

MEDICAID ADVISORY COMMITTEEJune 24th

9:00 a.m. – 12:00 p.m.

General Services Building

Mazama Conference Room

1225 Ferry St. SE, Salem, Oregon

Time	Item	Presenter
9:00	Opening Remarks <ul style="list-style-type: none"> Approval of Minutes – March and April 2015 OHA Update: CCOs and OHP Renewals 	Co-Chairs; Rhonda Busek, OHA
9:10	2015 Legislative Session - Outcomes	Brian Nieubuurt, OHA
9:15	Medicaid 12 Month Continuous Eligibility <ul style="list-style-type: none"> Cost projections for 2017-19 	Co-Chairs; OHA staff
9:40	Patient-Centered Primary Care Home Program (PCPCH)	Nicole Merrithew, OHA
10:10	Columbia Pacific CCO CAC <ul style="list-style-type: none"> Columbia Pacific CCO CAC membership and community engagement activities Council priority areas and implementation activities outlined in the CHIP 	Nancy Knopf, Columbia Pacific CAC
10:40	FamilyCare Community Advisory Council <ul style="list-style-type: none"> FamilyCare CAC membership and community engagement activities Council priority areas and implementation activities outlined in the CHIP 	Brett Hamilton, FamilyCare CAC
11:10	Break	
11:15	Oregon MAGI Eligibility Transition Project	Sarah Miller, OHA
11:40	Medicaid 12 Month Continuous Eligibility (cont.) <ul style="list-style-type: none"> Committee direction/potential recommendations 	Co-Chairs; OHA staff
12:00	Closing comments: July visit by Lynne Saxton	Co-Chairs; staff

Materials:

1. Agenda
2. Draft Minutes, March and April 2015
3. OHP Dashboard June 2015
4. 2015 Oregon Legislative Tracker
5. OHP 12 month Eligibility Cost Analysis (*draft)
6. Oregon CAC Health Affairs Blog (background)
7. Family Care CAC Presentation
8. Oregon Health Plan, Section 1115 Quarterly Report, Spring 2015 (w/attachments)

Next Meeting:

Wednesday, July 22nd: 9:00 a.m. – 12:00 p.m.
Salem, Oregon

June 24th, 2015

OREGON MEDICAID ADVISORY COMMITTEE
March 25th 2015
9:00am – 12:00pm
Mazama Conference Room, General Services Building
1225 Ferry St. SE, Salem, Oregon

MEMBERS IN ATTENDANCE: Janet Patin, Rhonda Busek , Carol Criswell, Karen Gaffney, Alyssa Franzen, Kristen Dillon, Leslie Sutton, Glendora Claybrooks, Carol Criswell, Bob Diprete, Ross Ryan

MEMBERS ABSENT:

PHONE PARTICIPANTS: Kay Dickerson, Laura Etherton

PRESENTERS: OHA: Brian Nieubuurt, Rhonda Busek, Ellen Pinney, Adrienne Mullock, Tom Cogswell; Sandra Clark, Amy Anderson, Health Share CAC,

STAFF: Jeannette Nguyen-Johnson, Oliver Droppers

TOPIC	Key Discussion Points	Responsible Party
Opening Remarks and Staff Update	Introduction and roll call. Staff reviewed the agenda and the list of topics to cover. Staff also commented about the final report on Senate Bill 1526 that was submitted to the Legislature on behalf of OHA and Committee.	Co-Chair & MAC staff
Approval of Minutes	The committee reviewed meeting minutes from January 28 th , 2015. A motion was made to approve the minutes, motion was seconded; minutes were approved.	Co-Chair & Committee
OHA Transformation Center	<p>Adrienne Mullock presented on the work of the Transformation Center (see slides 4-22). The presentation is outlined as follows:</p> <ul style="list-style-type: none"> • Overview of the 36 Community Advisory Councils that operate statewide. • Summary of the key priority areas identified in the CACs' community health improvement plans (CHIPS) developed by the CACs. • Brief overview of Senate Bill 436, which requires CCOs to focus on children's health to the extent possible. • Outlined the focus for the OHA Transformation Center in 2015 in terms of working with the CACs. 	Adrienne Mullock, OHA
Health Share CAC	<p>Staff with Health Share's Community Advisory Council (CAC), presented on the work of the CAC (see slides 24-45). The presentation is outlined as follows:</p> <ul style="list-style-type: none"> • Sandra provided the committee with an overview of Health Share and, it's CAC. • The CAC played the leading and extensive role in the develop of the community health and needs assessment and community improvement plan in 2013-2014, investing over 500 hours in this work. • The presentation highlighted the importance of having OHP members actively involved and leading the assessment and improvement development processes. 	Sandra Clark, Amy Anderson

	<ul style="list-style-type: none"> • Health Share’s CAC learned a lot from developing the CHNA and CHP over the two-year period. 	
Committee Work Plan	<p>Committee Strategic Planning and Draft Work Plan (slides 47-50).</p> <ul style="list-style-type: none"> • Staff introduced the draft committee charter and the proposed work plan for 2015. • Staff then introduced the next body of work for the committee. The issue is whether 12-month continuous eligibility for adults is financially feasible in Oregon for the 2017-19 biennium. • Outlined was the timeline and work plan for completing the financial analysis. • Several questions were raised regarding existing Medicaid eligibility in Oregon in OHP. Staff provided clarification about the different between 12-month continuous eligibility and 12-month certification. Staff will follow-up on several questions at the next committee meeting. 	Co-Chair, Staff & Committee
Public Comment	No public comment was made.	Co-Chair
Adjourn	The meeting was adjourned at 12:00 p.m.	Co-Chair

Next MAC meeting:

April 22nd, 2015

9:00am – 12:00pm

Mazama Conference Room, General Services Building

1225 Ferry St. SE, Salem, Oregon

OREGON April 22, 2014
9:00am – 12:00pm
Mt. Mazama Conference Room
1225 Ferry Street SE; Salem, OR 97301

MEMBERS IN ATTENDANCE: Janet Patin, Karen Gaffney, Rhonda Busek, Glendora Claybrooks, Carol Criswell, Kristen Dillon, Bob Diprete, Alyssa Franzen, Marcia Hill, Ross Ryan, Leslie Sutton

MEMBERS ABSENT:

PHONE PARTICIPANTS: Kay Dickerson, Laura Etherton

PRESENTERS: Rhonda Busek, OHA; Oliver Vera, OHA; Sarah Bartelmann, OHA; Leah Edelman and Tara Davee, Trillium CAC

STAFF: Oliver Droppers, Jeannette Nguyen-Johnson

VISITORS:

TOPIC	<i>Key Discussion Points</i>	<i>Responsible Party</i>
Opening Remarks and Staff Update	<p>Introduction and roll call. Staff reviewed the agenda and the list of topics to cover.</p> <ul style="list-style-type: none"> Staff reviewed the changes to the committee charter that reflected feedback from the March 25th meeting. Committee charter was approved. 	Co-Chairs & MAC staff
Oregon Health Authority Update	<p>Rhonda Busek, Interim Director, OHA, Division of Medical Assistance Programs (DMAP), provided updates on Oregon's Health System Transformation.</p> <ul style="list-style-type: none"> OHA continues to focus on determination and enrollment with continued monitoring shown by the 2015 OHP Enrollment Determination and Enrollment Project dashboard from April 2015. Focus has also been on how staff is being deployed to meet the need. OHA continues to work with CCOs to ensure folks are receiving services and on health system transformation. Also happening is the OHA reorg and Lynne is scheduled to speak to the committee in July and can address this issue and what her vision is and how it is being implemented. There will still be a health system type division, which is where we will see the delivery system and integration come together under this division. Goal is to align the organizational structure with health system transformation. Committee members asked Rhonda about clarity regarding the average maximum wait times on the dashboard and whether disenrollment data could be included. Rhonda said she would follow-up with these inquiries at the next meeting. 	Rhonda Busek, OHA
Oregon 2015 Legislative Update	Staff briefly reviewed the legislative summary handout, noting that it was current as of April 16 th , and that April 21 st , the day before the committee met, was a legislative deadline for committees to hold a work session on first chamber measures.	MAC Staff

<p>OHA Community Partner Outreach Program</p>	<p>Oliver Vera, Manager, OHA Community Partner Outreach Program</p> <ul style="list-style-type: none"> • Oliver provided an overview of the community partner outreach program including the composition of the team as well describing the community partners they serve • There are over 230 contracted partner organizations statewide and a network of over 800 certified Application Assisters (staff/volunteer), comprised of health care providers, community-based organizations, faith-based organizations, Tribes, health advocacy groups, health care systems, safety-net clinics, county health departments, etc. who provide culturally and linguistically appropriate assistance at no-cost. The office ensures the staff and community partners are able to offer assistance statewide and that they reflect the demographics of Oregon. • Oliver also described the role of the outreach team, which includes Training and Certification, staffing Collaborative Meetings, providing Technical Support and developing Outreach Strategies, providing Community Level Support and producing information Materials as needed. 	<p>Oliver Vera, OHA</p>
<p>OHA Metrics and Scoring Committee</p>	<p>Sarah Bartelmann, Office of Health Analytics, OHA</p> <ul style="list-style-type: none"> • Sarah reviewed the Health System Transformation 2014 Mid-Year Performance Report. The OHA is accountable to CMS under the waiver for many different measures that hold the agency and CCOs accountable. See slides 10-47 of the presentation. In her presentation, Sarah discussed what we learned about the ACA population, the Coordinated Care Model, behavioral health and public health. She also summarized across the different measures sets and provided an update as to what metrics will be retired and which ones will be added, as well as upcoming work by the Child and Family Wellbeing Measures Workgroup and the Metrics & Scoring Committee. 	<p>Sarah Bartelmann, OHA</p>
<p>Trillium Community Health Plan, CAC</p>	<p>Leah Edelman staff to the Trillium CAC and Tara Davee, Trillium CAC member</p> <ul style="list-style-type: none"> • Leah and Tara described the purpose and structure of the Trillium CAC (see slides 48-56). • They also described the different CAC Committees that focus on prevention, health equity and member engagement. They also highlighted some of the work from their community health improvement plan that the CAC was responsible for developing. That included work to reduce tobacco use and childhood obesity, as well as address mental health and substance abuse. Lastly, they described some of the advantages and challenges of their CAC. 	<p>Leah Edelman and Tara Davee, Trillium CAC</p>
<p>Medicaid 12 Month Continuous Eligibility</p>	<p>MAC Staff, 12-Month Continuous Eligibility Policy for OHP Adults (see slides 57-68)</p> <ul style="list-style-type: none"> • Staff reviewed background on Oregon’s Medicaid’s coverage landscape and current policies relating to eligibility and financing as well as the issue of churn. Staff also reviewed the MAC’s previous work on churn and recommendation for the OHA to conduct a financial analysis on 12-month continuous eligibility for OHP adults. • Staff reviewed the 12-month continuous eligibility policy, including authority and financing from CMS guidance, as well as the impact of the policy on stakeholders. Lastly, staff previewed the financial analysis of the policy and the summer MAC work schedule. 	<p>MAC Staff</p>

Public Comment	No public comment was made.	Co-Chairs
Adjourn	The meeting was adjourned at 12:00 p.m.	Co-Chairs

Next MAC meeting:

June 24th, 2015

9:00 a.m. – 12:00 p.m.

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2015 OHP Determination and Enrollment Project

Main 800 number Weekly Averages	Baseline*	6/5/2015	6/12/2015	Target
Total Daily Calls Received	6,846	4,523	4,223	
Total Daily Calls Answered	3,310	3,628	3,630	90%
Average Wait Time (minutes)	33	7	5	<10
Average Maximum Wait Time (minutes)	166	32	36	<20

*The baseline column represents the reporting numbers at the beginning of the project in February 2015.

Closure Line Weekly Averages	Baseline	6/5/2015	6/12/2015	Target
Closure Line Calls Received	1,221	1,129	638	
Closure Line Calls Answered	664	778	541	90%
Closure Line Average Wait Time	21	9	4	<10
Closure Line Average Maximum Wait Time	149	51	34	<20

Full Application Calls Weekly Averages	Baseline	6/5/2015	6/12/2015	Target
Full Application Calls Received	612	991	891	
Full Application Calls Answered	340	788	640	90%
Full Application Average Wait Time	55	15	6	<10
Full Application Average Maximum Wait Time	132	43	30	<20

Oregon Application Process	Baseline	6/5/2015	6/12/2015	
2015 Enrollments Into Oregon Health Plan	46,563	225,449	230,728	
Applications Awaiting Determination	26,210	14,987	14,052	
Applicants Requiring Manual Review	23,749	43,084	39,752	

Federal Application Process	Baseline	6/5/2015	6/12/2015	
Enrolled Into Oregon Health Plan	61,888	179,905	181,993	
Applicants Requiring Manual Review	66,664	22,058	20,439	

Oregon Health Plan Enrollments	Baseline	6/5/2015	6/12/2015	Difference
Net Total Enrollment in OHP	1,098,200	1,101,219	1,108,100	+6881



2015 OHP Determination and Enrollment Project

Our mission is to provide excellent customer support to all OHP members.

Last week's accomplishments:

- All backlog of pregnancy related applications are now complete
- Over 10,000 enrollment applications were processed

Last week's challenges:

- The increased volume of applications continues to be a challenge for staff, but process improvements are now in place that allow staff to continue reducing the backlog
- A high volume of Cover Oregon report out files are requiring manual review
- High call volumes continue to pull staff from processing paper applications

This week's goals:

- Train twenty additional staff to work on manual review files
- Complete individual staff skills chart
- Identify process improvements and update the escalation to handle the end-of-month peak in closure calls

Feedback

"I live on a budget and if I would not have had OHP I would likely have been dead. Because I was able to go to the doctor, my cancer was detected early. I was able to get the treatment I needed and am now cancer free. OHP has been a real Godsend." Call center customer

"I really appreciated your ability to tell me what was going on. I have worked in customer service for most of my life, and I know when I am getting great service. Thank you!" Call center customer

2015 Oregon Legislative Session Update -- Medicaid Policy-Related Bills*

Prepared for the Medicaid Advisory Committee

Current as of June 18, 2015

Bill	Summary	Relationship to MAC/OHP	Current Status
OHA Bills			
HB 2395	Extends hospital assessment from September 30, 2015, to September 30, 2019.	Funding for the Oregon Health Plan	Governor signed March 23rd
House Bills			
HB 2302	Modifies definition of "prepaid managed care health services organization."	Changes meaning of an MCO to "person who is reimbursed through the state medical assistance program for providing care to a recipient of medical assistance."	Assigned to Subcommittee on Human Services.
HB2231	Prohibits CCO from requiring organizational providers to produce information that is redundant with respect to or outside scope of on-site quality assessment of organizational provider conducted by OHA	Quality improvement and measurement; administrative burden.	Governor signed May 26th
HB 2522	Creates Islander Health Coverage Gap Assessment Office in OHA to promote access to health care for island citizens residing in United States under Compact of Free Association (COFA)	Would provide coverage to low-income individuals (COFA) currently barred from Medicaid coverage.	Assigned to Subcommittee on Transportation; DCBS companion.
HB 2638	Allows OHP members and CCOs to use the Oregon Prescription Drug Program.	Allow CCOs the opportunity to take advantage of the discounted prescription drug rates	Waiting for Governor's signature
HB 2696	Requires OHA to collaborate with CCOs to develop uniform audit processes and forms.	Potentially lessen the administrative burden for CCOs.	Waiting for Governor's signature
HB 2879	Establishes task force to study financing and delivery of health care in this state and make recommendations regarding legislative changes to ensure that residents of this state have access to high-quality health care.	Task force could identify improved options for financing and delivery of health care for individuals eligible for OHP and others in this state.	Public hearing and possible work session June 18 th
HB 2934	Requires OHA to submit blueprint for Basic Health Plan to CMS by December 31, 2015	MAC issued recommendation on BHP in 2014.	Governor signed June 4, 2015
HB 3300	Requires primary care physician to serve specified percentage of medical assistance recipients in order to contract with Public Employees' Benefit Board or Oregon	Would increase access to OHP members.	Referred to Ways and Means, June 19 th .

*This tracker is not an exhaustive list of bills introduced during the 2015 legislative session.

2015 Oregon Legislative Session Update -- Medicaid Policy-Related Bills*

Prepared for the Medicaid Advisory Committee

Current as of June 18, 2015

Bill	Summary	Relationship to MAC/OHP	Current Status
	Educators Benefit Board to provide medical care.		
HB 3343	Requires medical assistance program to include 12 months' coverage of prescription contraceptives under specified conditions	Would ensure one year's access to prescription contraceptives for eligible OHP members.	Governor Signed, June 11th
HB 3464	Establishes task force to study financing and delivery of health care in this state and make recommendations regarding legislative changes to ensure that quality health care is delivered in cost-effective manner	Task force could identify improved options for financing and delivery of health care for individuals eligible for OHP and others in this state.	House conference, June 18 th
HB 3517	Authorizes Oregon Health Authority to provide medical assistance, within available funds, to low income children residing in Oregon if necessary to move toward goals of Legislative Assembly expressed in law and to improve health of Oregon communities	Could help children below 300% FPL who do not qualify for OHP gain access to health care.	Referred to Ways and Means, May 11 th
Senate Bills			
SB1	Abolishes Cover Oregon and board of directors of corporation and transfers powers, rights, obligations, liabilities, functions and duties to Department of Consumer and Business Services	Coverage transitions between OHP and Marketplace coverage; churn.	Governor signed into law, March 6th.
SB 231	Requires certain carriers, Public Employees' Benefit Board and Oregon Educators Benefit Board to report to DCBS proportion of carrier's and board's total medical expenses allocated to primary care	Would establish a multi-payer primary care collaborative. Collaborative to support primary care providers, including providers that serve OHP.	Waiting for Governor's signature.
SB 309	Prohibits discrimination based on age, expected length of life, present or predicted disability, degree of medical dependency or quality of life in issuance of health benefit plans and in determination of medical services covered by state medical assistance program.	Would ensure improved health equity for OHP members.	Public hearing and possible work session on April 20 th .
SB 440	Requires Oregon Health Policy Board to establish Health	Could affect the Metrics and Scoring	Governor signed, June 11th

*This tracker is not an exhaustive list of bills introduced during the 2015 legislative session.

2015 Oregon Legislative Session Update -- Medicaid Policy-Related Bills*

Prepared for the Medicaid Advisory Committee

Current as of June 18, 2015

Bill	Summary	Relationship to MAC/OHP	Current Status
	Plan Quality Metrics Committee to develop health outcome and quality measures for CCOs and plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board.	Committee.	
SB 695	Repeals sunset on authorization for Oregon Health Authority to contract with prepaid managed care health services organization to provide care to OHP recipients.	Repeals sunset on authorization for OHA to contract with prepaid managed care organization to provide care to OHP	Senate, public hearing held, June 16 th
SB 832	Requires Oregon Health Authority to prescribe by rule standards for integrating behavioral health services and physical health services in patient centered primary care homes and behavioral health homes.	Would prohibit CCOs from restricting access to mental health services for OHP enrollees.	Referred to Rules, June 11 th
SB 841	Modifies requirements for health plan coverage of prescription drugs dispensed in accordance with synchronization policy.	Would affect OHP members not enrolled in a CCO.	Public hearing/work session scheduled June 22 nd

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*This tracker is not an exhaustive list of bills introduced during the 2015 legislative session.

2015 Oregon Legislative Session Update -- Medicaid Policy-Related Bills*

Prepared for the Medicaid Advisory Committee

Current as of June 18, 2015

Bills that died as of June 18th, 2015

- HB 2421: Would include mental health medications in CCO global budgets.
- HB 2204: Funding for the Oregon Health Plan
- HB 2697: Potentially lessen the administrative burden for CCOs.
- HB 2877: require State of Oregon to contract with 3rd party to evaluate CCOs.
- HB 2935: Ensures representation of dental care organizations on CCO governing boards; could improve access to dental care for OHP members.
- HB 2937: Expands the definition and coverage criteria for durable medical equipment
- HB 2950: Could improve customer service experience for OHP members; reduce administrative burden related to Medicaid eligibility.
- HB 3023: Will ensure better dental health care for OHP pregnant women.
- HB 3513: Creates Rural Medicaid Access and Development Act.
- SB 147: Changes communication requirements for pharmacy or pharmacist that substitutes biological product.
- SB 309: Prohibits discrimination on age, length of life, present predicted disability....in determine issuance of health plans or OHP determination.
- SB 609: Would establish a multi-payer primary care collaborative. Collaborative to support primary care providers, including providers that serve OHP.
- SB 631: Would provide publicly funded, comprehensive, quality, patient-centered, equitable and affordable health care to all Oregonians
- SB 679: Create MMIS oversight committee
- SB 773: Would help provide continuity of coverage for child eligible for OHP.
- SB 791: Potentially impact OHA and CCOs
- SB 838: Create taskforce to review/report on prescription drugs coming to U.S. in 2015/16
- SB 892: Would potentially impact eligibility and enrollment in OHP.
- SB 928: OHA to operate 24-hour nurse advice line.

Upcoming Deadlines:

- June 26 – target *Sine Die*
- July 11 – Constitutional *Sine Die*

*This tracker is not an exhaustive list of bills introduced during the 2015 legislative session.

- Health Affairs Blog - <http://healthaffairs.org/blog> -

Oregon Bridges The Gap Between Health Care And Community-Based Health

Posted By [Chris DeMars](#) On February 12, 2015 @ 9:00 am In [Costs and Spending](#), [Following the ACA](#), [Medicaid and CHIP](#), [Organization and Delivery](#), [Population Health](#), [Public Health](#), [Quality](#) | [No Comments](#)

It is now commonly accepted that to achieve health, [the U.S. health system must address](#) ^[1] the social determinants of health. While the integration of [health care with social services and public health](#) ^[2] is happening relatively infrequently across the country, one bright spot can be found in Oregon, where an innovative Medicaid health system model, referred to as the coordinated care model, is showing early signs of success in bridging the gap between the community and the health care system.

Under Oregon Governor John Kitzhaber's leadership, newly created [coordinated care organizations](#) ^[3] (CCOs)—partnerships between physical, behavioral, and oral health providers—have over the past two years adopted Oregon's coordinated care model, which was created as the foundation for Oregon's health system reform efforts to ensure care is coordinated, performance is measured, positive outcomes are rewarded, and that there is a shared responsibility for health, sustainable rate of growth, and transparency in price and quality—all with the goal of promoting positive health outcomes.

In fact, Oregon's recently released mid-year [Health System Transformation progress report](#) ^[4] shows continuing improvements in areas such as enrollment in patient-centered primary care homes and decreases in emergency department visits and hospital admissions from chronic diseases. Additionally, financial data indicate coordinated care organizations are continuing to hold down costs. Oregon is staying within the budget that meets its commitment to the Centers for Medicare and Medicaid Services to reduce the growth in spending by two percentage points per member, per year.

CCOs are also required by statute to have a community advisory council (CAC) that includes representatives from community-based organizations and local government; more than half of the council must be Medicaid beneficiaries. CACs advise the CCO on how to meet their communities' health needs and move upstream to improve population health.

Oregon's Success

There are early signs that many CACs are successfully connecting CCOs with community partners to address social factors that influence health, thereby beginning to break down long-standing silos between entities that deliver health care and promote health. They are already driving partnerships between the CCO and the community around projects as diverse as a health program for Latino adolescents in a local high school, parenting and exercise classes for new mothers, and a food-delivery program for patients recently discharged from the hospital.

For example, Eastern Oregon CCO's community health assessment indicated cultural and linguistic barriers to accessing traditional health services, including adolescent well-care visits, for the Latino population. To address these issues, the CCO funded a community health worker to support pregnant or parenting adolescents—many of whom are Latino—in a local high school. The community health worker not only links these teens to health services, but provides supports to address the social determinants of health, such as housing, food security, and income stability. She recently helped a parenting teen apply for safe and affordable housing through the local community housing agency.

A key factor of CACs' initial success in bridging the community with health care is that they give Oregon's Medicaid members a voice in setting their CCOs' priorities. CACs recently completed

community health improvement plans for their CCOs, which included social-determinants-related priorities such as promoting access to healthy food and opportunities for physical activity; availability of affordable housing and transportation; and connections with the early childhood system. For example, early literacy is one of the priorities identified in the plan developed by PrimaryHealth of Josephine County's CAC and, as a result, the CCO purchased books for young children that the CAC members hand out at food banks and community events.

Addressing Patients' Social Needs

CACs can also help CCO providers better understand how to address their patients' social needs within the clinical walls. For example, the PacificSource Columbia Gorge CCO's CAC met with a group of the CCO's providers to offer insights about why Medicaid members sometimes don't show up for appointments as well as suggestions for how providers can help.

Not only did this conversation give providers an insider's perspective about the daily challenges their patients face, but the CAC members gave suggestions about how relatively minor actions from providers—such as asking patients if they face transportation challenges in getting to appointments, and offering non-emergent medical transportation (a covered Medicaid service within Oregon's CCOs) if they do—can play a vital role in addressing patients' social needs while simultaneously ensuring they receive necessary health care.

In addition, this CAC initiated a program, in partnership with the CCO's clinicians, focused on Medicaid members discharged from the hospital who need food assistance as part of their recovery. The program leverages the local Meals on Wheels system to deliver meals to Medicaid members of any age (beyond the Meals on Wheels' traditional senior population), providing not just nutritious food but an in-person visit that offers social support for members and, ideally, decreased emergency department readmissions.

While it is too early to determine the long-term impact of the CAC model on population health, we have seen early indications of success in Oregon. Policy makers interested in improving care while reducing costs would be wise to follow the model and, perhaps if its success continues, replicate it across the country to help move the US health system toward our primary goal: health.

Article printed from Health Affairs Blog: <http://healthaffairs.org/blog>

URL to article: <http://healthaffairs.org/blog/2015/02/12/oregon-bridges-the-gap-between-health-care-and-community-based-health/>

URLs in this post:

[1] the U.S. health system must address:

<http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier/>

[2] health care with social services and public health:

<http://jama.jamanetwork.com/article.aspx?articleID=1938574>

[3] coordinated care organizations: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>

[4] Health System Transformation progress report: <http://www.Oregon.gov/oha/metrics>

FamilyCare Health

PRESENTATION TO MEDICAID ADVISORY COUNCIL JUNE 10, 2015



FamilyCare Health: The Basics

Creating healthy individuals through innovative systems

Our Company

- FamilyCare just celebrated its 30 year anniversary.
- FamilyCare was the first Medicaid health plan in Oregon to integrate mental and physical health coverage into one plan beginning in 1996.
- We received “Best Place to Work” designation in 2012, 2013 and 2014.
- The entry level base salary has been at or above \$15.00 for the last two years.

Our Members

- Plan area: Clackamas, Multnomah, Washington and parts of Marion County
- Membership is approximately 130,000, more than 80,000 of whom were added due to Medicaid expansion.
- By percentage, FamilyCare is the fastest growing CCO in the state.
- Every member has an assigned Primary Care Provider.



Member Demographics

Between January 2013 and May 2015, FamilyCare's membership grew from ~45,500 to ~130,000.

The biggest population difference is the ratio of adults to children; in 2013, 68% of members were children.

Age	Count	%
Adults	79,150	61%
Children	51,086	39%
TOTAL	130,236	100%

Sex	Count	%
Female	66,818	51.3%
Male	63,418	48.7%
TOTAL	130,236	100.0%

Race/Ethnicity	Count	%
OHA Unspecified	28,228	22%
Asian	5,888	5%
Black	7,347	6%
White	65,209	50%
Hispanic	22,660	17%
Native American	904	1%
TOTAL	130,236	100%



Structure and Partners

Structure

- FamilyCare, Inc. is a 501(c)(4) public benefit corporation.
- Corporate structure is simple and transparent – revenue comes in from the State and is contracted directly with community providers.

Partners

- Because FamilyCare is a single entity, our key partners are our provider network and community stakeholders.
- Our Medical Advisory Panel is comprised of providers with whom we contract.
- We are also working with Health Share to coordinate a variety of areas including:
 - Non-Emergency Transportation
 - Flexible Benefits
 - Tri-County 911, focused on 911 high utilizers
 - Transgender Benefits
 - Healthy Columbia Willamette Consortium – Community Health Needs Assessment



Community Advisory Council

- The Community Advisory Council is comprised of FamilyCare community members and providers.
- Its purpose is to guide and participate in the planning and development of programs to improve the health of individuals residing in the metro area.
- The Council meets monthly, with quarterly meetings open to the public.
- Based on the Community Health Needs Assessment, the Council prioritized services in its Community Health Improvement Plan on the Transition-Aged Youth (TAY) population, ages 15-24. There are approximately 22,000 FamilyCare members in this age range.
- Specific focus areas includes:
 - Access to and engagement in care, specifically around mental health and substance use treatment.
 - Support in transitioning from child to adult healthcare systems, especially in the area of mental health services, and for youth exiting the foster care system.
 - A culturally-competent healthcare system that has understanding of the transition age youth population, and operationalizes best practices in services.



Challenges and Opportunities

- Authentic Consumer Voice vs. Advocate
 - Sharing lived experiences vs. Representing lived experiences
- Advisory vs. Operations
 - Recommendation vs. Authorization
- Tokenism vs. Engagement
 - Requirement of contract vs. requirement of success

Thank you for your attention.

Questions?

CCO Appeals by NOA Reason	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon	Family Care	Health Share	IHN	Jackson Care	PSCS CO	PSCS CG	Primary Health	Trillium	Umpqua	Western Oregon	Willamette Valley	Yamhill County
a) Denial or limited authorization of a requested service.	45	56	19	38	162	235	69	23	110	22	13	180	111	57	378	14
b) Single PHP service area, denial to obtain services outside the PHP panel	0	0	0	0	0	2	4	1			0	0	1	0		0
c) Termination, suspension or reduction of previously authorized covered services	0	0	1	5	0	50	0	0			0	0	0	0		0
d) Failure to act within the timeframes provided in 438.408(b)	0	0	0	0	0	1	0	0			0	0	0	0		0
e) Failure to provide services in a timely manner, as defined by the State	0	0	0	0	0	0	0	0			0	0	0	0		0
f) Denial of payment, at the time of any action affecting the claim.	89	0	11	182	15	79	93	2	72	15	0	0	0	0		0
TOTAL:	134	56	31	225	177	367	166	26	182	37	13	180	112	57	378	14
Appeals per 1000 members	2.63	3.15	1.05	4.70	1.41	1.49	2.85	0.83	3.40	2.88	1.11	1.90	4.25	2.67	3.73	0.56
Number overturned at Plan level	38	15	6	65	87	60	59	8	53	9	5	93	32	12	124	4
Appeal decisions pending	1	4	0	0	1	0	0	0	0	0	0	0	4	3	0	0

NOA Reason	AllCare	Cascade Health	Columbia Pacific	Eastern Oregon	Family Care	Health Share	IHN	Jackson Care	PSCS CO	PSCS CG	Primary Health	Trillium	Umpqua	Western Oregon	Willamette Valley	Yamhill County
a) Denial or limited authorization of a requested service.	2334	2677	624	668	2036	4522	1280	676	456	671	624	1595	2182	1807	2432	414
b) Single PHP service area, denial to obtain services outside the PHP panel	0	3	2	0	0	55	116	3			0	0	1	30	7	
c) Termination, suspension or reduction of previously authorized covered services	90	13	32	34	0	127	0	17			9	0	0	0		18
d) Failure to act within the timeframes provided in § 438.408(b)	0	5	0	0	0	4	0				0	304	0	0		
e) Failure to provide services in a timely manner, as defined by the State	0	0	3	0	0	0	0				0	0	0	0		
f) Denial of payment, at the time of any action affecting the claim.	3609	0	1273	11319	1490	3236	1310	339	806	184	0	0	7	0	4582	56
TOTAL:	6033	2698	1934	12021	3526	7944	2706	1035	1262	855	633	1899	2190	1807	7021	488
NOAs Per 1000 members	118.51	151.85	65.54	251.22	28.11	32.35	46.42	32.93	23.55	66.55	53.94	20.02	83.12	84.61	69.22	19.53
Enrollment Numbers 03/01/15	50,909	17,768	29,507	47,851	125,426	245,573	58,297	31,430	53,580	12,848	11,735	94,868	26,346	21,356	101,423	24,985

Oregon Health Authority
Second Quarter 2015 Attachment
CCO Notices of Action by Reason

Hearing Outcome Types Completed – January-March 2015

Plan Name	Affirmed	Client Failed to Appear	Clients Withdrew Hearing Request	Decisions Overturned by DMAP (FFS)	Decisions Overturned by Plan	Dismissed as No Jurisdiction	Dismissed as Not Hearable	Dismissed as Not Timely	Reversed	Set Aside
ALLCARE HEALTH PLAN, INC.	5	2	5		2		1			
CASCADE HEALTH ALLIANCE	8	4	9		4		2	1		
COLUMBIA PACIFIC CCO, LLC	2	1					1			
EASTERN OREGON CCO, LLC	2		4		3		56	3		
FAMILYCARE, CCO	6	9	18		4		4	1		
HEALTH SHARE OF OREGON	17	22	24		5		19	6		
INTERCOMMUNITY HEALTH NETWORK	8	5	14				9	3		
JACKSON CARE CONNECT	1	4	5				2			
KAISER PERMANENTE OR PLUS, LLC	1		2				1			
PACIFICSOURCE COMM. SOLUTIONS	9	7	19				15	1		
PACIFICSOURCE COMM. SOLUTIONS - GORGE										
PRIMARYHEALTH JOSEPHINE CO CCO	3	1	2		1		1	1		
TRILLIUM COMM. HEALTH PLAN	9	3	11		2		13	3		
UMPQUA HEALTH ALLIANCE, DCIPA	9	7	15		1		4	2	1	
WESTERN OREGON ADVANCED HEALTH	4	2	7		1		1			
WILLAMETTE VALLEY COMM. HEALTH	10	8	30		4		33	2		
YAMHILL CO CARE ORGANIZATION		1	2							
ACCESS DENTAL PLAN, LLC										
ADVANTAGE DENTAL			2		1		1			
CAPITOL DENTAL CARE INC										
CARE OREGON DENTAL										
FAMILY DENTAL CARE										
MANAGED DENTAL CARE OF OR										
ODS COMMUNITY HEALTH INC	1		4				1			
WILLAMETTE DENTAL GROUP PC										
FFS	3		9	4			10	2		
Total	98	76	182	4	28	0	174	25	1	0

Oregon Health Plan

Section 1115 Quarterly Report



1/1/2015 – 3/31/2015

Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)

Demonstration Quarter (DQ): 3/2015

Federal Fiscal Quarter (FQ): 2/2015

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I. Introduction

A. Letter from the State Medicaid Director

From January through March 2015, the Oregon Health Authority (OHA) continued to move forward in meeting the goals of the Oregon Health Plan (OHP) demonstration.

- **Lever 1: Improving care coordination** – As of March 2015, there were 548 recognized Patient Centered Primary Care Home (PCPCH) clinics in the state. This represents over 50 percent of the estimated number of primary care clinics in Oregon. The proportion of CCO members enrolled in a PCPCH continues to increase, ranging from 60.7 to 99.0 percent across CCOs.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – Hospitals submitted baseline data for the first year of Oregon’s hospital incentive measure program, the Hospital Transformation Performance Program. OHA has also contracted with the OHSU Center for Evidence-Based Policy to provide CCOs technical assistance in developing and implementing APMs.
- **Lever 3: Integrating physical, behavioral and oral health care** – OHA is working on several improvement activities to address integration challenges uncovered in the prior quarter’s environmental scan, including a new Behavioral Health Information Sharing Advisory Group; coding and billing guidelines for integrated care; and including integration consultants in the Transformation Center’s Technical Assistance Bank. OHA also continues work on “reverse” integration (bringing primary care into behavioral health settings).
- **Lever 4: Increased efficiency in providing care** – The Traditional Health Worker (THW) program continued work to integrate THWs into the community by establishing Medicaid provider specialties for Peer Support Specialists, and drafting a toolkit for CCOs and providers about working with THWs. The Transformation Center also continues its formal assessment of the barriers to CCO use of THWs.
- **Lever 5: Implementation of health-related flexible services** – OHA provided feedback to CCOs about their flexible services policies, and provided a standardized definition of flexible services to guide CCOs as they updated their policies.
- **Lever 6: Innovations through the Transformation Center** – The OHA Office of Health Analytics and the Transformation Center are contracting with the Providence Center for Outcomes Research and Education to develop a central database of innovative ideas in health system transformation. The database will include current projects and initiatives from the CCO Transformation Plans, Quality Improvement Plans, Transformation Fund projects and Community Health Improvement Plans.

During this quarter, the CCOs submitted their draft Transformation Plans for 2015-2017. Since receiving Transformation Fund grants in Fall 2013, CCOs have implemented 123 innovative projects to decrease emergency room use, expand provider capacity, advance care integration, enhance primary care, improve health outcomes of patients with complex needs, and decrease costs through changing payment models. Over half of these projects are in mid-stage or advanced implementation, and we look forward to learning how these innovations can help support and spread health system transformation.



Judy Mohr Peterson, PhD., State Medicaid Director

B. Demonstration description

The Oregon Health Plan (OHP) is the state’s demonstration project under Section 1115 of the Social Security Act, funded through titles XIX and XXI of the Social Security Act.

Phase I of OHP started on February 1, 1994, for Medicaid clients in the Poverty Level Medical (PLM) and Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance to Needy Families/TANF) populations. One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody/foster care.

Following the creation of the Title XXI Program in 1997, the State Children’s Health Insurance Program (SCHIP) was incorporated into the OHP, providing SCHIP-eligible people with the same benefits and delivery system available to Medicaid clients.

The OHP 2 demonstration began November 1, 2002, which established the OHP Plus and OHP Standard benefit packages, and included the Family Health Insurance Assistance Program. In 2007 and 2009, more children became eligible through expanded SCHIP eligibility and the creation of the Healthy Kids program.

On July 5, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the current demonstration, Oregon’s **Health Care Transformation**, through June 30, 2017. Key features include:

- **Coordinated Care Organizations (CCOs):** The State established CCOs as the delivery system for Medicaid and CHIP services.
- **Flexibility in use of federal funds:** The State has ability to use Medicaid dollars for flexible services (e.g., non-traditional health care workers), to be used for health-related care that is authorized under managed care rules and regulations. CCOs will have broad flexibility in creating the array of services necessary to improve care delivery and enrollee health.
- **Federal investment:** The federal government agreed to provide federal financial participation (FFP) for several health care programs that had been previously supported entirely by State funds. These are called Designated State Health Programs (DSHP). Expenditure authority for DSHP is limited to \$704 million FFP over the demonstration period July 5, 2012 through June 30, 2017, allocated by Demonstration Year (DY) as follows:

DY	Time Period	FFP Limit
11	07/1/12-06/30/13	\$230 M
12	07/1/13-06/30/14	\$230 M
13	07/1/14-06/30/15	\$108 M

DY	Time Period	FFP Limit
14	07/1/15-06/30/16	\$ 68 M
15	07/1/16-06/30/17	\$ 68 M

- **Workforce:** To support the new model of care within CCOs, Oregon will establish a [loan repayment program](#) for primary care physicians who agree to work in rural or underserved communities in Oregon, and training for 300 community health workers by 2015.

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians:** The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.
- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services

they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.

- **Reducing the growth in Medicaid spending:** The state has agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

In December 2013, conforming amendments for the Affordable Care Act and the full implementation of the Tribal Uncompensated Care amendment to the 1115 Demonstration were approved.

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved, and OHA and CMS concluded final negotiations regarding the measures included in the program in September 2014. This two-year program will offer hospitals incentive payments to support quality improvement.

C. State contacts

Demonstration and Quarterly Reports

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II. Title

Oregon Health Plan Section 1115 Quarterly Report
 1/1/2015 – 3/31/2015
 Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)
 Demonstration Quarter (DQ): 3/2015
 Federal Fiscal Quarter (FQ): 2/2015

III. Events affecting health care delivery

A. Overview of significant events across the state

Category of event	Impact? (Yes/No)			Interventions or actions taken? (Yes/No)
	Demonstration goals	Beneficiaries	Delivery system	
A. Enrollment progress	No	No	No	-
B. Benefits	No	No	No	No
C. CCO Complaints and Grievances	No	No	No	Potential access issues being tracked See tables for details
D. Quality of care – CCO / MCO / FFS	No	No	No	No
E. Access	No	No	No	Potential access issues being tracked
F. Provider Workforce	No	No	No	-
G. CCO networks	No	No	No	-

Detail on impacts or interventions

See Sections III.B through C for information about interventions for potential access issues.

B. Complaints and grievances

Table 2 – Complaints and grievances

This information is from quarterly submissions received from the contracted health plans and cross-referenced with complaint and grievance calls received internally by the Oregon Health Authority.

The following chart shows CCO complaint totals and rates per 1,000 members for the reporting period. CCO totals and ranges by complaint category CCO are [attached separately](#).

Coordinated Care Organization	Total Complaints/ Grievances Received	Enrollment as of 3/1/2015	Per 1000 Members
AllCare Health Plan, Inc.	55	50,909	1.08
Cascade Health Alliance	60	17,768	3.38
Columbia Pacific CCO, LLC	98	29,507	3.32

Coordinated Care Organization	Total Complaints/ Grievances Received	Enrollment as of 3/1/2015	Per 1000 Members
Eastern Oregon CCO, LCC	77	47,851	1.61
FamilyCare CCO	306	125,426	2.44
Health Share of Oregon	1635	245,573	6.66
Intercommunity Health Network	15	58,297	0.26
Jackson Care Connect	75	31,430	2.39
PacificSource Community Solutions	76	53,580	1.42
PacificSource Community Solutions – Gorge	8	12,848	0.62
PrimaryHealth of Josephine County CCO	10	11,735	0.85
Trillium Community Health Plan	306	94,868	3.23
Umpqua Health Alliance, DCIPA	30	26,346	1.14
Western Oregon Advanced Health	114	21,356	5.34
Willamette Valley Community Health	33	101,423	0.33
Yamhill County Care Organization	29	24,985	1.16

Trends related to complaints and grievances

The current trend rate is from 0.26 to 6.66 per 1,000 members. This is an increase from the previous quarter and individual drivers will be analyzed over the next 3 quarters with attention to access and billing categories.

The Client Services Unit received 7,690 calls related to complaints and grievances for this quarter.

- The large majority of these calls (3,569) were received in January accounting for new enrollment/reenrollment processes .
- FFS concerns consisted of 1,768 calls, with the highest categories for FFS outside of general information being seen in the areas of enrollment and choice, billing and pharmacy.
- Among calls to the Call Center related to plans, the highest categories remained information, client choice, third party liability and billing.

Data is being shared with the plans related to trends seen in the Medicaid call centers with those reported by the plans.

Interventions

In reviewing the plans' analysis there remains a large discrepancy in the reporting and logging of complaints and grievances. MAP has held 2 session this quarter to review practices and share data around reporting and will be working with plans to allow statewide trending along with individual plan trending.

C. Appeals and hearings

Table 2.1 – Appeals and hearings – statewide report – all categories of CCO appeals and contested case hearings for the current quarter

Reporting according to the following categories is still in development. While we are able to provide totals for the status of appeal and hearings during the quarter, we are unable to provide these numbers by category.

CCO appeals and hearings

[Attached separately](#). This table represents Plan-reported outcomes related to appeals according to Notice of Action (NOA) category, overturned rates and outstanding appeals for the first quarter.

Oregon Health Authority

A breakdown, by reason and CCO, of all NOAs issued during the reporting period is [attached separately](#). This table represents the number of denials or reductions in services by NOA categories.

Contested case hearings

The following table represents the contested case hearings that were processed during the first quarter of 2015.

Plan Name	Total Hearing Requests Received	Avg. Plan Enrollment *	Per 1000 Members
ALLCARE HEALTH PLAN, INC.	26	49,621	0.5240
CASCADE HEALTH ALLIANCE	36	16,476	2.1850
COLUMBIA PACIFIC CCO, LLC	7	27,232	0.2571
EASTERN OREGON CCO, LLC	95	47,541	1.9983
FAMILYCARE, CCO	91	120,272	0.7566
HEALTH SHARE OF OREGON	111	236,652	0.4690
INTERCOMMUNITY HEALTH NETWORK	48	55,777	0.8606
JACKSON CARE CONNECT	17	29,403	0.5782
KAISER PERMANENTE OR PLUS, LLC	1	2,109	0.4742
*PACIFICSOURCE COMM. SOLUTIONS	70	53,242	1.3148
*PACIFICSOURCE COMM. SOLUTIONS - Gorge		12,791	
PRIMARYHEALTH JOSEPHINE CO CCO	6	11,337	0.5292
TRILLIUM COMM. HEALTH PLAN	61	84,733	0.7199
UMPQUA HEALTH ALLIANCE, DCIPA	38	26,491	1.4344
WESTERN OREGON ADVANCED HEALTH	26	20,523	1.2669
WILLAMETTE VALLEY COMM. HEALTH	117	97,817	1.1961
YAMHILL CO CARE ORGANIZATION	5	22,242	0.2248
ACCESS DENTAL PLAN, LLC	0	2,021	0.0000
ADVANTAGE DENTAL	3	25,785	0.1163
CAPITOL DENTAL CARE INC	0	15,628	0.0000
CARE OREGON DENTAL	0	2,128	0.0000
FAMILY DENTAL CARE	1	2,045	0.4889
MANAGED DENTAL CARE OF OR	0	2,097	0.0000
ODS COMMUNITY HEALTH INC	6	8,381	0.7159
WILLAMETTE DENTAL GROUP PC	Closed 12-31-14		
FFS	37	246,147	0.1503
Total	802	1,225,071	0.6547

* Pacific Source has combined hearing data from both of its CCOs.

The following chart shows the outcomes of the hearings completed this quarter. A breakdown of hearing outcomes for each plan is [attached separately](#).

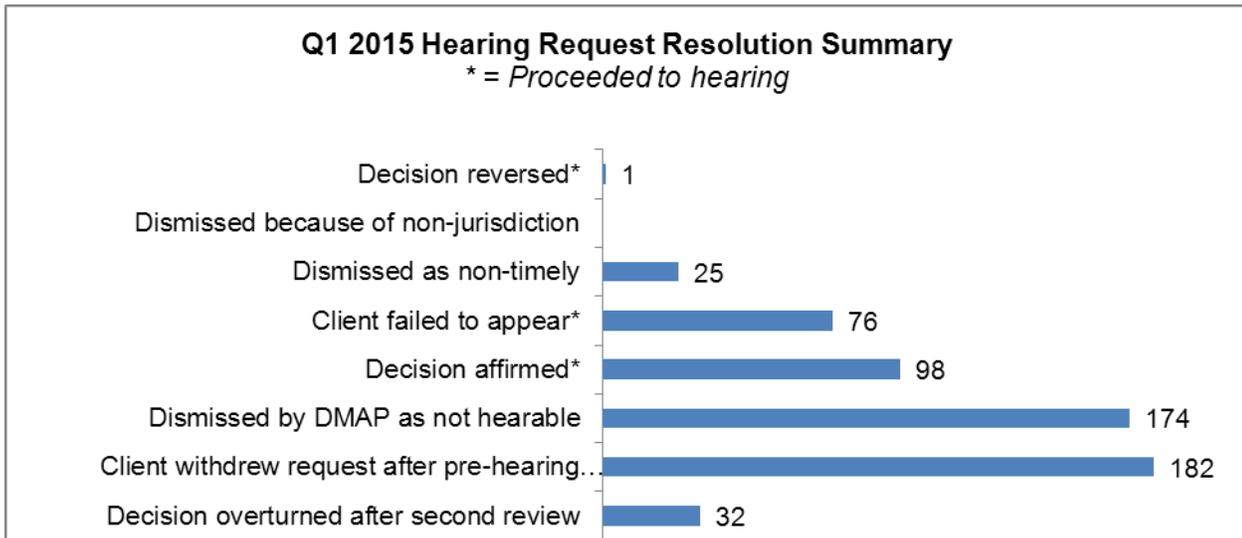
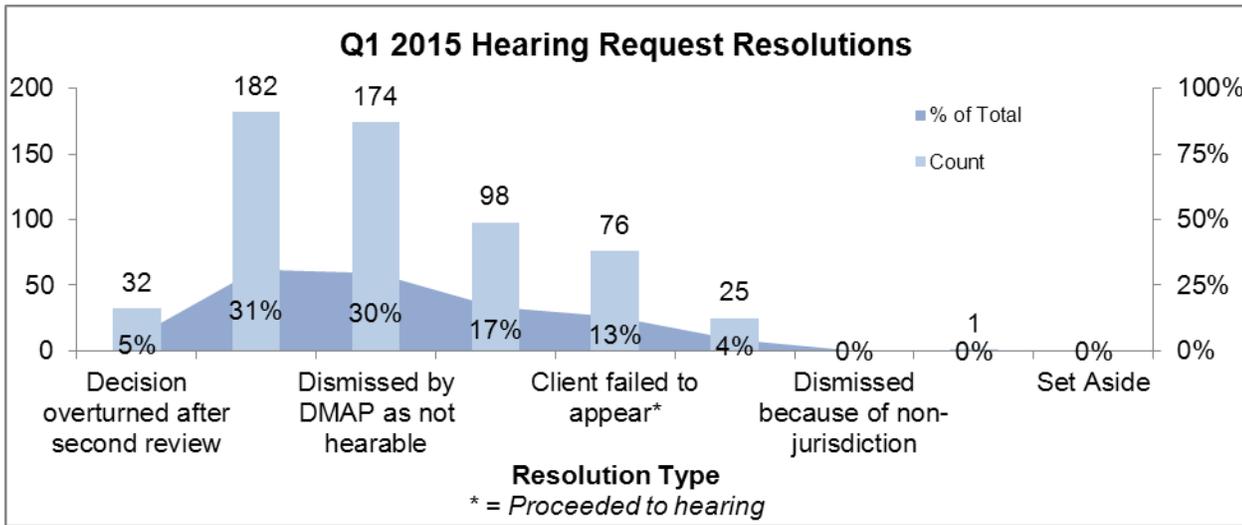
Outcome	Count	% of Total
Decision overturned after second review	32	5%
Client withdrew request after pre-hearing conference	182	31%
Dismissed by DMAP as not hearable	174	30%
Decision affirmed*	98	17%
Client failed to appear*	76	13%
Dismissed as non-timely	25	4%
Dismissed because of non-jurisdiction		0%
Decision reversed*	1	0%

Outcome	Count	% of Total
Set Aside		0%

Trends

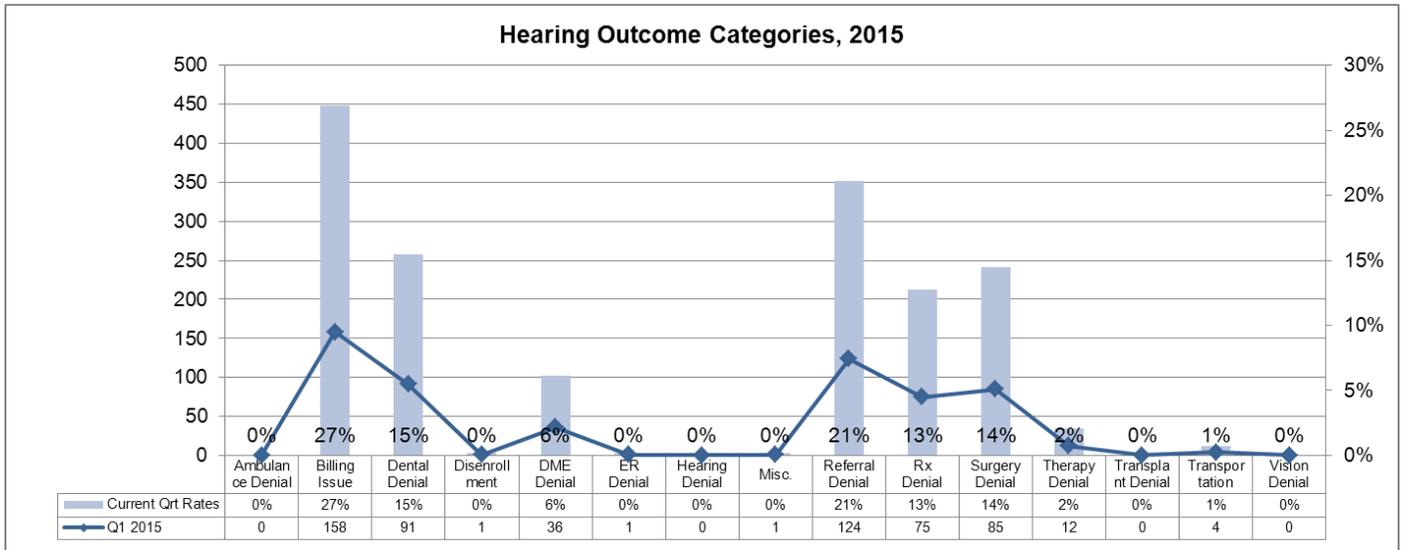
The low number of outstanding appeals reflect the ability of plans to work with their members to address service denials in a timely fashion. The number of appeals overturned by the plans has increase slightly and is being monitored as a focus area over the 2015 quarterly review. Large variances can be noted across the plans as it relates to NOA (Notice of Actions) outputs.

Trends in contested case hearings range from 0.22 to 2.1 per 1000 members, representing a small trend upward. A focused review of plans with high hearing rates continues to review plan processes and member communications including communication through Notices of Action.



The graph below represents the hearings categories. Referrals, pharmacy and surgery have seen a slight decrease. This is supportive of the outreach done by the plans and the decrease in movement of clients between benefit plans and CCOs.

Billings have increased 7 percent and dental has remained high at 15 percent.



Interventions

The plans and MAP staff will be developing metrics to help evaluate and address best practices for appeals and NOAs. A breakout of NOAs by specific programs is currently being developed.

Plans continue to have high affirmation responses to the hearing processes. The upfront review work completed by MAP hearings staff with the members and plan representatives results in the dismissal, early with drawl or reconsideration from the plan prior to the hearing date. Continued review of member communications to assist with education related to the hearings process along with continued review of NOA communications has allowed for a decrease in the numbers of dismissed cases.

To address the increase in hearings related to billing issues and dental care, billing practices across all plans has been requested for a focused review and sharing of best practices to occur during the 3rd quarter of 2015. Dental access will be monitored and assessed closely after the receipt of the updated July network contracting report.

D. Implementation of 1% withhold

During this quarter, DMAP analyzed encounter data received for completeness and accuracy for the subject months of June 2014 through August 2014. All CCOs met the Administrative Performance (AP) standard for all subject months and no 1% withholds occurred. Future reports will contain the following information:

Table 3 – Summary

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by: <ul style="list-style-type: none"> ■ Average/mean PMPM ■ Eligibility group ■ Admin component ■ Health services component 	X	X
For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)		

Metric	Frequency	
	Quarterly	Annually
Actual amount paid in incentives monthly broken out by: <ul style="list-style-type: none"> Total by CCO Average/mean PMPM incentive The over/under 100% of capitation rate by CCO and by average enrollee PMPM 	X	X
Best accounting of the flexible services provided broken out by: <ul style="list-style-type: none"> Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) Services that are not reflected in encounter data (e.g., air-conditioners, sneakers) 	X	X
CCO sub-contractual payment arrangements – narrative <ul style="list-style-type: none"> Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network 		X
Encounter data analysis <ul style="list-style-type: none"> Spending in top 25 services by eligibility group and by CCO To the extent that this can be further indexed to the payment arrangements listed above, that would be helpful analysis as well 	X	X

E. Statewide workforce development

Traditional Health Workers (THW)

THW Program	Total number certified statewide*		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
Community Health Workers (CHW)	26	131	1	7
Personal Health Navigators (PHN)	0	5	1	2
Peer wellness/support specialists	48	286	2	18
Other THW	1	17	0	1 (Doula)
Total Certified	75	354	4	28

*Statewide registry currently under reconstruction to add enhanced data collection features.

Total number trained statewide and to date – Current quarter

Training program	THW Type				
	CHW	PHN	Peer Support	Peer Wellness	Other (doula)
Multnomah County Community Capacitation Center	28				
Lane Community College	9				
Community Connections			67		
OFSN			5		
Peer Services Consulting			10		
Addictions Counselor Certification Board of Oregon			11		
Relief Nursery			2		
Total for current quarter	37	-	95	-	-
Total to date	304	2	371	37	14

Approved training programs

Program name	THW Type				
	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
Addiction Certification Board of Oregon				✓	
Cascadia Behavioral Health			✓		
Central City Concern				✓	
Central Oregon Community College	✓				
Chemeketa Community College	✓				
Cultivating a New Life through Community Connections			✓		
Empowerment Initiatives				✓	
Eugene Relief Nursery				✓	
Institute for Professional Care Education	✓	✓			
Intentional Peer Support Program				✓	
International Center for Traditional Childbearing					✓
Lane/Clackamas Community College	✓				
Mental Health of America			✓	✓	
Miracles Club Inc				✓	
Multnomah County Health Department	✓				
National Alliance on Mental Illness				✓	
Northeast Oregon Network	✓				
Oregon Behavioral Consultation and Training				✓	
Oregon Family Support Network/Youth MOVE				✓	
Parish Promotores	✓	✓			
Portland Community College				✓	
Project ABLE				✓	
Recovery and Beyond				✓	
Rogue Community College	✓				
Willamette Family Treatment Services				✓	
Total Approved Programs	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
	8	2	3	14	1

Training programs pending approval:

Changing Perceptions – Peer Support Specialist Training

Narrative detail on regional distribution of certified THWs and THW training programs; news about relevant recruitment efforts or challenges

System integration

- House Bill 2024 – utilizing THWs to support oral health initiatives was introduced in the 2015 Oregon Legislative Session.
- Working with the Medical Assistance Program division staff to establish specialty categories for Peer Support Specialists to align with Medicaid/Addictions and Mental Health peer provider categories

Training, certification and hiring of THWs

- Finalized the Continuing Education Scoring Rubric

- Drafted a CCO/Provider Toolkit on working with Traditional Health Workers
- Refining Personal Health Navigator role, competencies and scope of practice

THW presentations

- February 18-20, 2015 – THW Presentation to San Francisco Foundation
- March 18-20, 2015 – THW Program Site Visit in Lakeview, OR

Meetings with stakeholders

- January 20, 2015 – Scope of Practice Subcommittee
- January 23, 2015 – THW System Coordination: Rogue Community College
- January 26, 2015 – THW Commission Meeting
- February 23, 2015 – THW Commission Meeting
- February 26, 2015 – THW System Coordination: Multnomah County
- March 9, 2015 – THW System Coordination: Addictions & Mental Health
- March 23, 2015 – THW Commission

Health professional graduates participating in Medicaid

No new results to report this quarter, since few health professions programs have graduation dates in January – March. OHA will request updated data files from Oregon Health and Sciences University (OHSU) in fall 2015 for an initial match of 2015 graduates against Medicaid provider enrollment data. At that time, the state also intends to re-run 2012-2014 dental, nursing, and physician assistant graduate data to ascertain whether graduates are more likely become enrolled Medicaid providers as time goes on.

F. Table 5- Significant CCO/MCO network changes during current quarter

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
None	-	-	-	-

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Non emergent medical transportation (NEMT) integration, effective 1/1/15: <ul style="list-style-type: none"> • Columbia Pacific CCO 	Integrated NEMT	None	1	0 – Their brokerage remains the same
NEMT integration, effective 1/1/15: <ul style="list-style-type: none"> • Health Share of Oregon • FamilyCare 	Integrated NEMTs Two new brokerages in Clackamas, Multnomah and Washington counties	New brokerage (Ride to Care) for Health Share and FamilyCare members New brokerage (Tri-County MedLink) for FFS members (6,000 households)	2	116,000 households

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
None	-	-	-	-

G. Transformation Center

The Transformation Center continues to assist CCOs through Innovator Agent leadership, learning collaboratives and technical assistance.

Key highlights from this quarter:

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center facilitated three sessions for the statewide CCO learning collaborative in this period, at which Innovator Agents served as small group discussion facilitators. Sessions focused on:

- Applying dental sealants on permanent molars for children, with presentations from clinicians in rural and urban areas in Oregon on challenges and emerging best practices.
- Effective contraceptive use with presentations from CCO leaders on the importance of measuring effective contraceptive use, screening and collaborative relationships with family planning clinics.
- Emerging best practices in Oregon to treat chronic pain and address opiate misuse. Six initiatives, including clinical and community approaches, were presented during rotating table discussions allowing attendees to participate in three different discussions.

More information is available at <http://transformationcenter.org/learning-collaborative/statewide-cco-learning-collaborative/>.

Community Advisory Council Learning Collaborative

During the reporting period, the Transformation Center hosted monthly conference calls for the two Community Advisory Council (CAC) leadership networks – one for the CAC chairs and co-chairs (who are CAC members) and one for the CCO CAC coordinators (who are primary staff of the CCOs) – to provide ongoing leadership development for the CACs. Guest presenters from the Oregon Public Health Division and the Oregon Opportunity Network (a statewide association of affordable housing nonprofits) were invited to participate on the calls, share their work and highlight available resources to support CACs.

In addition, the CAC Steering Committee convened bimonthly during this time to make recommendations for the CAC Learning Collaborative and to help plan the CAC Summit, scheduled to take place on June 3-4. More information is available at <http://transformationcenter.org/learning-collaborative/cac/>.

Also during the reporting period, the Transformation Center hosted two webinars for CAC members: 1) An Introduction to Motivational Interviewing, and 2) From Goals to Outcomes (which provided an overview of logic models to support implementation of community health improvement plans). Lastly, during this reporting period, the Transformation Center began publishing a *CAC Bulletin*, an electronic communication compiling professional development and funding opportunities relevant to CAC members across the state.

Health Equity Learning Collaborative

In the first quarter of 2015 the Health Equity Learning Collaborative planned a health equity learning series for CCOs. The goals are to share promising practices on advancing health equity and build a support network across CCOs. All meetings will have Web-based and in-person participation options at the host CCOs: Health Share of Oregon, Trillium Community Health Plan and Eastern Oregon CCO.

- The first meeting was held in February and focused on identifying health disparities by using metrics and CAHPS data.
- Upcoming topics will include organizational cultural competence and language access, and engaging diverse communities with a focus on Latinos.

Our topic area experts represent local and national organizations including the OHA Office of Health Analytics, Families USA, National Health Law Program and Oregon Health Equity Alliance. Meeting materials will be shared at <http://www.oregon.gov/oha/Transformation-Center/Pages/Health-Equity-Learning-Community.aspx>.

Quality Improvement Community of Practice

The Transformation Center's efforts to support quality improvement across the CCOs include a variety of activities, including periodic webinars, training and a large upcoming event.

- The Transformation Center hosted a webinar in February with CCO quality improvement and measurement leads to discuss common challenges and share approaches. The agenda was focused on case studies with one CCO leader presenting on a successful project and a project that did not go as planned. Both case studies prompted meaningful discussion, with many CCOs sharing their projects.
- The Transformation Center supported a quality improvement or measurement lead within each CCO to enroll in the three-month IHI online training, *Leading Quality Improvement: Essentials for Managers*, which launched in February.
- Planning began for the Oregon Health System Innovation Café to promote peer-to-peer learning, information sharing and networking. The June 8 and 9 event will support the spread of innovative health system models addressing complex care, behavioral health integration, traditional health workers, health information technology and telehealth.

Council of Clinical Innovators

In January 2015, the Clinical Innovation Fellows submitted six-month progress reports describing the status of their projects and feedback on their experience of the fellowship to date.

- All 13 fellows indicated that the fellowship was very valuable or valuable for supporting their work. The mentorship was rated as one of the most valuable components of the program.
- In general, narrative feedback indicated that the fellowship has contributed to cross-discipline learning, project implementation and skill building: "...the CCI program has shown me how to turn the daydreams into deliverables, how to turn 'what ifs' into achievable action items." According to another fellow, "The CCI fellowship has been the highlight, to date, within my professional career."

This quarter the Clinical Innovation Fellows program held two online meetings and one in-person meeting.

- The January online meeting focused on organizational trauma and leadership resilience, and the February online meeting covered project management tools.

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- In March, the program held a day-long, in-person meeting focused on key attributes of high-functioning teams, public policy development and strategies for exerting leadership in complex situations.

Each fellow continued to meet monthly with their faculty mentor, both individually and in small groups, to receive support on project implementation.

This quarter the council also planned and recruited for the second cohort of the fellows program. We received 26 complete applications with a diverse representation of coordinated care organizations, clinical disciplines and innovation projects.

More information about the Council of Clinical Innovators is available at www.transformationcenter.org/cci.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs, in October 2014 the OHA Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance in key areas to help foster health system transformation.

- In addition to support and technical assistance provided by other parts of OHA, each CCO is designated 35 hours of free consultation from outside consultants on contract with the Transformation Center. The designated 35 hours include 10 hours of consultation to support CACs and other community-based work and will be accessible through September 2015. CCOs that do not use all 35 hours of technical assistance by September 2015 will forfeit their remaining hours.
- Starting October 2015, there will be a new allocation of 40 hours per CCO for use until September 2016.

To continue to provide technical assistance through September 2016, the Transformation Center plans to release a Request for Applications (RFA) for consultants to contract as technical assistance providers. The Transformation Center received feedback from CCOs through the Innovator Agents to inform the RFA process. The Transformation Center has also requested the Innovator Agents work with their CCOs to advertise the RFA to potential contractors that might be a good fit with the Technical Assistance Bank. The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

TA Bank technical assistance topics:

1. Alternative payment methods	9. Improving health equity
2. Behavioral health integration	10. Oral health integration
3. Community health improvement plan (CHIP) review, implementation and evaluation	11. Organizational development for CCOs and/or CCO community advisory councils
4. Early learning systems and strategies	12. Primary care transformation, including patient-centered primary care homes
5. Engagement strategies for person and family-centered health care systems	13. Project management*
6. Health information technology	14. Public health integration
7. Health program evaluation	15. Quality improvement science
8. Health systems leadership*	16. Other topics upon request

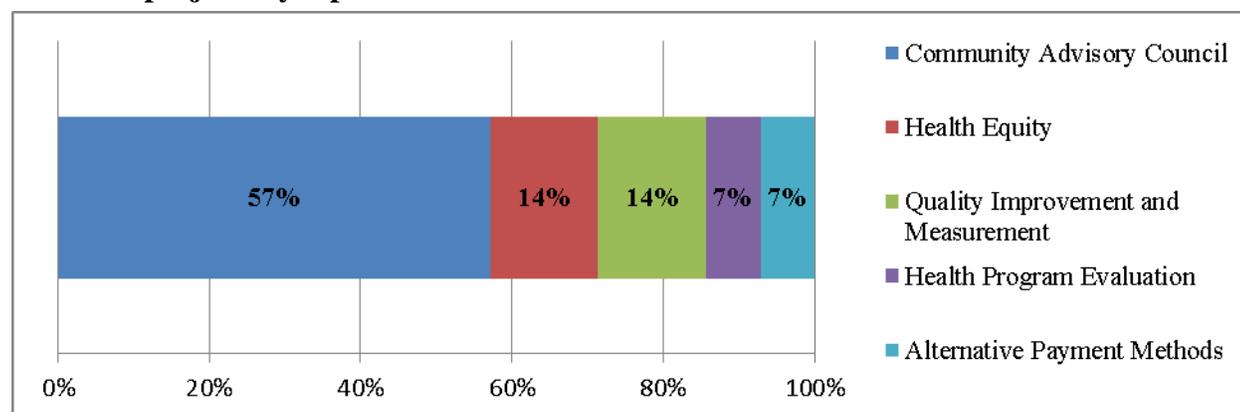
*Topics added to the Technical Assistance Bank during the RFA development process.

TA Bank projects through April 2015:

CCO	Topic	Hours Requested
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CCO	Topic	Hours Requested
1. Willamette Valley Community Health	Health equity	4
2. Intercommunity Health Network	Measurement	7
3. FamilyCare	CAC development, CHIP implementation	21
4. PacificSource Central Oregon	Measurement	25
5. Eastern Oregon CCO	CAC member engagement	6
6. AllCare	CAC member engagement	33
7. PrimaryHealth Josephine County	CAC member engagement	7
8. PrimaryHealth Josephine County, Jackson Care Connect, AllCare	Health literacy	5
9. Jackson Care Connect	CAC development, CHIP implementation	8
10. Trillium Community Health Plan	Health program evaluation	15
11. Western Oregon Advanced Health	CHIP development	16
12. Intercommunity Health Network	Alternative payment method training	4
13. Columbia Pacific CCO	CHIP implementation	22
14. Cascade Health Alliance	CAC member engagement	TBD
Total Anticipated Hours:		173

TA Bank projects by topic:



Coordinated Care Model Summit

The Transformation Center plans to hold a one-day summit on November 17, 2015, titled “Coordinated Care Model: Implementing and Spreading the Model.” The goal of the summit is to connect and engage stakeholders, share outcomes and lessons learned, support the coordinated care model implementation across sectors and inspire future innovation. CCOs, other public and private health care purchasers, providers and clinicians, CCO community advisory council members, community stakeholders, health leaders, lawmakers, policymakers and funders will come together to share outcomes and lessons learned from innovative strategies for implementing health system transformation.

Breakout sessions during the conference will focus on the following topics, and a call for proposals will be opened April 3 to elicit high-quality, results-oriented presentations:

- Alternative Payment Methods
- Clinical Delivery of Care
- Complex Care Management
- Health & Early Childhood/Learning Coordination
- Health Equity

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- Health Information Technology
- Health Care Workforce
- Measurable Outcomes/Evaluating the Coordinated Care Model
- Member Engagement/Wellness Programs
- Mental Health/Behavioral Health Integration
- Oral Health/Dental Health Integration
- Social Determinants of Health
- Trauma-Informed Care (includes Adverse Childhood Experiences)

Health Equity and Health & Early Learning Conferences

In conjunction with the 2015 Coordinated Care Model Summit, there will be half-day conferences focused on health equity and health and early learning.

The OHA Office of Equity and Inclusion is hosting a half-day conference that focuses exclusively on the implementation of health equity, diversity and inclusion policies and strategic equity initiatives throughout Oregon's health system. The health equity conference will provide training, information and resources to employees of OHA, coordinated care organizations, key health and health care stakeholders, and organizations and groups that address social determinants of health.

The OHA Child Well-being Team and the Early Learning Division of the Oregon Department of Education are collaborating to host a half-day conference that will bring together representatives from CCOs and Early Learning Hubs to 1) identify concrete collaborative actions to support early learning and children's health, 2) make cross-sector connections and identify roles and responsibilities and 3) learn about existing CCO/Hub initiatives, projects and polices that can be replicated in other regions of Oregon.

Traditional Health Worker (THW) survey

In the fall of 2014, the Transformation Center initiated the first phase of a formal assessment of CCOs to identify barriers to their use of traditional health workers (THWs). This first phase identified financial sustainability and accessibility to trained THWs as top barriers to the use of THW services in CCOs. The next phase of the assessment will focus on financial sustainability of THW services. The Transformation Center will procure a vender who can assess the current financial models for THW services in Oregon and develop a sustainability plan for THW programs in the state.

Table 6 - Innovator Agents – Summary of promising practices

Innovator agent learning experiences

Summary of activities

The Transformation Center convenes Innovator Agents for monthly in-person meetings to share information and learn from others in OHA as well as outside experts. Meetings this quarter included presentations from Trauma Informed Oregon, a statewide collaborative designed to promote trauma-informed care, and from other areas of OHA such as the OHA Director's Office, Office of Health Analytics, Addictions and Mental Health, and the Women, Infants and Children program.

Promising practices identified

These meetings allow Innovator Agents to build and sustain relationships with executive leadership across OHA. For example, the new OHA Director started in January 2015, and she met with the Innovator Agents in March 2015 to share her vision for the role of the Innovator Agents in the new OHA organizational structure and how OHA will continue to support the CCOs.

Participating CCOs

16

Participating IAs

9

Learning Collaborative activities

Summary of activities

The IAs play a key role in helping the Transformation Center develop and fine-tune its learning collaboratives. For example, Innovator Agents gave instrumental guidance to the planning of the Oregon Health System Innovation Café (to be held June 8-9, 2015) and the CAC Summit (June 3-4, 2015). They also helped to identify subject matter experts and CCO leaders to speak at the Statewide CCO Learning Collaborative. This quarter one Innovator Agent co-presented with a CCO representative at the February session on the effective contraceptive use incentive measure.

Promising practices identified

Innovator Agent engagement with learning collaborative development is key to ensuring that innovative CCO projects are identified and shared at learning collaborative events.

Participating CCOs

16

Participating IAs

9

Assisting and supporting CCOs with Transformation Plans

Summary of activities

IAs provided support to their CCOs in writing their 2015-2017 Transformation Plans. The 2015-2017 draft Transformation Plans have been received and are under review by OHA, with final plans due back to OHA by June 10, 2015.

In addition, the Transformation Center staff worked with the IAs to update guidance to the CCOs and CACs for their Community Health Improvement Plan progress reports (due June 30, 2015).

Promising practices identified

Since CCOs are in different stages of development, each Innovator Agent's role is different. Some Innovator Agents provide internal support for CCOs' transformation, whereas others focus more on identifying solutions and addressing barriers within OHA.

Participating CCOs

16

Participating IAs

9

Assist CCOs with target areas of local focus for improvement

Summary of activities

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Innovator Agents supported conversations between their CCOs and state and local public health representatives related to Targeted Case Management. They also assist with local Oregon Health Plan outreach efforts by coordinating with community application assisters. IAs continue to assist with behavioral health integration, oral health, alternative payment methodology, non-emergency medical transportation, cultural competency and data collection.

Promising practices identified

Innovator Agents are an instrumental liaison between their CCOs and their communities, and the role is uniquely situated to provide value in this area.

Participating CCOs

-

Participating IAs

-

Communications with OHA

Summary of activities

Innovator Agents meet regularly with leaders across OHA to strategize on how to collaborate and to stay informed about OHA programs and policies. For example, this quarter the Innovator Agents met with public health staff to discuss opportunities for CCOs to access Community Health Improvement Plan technical assistance.

Promising practices identified

Regular and frequent communication with the Medical Assistance Program helps the Innovator Agents support continuous quality improvement efforts within OHA related to Oregon's Medicaid implementation.

Participating CCOs

16

Participating IAs

9

Communications with other Innovator Agents

Summary of activities

Innovator Agents continue to work together on internal transformation, sharing information on promising practices to promote spread through in-person and electronic communication.

Promising practices identified

The Innovator Agents work as a team, sharing and benefitting from the expertise each IA brings to their job as well as their unique CCO experiences. They meet as a team twice each week by phone, and once monthly for a day-long in-person meeting. In addition to these regularly scheduled meetings, they communicate frequently via email and phone and periodically in person, as needed.

Participating CCOs

16

Participating IAs

9

Community Advisory Council activities

Summary of activities

See CAC Learning Collaborative summary. In addition, the Innovator Agents continue to regularly attend CAC meetings for their CCOs.

Promising practices identified

Some CACs allocate agenda time at CAC meetings for Innovator Agents to update the council on OHA-related items. This helps to build open communication with CAC members and OHA and increases CAC members' knowledge about Medicaid policies.

Participating CCOs

CCO participation varied at each event, with a range of three to six CCOs represented.

Participating IAs

One Innovator Agent participated in the CAC Summit planning committee. All nine Innovator Agents contributed to planning discussions about the CAC Summit.

Rapid-cycle stakeholder feedback (to identify and solve barriers; assist with adapting innovations; simplify and/or improve rate of adoption; and increase stakeholder engagement)

Summary of activities

Innovator Agents regularly gather feedback from CCOs and present issues to OHA leadership for problem solving. For example, this quarter the Innovator Agents provided feedback to the Medical Assistance Program on CCO challenges related to developing innovative flexible services policies.

Promising practices identified

Each CCO has distinct priorities and initiatives to support innovation in different areas of transformation. Innovator Agents inform the development of learning collaboratives on key topic areas, such as flexible services, that are designed to support CCOs in adapting innovations.

Participating CCOs

16

Participating IAs

9

Data base implementation (tracking of CCO questions, issues and resolutions in order to identify systemic issues)

Summary of activities

The Issue Tracker is being revised to capture additional information about Innovator Agent presentations.

Promising practices identified

The Issue Tracker continues to be helpful for documenting issues and steps toward resolution.

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Participating CCOs

16

Participating IAs

9

Information sharing with public

Summary of activities

Innovator Agents continue to present to a large variety of stakeholders and share information on enrollment, health equity data, leadership opportunities and community partnership opportunities with their community advisory councils and community partners.

Promising practices identified

Communicating with community advisory councils is a good way to more broadly disseminate information to community members. Both the Transformation Center program staff and the Innovator Agents use this approach to disseminate information to the public.

Participating CCOs

16

Participating IAs

9

Table 7 - Innovator Agents – Measures of effectiveness

Measure 1: Surveys rating IA performance

Data published for current quarter? Type?

N/A: Plans for qualitative interviews with CCO stakeholders are forthcoming in early 2015.

Web link to Innovator Agent quality data

N/A

Measure 2: Data elements (questions, meetings, events) tracked

Data published for current quarter? Type?

Innovator Agents submit quarterly reports that track their activities in three areas: (1) supporting transformation within their CCO; (2) partnership with OHA and (3) other activities focused in the community. Innovator Agents also submit questions and issues to an internal Issue Tracker.

Web link to Innovator Agent quality data

N/A

Measure 3: Innovations adopted

Data published for current quarter? Type?

The OHA Office of Health Analytics and the Transformation Center are contracting with the Providence Center for Outcomes Research and Education to code and populate an internally searchable database of current CCO projects and initiatives from the CCO Transformation Plans, Quality Improvement Plans,

Transformation Fund projects and Community Health Improvement Plans. This internal database will provide a single data source to identify innovative ideas in health system transformation.

Web link to Innovator Agent quality data

N/A

Measure 4: Progress in adopting innovations¹

Data published for current quarter? Type?

CCOs are making marked progress in adopting innovations. For example, the Transformation Fund grant dollars the CCOs received from the Legislature in the fall of 2013 have led to the implementation of more than 120 innovative projects across all CCOs.

Projects are designed to decrease emergency room visits; expand provider capacity; advance the integration of care; enhance primary care; improve health outcomes of patients with complex needs; and decrease costs through changing payment models. Preliminary results show that:

- 31 projects (26 percent) are in the early stage of implementation, meaning they have a defined metrics plan, the project team is formed, and activities are beginning to be implemented.
- 59 projects (49 percent) are in the mid-stage of implementation and early evaluation data has been collected.
- 30 projects (25 percent) are in an advanced stage of implementation and have enough data to inform next steps for spreading and sustaining them.

Web link to Innovator Agent quality data

<http://transformationcenter.org/transformation-funds/>

Measure 5: Progress in making improvement based on innovations²

Data published for current quarter? Type?

CCOs are making solid progress based on submitted progress reports and milestone reports that report on eight areas of transformation, including: oral and behavioral health integration; primary care home; alternative payment; health information; and community empowerment.

Web link to Innovator Agent quality data

Transformation Plan Reports available online:

<http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx>

Measure 6: CCO Transformation Plan implementation

Data published for current quarter? Type?

Transformation Plans are on track, as evidenced by milestone reports recently submitted.

¹ This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

² This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

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As noted above, the Transformation Center launched a Technical Assistance Bank for CCOs, which will help CCOs move toward their Transformation Plan goals. The Transformation Center has created a menu of technical assistance topics for which CCOs may access a set number of hours of technical assistance. Each CCO decides how to best use the resources by selecting the topics of most interest and need.

Web link to Innovator Agent quality data

N/A

Measure 7: Learning Collaborative effectiveness

Other evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.

Data published for current quarter? Type?

An increasing number of stakeholders participate in the Transformation Center's learning collaboratives.

- For example, in the first quarter of 2015, the average number of attendees at the three Statewide CCO Learning Collaborative sessions increased to 79 (compared to an average of 70 participants in 2014 and 61 participants in 2013).
- Participant evaluations for the first quarter of 2015 also indicated an increase in the percent who found sessions valuable or very valuable (97 percent in 2015 compared to 90 percent in 2014) and an increase in the percent who planned to take action based on the learning collaborative (62 percent in 2015 compared to 52 percent in 2014).

Web link to Innovator Agent quality data

N/A

Measure 8: Performance on Metrics and Scoring Committee metrics

Data published for current quarter? Type?

All Innovator Agents assist their CCOs in internal planning to align internal work with improvements on performance metrics. Their consultation and guidance include contract review and in some cases, clinical recommendations related to behavioral health integration. This quarter the Transformation Center facilitated learning collaboratives on new incentive measures for 2015 on dental care and contraceptive use.

Web link to Innovator Agent quality data

N/A

H. Legislative activities

The 2015 Session of the Oregon State Legislature began on February 2. There are several dates worth noting for the session. First, April 21 is the deadline by which bills have to be passed through policy committees in the chamber origin. Additionally, bills have to be passed out of the second chamber policy committees by June 5. Finally, the legislature has targeted June 26 as sine die, although it may go until July 11. Bills will continue to change or drop from the agenda until then.

OHA has been following many bills that affect the administration of OHP, including:

- **HB 2395:** The bill extends the sunset date for the hospital assessment from September 30, 2015, to September, 30, 2017. The hospital assessment currently provides significant funding to support the Oregon Health Plan's budget. The bill has passed both chambers and been signed by the Governor.
- **HB 2696:** OHA collects information from certain entities that contract with CCOs. As HB 2696 is currently written, this bill would task OHA with sharing this information with all of the CCOs the

entity contracts with. OHA has expressed concerns that the bill may impede with OHA’s adherence to federal regulations regarding external quality review. In addition, OHA has concerns about data privacy and the costs of tracking data requests and releases of data.

- **HB 3517:** The legislature seeks to provide medical assistance to all of Oregon’s children up to 300 percent of FPL. This bill will allow OHA to provide medical assistance to children up to 300 percent of FPL who are otherwise unable to receive medical assistance if OHA can find funding for it.
- **SB 233:** OHA currently terminates OHP coverage for clients who are expected to be incarcerated for more than 12 months. Senate Bill 233 would have OHP suspend rather than terminate coverage for these clients.
- **SB 902:** Oregon’s health care transformation began prior to the existence of newly formed entities that oversee early learning programs that intersect with health care. This bill seeks to make those entities part of CCO Community Health Improvement Plans to address shared concerns about a workforce shortage in primary care and pediatrics in the community private practice delivery system and shared beliefs that school-based access points for routine preventive care, screening, and prevention and promotion are a good thing to expand.

I. Litigation status

Nothing to report this quarter.

J. Two-percent trend data

See [Appendix C](#).

K. DSHP terms and status

See [Appendix D](#).

IV. Status of Corrective Action Plans (CAPs)

Table 8 – Status of CAPs

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments
Health Share of Oregon	EQRO report findings	1/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	2/2015	Re-evaluate progress with 2015 Quality Plan
Cascade	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan

Entity (CCO or MCO)	Purpose and type of CAP	Start date of CAP	Action sought	Progress during current quarter	End date of CAP	Comments
FamilyCare	EQRO report findings	1/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
IHN	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
Primary Health of Josephine	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	
Trillium	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
Yamhill	EQRO report findings	3/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
Western Oregon Advanced Health	EQRO report findings	3/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
Umqua Health Alliance	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan
AllCare	EQRO report findings	2/2015	CCO developed Action Plan to correct findings	Action Plan received and approved	3/2015	Re-evaluate progress with 2015 Quality Plan

V. Evaluation activities and interim findings

In this quarter, Mathematica worked on final amendments to the initial draft report of its independent midpoint evaluation of the waiver. The draft report was submitted to CMS on December 23rd. The final report will be submitted to CMS in the next quarter per the Special Terms and Conditions (STCs) of the waiver. OHA also began initial procurement planning for the independent summative evaluation of the waiver required in the STCs.

In February a team of Oregon researchers presented findings from the Robert Wood Johnson-funded State Health Access Reform Evaluation (SHARE) at a State Health Access Data Assistance Center (SHADAC) webinar, and the final SHARE report was completed in March. SHARE assesses the impact of the CCOs on health care access, quality, outcomes, and costs in the first year of CCO existence; more detailed findings are included in the table below.

Table 9 - Evaluation activities and interim findings

In the tables below, relevant OHA and CCO activities to date are reported by the “levers” for transformation identified in our waiver agreement and Accountability Plan.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH)

Evaluation activities:

The PCPCH program continued planning for future evaluation efforts as well as working on its annual report. The formal reports for the initial evaluation of the program will be published later in 2015.

Interim findings:

As of March 2015, there were 548 recognized clinics in the state (surpassing Oregon’s goal of 500 clinics by 2015). This represents over 50 percent of the estimated number of primary care clinics in Oregon.

- OHA’s goal is to enroll 100 percent of CCO members in a recognized PCPCH. The statewide baseline (for 2012) for this measure is 51.8 percent.
- Updated CCO performance metrics (see Appendix E) show that the proportion of CCO members enrolled in a PCPCH has continued to increase from the baseline to 81.0 percent by December 2014, ranging from 60.7 percent to 99.0 percent across CCOs.
- It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

Improvement activities:

Oregon’s Patient-Centered Primary Care Institute provides technical support and transformation resources to practices statewide, including learning collaborative opportunities.

In this quarter, the Institute conducted four in-person sessions for its learning collaboratives. These sessions focused on patient experience of care, improving access, and patient-centered communication. Each session was attended by an average of 26 participants.

The Institute also held four webinars:

- Shared Decision Making: What, Why & How (attended by 20 people)
- Working at the Top of License (attended by 55 people)

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- Building Sustainable Quality Improvement Systems in your Practice (attended by 30 people)
- POLST: What's new and how can we do better? (attended by 54 people)

Webinar attendees were asked to rate the quality of the webinars on a scale ranging from 1 (poor) to 5 (excellent). The average response for these webinars was 4.4.

Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes

Evaluation activities:

In this quarter, hospitals submitted baseline data for the first year of Oregon's hospital incentive measure program, the Hospital Transformation Performance Program (HTPP; see Appendix E for details). OHA continues to work with the Oregon Association of Hospitals and Health Systems (OAHHS) to provide hospitals with support and guidance on HTPP.

In this quarter, the CCO Metrics Technical Advisory Workgroup (TAG) met monthly, and the CCO Metrics and Scoring Committee reconvened to review performance to date and begin considering 2016 measurement (see Appendix E for details).

Interim findings:

Internal analysis of the most recent quarterly CCO financial reports (for October-December 2014) show that that 51.4 percent of all plan payments are non-fee-for-service (FFS). This is a decline from the previous quarter, in which 57.3 percent of plan payments were non-FFS; some of this decline is due to an accounting change at one CCO. The non-FFS payment arrangements include salary, capitation, and 'other' payment arrangements. OHA continues to work with CCOs to improve reporting of APMs and flexible services.

Improvement activities:

Following the November 2014 statewide learning collaborative for CCO Medical Directors and Quality Improvement Coordinators that focused on exploring the link between payment methodologies and improving quality of care through measurement, one CCO has requested technical assistance on APMs from Michael Bailit of Bailit Health Purchasing. The technical assistance is expected to be provided next quarter.

OHA has contracted with the Center for Evidence-based Policy at OHSU (the Center) to provide technical assistance to CCOs developing and implementing APMs. The assistance will consist of focused, detailed work with two to three CCOs and more general resources and webinars for the remaining CCOs and other payers and providers.

Lever 3: Integrating physical, behavioral, and oral health care structurally and in the model of care

Evaluation activities:

In partnership with Oregon Health & Science University, the Transformation Center completed an environmental scan of behavioral health integration activities across the state. The scan was used to develop a technical assistance plan for physical and behavioral health integration, including content areas and delivery strategies.

To further document participants' integration activities and capture lessons learned, OHA added a qualitative component to the evaluation plan for Oregon's Adult Medicaid Quality Grant. OHA's contracted qualitative research specialist began to coordinate the plan's implementation in March.

Interim findings:

Findings from the Transformation Center’s environmental scan of behavioral health integration include:

- There has been extensive integration activity statewide and patients are being positively impacted. However, the penetration of integrated care is variable, with smaller and rural practices facing the most challenges.
- Greater clarity and guidance is needed on key integration issues, such as sharing behavioral health information, credentialing, coding, billing, practice standards and measures.
- Although there is a wealth of information about integration best practices available, many practices are challenged by the breadth and magnitude of change being required. They often lack capacity to successfully implement integration strategies. Ongoing access to program consultation and on-site practice coaching are often the most effective.

Five of the CCO incentive measures relate to integration. Updated data comparing the 2011 baseline to the period November 2013 – October 2014 is available for three of the measures (see Appendix E). The data continue to show progress, though this varies across the CCOs:

- SBIRT (screening for unhealthy drug and alcohol use) increased from 0.0 to 6.0 percent, below the 13.0 percent benchmark (ranging from 0.3 to 18.2 percent across CCOs).
- Follow-up after hospitalization for mental illness increased from the 65.2 percent baseline to 66.2 percent, a slight decrease from the previous reporting period (68.3 percent), and still under the benchmark of 68.8 percent (ranging from 49.4 to 85.7 percent across CCOs).
- Follow-up care for children initially prescribed ADHD medications continued to exceed the benchmark (58.1 percent versus a 51.0 percent benchmark), though this varied by CCO (from 46.0 to 69.6 percent). Note that this measure has been dropped from the incentive measure set for 2015 (though OHA will continue to monitor and report on this as part of the quality and access test).

Improvement activities:

OHA is working on the following improvement activities which will address the findings from the environmental scan of behavioral health integration:

- Behavioral Health Information Sharing Advisory Group and website (see <http://www.oregon.gov/oha/amh/Pages/bh-information.aspx>)
- Development of integrated care coding and billing guidelines
- Including integration consultants as part of the Transformation Center’s Technical Assistance Bank (see Section G for more information)
- Convening an integrated psychiatry interest group
- Supporting the Behavioral Health Home Learning Collaborative
- Coordination with the Integrated Behavioral Health Alliance of Oregon and Children’s Health Alliance Integration Work Group

Oregon’s Adult Medicaid Quality Grant was extended by 12 months, allowing Oregon to continue and deepen its work on “reverse” integration (bringing primary care into behavioral health settings). The Behavioral Health Home Learning Collaborative is continuing into a second year with nine mental health and chemical dependency treatment settings. The sites produced final reports on their improvement project activities in January. Although processes had been in place for only a few months, one site reported diabetic patients with lower HgBA1c levels, decreasing hypertension, and improved scores on depression and anxiety. Another site reported increasing the number of clients who were ready to quit smoking. And a third reported lower hospital admission and Emergency Department (ED) visit rates. Sites were asked to reapply to continue into Year 2, including a proposed improvement project. Six of the original ten sites were invited to continue. OHA issued a statewide RFA in February and recruited three new sites to join the Learning Collaborative. OHA also increased practice coaching to two visits per month as this was found to be very

helpful in the first year. Also in March, OHA solicited applications for a limited number of slots for specialized training in care.

Lever 4: Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources

Evaluation activities:

In this quarter Mathematica worked on final amendments to the final report of the independent midpoint evaluation of the waiver; this will be submitted to CMS in the next quarter.

The final report for the RWJF-funded State Health Access Reform Evaluation (SHARE) assessing the early impacts of CCOs on health care access, quality, outcomes, and costs was finalized in March. This work was conducted by external researchers from Portland State University and Providence’s Center for Outcomes Research and Education (CORE), who used survey data to assess the short-term impact of CCOs on member-reported use of care, care quality, and their own health and behaviors. This was supplemented with an analysis of claims data to measure the impact of CCOs on utilization patterns, per-member costs, and per-user costs. Findings are below.

Interim findings:

Overall, the SHARE project found evidence of early, positive impact of CCOs on member-reported access to care, quality of care, and aspects of care coordination. There was not evidence of a CCO-specific impact on preventative care (which increased for all on Medicaid, regardless of CCO status), or ED utilization (which decreased for all). Specifically:

- The survey showed that CCOs were associated with better improvements in member-reported access to medical care compared to both FFS Medicaid and the uninsured.
- The survey showed an association between CCOs and more frequent primary care use compared to both FFS Medicaid and the uninsured. Self-reported ED visits went down for CCO members, but they also went down for everyone else. This was supported by the claims analysis. In addition, the claims analysis found that specialty care use and cost-per-person decreased.
- CCOs were associated with better improvements in member ratings of care quality compared to both FFS Medicaid and the uninsured. CCOs were also associated with better connections to personal care providers compared to FFS Medicaid.
- Medicaid members were about twice as likely to have had a preventive screening (cholesterol test, etc.) than the uninsured, but CCOs did not see any bigger improvements than general FFS Medicaid.
- CCOs provided better “social determinants of health” assistance than non-CCOs, and did much better on care coordination than the uninsured.
- CCOs were associated with better improvements in self-reported health compared to the uninsured, which was not the case among FFS Medicaid.
- Pharmacy and costs shifted: There was a reduction in the probability of filling a prescription but an increase in the cost per user and cost per person.
- The claims analysis found no changes in *overall* or *total* service use and costs.

The data in Appendix E show CCO progress on quality measures from November 2013 – October 2014 compared to baseline data from 2011. Calendar Year (CY) 2014 data will be published next quarter.

Promising findings:

- Decreases³ continue in emergency department (ED) visits and hospitalizations for chronic conditions.
- Increases continue in PCPCH enrollment and developmental screening. While still far below the benchmark statewide, screening for risky drug or alcohol behavior (SBIRT) continues to increase from CY 2013.

Areas for improvement:

Updated data for areas previously noted for improvement (*e.g.*, access to primary care providers for children and adolescents, immunizations among children and adolescents, etc) are not yet available. OHA will be carefully monitoring these areas when CY 2014 data are complete.

Improvement activities:

In February 2015, the OHA Public Health Division awarded five grants to local consortia consisting of coordinated care organizations (CCOs), local public health authorities and chronic disease self-management program providers. From February through September 2015, grantees will participate in a series of three institutes designed to establish improved referral and programmatic relationships to improve health outcomes for pre-diabetes, diabetes and hypertension. Grantees will develop work plans that address the use of electronic health records and health information technology to improve quality of care; use of team-based care and traditional health workers; and increase referrals to chronic disease self-management programs, including the Stanford Chronic Disease Self-Management Program and the National Diabetes Prevention Program.

These efforts are funded by the Centers for Disease Control and Prevention and align with Oregon's CCO incentive measures and statewide performance improvement project.

OHA's Office of Health Information Technology (OHIT) staff have completed the compilation of information gathered during a series of on-site meetings with each CCO. The aim of the meetings was to ensure that state health IT initiatives align with and support CCO needs. OHIT is producing a summary document along with detailed individual profiles of health information technology at each of the CCOs. This will be part of a broader environmental scan on the status of health information technology and exchange across the state.

OHA continues to release monthly quality metric progress reports for CCOs, utilizing the automated metric reporting tool ("dashboard") developed by OHA's contractor, the Center for Outcomes Research and Education (CORE) at Providence. The dashboards utilize rolling 12-month windows and have the ability to filter key measures by population subgroups such as race/ethnicity, ZIP code, and eligibility.

The dashboards currently include a limited number of incentive and quality and access measures, but will be expanded to include additional measures as well as cost and utilization data in future releases (see Appendix E).

OHA is launching a functional reorganization process to ensure we are appropriately staffed, resourced, and organized to meet agency goals. This includes integrating all health systems work under a newly created Chief Health Systems Officer; OHA is currently recruiting for this position.

³ Unless otherwise noted, increases and decreases are from the baseline period (2011 for most measures) to the current review period (November 2013 – October 2014)

Lever 5: Implementation of health-related flexible services aimed at improving care delivery, enrollee health, and lowering costs

Evaluation activities:

Analysis of the CCO financial reports has shown a relatively low level of flexible service provision (though this varied across the CCOs). These data are being tracked each quarter to understand the level of flexible service provision at an aggregate level.

Interim findings:

None at this time.

Improvement activities:

OHA reviewed CCOs' flexible services policies and procedures and provided each CCO with feedback in February 2015; OHA also provided a standardized definition of flexible services and highlighted additional feedback related to member engagement. Most CCOs resubmitted updated flexible services policies to OHA in March.

OHA's Transformation Center and Medical Assistance Programs are continuing to develop a learning collaborative for CCOs to share best practices related to implementation and reporting of flexible services. In addition, the flexible services reporting form is being reviewed to improve the quality of the data reported.

Lever 6: Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Transformation Center

Evaluation activities:

The formative evaluation of the Transformation Center continued in this quarter. The team continues to analyze the data in real-time and debrief with the Transformation Center routinely to share emerging findings and to refine the direction of the evaluation.

Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.

The Transformation Center also completed its environmental scan of behavioral health integration across the state. See Lever 3 for more information and findings.

Interim findings/Improvement activities:

Over the last quarter, the Transformation Center continued work on its seven external learning collaboratives. From January – March 2015 four of the learning collaboratives met, for a total of 11 formal sessions attended by an average of 33 people per session; this is an increase from an average of 24 attendees per session in the previous quarter.

- The roles of attendees are as follows: 22 percent clinical; 16 percent administrative or operational lead; 13 percent QI/QA staff; the remainder hold other roles.
- The sessions were a mix of teleconferences, in-person sessions, and webinars. Topics ranged from Organizational Stress and Leadership Resilience to Identifying Health Disparities in CCOs Using Metrics and CAHPS Data.

Results from the Transformation Center's internal evaluation of the effectiveness of the learning collaboratives shows that:

- 91.9 percent of respondents found the session valuable or very valuable to their work.

- 58.0 percent of respondents say they will take action at their organization as a result of attending the learning collaborative session.

The evaluation forms also include free response questions asking attendees to note what they found most helpful from the session, as well as suggestions for improvement. Feedback from the Statewide CCO Learning Collaborative for Medical Directors and Quality Improvement Coordinators session on effective contraceptive use was particularly positive. The Transformation Center will seek to replicate the combination of expert presentation and practical, on the ground examples.

Two additional external learning collaborative events are planned for next quarter:

- Oregon Innovation Café (event planned for June 8-9)
- Flexible services (1-2 meetings, beginning in June).

The Transformation Center also continued to provide technical assistance to CCOs through its Technical Assistance Bank, and continued work on its formal assessment of barriers to CCO use of traditional health workers (see Section G for details).

VI. Public Forums

Public comments received

Medicaid Advisory Committee

No comments received this quarter.

Oregon Health Policy Board

January and February did not have any public testimony. In March, Jody Smith of GlaxoSmithKline presented testimony about SB 440, which she believes is a sleeper bill that would have a huge impact. This bill puts the Metrics and Scoring Committee under the Policy Board and could have an impact in moving them from pay for procedures to pay for performance. GlaxoSmithKline is working with a number of states that are coming up with a statewide set of measures to measure health care across the state. The most recent effort is with Washington state where a bill was passed similar to that of SB 440. The success of that effort had three points that Jody highlighted:

- Diverse group of stakeholders
- Very public process
- The committee struggled most with the difference between what an outcome measure and a process measure are.

VII. Transition Plan, Related to Implementation of the Affordable Care Act

No updates to the Transition Plan this quarter.

VIII. Appendices

Appendix A. Quarterly enrollment reports

1. SEDS reports

Nothing to report (the report format and data collection process is currently being reprogrammed).

2. State reported enrollment tables

Enrollment	January 2015	February 2015	March 2015
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,026,368	1,043,544	1,059,101
Title XXI funded State Plan	68,501	68,213	69,310
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	NA	NA	NA
Title XXI funded Expansion Populations 16, 20	NA	NA	NA
DSH Funded Expansion	NA	NA	NA
Other Expansion	NA	NA	NA
Pharmacy Only	NA	NA	NA
Family Planning Only	NA	NA	NA

Enrollment current as of	1/31/2015	2/28/2015	3/31/2015

*Numbers reflect final movement in enrollment reporting systems of CHIP children with incomes to 138% FPL to Medicaid.

3. Actual and unduplicated enrollment

Ever-Enrolled Report

POPULATION		Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year	
Expansion	Title 19	PLM Children FPL > 170%	990	2,706	-67.88%	-104.85%
		Pregnant Women FPL > 170%	671	1,695	-35.47%	-43.37%
	Title 21	SCHIP FPL > 170	18,970	51,536	-69.97%	-82.20%
Optional	Title 19	PLM Women FPL 133-170%	11,043	26,138	-26.59%	-18.92%
		Title 21	SCHIP FPL < 170%	57,851	158,105	-12.80%
Mandatory	Title 19	Other OHP Plus	284,264	778,279	-60.48%	-74.94%
		MAGI Adults/Children	746,887	2,075,449	10.41%	0.00%
		MAGI Pregnant Women	12,061	32,656	12.63%	0.00%
QUARTER TOTALS			1,132,737			

* Due to retroactive eligibility changes, the numbers should be considered preliminary.

OHP eligibles and managed care enrollment

OHP Eligibles*	Coordinated Care				Physical Health	Dental Care	Mental Health	
	CCOA**	CCOB**	CCOE**	CCOG**	FCHP	DCO	MHO	
January	1,028,263	864,132	1,328	1,543	53,547	2,710	55,836	4,428
February	1,044,073	896,304	1,272	1,458	39,552	2,695	57,317	4,423
March	1,060,093	918,924	1,187	1,363	36,760	2,647	56,137	3,853
Qtr Average	1,044,143	893,120	1,262	1,455	43,286	2,684	56,430	4,235
		85.54%	0.12%	0.15%	4.15%	0.26%	5.40%	0.41%

*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, MAGI Adults/ Children, MAGI Pregnant Women, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.

**CCOA = CCO provides physical, dental and mental health services
CCOB = CCO provides physical and mental health services.
CCOE = CCO provides mental health services only.
CCOG = CCO provides dental and mental health services.

Appendix B. Neutrality reports

1. Budget monitoring spreadsheet

[Attached separately.](#)

2. CHIP allotment neutrality monitoring spreadsheet

[Attached separately.](#)

Appendix C. Two-percent trend reduction tracking

[Attached separately.](#)

Appendix D. DSHP tracking

[Attached separately.](#)

Appendix E. Oregon Measures Matrix

[Attached separately.](#) In this period, OHA continued reporting on 2014 data for Coordinated Care Organizations (CCOs) and published the Health Systems Transformation 2014 Mid-Year Report. OHA also collected year one data from hospitals under the Hospital Transformation Performance Program (HTPP).

This quarterly report includes updated data for a rolling 12-month window (November 2013 – October 2014) for a subset of the 17 CCO incentive measures and 33 quality and access test measures.

CCO incentive metrics updates

CCO reporting and validation

During this reporting period:

- OHA provided monthly progress reports for CCOs, utilizing the automated metric reporting tool (“dashboard”) developed by OHA’s contractor, the Center for Outcomes Research and Education (CORE) at Providence.
 - Eleven incentive measures and four additional state performance measures were included in the dashboard during this reporting period.
 - The dashboards will continue to be expanded in the future.
- OHA continued to work with its contractor, the Oregon Health Care Quality Corporation to validate measures for multiple measurement periods. See the Validation Update below for additional details.

Public reporting

On January 14, 2015, OHA published a public report on the CCO incentive, quality and access test, and core performance measures. This report lays out the progress of Oregon’s CCOs on quality measures from July 1, 2013 through June 30, 2014, and is available online at <http://www.oregon.gov/oha/metrics>. Note this is the measurement period OHA provided in the previous quarterly report to CMS.

Oregon Health Authority

This report is also the first to include data on some key measures for the more than 380,000 additional Oregonians who have enrolled in the Oregon Health Plan (Medicaid) since the Affordable Care Act (ACA) took effect January 1, 2014. Key findings include:

- Statewide, newly enrolled ACA members use emergency rooms less frequently than other members, such as those who were enrolled in the Oregon Health Plan prior to January 1, 2014, and those who had been enrolled in the Oregon Health Plan in recent years.
- Newly enrolled ACA members also have fewer avoidable emergency room visits than other members.

Year Two clinical quality measures

During this reporting period, all 16 CCOs successfully submitted their year two Technology Plans. Technology Plans underwent a two-step review process and all Technology Plans were approved by March 31. CCOs received advance distribution of 50 percent of 3/17ths of their 2014 quality pool payments upon approval of their Technology Plans. CCOs will submit their year two data for the Clinical Quality Measures no later than April 1.

Measure validation updates

OHA contracted with the Oregon Health Care Quality Corporation (Q Corp) to independently calculate and conduct a multi-directional validation process on the 33 quality and access test measures. This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, Calendar Year (CY) 2013, the “dry run” period (July 2012 – June 2013) and the first year of the test (July 2013 – June 2014). Q Corp will also validate CY 2014 and the second year of the test moving forward.

In this reporting period, Q Corp has completed additional validation on several of the 22 measures that are computed using administrative claims data.

Time Period	Baseline	Dry Run	CY 2013	Year One Test	CY 2014	Year Two Test
Measures Signed Off (as of 12/31/15)	19	19	17	15	TBD	TBD
Measures Signed Off (as of 3/31/15)	20	20	20	19	TBD	TBD
Total Measures	22	22	22	22	22	22

Hospital metrics updates

Implementation of HTPP, Oregon’s hospital incentive measure program, continued in this quarter.

During this reporting period, hospitals submitted baseline data for the first year of the program (covering September 2013 – October 2014). Hospitals are responsible for tracking data for the majority of the HTPP measures. The individual hospitals then worked with the Oregon Association of Hospitals and Health Systems (OAHHS) to compile these data and make the official data submission to OHA. The exception to this was the follow-up after hospitalization for mental illness measure, which was calculated directly by OHA through encounters/claims.

OAHHS made the official baseline submission on behalf of hospitals in February 2015. OHA then worked with the hospitals to address questions about the baseline data submissions and validate the data. OHA will use these data to calculate the official baseline rates.

Overall, all participating hospitals successfully submitted baseline data for over 90% of the measures for which they were eligible. These data will be compiled and published in the HTPP Baseline Year Report in the next quarter, and the first incentive payments will be made to hospitals in April 2015.

During this period, OHA also partnered with OAHHS on a webinar on the measure focused on ensuring hospitals notify primary care providers when frequent utilizers are seen in the emergency department. This measure utilizes the Emergency Department Information Exchange (EDIE) system. The webinar was well-attended and the EDIE contractor also participated.

Committee and workgroup updates

The **CCO Metrics & Scoring Committee** met in March 2015 to review results of the 2014 Mid-Year Report and to begin consideration of potential CCO incentive measures for CY 2016. Meeting materials are available online at <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

The **CCO Metrics Technical Advisory Workgroup (TAG)** also met monthly in this quarter. Meeting materials are available online at www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx.

- In January, the TAG reviewed new functionalities of the metrics dashboard and received an update on OHA's vision for years 3-5 of clinical quality metrics reporting and the development of the clinical quality metrics registry.
- In February, the TAG received a demonstration of the Oregon Public Health Assessment Tool and discussed measurement challenges and options for a tobacco prevalence measure.
- In March, the TAG continued to discuss options for a tobacco measure, including utilizing Meaningful Use attestation reports or structured data to identify tobacco prevalence.

The **Hospital Performance Metrics Advisory Committee** did not meet during this reporting period.

OHA also opened up nominations for new members for both the CCO Metrics & Scoring Committee and the Hospital Performance Metrics Advisory Committee. New members will be selected next quarter.

Core Performance Measure Matrix and PQI Matrix

[Attached separately](#). OHA has continued development work on the core performance measures outlined in the waiver; 2011 baseline data, Calendar Year 2013 data, and a rolling 12-month measurement period at the state level are included in the table, as are high and low CCO performance on each measure where possible. Updates provided in red.

Hospital Transformation Performance Program (HTPP) Measures Matrix

[Attached separately](#).

Appendix F: Uncompensated Care Program

Nothing to report this quarter. OHA awaits system updates to support collection of UCCP claim data.