# What is the CCO Quality Incentive Program?

Oregon's Quality Incentive Program (sometimes shortened to "QIP") helps improve the quality of care for people with Oregon Health Plan (OHP) coverage.[1] The program gives Coordinated Care Organizations[2] (CCOs) the opportunity to earn financial bonuses each year by improving on a set of health care quality measures. These measures are often called "incentive metrics" and they are selected by a public body called the Metrics and Scoring Committee. The committee also selects the annual requirements for how much CCOs must improve on each measure to earn the bonus money.

**The Quality Incentive Program is important because:**

- CCOs are more likely to improve on measures with a financial incentive tied to them. The measures included the program are an effective tool for driving progress.[3]
- The program gives out a lot of money to CCOs (more than $300 million in 2024) and it's important that the money is spent toward improving areas of care that matter to OHP members.
- Finally, OHA publicly reports CCO performance on all the incentive measures. This is important for public transparency and accountability. (In fact, OHA reports dozens of additional health care quality measures, not just the incentive measures. Learn more in the Regular Reporting section on page 4.)

# Who decides which measures are in the program?

Incentive measures are selected by a public body called the Metrics and Scoring Committee. The committee also selects the benchmarks and targets that CCOs must meet to earn credit for incentive measures. Measures and benchmarks are selected annually.

The committee makes decisions by voting, and it is made up of people with different expertise and perspectives. The public is welcome to attend Metrics and Scoring Committee meetings. People can also provide public testimony to the committee—either by attending meetings and speaking to the committee, or by submitting written testimony. Public testimony helps committee members understand the personal experiences and different views of people who are impacted by Quality Incentive Program.

### Metrics and Scoring Committee

The Metrics and Scoring Committee is a nine-member public body. Members include three measurement experts, three CCO representatives, and three members at large. They are appointed by the director of the Oregon Health Authority (OHA), which is the state agency that oversees the Quality Incentive Program. Employees of OHA help staff the committee.

The committee has existed since 2012, when it was established by the Oregon Legislature with Senate Bill 1580. It is a committee of the Oregon Health Policy Board (OHPB), which is a citizen board that oversees OHA and helps guide health policy in Oregon.

The committee meets on the third Friday of each month from 9 am – noon. The meetings are usually virtual (via Zoom), but about twice per year members and the public have the option to attend in-person.

[1] OHP is Oregon's version of Medicaid, which offers free health insurance to people with lower incomes.
[2] CCOs are local networks of health care providers that work together to provide care to OHP members. There are currently 16 CCOs in Oregon.
[3] https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2012-2017-Evaluation.pdf

# What types of measures can the committee select?

There are some limits to which measures the Metrics and Scoring Committee can choose. Beginning with the 2025 measure set, the committee is required to choose two types of measures: downstream and upstream.

- **"Downstream" measures** focus on traditional health care and medical services, such as the prevention and treatment of disease. The Metrics and Scoring Committee must select downstream measures from the CMS Child and Adult Core Sets, which are lists of standardized health care quality measures selected by the federal government. (CMS stands for the Centers for Medicare and Medicaid Services. It's the federal agency that oversees state Medicaid programs.)
- **"Upstream" measures** focus on the social determinants of health. The Metrics and Scoring Committee must include at least four upstream measures in the program each year. Upstream measures are typically unique to Oregon and are created by OHA and community partners. *Social determinants of health* (often abbreviated to SDOH) means:
  - Nonmedical factors that influence health outcomes,
  - 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 systems, development agendas, social norms and policies, racism, climate change and political systems.

# Measuring Success

**CCOs typically receive credit for incentive measures by reaching a benchmark or improvement target.**

CCOs earn bonus money through the Quality Incentive Program by demonstrating improvement or exceptional performance on a set of quality measures. In addition to selecting the measures, the committee also selects a **benchmark** for each measure. Benchmarks are intended to be aspirational goals and reflect *exceptional* performance. Historically, the committee has often selected benchmarks equal to top performance in the country (such as 75$^{th}$ or even 90$^{th}$ national Medicaid percentiles). If a CCO reaches the benchmark for a measure in a given year, then they have "met" that measure. [4]

Another way CCOs can meet a measure is to *improve* toward the benchmark. To determine improvement, OHA calculates an individual **improvement target** for each CCO. Improvement targets are based on each CCO's performance in the prior year (known as "baseline" performance) compared with the benchmark.

More specifically, improvement targets are calculated so that each CCO must *either:*

a) close the distance between their baseline performance and the benchmark by ten percent (one-tenth), *or*
b) improve by at least a certain number of percentage points from their baseline,

…*whichever value is greater*. Part a) described above is called the "Minnesota Method."[5] Part b) is called the "improvement target floor" and the Metrics and Scoring Committee chooses the floor for each measure. See Appendix A for a more detailed explanation (with pictures!) of how improvement targets are calculated.

### Key principles of benchmarks and improvement targets

- A CCO can meet a measure by meeting either the benchmark or the improvement target.
- Benchmarks are aspirational goals. Each measure has its own benchmark, selected by the Metrics and Scoring Committee. Benchmarks are the same for all CCOs.
- Improvement targets are unique to each CCO. They depend on performance in the prior ("baseline") year.

[4] Occasionally when a measure is new, the "benchmark" might be reporting data or other requirements.
[5] So called because it was created by the Minnesota Department of Health.

## How is the Quality Incentive Program funded?

**Background: CCOs receive capitation payments to care for their members.**

Each month OHA pays CCOs a fixed, predefined amount of money for each OHP member enrolled in the CCO. These are called **capitation payments**. CCOs use capitation payments for the care OHP members receive from providers. The federal government reviews OHA's capitation rates and approves the rates to cover members' OHP benefit and health care costs.

**The money that CCOs can earn through the Quality Incentive Program is bonus money.**

In addition to the capitation payments described above, OHA sets aside extra money to reward CCOs through the Quality Incentive Program. This extra money is called the **quality pool**. The amount in the quality pool each year is based on a percentage of CCOs' capitation payments as decided by OHA. In 2024, the quality pool was 4.25% of CCO capitation, or more than $300 million across all 16 CCOs.

If you think of capitation as a salary that CCOs receive for doing their job (i.e., taking care of their members) then the quality pool is an end-of-year bonus for providing *exceptional* care. CCOs have discretion in how they use their quality pool earnings, but they must tell OHA both their planned and actual spending. Reporting suggests that on average, CCOs distribute about 90 percent of their quality pool earnings to community-based organizations, clinics, and providers.

Since CCOs vary greatly in their membership numbers (the smallest CCO serves fewer than 20,000 members, and the biggest serves almost 450,000), their capitation payments – and thus their annual quality pool – also varies. In 2024, the quality pool for the biggest CCO was more than $100 million, and the quality pool for the smallest CCO was $4.4 million.

**Key principles of the quality pool**

- The quality pool is **bonus** money.
- The amount of money in each CCO's quality pool is **proportional** to how many members are in that CCO.

## How do CCOs earn quality pool dollars?

**To earn their entire quality pool, a CCO must meet at least 75 percent of the incentive measures that year.** In 2024 there were 15 incentive measures, so if a CCO meets anywhere from 12 to 15 of those measures, they get all their quality pool money.

If a CCO meets *fewer* than 12 of the 15 measures, then they earn a *portion* of their quality pool money. For example, a CCO that meets 11 measures will earn 90% of its quality pool; while a CCO that only meets 6 measures will earn 50%.

**What happens with unearned quality pool dollars?**

As described above, any CCOs that don't meet at least 75 percent of the incentive measures in a year will not earn their entire quality pool. That's where the **challenge pool** comes in. Any unearned quality pool dollars are diverted to the annual challenge pool, which is distributed to CCOs in a second round of payments based on how CCOs perform on a special subset of incentive measures ("challenge pool measures"). Challenge pool measures are decided by the Metrics and Scoring Committee.

Since the amount of money in the annual challenge pool is based on CCOs' initial quality pool distribution, nobody knows just how big it will be until final performance is calculated. If most CCOs earn all their quality pool dollars in the first round, then the challenge pool will be smaller. But if several CCOs *do not* earn all their quality pool dollars in the first round, then the challenge pool can be quite large. That's especially true if bigger

CCOs (i.e., CCOs with more members) have leftover quality pool dollars, since their quality pools are bigger to begin with.

### How is the challenge pool distributed?

All CCOs – regardless of how much of their quality pool they earned – can earn extra bonus money through the challenge pool. The total challenge pool is divided into equal parts, depending upon how many CCOs meet each of the challenge pool measures. For example, suppose there are four challenge pool measures in a given year. Then suppose that between all 16 CCOs, those four challenge measures are met a total of 32 times – with some CCOs meeting all four measures, some meeting none, and anything in between. Then the total challenge pool will be divided into 32 parts and distributed to CCOs based on how many times they met a challenge pool measure. The individual payments are also adjusted for the size of each CCO (a large CCO that meets one challenge pool measure will receive a larger payment than a small CCO that meets one challenge pool measure).

**Key principles of the challenge pool**

- Through the challenge pool, **all** quality pool dollars are distributed each year.
- The Metrics and Scoring Committee **chooses** challenge pool measures, which are typically a subset of the regular incentive measure set.
- The challenge pool is distributed in based on how many times each challenge pool measure is met.
- The amount of money that will be in the challenge pool **is not known in advance** of the performance year.

**Feeling confused?** See Appendix B for a visual summary of how the quality pool is distributed, or read the more detailed 2024 Quality Pool Methodology online.

# Regular Reporting

OHA publishes an annual CCO Performance Metrics Dashboard which allows users to explore results for quality incentive measures as well as dozens of other health care measures. The dashboard shows CCO performance and demographic breakdowns by granular race, ethnicity, language and disability categories.

The dashboard is typically updated in the fall with new data from the prior calendar year. Most measures also show trend over time – sometimes as far back as 2011.

Every summer, OHA also publishes an annual Quality Incentive Final Report which describes results for the prior measurement year. (Learn more about program cadence in the next section.) The report includes a summary of CCOs' performance on the quality incentive measures and shows the amount of bonus money CCOs were rewarded. Read the 2023 Final Report, which was published in the summer of 2024.

The dashboard, annual reports, and other reports and analysis can all be found on CCO Quality Metrics Dashboards and Reports webpage.

# Program Timeline

The Quality Incentive Program runs annually (following the calendar year) and it has been ongoing since 2013. At any point in time, the program is focused on last year, the current year, and next year – all at the same time! That can be somewhat confusing, so the purpose of this section is to lay out the annual cadence and some of the terminology used.

- Measures are incentivized for a calendar year (from January to December). This is called the **measurement year.**
  - *For example, as of this publication (in January 2025) we are just beginning measurement year 2025. That means CCOs will actively work to improve on the 2025 incentive measure set during this calendar year.*

- To calculate improvement targets, we look at each CCO's performance during the year *prior* to the measurement. This is called **baseline** performance.
  - *For example, 2024 is the baseline (comparison) year to measurement year 2025.*

- We find out how CCOs **performed** (and how much money they earned as a result) at the end of June *following* the measurement year.[6]
  - *For example, CCO performance and quality pool distribution for the 2025 measurement year will be known in June 2026.*

- Measures and benchmarks for a measurement year are **selected** by the Metrics and Scoring Committee (MSC) during the year *before* the upcoming measurement year. The measure set is typically finalized in July, and the benchmarks and targets are finalized in October.
  - *For example, the measures and benchmarks for measurement year 2025 were selected by the committee in 2024.*

To illustrate, the table below shows these key milestones for three measurement years: **2024**, **2025**, and **2026**.

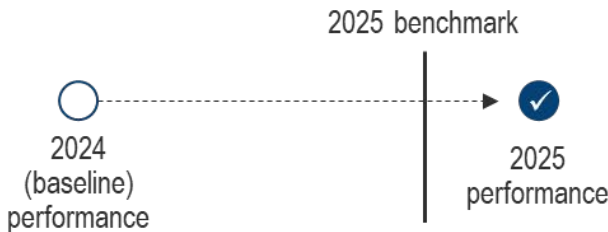
| | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|
| Milestones related to *measurement year* **2024** | – Baseline year to 2024<br>– 2024 measures and benchmarks selected by MSC (summer and fall) | 2024 measurement year | 2024 performance reported and quality pool money is distributed to CCOs (June) | | |
| Milestones related to *measurement year* **2025** | | – Baseline year to 2025<br>– 2025 measures and benchmarks selected by MSC (summer and fall) | 2025 measurement year | 2025 performance reported and quality pool money is distributed to CCOs (June) | |
| Milestones related to *measurement year* **2026** | | | – Baseline year to 2026<br>– 2026 measures and benchmarks selected by MSC (summer and fall) | 2026 measurement year | 2026 performance reported and quality pool money is distributed to CCOs (June) |

[6] Why does it take six months to know performance for the measurement year? Health care quality measures are calculated using various sources – such as billing information, records from health care clinics, and information compiled by CCOs. These sources have a data lag, which means the information is not available instantaneously. OHA staff and others also need time to calculate the metrics and make sure everything is correct.

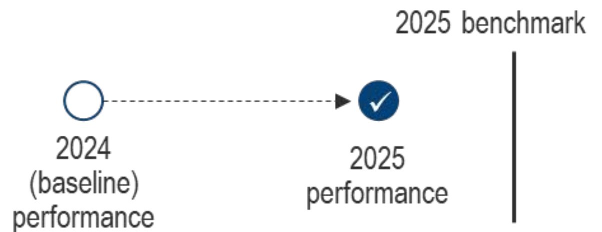
# Appendix A: Improvement Target Methodology

## How does a CCO "meet" a measure?

Option 1: By **reaching or passing** the benchmark.




Option 2: By **improving toward** the benchmark.



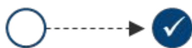

## How do we define *improvement* in option 2 above?

***Either* by closing the gap between baseline and benchmark by one-tenth (10 percent).**

Step 1: Calculate the gap:

Step 2: Calculate one-tenth of the gap:

That distance is the CCO's individual **improvement target.** If the CCO reaches its improvement target in the next measurement year, then it meets the measure.

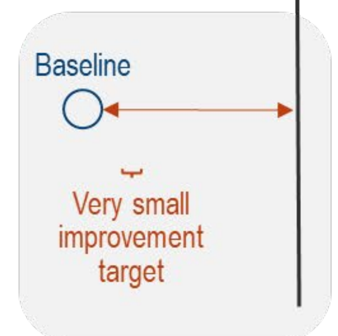


***Or* by improving by a pre-defined percentage point increase.**

This is called the **improvement target floor.** The floor is important because sometimes, the gap between a CCO's baseline and the benchmark is quite small…

And then one-tenth of the gap is *very* small (less than a few percentage points)…

So, the Metrics and Scoring Committee says **"a CCO must improve by *at least* 3 percentage points** (for example) **to meet a measure."**




In other words, a CCO must *either* meet its individual improvement target (close the gap by one-tenth) *or* meet the improvement target floor (improve by a predefined percentage point) – whichever value is greater.

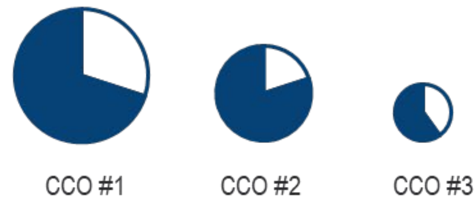
# Appendix B: Quality Pool Distribution

Each CCO has a maximum **quality pool** which is based on a percent of their capitation payments.
(bigger CCO = bigger pool)

To earn their quality pool, CCOs must "meet" (✓) incentive measures.

If a CCO meets **75%** (12/15) of the incentive measures, they will earn **100% of their quality pool**.

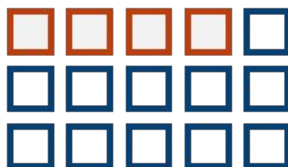
If a CCO meets **fewer than 75%** of the incentive measures, they earn a **portion of their quality pool.**



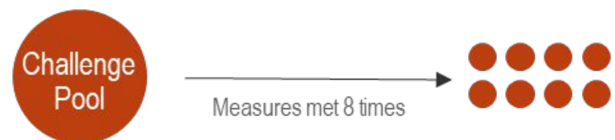

Any unearned quality pool dollars are combined into a **challenge pool.**

**The challenge pool is distributed to CCOs in a second round of payments:**

To earn challenge pool money, CCOs must meet a subset of **"challenge pool" incentive measures**.



The total challenge pool is divided into equal parts, based upon how many instances the challenge pool measures are met.




The challenge pool payments are adjusted for the size of each CCO and distributed based on how many times each CCO met a challenge pool measure.