Phase 1			Challenge Pool			Quality Pool
	Measures met (15 possible)	Earned in Phase 1 (% of eligible bonus)	Paid in Phase 1	Measures met (4 possible)	Challenge Pool paid in Phase 2	Earned after Phase 2 (% of eligible bonus)	Total Quality Pool earned
Advanced Health	8	60%	$4,399,059	2	$353,245	65%	$4,752,304
AllCare Health Plan	12	100%	$15,219,209	4	$1,572,123	110%	$16,791,331
Cascade Health Alliance	12	100%	$6,637,945	4	$656,572	110%	$7,294,517
Columbia Pacific	6	50%	$4,950,955	3	$681,669	57%	$5,632,623
Eastern Oregon	13	100%	$20,040,379	3	$1,371,262	107%	$21,411,641
Health Share of Oregon	14	100%	$103,373,778	4	$10,189,020	110%	$113,562,798
InterCommunity Health Network	9	70%	$15,117,390	4	$2,006,122	79%	$17,123,512
Jackson Care Connect	13	100%	$15,458,533	3	$1,189,436	108%	$16,647,969
PacificSource Central	13	100%	$21,232,671	4	$1,809,911	109%	$23,042,582
PacificSource Gorge	9	70%	$3,077,320	4	$409,160	79%	$3,486,480
PacificSource Lane	9	70%	$15,721,258	3	$1,683,367	77%	$17,404,625
PacificSource Marion Polk	11	90%	$30,858,376	4	$3,464,008	100%	$34,322,384
Trillium North	10	80%	$8,065,350	3	$1,012,054	90%	$9,077,404
Trillium South	12	100%	$7,933,326	3	$648,507	108%	$8,581,833
Umpqua Health Alliance	11	90%	$9,033,996	4	$966,641	100%	$10,000,636
Yamhill Community Care	13	100%	$8,545,693	4	$854,802	110%	$9,400,495
Total			$289,665,238		$28,867,899		$318,533,136

Continued on next page

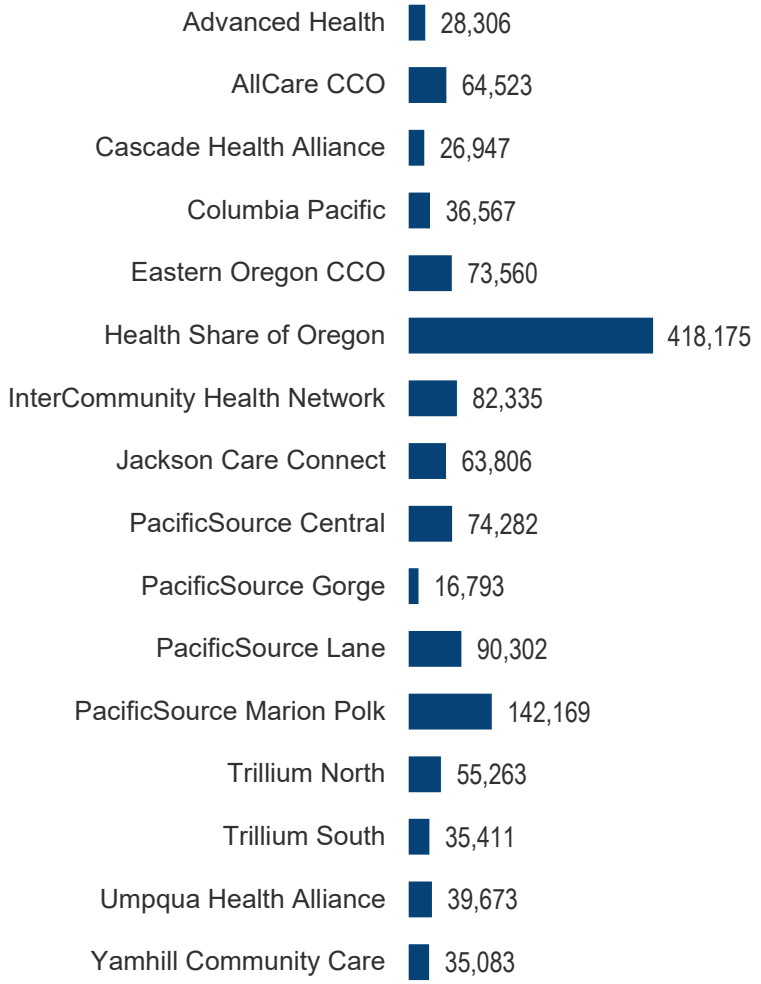
	Quality Pool			PMPM	
	Total Quality Pool earned	MCO tax cost paid to CCOs thru Quality Pool[n]	Total Quality Pool paid	Total PMPM paid	Total CCO payment (% of PMPM)
Advanced Health	$4,752,304	$96,986	$4,849,290	$176,032,774	102.8%
AllCare Health Plan	$16,791,331	$342,680	$17,134,012	$365,407,178	104.7%
Cascade Health Alliance	$7,294,517	$148,868	$7,443,385	$159,374,437	104.7%
Columbia Pacific	$5,632,623	$114,951	$5,747,575	$237,740,915	102.4%
Eastern Oregon	$21,411,641	$436,972	$21,848,614	$481,161,564	104.5%
Health Share of Oregon	$113,562,798	$2,317,608	$115,880,406	$2,481,963,445	104.7%
InterCommunity Health Network	$17,123,512	$349,459	$17,472,971	$518,517,905	103.4%
Jackson Care Connect	$16,647,969	$339,754	$16,987,723	$371,153,257	104.6%
PacificSource Central	$23,042,582	$470,257	$23,512,839	$509,788,023	104.6%
PacificSource Gorge	$3,486,480	$71,153	$3,557,633	$105,550,343	103.4%
PacificSource Lane	$17,404,625	$355,196	$17,759,821	$539,230,265	103.3%
PacificSource Marion Polk	$34,322,384	$700,457	$35,022,841	$823,219,318	104.3%
Trillium North	$9,077,404	$185,253	$9,262,658	$242,057,326	103.8%
Trillium South	$8,581,833	$175,139	$8,756,973	$190,476,011	104.6%
Umpqua Health Alliance	$10,000,636	$204,095	$10,204,731	$241,002,953	104.2%
Yamhill Community Care	$9,400,495	$191,847	$9,592,342	$205,178,699	104.7%
Total	$318,533,136	$6,500,676	$325,033,813	$7,647,854,413	

[n] Oregon requires managed care organizations (MCOs) to pay a tax to support OHP. In 2024, the MCO tax rate was 2.0%. OHA pays the tax gross back to CCOs by building the cost of the tax into capitation rates, qualified directed payments, maternity kick payments and Quality Incentive payments.

Total Quality Pool dollars paid to CCOs



Total enrolled by CCO (n = 1,283,194)º



º Total enrollment is the average of monthly members in 2024. These estimates come from OHA's Office of Financial and Actuarial Services (OAFA) and are used to calculate Quality Pool payments.

Appendices

Appendix A: Background

About the CCO Quality Incentive Program

The CCO Quality Incentive Program rewards exceptional care and continuous quality improvement by CCOs, which serve over one million Oregonians on the Oregon Health Plan (Medicaid). The program is an important part of the coordinated care model. Independent evaluation showed that the program successfully drove improvements overall from 2012 to 2017.

Medicaid

Medicaid is a federal program that provides health coverage for people earning less than 138% of the federal poverty level and people with disabilities. Each state administers Medicaid and must follow federal requirements. Some states obtain waivers from the federal government for following certain federal requirements. These waivers grant states flexibility in how they use federal Medicaid funds in their state, with the goal of improving health care outcomes.

Oregon has had a type of waiver, known as an 1115 waiver, since 1994. The waiver allows Oregon to deliver Medicaid services in unique ways, such as through the coordinated care model. Some of the key elements of Oregon's coordinated care model include using best practices to manage and coordinate care; transparency in price and quality; and paying for better quality care and better health outcomes, rather than just more services.

In October 2022, Oregon began a new demonstration period which will run through September 2027. The goal of the new waiver is to advance OHA's goal of eliminating health inequities by 2030.

Coordinated care

A coordinated care organization (CCO) is a network of health care providers (physical, behavioral, and oral health care providers). Each CCO agrees to work together with their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs were formed in Oregon in late 2012.

CCOs have the flexibility to support new models of care that are patient-centered and team-focused and eliminate health inequities. CCOs are able to better coordinate services and focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services beyond medical benefits.

Requirements for CCOs have evolved over time and a new phase, CCO 2.0, began in 2020. CCO 2.0 priority areas include work to improve the behavioral health system, increase value and pay for performance, focus on social determinants of health and health equity, and maintain sustainable cost growth.

Appendix B: How improvement targets are calculated

Improvement targets are calculated for each CCO based on the Minnesota Department of Health Quality Incentive Payment System method (called the **Minnesota or MN method**). A CCO meets its improvement target by reducing the gap between its baseline (historically the previous year's performance) and the benchmark (the aspirational goal).

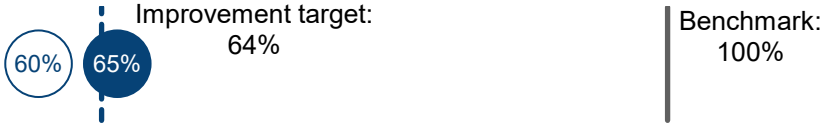
A CCO must show at least a 10 percent reduction in the gap between baseline and the benchmark to meet its improvement target. To ensure meaningful progress toward the benchmark, typically a floor is applied to each CCO's improvement target.

Suppose CCO A's performance in 2023 (their baseline) on a measure was 60.0% and the benchmark is 100.0%.

The gap between baseline and the benchmark is 100% - 60% = 40%.

Ten percent of 40% = 4%. Thus, CCO A must improve by 4 percentage points in 2026. Their improvement target is [baseline + 4%] = 60% + 4% = 64%.

Suppose that CCO A's performance in 2024 is 65%. They **reached their improvement target and met the measure**.



Stated as a formula:

$$\frac{[\text{Benchmark}] - [\text{CCO baseline}]}{10} = X$$

$$[\text{CCO baseline}] + [X] = \text{Improvement target}$$

In some cases, depending on the difference between the CCO's baseline and the benchmark, the Minnesota method may result in a very small improvement that may not represent a meaningful change. For example, suppose the benchmark was 75 percent, and CCO B's performance in 2023 was 60 percent. In this case, CCO B's improvement target using the formula would be:

$$\frac{75\% - 60\%}{10} = 1.5\%$$

$$60\% + 1.5\% = 61.5\%$$

Where the Minnesota method results in small improvement targets like this, the Metrics and Scoring Committee typically has established a “floor” or minimum level of required improvement before the CCO would meet its improvement target. In this example, suppose the floor is three percentage points. The Minnesota method formula results in 1.5% increase. Instead of 61.5%, CCO B’s improvement target with the 3% floor applied would be: [baseline + floor] = 60% + 3% = 63%.

Appendix C: How we describe change over time

For some charts we describe the change in CCO performance over time. Descriptions are based on **percent change**, or the relative rate of change. For example, a 100% increase means that CCO performance doubled from one year to the next. For consistency, we use the following descriptions for ranges in percent change:

- Improved: 10% or more
- Slightly improved: 3.01% to 9.99%
- Held steady: -3% to 3%
- Slightly worsened: -3.01% to -9.99%
- Worsened: Less than 10%

Appendix D: 2024 CCO rates and percentage point change from 2023

	Advanced Health	AllCare Health Plan	Cascade Health Alliance	Columbia Pacific	Eastern Oregon	Health Share of Oregon	InterCommunity Health Network	Jackson Care Connect	PacificSource Central	PacificSource Gorge	PacificSource Lane	PacificSource Marion Polk	Trillium North	Trillium South	Umpqua Health Alliance	Yamhill Community Care	CCO statewide
Assessments for Children in ODHS Custody	93.9% -1.8	91.8% +12.5	98.3% +7.1	74.4% +5.5	96.7% +4.5	93.8% +4.9	85.7% -5.4	93.8% +1.3	68.0% -16.9	94.4% -0.3	72.8% -5.8	96.8% +2.5	83.3% +8.3	71.8% -6.0	96.9% +4.2	96.2% +4.5	88.9% +1.1
Meaningful Language Access (Health Equity)	4.3% -1.8	9.3% +9.3	4.2% +3.2	4.9% +3.4	11.0% +0.3	15.8% +8.8	1.1% -0.9	11.1% +7.0	14.6% +3.8	1.5% -19.8	11.7% -9.0	15.1% -0.5	17.5% +4.1	14.8% +8.2	7.9% +3.8	23.7% +13.8	14.4% +3.7
Child and Adolescent Well-Care Visits (Ages 3-6)	68.5% +1.1	66.3% +4.2	70.8% +4.6	60.6% +0.9	68.2% +0.8	69.9% +3.8	70.8% +5.3	66.3% -0.3	75.2% +4.7	77.5% +3.1	59.9% -1.4	72.9% +8.7	49.2% +7.7	60.3% +8.9	75.4% +4.7	71.5% -1.8	69.0% +3.6
Childhood Immunization Status: Combo 3	62.4% +0.8	43.0% -2.4	61.5% +3.0	49.2% -6.1	66.5% +1.6	61.5% +2.0	61.7% +6.1	53.5% -1.7	60.7% +0.5	61.1% -1.5	64.1% 0	62.9% +1.6	43.4% -0.8	55.4% +8.3	51.9% -3.5	62.4% -2.3	60.0% +1.0
Immunizations for Adolescents: Combo 2	27.8% +0.5	16.7% +0.7	39.6% +2.8	22.7% -6.2	37.3% +0.8	39.2% +0.8	23.1% +0.7	29.4% +3.0	36.7% +2.2	49.5% +7.4	27.9% -1.5	37.1% +4.2	17.9% +1.4	26.0% +3.8	25.9% -0.1	39.8% +2.7	33.9% +1.2
Prenatal and Postpartum Care: Postpartum Care	85.4% -6.0	85.9% +4.4	89.8% +3.5	86.4% -0.5	79.6% +3.9	88.1% +1.9	86.5% +1.4	87.6% +3.9	87.1% +1.4	87.7% +0.7	87.6% +5.4	86.1% +3.5	76.9% +3.4	87.0% +4.1	87.8% +4.9	86.1% +1.6	85.9% +2.3
Diabetes: HbA1c Poor Control§	28.1% +1.7	20.7% -3.4	23.0% -4.0	21.8% -1.1	20.8% +0.8	23.8% -2.6	28.2% -2.0	22.0% -2.2	20.6% -2.1	19.6% -5.0	20.2% -0.6	24.9% -0.4	21.8% +1.4	18.4% -6.1	23.5% -7.5	19.4% -4.9	22.9% -1.7
Cigarette Smoking Prevalence§	21.7% -21.0	15.2% -7.6	23.7% -2.6	23.2% -0.1	15.6% -1.1	14.4% -1.9	19.6% -0.1	17.8% -1.8	17.0% -1.1	14.1% -1.1	19.0% -3.2	14.8% -1.2	15.6% -0.6	16.9% -2.1	21.6% +7.9	14.4% -0.7	16.4% -1.8
Substance Use Disorder Treatment: Initiation	42.7% +4.9	38.3% +0.7	43.7% -3.2	36.7% -0.5	36.8% -0.2	46.5% +0.4	38.3% +0.6	44.0% +2.4	40.1% -1.9	34.5% -5.5	39.4% -2.1	37.9% -3.2	45.9% +0.2	40.9% -1.6	36.2% -3.1	36.7% -5.0	41.7% -0.6
Substance Use Disorder Treatment: Engagement	14.6% +2.7	12.4% -2.4	18.3% -3.1	13.5% -0.5	13.5% -0.5	17.9% +0.9	19.0% +0.4	16.4% +1.2	17.4% +1.0	11.4% -3.2	15.7% -1.2	16.9% -1.9	14.7% -2.8	17.7% +1.3	15.1% +0.4	14.2% -0.9	16.5% -0.1

§ A lower rate is better for this measure

	Advanced Health	AllCare Health Plan	Cascade Health Alliance	Columbia Pacific	Eastern Oregon	Health Share of Oregon	InterCommunity Health Network	Jackson Care Connect	PacificSource Central	PacificSource Gorge	PacificSource Lane	PacificSource Marion Polk	Trillium North	Trillium South	Umpqua Health Alliance	Yamhill Community Care	CCO statewide
SBIRT: Rate 1	64.3%	68.8%	65.2%	53.9%	60.5%	63.8%	51.5%	76.7%	79.0%	62.5%	57.3%	67.4%	72.8%	75.9%	65.6%	81.8%	65.0%
	-8.7	+11.2	+9.2	-13.6	+5.3	+4.7	+24.0	+6.6	-2.2	+2.4	+3.4	+0.2	+1.2	-1.8	+6.9	+4.8	+4.8
SBIRT: Rate 2	20.0%	52.3%	43.1%	39.7%	30.3%	36.9%	7.8%	44.8%	65.7%	30.4%	46.7%	42.1%	49.1%	56.7%	65.5%	49.1%	43.3%
	+6.8	+4.8	-3.4	+19.7	+4.1	+12.8	-11.1	+14.0	+12.4	-4.5	-1.5	-4.3	+19.8	-5.7	+3.6	+18.8	+4.4
Screening for Depression and Follow-Up Plan	58.8%	67.1%	57.5%	67.7%	69.2%	69.6%	50.6%	76.7%	77.5%	58.8%	71.3%	61.8%	68.3%	74.0%	70.3%	78.6%	67.8%
	+9.8	+3.5	+20.2	-1.8	-5.4	+2.0	+5.7	+3.8	+1.8	-8.8	+4.1	+6.4	-1.6	+5.8	+11.6	+7.6	+2.9
Adults with Diabetes - Oral Evaluation	29.9%	25.1%	27.1%	28.8%	30.6%	30.8%	23.5%	28.2%	28.8%	30.8%	30.9%	26.9%	21.0%	27.9%	36.6%	32.2%	29.2%
	+4.6	+3.9	+7.0	+3.7	+3.1	+1.0	+0.5	+3.0	+5.4	-1.2	+3.4	+3.0	+1.7	+2.0	+5.3	+1.7	+2.4
Preventive Dental or Oral Health Services (Ages 1-5)	69.2%	66.0%	57.6%	54.5%	65.7%	60.4%	62.2%	66.6%	59.4%	51.0%	62.7%	63.4%	43.3%	60.9%	59.6%	56.3%	61.1%
	+9.6	+4.4	-1.2	+7.3	+5.0	+5.3	+5.4	+6.1	+0.9	+1.0	+6.7	+7.2	+6.5	+5.1	+8.6	-0.4	+5.1
Preventive Dental or Oral Health Services (Ages 6-14)	71.3%	64.7%	61.0%	57.9%	70.8%	59.8%	65.9%	66.1%	65.7%	65.8%	68.3%	69.3%	37.2%	59.8%	70.8%	62.0%	63.7%
	+5.3	+4.8	-3.5	+2.3	+5.2	+1.8	+4.4	+3.2	+2.2	+2.3	-0.7	+0.8	-1.7	-0.6	+9.3	+2.1	+1.9

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Metrics.Questions@odhsoha.oregon.gov or 503-201-1949 (voice/text). We accept all relay calls.

Health Policy and Analytics Division
CCO Quality Incentive Program
Metrics.Questions@odhsoha.oregon.gov
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics.aspx

OREGON HEALTH AUTHORITY