

MEDICAID ADVISORY COMMITTEE
March 25th
9:00a.m. – 11:30 p.m.
General Services Building
Mazama Conference Room
1225 Ferry St. SE, Salem, Oregon

Time	Item	Presenter
9:00	Opening Remarks – Introduction of new members – Committee memo, OHA Report on SB 1526 – Approval of minutes – January 2015	Co-Chairs
9:15	2015 Legislative Update	Brian Nieubuurt, OHA
9:20	OHA Ombuds Advisory Council: Update	Ellen Pinney, OHA
9:35	OHA Transformation Center – Update on CCO Community Advisory Councils (CACs)	Adrienne Mullock, Tom Cogswell, OHA
10:10	Health Share Community Advisory Council – Health Share’s CAC membership and community engagement activities – Council priority areas and implementation activities outlined in the CHIP	Sandra Clark, staff; Amy Anderson, member
10:40	BREAK	
10:50	Oregon Health Authority: Updates – Oregon Health Plan (OHP) Enrollment and Redeterminations – Coordinated Care Organizations (CCOs)	Rhonda Busek, OHA
11:00	Committee Strategic Planning and Draft Work Plan – Review Committee Charter – Proposed 2015 work plan & meeting calendar – Brainstorm future policy topics	Co-Chairs; staff
11:30	Public Comment or Testimony	Co-Chairs
11:35	Closing comments	Co-Chairs; staff
11:40	Adjourn	Co-Chairs; staff

Materials:

1. Agenda
2. Draft Minutes, January 2015
3. Committee memo, SB 1526
4. OHA report to Legislature, SB 1526
5. 2015 Legislative Summary
6. OHA Dashboard
7. OHA Transformation Center
8. Draft Committee Charter
9. 2015 Meeting and Topic Schedule
10. OHP Section 1115 Quarterly Report, 10/1-12/31

Next Meeting:
April 22nd, 2015 – 9:00-12:00pm
General Services Building
Mazama Conference Room
1225 Ferry St. SE, Salem, Oregon



OREGON MEDICAID ADVISORY COMMITTEE
January 28, 2015
9:00am – 12:00pm
Mazama Conference Room, General Services Building
1225 Ferry St. SE, Salem, Oregon

MEMBERS IN ATTENDANCE: Janet Patin, Romnee Auerbach, Rhonda Busek , Carol Criswell, Kay Dickerson
MEMBERS ABSENT: Alyssa Franzen, Karen Gaffney
PHONE PARTICIPANTS: Kristen Dillon, Leslie Sutton
PRESENTERS: OHA: Linda Hammond, Rhonda Busek, Janna Starr, Brian Nieubuurt, Jen Lewis-Goff, and Susan Otter
STAFF: Jeannette Nguyen-Johnson
VISITORS:

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. Announced that a new OHA Director, Lynne Saxton, started on January 20 th .	Co-Chair & MAC staff
Approval of Minutes	The committee reviewed meeting minutes from December 10 th , 2014. A motion was made to approve the minutes, with one correction. The motion was seconded; minutes were approved, with correction.	Co-Chair & Committee
Oregon Health Authority Updates	<p>Linda Hammond, Interim Chief Operating Officer, OHA, provided an update on the OHP enrollment and redetermination process.</p> <ul style="list-style-type: none"> • There is currently not a single system for processing applications and redeterminations. A hybrid process is being used for doing any work related to members’ enrollment or redetermination and is a primarily manual process. To assist an individual OHP member or applicant, each staff person has to be able to operate in four different systems simultaneously. • Initially this process took about 45 mins. During the most recent open enrollments period (Fall 2014 – Winter 2014), there were 600 employees working 24/7 to deal with the volume of work. • Today the same challenges are in place, but the hybrid process now takes 20-25 mins. and the workforce consists of 200 staff. Success has been due to partnerships with CMS allowing OHA to expedite some processes, applying LEAN to improve work flow, and understanding and addressing members’ needs as far upstream as possible. • About 1,000 applications are being received each day through the hybrid process. All of the applications that need processing are January applications. • The process from receiving applications from the federal site and getting them into the MMIS system is extremely complicated and staff is working diligently to improve the flow of working with the flat files. • If individuals have applied through the federal website, where there can be a few weeks delay in processing their 	Linda Hammond, OHA

	<p>applications, OHA is working with them on the phone to get their information to try to prevent any closures of coverage. OHA is taking further steps with data matching to ensure individuals whose applications are being processed in the federal hub are not having their coverage cancelled.</p> <ul style="list-style-type: none"> • Working to address the flow across the entire year and are focused on the gap analysis between the Kentucky model and our current system to make sure we are maximizing the advantages from the Kentucky system, because it has been successful for Kentucky in the two years it has been in operation. • Have made progress since last December when there were 33,000 stuck applications and 33,000 complex applications. • Individuals applying for OHP should go to http://www.oregonhealthcare.gov/ to apply. • Question from Leslie S. as to whether there is anything new around continuous eligibility. Linda indicated the ACA makes possible administrative redeterminations, which is an expedited process to redetermine eligibility, where we only ask for missing information and for applicants to verify anything that we cannot verify. <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"> • Call wait times are still about an hour and address determination issues, including closure notices, and the needs of existing members, of which there are about one million OHP enrollees. • OHA has implemented a number of outreach strategies including calling members who we have not heard from within 90 days. • Working with CCOs and providers to inform them if someone comes in with a letter that has an application being processed in the federal hub that providers should see them and that OHA will ensure payment. <p>Janna Starr, Medical Assistance Programs, OHA, presented an update on the Oregon Health Plan, Section 1115 Quarterly Report from the fourth quarter of 2014.</p> <ul style="list-style-type: none"> • Janna reviewed highlights from the fourth quarter (7/1/2014 – 9/30/2014) report, including the Letter from the State Medicaid Director, history on the Demonstration description, events affecting health care delivery, including Evaluation activities and interim findings, the public input section, and the quarterly enrolments reports. <p>Brian Nieubuurt, Legislative Coordinator for Health Care Programs, OHA, provided a preview for the 2015 Legislative Session.</p> <ul style="list-style-type: none"> • OHA health care programs include Medical Assistance Programs, including the Oregon Health Plan, PEBB and OEBC. • Jen Lewis- Goff is also on the legislative team and supports the Office for Health Policy and Research, Data Analytics, Office of Equity and Inclusion and the Health Licensing Office. • A formal list of OHP related bills was not produced because they are still in the early stages of the Legislative session. There were over 1,400 pre-session filed bills, which is actually less than normal which can be contributed 	<p>Rhonda Busek, OHA</p> <p>Janna Starr, OHA</p> <p>Brian Nieubuurt, OHA</p>
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	<p>at least in part to the Governor’s priorities shifting, a lot of new Legislators and if you’re not elected you cannot pre-session file a bill by the deadline.</p> <ul style="list-style-type: none"> • February 2nd we should start seeing an increase in the volume of bills. • Currently not a lot of bills that have a direct impact on OHP, in part to give time for CCOs to continue their work and development, the Governor is more focused on public health investments this year. • The Legislative team is still working to evaluate the bills to understand their impacts and get a sense of what bills may move. • Primary impacts to OHP will be OHA’s budget and extending the sunset of the provider tax (HB 2395). Some other bills of interest coming up early this session are HB 2306 which authorizes OHA to limit providers from which medical assistance recipient may obtain prescription drugs if recipient meets specified criteria and HB 2421 which makes mental health drugs subject to Practitioner-Managed Prescription Drug Plan. • A lot of the substantive bills related to OHP are on the House side. • There are legislative bills specific to Oregon Health Authority, which can be viewed here. 	
<p>Health Information Technology</p>	<p>Susan Otter, State Coordinator for HIT at OHA, presented on Health Information Technology efforts in Oregon (see slides 8-26). Susan’s presentation is outlined as follows:</p> <ul style="list-style-type: none"> • Reviewed the definitions and some examples of health information technology (HIT), health information exchange (HIR) and interoperability. • The vision of “HIT-optimized” health care system, which is “The vision for the State is a transformed health system where statewide HIT/HIE efforts ensures that all Oregonians have access to “HIT-optimized” health care.” Identified goals for HIT-optimized health care for providers, systems and individuals. • Reviewed EHR adoption and Meaningful Use in Oregon, including data on the adoption level by eligible professional and hospitals. • Reviewed the level of HIE in Oregon and CCO investments in HIE. • Lastly, Susan reviewed the state’s role in Health IT, which is largely to support efforts and utilization by providers, systems and individuals; support standardization and alignment where possible; and lastly, a smaller role in providing actual HIT. • There was discussion around meaningful use and integration of behavioral health data into HER systems. CCOs were also identified as drivers for change in HIT and HER adoption and use. 	<p>Susan Otter, OHA</p>
<p>Committee Churn Mitigation Report</p>	<p>Children’s Health Insurance Program in the Affordable Care Act Coverage Landscape, premium assistance policy and implementation considerations—Co-Chair and MAC Staff</p> <ul style="list-style-type: none"> • Committee members reviewed the draft memo on SB 1526, intended for OHA leadership, and recommended the following changes before finalizing the memo: <ul style="list-style-type: none"> ○ Add language to the cover letter to emphasize that OHP eligibility and enrollment systems for and the Marketplace itself are still stabilizing. Also that children covered in CHIP today have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market, and are served by innovative care delivery models via CCOs. Finally, that only a subset of 	<p>Co-Chair, Staff & Committee</p>

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	<p>members in OHP would have the option to pursue premium assistance under the parameters of SB 1526 which would pose a parity issue.</p> <ul style="list-style-type: none"> • The Committee also recommended clarification around cost effectiveness of a premium assistance program and addressing any confusing or contradictory language in the analysis. • The Committee agreed to have the Co-chairs review and approve the changes made by staff on behalf of the Committee. Staff will then send the memo to OHA leadership. 	
Public Comment	No public comment was made.	Co-Chair
Adjourn	The meeting was adjourned at 12:00 p.m.	Co-Chair

Next MAC meeting:

March 23, 2015

9:00am – 12:00pm

Mazama Conference Room, General Services Building

1225 Ferry St. SE, Salem, Oregon

MEMORANDUM

DATE: January 6, 2015
TO: Oregon Health Authority, Medical Assistance Programs
FROM: Oregon Medicaid Advisory Committee
RE: Senate Bill 1526: Options and Considerations for Premium Assistance in Oregon's Children's Health Insurance Program

Senate Bill 1526 (2014) charges the Oregon Health Authority (OHA) with assessing the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance premiums for children in families with incomes between 200-300% of the federal poverty level (FPL), commonly referred to as premium assistance.

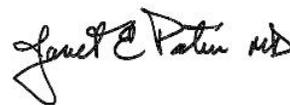
In the fall of 2014, Oregon's Medicaid Advisory Committee (MAC) was tasked by OHA to examine the issue of a voluntary premium assistance program, per SB 1526, and advise the Authority. The Committee reviewed federal regulations and guidance, assessed Oregon's health coverage and reform landscape, and considered the state's historical experience with premium assistance programs. The Committee then examined the benefits and challenges of a CHIP premium assistance program, viewed through the lens of CHIP beneficiaries and their families, the State, Coordinated Care Organizations (CCOs), the commercial market/Marketplace, and providers.

While the Committee identified some benefits, they recognize such programs are complex, costly to administer, and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and Marketplace are still stabilizing. Further, the post-2014 coverage environment is very different, as most Oregon children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market. OHP enrollees are also served by innovative care delivery models via CCOs. Lastly, per SB 1526, the option to enroll in premium assistance would only be available to a very small fraction of children in OHP. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim.

Based on the Committee's work, it advises OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time and that the state reassess future opportunities to improve Oregon's CHIP program after the status of the program's federal funding is resolved by Congress.



Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee



Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Background

Premium assistance programs aim to offer low- and moderate-income families access to affordable commercial health insurance coverage. These programs provide eligible beneficiaries additional coverage options, and may support whole family coverage, by allowing all members of a family to remain in a single commercial plan and be served by the same provider network, regardless of their coverage type.

States have varied experiences with implementing such programs through Medicaid and CHIP.¹ States that offer CHIP premium assistance programs are required to provide “comparable coverage” and ensure that children do not have greater out-of-pocket costs (premiums and cost sharing) than under direct CHIP coverage through Title XXI of the Social Security Act. States must fill benefit gaps that exist between commercial plans and CHIP benefits and wrap consumer out-of-pocket costs, to the extent that they exceed CHIP levels, if premium assistance is offered. States must also ensure that the program is cost effective, that is, the cost of covering an individual through premium assistance must be no more than providing “comparable coverage” than in the direct CHIP program.²

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP and several premium assistance programs through Healthy Kids. Oregon’s premium assistance programs were available in a variety of formats, but in general, subsidized both employed sponsored insurance (ESI) as well as certain individual plans for children in families up to 300% FPL. Due to ACA coverage expansions, these programs ended December 31, 2013. Starting in 2014, children in Oregon in families up to 300% FPL receive comprehensive, no-cost coverage through the Oregon Health Plan (OHP).

Program Design Considerations for CHIP Premium Assistance in Oregon

In order to assess issues relating to the design and implementation of a CHIP premium assistance program in Oregon, the Committee reviewed the general structure for the program based on current federal guidelines and taking into account the state’s health coverage landscape. Table 1 provides an overview.

¹ Kaiser Commission on Medicaid and the Uninsured. Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act. March 2013

² U.S.C. 1397ee(c)(3)(A)

Table 1. Program Design Considerations for CHIP Premium Assistance in Oregon

Program Element	Requirements and Options
Benefits	State must provide “comparable coverage” to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits
Premiums and Cost Sharing	State must ensure children in premium assistance do not have greater out-of-pocket costs than those with direct CHIP, and wrap consumer out-of-pocket costs to the extent they exceed CHIP levels
Carriers/ Delivery System	Commercial coverage options that may be subsidized include: <ul style="list-style-type: none"> - QHPs, including CCOs offering certified QHPs - Individual plans available outside the Marketplace - Commercial plans offered by employers <i>* Provider networks between OHP and the commercial markets vary</i>
Employer Contribution	Optional; historically, has been a requirement in past Oregon ESI premium assistance programs
Administering Entity	Oregon Health Authority
Program Administration	At a minimum, administrative capability would need to be developed for: <ul style="list-style-type: none"> - Eligibility determination and enrollment - Tracking of benefits and consumer out-of-pocket costs - Education and outreach, customer service, etc. - Coordination with plan administration
Financing	<ul style="list-style-type: none"> - FY 2015 federal match rate = 74.84%³ - FY 2017 federal match rate = 74.25% (without ACA 23% bump); 97.25% (with 23% ACA bump)⁴
Cost Effectiveness⁵	The State’s cost of covering an individual through premium assistance must be the same or less than providing “comparable coverage” to the individual in the direct CHIP program; must include the cost of providing wraparound coverage and administrative costs; can be applied on an individual or aggregate basis.
Federal Budget Neutrality	If the state seeks a federal waiver to implement the program, the program must be budget neutral to the federal government, meaning the costs must not exceed what they would have been without the premium assistance demonstration.
Federal Authority	Several options for states interested in offering premium assistance coverage for children currently eligible for CHIP: CHIP State Plan options; 1115 Demonstration Waiver; or Innovation Waivers (starting in 2017, ACA provides states the flexibility to apply for federal “Innovation Waivers”).

³ FY 2015: [Federal Register, January 21, 2014 \(Vol 79, No. 13\), pp. 3385-3388](#).

⁴ The ACA extends CHIP through most of 2015 and beginning October 1, 2015 the already enhanced CHIP federal matching rate will increase by 23 percentage points, not to exceed 100%. The enhanced federal matching rate continues until September 30, 2019.

⁵ See P.L. 111-3 and P.L. 111-148 §10203(b)(1). An exception to this lies in the 1905(a) option, which does not include a statutory reference to cost effectiveness, however recent regulatory guidance mentioned above includes a cost effectiveness definition similar to the statutory definition described here.

CHIP Premium Assistance: Programmatic Benefits and Challenges

The Committee considered the potential structure for a CHIP premium assistance program in Oregon and identified benefits and challenges viewed through the lens of CHIP beneficiaries and their families, the State, CCOs, the commercial market/Marketplace, and providers. The table below is not an exhaustive list of benefits and challenges.

Table 2. Benefits and Challenges for CHIP Premium Assistance in Oregon

Stakeholder	Benefits	Challenges
Consumers	<ul style="list-style-type: none"> • Offers voluntary participation and choice of health plans • Safeguards benefits and consumer out-of-pocket costs and affordability • Fosters whole family coverage • Depending on design, may help consumers maintain continuity across plans and providers based on IAP eligibility 	<ul style="list-style-type: none"> • Creates an additional coverage option which may add consumer confusion • Equity issue: Per terms of SB 1526 not all CHIP children would have access to premium assistance, only those from 200-300% FPL • Unknown impact on access to health care providers, including care coordination and continuity
State	<ul style="list-style-type: none"> • Prior experience in offering premium assistance programs 	<ul style="list-style-type: none"> • Complexities with program administration; need to ensure comparable benefits and affordability to direct CHIP coverage • Increase in provider reimbursement may lead to higher PMPM charges; state could face increased costs • A performance and quality infrastructure similar to OHP's is not currently in place statewide in the commercial market • State responsible for start-up and ongoing administrative costs • Requires federal approval, and state legislative and budget approval • Federal cost effectiveness and budget neutrality are difficult to achieve
CCOs	<ul style="list-style-type: none"> • None identified unless certified as QHPs 	<ul style="list-style-type: none"> • Enrollment in CCOs could decline, potentially affecting risk pool
Commercial Plans	<ul style="list-style-type: none"> • More covered lives • PA through Marketplace could encourage more CCOs to offer certified QHPs 	<ul style="list-style-type: none"> • Oregon's Marketplace is still stabilizing • Complex plan administration if a separate CHIP look-alike plan is needed • Different enrollment periods between CHIP and the commercial market • Voluntary nature of program creates potential risk volatility for participating carriers as individuals could disenroll/reenroll at any time
Providers	<ul style="list-style-type: none"> • Enhanced provider reimbursement relative to OHP payment rates 	<ul style="list-style-type: none"> • Encourage consumers to switch providers more frequently; providers' patient panels could be less stable

Although CHIP premium assistance programs may offer some advantages—consumer choice, while maintaining benefit coverage and consumer affordability comparable to CHIP—the Committee concluded that these programs are often complex in design, face considerable implementation barriers, including costly administration, and may add to consumer confusion.

A recent synthesis of research on the impact of the Medicaid and CHIP programs found that beneficiaries experience improved access to care, utilization, and financial protection. Research also indicates that these programs are positively associated with the quality of care children receive, and that parents value the programs.⁶ In Oregon, the MAC acknowledges the success of Healthy Kids, which has brought affordable comprehensive coverage to over 100,000 children through Medicaid and CHIP.⁷ The Committee also noted that the benefit coverage for children in the OHP is also more generous than the essential health benefits (EHBs) benchmark plan offered through the Marketplace.⁸ Nearly 90% of OHP members are served through innovative care delivery models via CCOs, and as of March 2014, nearly 80% of CCO members were enrolled in a patient-centered primary care home.⁹ Overall, it is unclear at this time whether or to what degree establishing a CHIP premium assistance program leverages current statewide health reform initiatives, advances spread of the coordinated care model and supports triple aim goals.

In addition to weighing the benefits and challenges of a premium assistance program, the Committee considered the program in the context of Oregon’s existing coverage landscape and health care market trends. In Oregon and nationally, commercial market trends show a general decline in availability of ESI, increases in employee cost sharing, and expanding use of high deductible health plans. These trends make it increasingly difficult for states to meet the federal cost effectiveness requirement of a premium assistance program through ESI.^{10,11}

Conclusion

⁶ Paradise, J. The Impact of the Children’s Health Insurance Program (CHIP): What Does the Research Tell Us? Kaiser Family Foundation. July 2014.

⁷ <http://www.oregonhealthykids.gov/healthykids/history.html>

⁸ Wakely Consulting Group. Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans. July 2014.

⁹ Oregon Health Plan Section 1115 Annual Report. Demonstration Year: 12, 7/1/2013–6/30/201⁹ FY 2015: [Federal Register, January 21, 2014 \(Vol 79, No. 13\), pp. 3385-3388.](#)

⁹ The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security; does not include income from gifts, inheritance, Survivors Benefits, some other income sources are partially excluded; does not consider property, savings accounts, etc. for eligibility determination.

The Committee advises that Oregon's Medicaid and CHIP eligibility and enrollment systems as well as its Marketplace are still stabilizing. It is unclear how offering premium assistance to a limited number of low-income families aligns with the Oregon's priorities. These include ensuring all children in Oregon are healthy and Kindergarten ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim for all Oregonians. The Committee advises the OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time, and that future consideration may warrant further deliberation by interested stakeholders. The Committee recommends Oregon consider future opportunities to improve Oregon's CHIP program be reassessed after the status of the program's federal funding is resolved by Congress. Thank you for your consideration.

Medicaid Advisory Committee Members (*as of Jan. 2015)

Karen Gaffney, MS – Co-Chair, *Lane County health care executive, Trillium CCO Board Member*

Janet Patin, MD – Co-Chair, *physician, Columbia Pacific CCO Board Member*

Romnee Auerbach, MS, ANP, PMHNP-BC – *health care provider*

Rhonda Busek, MBA – *Interim Director, Medical Assistance Programs, OHA*

Carol Criswell, BA – *parent, patient advocate*

Kay Dickerson, BA – *OHP member, patient advocate*

Kristen Dillon, MD, FAAFP – *physician, Columbia Gorge CCO Board Member*

Alyssa Franzen, DMD – *dental provider; Dental Director, Care Oregon*

Leslie Sutton, JD – *children & disability advocate, Oregon Council on Developmental Disabilities*



SB 1526: Oregon's Children's Health Insurance Program and Premium Assistance

February 2015

**Prepared by
The Oregon Health Authority**

**Prepared for
The Oregon State Legislature
Per Senate Bill 1526**

This report is available online at:

**Oregon
Health
Authority**

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February 27th, 2015

Senate Committee on Health Care
and Human Services
Oregon Legislative Assembly

Dear Senators Monnes Anderson and Kruse,

In 2014, the Oregon Legislature passed Senate Bill 1526, charging the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families between 200-300% of the federal poverty level (FPL), commonly referred to as premium assistance. In response to the requirements of SB 1526, OHA has enclosed its report and recommendations to the Legislature.

In summary, creating a premium assistance program for a segment of Oregon's CHIP population is not recommended at this time. The following considerations support OHA's recommendation:

- Oregon's Medicaid/CHIP eligibility and enrollment systems and Marketplace are still stabilizing.
- Oregon Health Plan (OHP) provides children up to 300% FPL with access to high quality, no cost coverage, and richer benefits than generally available under commercial coverage.
- OHP enrollees are served by innovative care delivery systems through coordinated care organizations (CCOs) and patient centered primary care homes (PCPCHs).
- Offering premium assistance to a subset of OHP members poses an equity issue and may compromise Oregon's goals of achieving an integrated and coordinated health care delivery system.
- Implementation would result in significant administrative burden including startup costs for the state, and potentially for insurance carriers as well.
- Federal costs for premium assistance would be greater than direct CHIP coverage and the state would be responsible for the difference.

To preserve the gains achieved through Oregon's success in enrolling low- and moderate-income children in OHP coverage, the OHA does not recommend that the Legislature establish a CHIP premium assistance program for children served by the OHP at this time.

Sincerely,

Lynne Saxton, Acting Director

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Executive Summary

Senate Bill 1526 (2014) charged the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families between 200-300% of the federal poverty level (FPL), referred to as premium assistance. Federal statute requires states' CHIP premium assistance programs to:

- Provide "comparable coverage" to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits;
- Ensure CHIP beneficiaries do not have greater out-of-pocket costs (OOP) than those with direct CHIP coverage, and wrap consumer costs to the extent they exceed CHIP levels; and
- Be cost effective from the federal perspective, meaning that the federal cost of covering an individual through premium assistance is the same or less than providing "comparable coverage" to the individual in the direct CHIP program.

Contemplating premium assistance within the new context of the Affordable Care Act (ACA) and the Oregon's health system transformation presents new and important considerations as public and private health coverage options for children and families have changed. These changes have implications for consumer access, benefit coverage, quality and affordability.

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP and several premium assistance programs for families up to 300% FPL through Healthy Kids. As a result of the ACA and state's own reforms, Oregon's insurance affordability programs for low- and moderate-income families now include Medicaid, CHIP and federally subsidized commercial coverage through Marketplace qualified health plans (QHPs). Starting in 2014, children below 300% FPL in premium assistance through CHIP were transitioned to comprehensive, no-cost coverage through the Oregon Health Plan (OHP). Unsubsidized coverage for families remains available through individual plans outside the Marketplace and through employer sponsored insurance (ESI).

States that offer premium assistance to CHIP eligible children may help to support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type. In Oregon, the earliest feasible implementation date for the premium subsidy program described in SB 1526 would be calendar year 2017, when approximately 16,000 children from 200-300% FPL are projected to be enrolled in CHIP.

To determine whether the program would be cost effective, OHA staff assessed the potential budget impacts of CHIP premium assistance through Marketplace QHPs or analogous individual plans outside the Marketplace. The cost of each coverage option was compared to the cost of the direct CHIP program, taking into account premiums, costs for any wraparound of benefits and consumer OOP costs (if applicable), and administrative expenses to operate the program. Due to the widespread variation found across ESI plans

in Oregon, only general program estimates for this coverage option were examined. Assumptions relating to program take-up were not made as the number of enrollees did not ultimately affect whether a premium assistance program is cost effective.

Results suggest that Oregon would have to allocate an additional \$714-\$818 per member, annually, in state funds to establish a CHIP premium assistance program for individual plan coverage in or outside the Marketplace. (Projected costs for direct CHIP coverage in CY 2017 is \$2,109 per member per year.) In other words, the analysis finds that after taking into account total premium assistance program costs—additional federal and state share for premiums, wraparound and admin expenses—coverage for each option is not cost effective.

A final consideration is the status of future federal funding for CHIP. Currently, federal funds for CHIP are only appropriated through federal fiscal year (FFY) 2015 and a continuation requires Congressional action. If federal CHIP funding ends after FFY 2015, states are required to maintain income eligibility levels for CHIP children through FFY 2019 as a condition for receiving federal Medicaid payments. The current level of uncertainty makes it difficult for states interested in pursuing CHIP premium assistance to move forward.

Recommendation

The OHA advises that a premium assistance program for Oregon's CHIP population is not feasible at this time for the following reasons:

- Oregon's Medicaid/CHIP eligibility and enrollment systems and Marketplace are still stabilizing.
- OHP already provides children up to 300% FPL with access to high quality, no cost coverage, and richer benefits than generally available commercial coverage.
- CHIP enrollees are served by innovative care delivery systems through coordinated care organizations (CCOs) and patient centered primary care homes (PCPCHs).
- Offering premium assistance to only a subset of CHIP eligible children poses an equity issue and may compromise Oregon's goals of achieving an integrated and coordinated health care delivery system.
- Implementation would result in administrative burden for the state and insurance carriers due to tracking and monitoring children to ensure they receive comparable benefit coverage and pay no more in OOP costs than in CHIP.
- Oregon would be unable to meet federal cost effectiveness requirements for creating a CHIP premium assistance program in 2017 without additional state spending or significant changes to benefits and cost sharing in order to reduce overall program costs.

OHA does not recommend that Oregon create a CHIP premium assistance program at this time. Opportunities to improve Oregon's CHIP program should be reassessed after the status of the program's federal funding is addressed by Congress.

Background

Senate Bill 1526 (2014) charged the Oregon Health Authority (OHA) with examining the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance for children in families with between 200-300% of the federal poverty level (FPL). The use of public funds through Medicaid or CHIP to purchase commercial coverage is commonly referred to as premium assistance. States have flexibility to offer premium assistance programs using public funds through Medicaid and CHIP) to subsidize commercial coverage, including coverage through Marketplace Qualified Health Plans (QHPs).¹

There are a few options under federal CHIP authority to do premium assistance. In general, federal statute requires states' CHIP premium assistance programs to:

- Provide "comparable coverage" to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits;
- Ensure families with children do not have greater out-of-pocket costs (OOP) than those with direct CHIP, and wrap consumer costs to the extent they exceed CHIP levels; and
- Assure the program is cost effective to the state, meaning that the cost of covering an individual through premium assistance is the same or less than providing "comparable coverage" to the individual in the direct CHIP program.²

Premium Assistance Programs

In general, the structure of premium assistance programs aims to create a partnership between the government, commercial markets, health systems, and employers to provide health care for beneficiaries. Contemplating premium assistance within the context of the Affordable Care Act (ACA) and the state's health system transformation efforts presents new and important considerations as public and private health coverage options for children and families have changed. These changes have implications for consumer access, benefit coverage, quality and affordability.

The insurance affordability landscape in Oregon for low-income children includes Medicaid, CHIP and subsidized commercial coverage through Marketplace qualified health plans (QHPs). Alternative coverage options for families remains available through individual plans outside the Marketplace and through employer sponsored insurance (ESI). In examining the feasibility of a voluntary CHIP premium assistance program, the state considered the main types of commercial coverage available: Marketplace QHPs, analogous individual plans outside the Marketplace and ESI.

The earliest feasible implementation date for the program would be calendar year 2017, when approximately 16,000 children from 200-300% FPL are projected to be enrolled in

¹ Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, Final Rule. Federal Register/Vol. 78, No. 135 / Monday, July 15, 2013 (codified in title 45 of C.F.R.).

² 42 U.S.C. 1397ee(c)(3)(A)

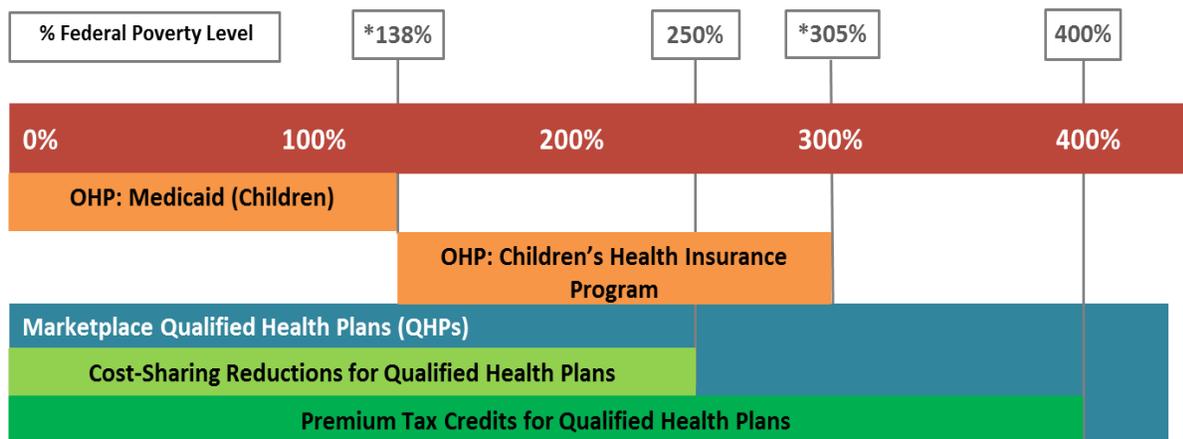
CHIP.³ These children would have the option to enroll in to commercial coverage. In addition to providing families a choice between direct CHIP and commercial coverage, offering premium assistance to CHIP eligible children may help support whole family coverage by allowing all members of a family to remain in a single commercial plan and served by the same provider network, regardless of their coverage type. In 2013, an estimated 154,000 Oregon children were in families with incomes between 200-300% FPL. An estimated 72% (111,650) of these children were covered by ESI. It is unknown how many of these children could qualify for CHIP eligibility in 2017 and potentially enroll in premium assistance.⁴

History of Children’s Public Insurance Coverage in Oregon

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP, and several premium assistance programs through Healthy Kids. Oregon’s premium assistance programs were available in a variety of formats, but in general, they subsidized both ESI as well as certain individual plans for children in families up to 300% FPL.

Due to ACA coverage expansions, these programs ended December 31, 2013. Starting in 2014, Oregon children in families up to 300% FPL became eligible to receive comprehensive, no-cost coverage through the Oregon Health Plan (OHP). Subsidized commercial coverage for individuals not eligible for Medicaid or CHIP and without access to affordable ESI is also available through QHPs. Figure 1 illustrates the insurance affordability programs available to children after 2014.

Figure 1. Insurance Affordability Programs for Oregon Children in 2014 and Beyond



*Indicates the 5% cross-the-board income disregard in Medicaid and CHIP. (Illustration adapted from the Washington State Health Care Authority.)

³ Office of Forecasting, Research and Analysis (OFRA), OHA: CHIP enrollment and forecast, Dec. 2014.

⁴ Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) [files](#).

Oregon continues to operate a separate CHIP program, offering coverage to children less than 19 years of age in families with incomes from above 138% through 300% FPL. Oregon's current CHIP enrollment for 2015 is estimated to be over 75,000. By 2017, Oregon's entire CHIP population is projected to be just below 60,000 beneficiaries, with 22% of those between 200-300% FPL.⁵ For more information as to how Oregon's current CHIP program is governed, see Appendix A.

Future of Federal CHIP Funding

Under current law, federal fiscal year (FFY) 2015 (10/1/14—9/30/15) is the last year federal appropriations are provided for CHIP, even though the program is still authorized. Continued federal funding beyond 2015 is important, as the ACA requires states to maintain the CHIP eligibility standards that were in place as of enactment (March 2010) through FFY 2019, otherwise known as maintenance of effort (MOE).⁶ If Congress extends CHIP funding, the existing enhanced federal match rate may increase by 23 percentage points, bringing the average CHIP federal matching rate to 93% and Oregon's rate to 97.25%. This enhanced federal matching rate continues until September 30, 2019.

Specifically, MOE requires:

- *Maintain eligibility standards.* States' "eligibility standards, methods and procedures" must be no more restrictive through September 30, 2019 than those in effect on March 23, 2010.
- *Ensure comparability of CHIP and QHP benefits.* The Secretary of Health and Human Services (HHS) must determine by April 1, 2015 whether the benefits and cost sharing under QHPs are at least comparable to CHIP. Beginning October 2015, states may meet their obligation to maintain eligibility standards for children by enrolling children eligible for CHIP into QHPs certified to be comparable to CHIP, if available. Federal guidance on how comparability will be assessed has not yet been issued.
- *Assure Marketplace coverage if CHIP funds exhausted.* States with separate CHIP programs, such as Oregon, may limit enrollment based on availability of federal CHIP funds, which effectively provides an exception to the MOE requirement in the absence of such funds. Such states would be required to have procedures to enroll eligible children in Medicaid or Marketplace plans certified as being comparable to CHIP. As a result, many children may be left uninsured or face significantly higher cost sharing.

Oregon's 1115 Demonstration further protects CHIP resources. Specifically, in the Special Terms and Conditions of the 2012 waiver approval (STC 18.f.), the State is required to maintain the funding line on the Prioritized List of Health Services at the level it was on the 2012-2013 list through the end of the Demonstration, June 30, 2017.

⁵ OHA Office of Forecasting, Research and Analysis, 12/19/14.

⁶ ACA §2101(b), creating SSA §2105(d)(3)(B)); 42 USC 1397ee(d)

Recommendation from the Medicaid Advisory Committee

In the fall of 2014, Oregon's Medicaid Advisory Committee (MAC) was asked by OHA to examine the issue of a voluntary premium assistance program, per SB 1526, and advise the Authority. The Committee reviewed federal regulations and guidance for CHIP and premium assistance, assessed Oregon's health coverage and reform landscape, and considered the state's historical experience with premium assistance programs. The committee assessed the benefits and challenges of a CHIP premium assistance program, viewed through the lens of CHIP beneficiaries and their families, the State, CCOs, the commercial market/Marketplace, and providers.

The Committee advises that, while premium assistance offers some benefits, such programs are complex and costly to implement and administer and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and the Marketplace are still stabilizing. Further, the post-2014 coverage environment is very different, as most Oregon children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market. OHP enrollees are also served by innovative care delivery models via CCOs. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim. Please see Appendix B (pg. 14) for the Committee's memo to OHA.

Implementation Considerations

A number of implementation considerations were identified if Oregon was to implement a premium assistance program in CHIP. Oregon would need to make system changes to ensure administrative capability and capacity for eligibility and enrollment determinations. Additional agency staff would be required to operate the program and provide customer support for the population served. Contractual arrangements with premium assistance plans would also have to be established. In addition, there may be an added administrative burden to the state and/or insurance carriers to ensure that participating children receive comparable benefit coverage and pay no more than 5% cost sharing as a percent of family income.

Further, OHA would need approval from CMS and the legislature to establish and administer the program. Federal premium assistance authority, whether achieved through the state plan option and/or a demonstration waiver, would depend on the program's design (see next section, technical assistance from CMS). In other words, implementation timing for any premium assistance program is determined by its scope and complexity.

CMS Guidance and Technical Assistance for Premium Assistance

OHA staff received technical assistance from the Centers for Medicare and Medicaid Services (CMS) regarding conditions CMS would likely require to approve a voluntary CHIP premium assistance program for children in families from 200-300% FPL. Preliminary feedback from CMS indicated:

- A premium assistance program for a subset of the CHIP population is permissible under federal authority.
- Under existing federal CHIP authority, the state is required to ensure that enrollees in premium assistance programs receive the same level of benefits and do not have greater OOP costs than the levels in the CHIP State Plan.
- If the program is implemented through a demonstration waiver, it must be “budget neutral,” meaning that the federal government’s costs must not exceed what they would have been without the premium assistance demonstration.
- The cost of providing coverage through premium assistance must be comparable to the cost of providing direct coverage under the State Plan.⁷
- There are several operational considerations that must be discussed and agreed upon between the state and CMS, subject to a more concrete proposal by the state. Examples include eligibility and enrollment system needs and processes for tracking and administering consumer OOP costs (if applied) to ensure they do not exceed federal limits.

As part of implementing the ACA, specifically, expansion of Medicaid, several states expressed interest in establishing Medicaid Marketplace Premium Assistance programs. In 2013, HHS issued guidance for states around offering premium assistance in the Marketplace through an 1115 waiver. In 2014, CMS approved two states’—Arkansas and Iowa—1115 waivers to establish a Medicaid Market Premium Assistance program by applying an alternative state-developed cost effectiveness test that considers, among other factors:

- Savings from reduced churn between Medicaid and the Marketplace
- Economic benefits of increased competition on the Marketplace
- Improved access
- Improved patient outcomes
- Benefits of family coverage under one product

OHA would need to engage in comprehensive research and analysis in order to determine whether an alternative cost effectiveness test would be approved by CMS.

Premium Assistance and Cost Effectiveness

To determine cost-effectiveness of the premium assistance program proposed in SB 1526, the cost of commercial coverage option was compared to the cost of the direct CHIP program, taking into account premiums, cost for any wraparound of benefits and consumer OOP costs (if applicable), and administrative expenses. Program costs were estimated for calendar year (CY) 2017, the earliest feasible implementation date for a premium assistance program in Oregon.

The Oregon Health Plan (direct CHIP) covers benefits not typically provided by Marketplace QHPs or employer sponsored insurance, including:

⁷ Medicaid and the Affordable Care Act: Premium Assistance. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>

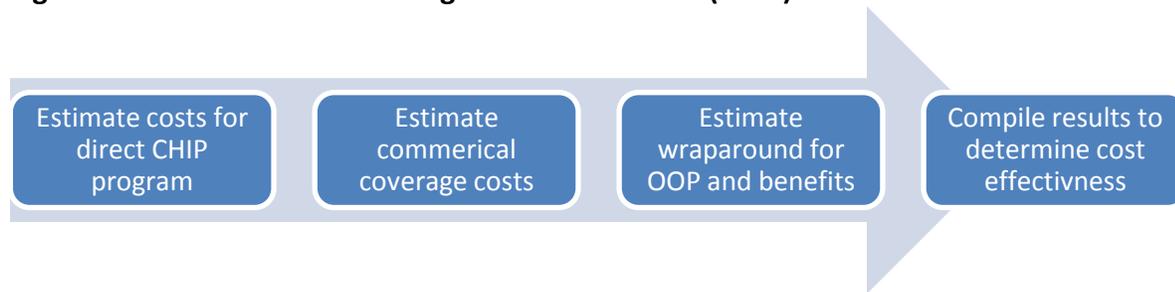
- Pediatric dental – QHPs are not required to provide this, so generally families must purchase a stand-alone dental plan incurring additional premiums and cost sharing.
- Vision services – Available in the Marketplace, but often with high deductibles, other cost sharing, and more limited benefits. These services are not limited by Oregon’s CHIP program due to federally required Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.⁸
- Hearing exams, hearing aids.
- Physical and speech therapy and habilitative services – Commercial plans often have limitations and exclusions compared to benefits covered in Medicaid/CHIP.
- Non-emergent medical transportation – Typically not available through QHPs or ESI coverage; transportation is frequently a barrier to access for children in lower income households.
- Enabling services – Sign language and other translation/interpretation for individuals with Limited English Proficiency.

In addition, QHPs and ESI have higher cost sharing through premiums and co-pays/deductibles than in Oregon’s CHIP program.⁹

Methodology for Estimating CHIP Premium Assistance Cost Effectiveness

Figure 2 illustrates the method used to determine cost effectiveness for a CHIP premium assistance program in Oregon. The analysis began by estimating premium and administrative costs for providing direct CHIP coverage in CY 2017, using available historical Medicaid data. To estimate the number of CHIP enrolled children that would be eligible for premium assistance between 200-300% FPL, OHA’s Office for Forecasting, Research and Analysis used caseload data from fall 2014. An estimated 16,458 would be eligible. We then estimated premiums for Marketplace coverage in Oregon, projecting costs to 2017. Finally, we compared the estimated costs for offering premium assistance (i.e. the cost of subsidizing children’s premiums, and wrapping benefits and OOP costs) through QHPs with direct CHIP coverage to determine cost effectiveness.

Figure 2. Method for Determining Cost Effectiveness (2017)



⁸ EPSDT provide comprehensive services for serious conditions that affect growth and development. This is particularly important set of benefits are low-income, publicly insured children are more likely than privately insured children to have a range of special health care needs. See Commonwealth Fund [Data Brief](#), September 2005.

⁹ Wakely Consulting Group. Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans. July 2014.

Table 1 shows the projected costs and federal and state funds, with and without the 23% bump in federal match for CHIP in CY 2017,¹⁰ CHIP premiums for CY 2017 are projected to cost \$1,968 per member per year (PMPY). Program administration expenses were estimated as a percent of total program expenditures using Oregon’s current CHIP admin rate of 6.7%. Prior to calculating the projected state funded portion of CHIP in 2017, we reviewed the 2015-17 Governor’s Budget. The budget assumes that federal CHIP funding will be reauthorized and includes the 23% bump provided by the ACA, bringing Oregon’s federal CHIP match rate to 97.25% in CY 2017. We estimated the total state and federal funds with and without the ACA bump. Total projected costs for direct CHIP coverage in CY 2017 is \$2,109 PMPY.

Table 1. Projected CHIP Costs and Federal and State Funds, PMPY, CY 2017		
CHIP Premium	\$1,968	
Federal Match	97.25% (with 23% bump)	74.25% (without 23% bump)
Federal Funds	\$1,914	\$1,461
State General Funds	\$54	\$507
CHIP Admin (6.7% of Total Program Expenditures)	\$141	
Total CHIP Program Cost (PMPY)	\$2,109	

After determining the total projected cost for CHIP in CY 2017, which established the ceiling for funds available for any premium assistance program for it to be cost effective, we estimated the cost for a premium assistance option for individual coverage. For individual coverage, costs for individual plans both in and outside of the Marketplace were assumed to be the same.¹¹ The annual premium rate used for individual plans was the second lowest cost silver plan (SLCSP). To conservatively estimate program costs, the Medford region, with the highest SLCSP was selected.¹² It is necessary to estimate the premium of the second-lowest cost silver plan in the Marketplace to determine the amount of subsidy the state would have to cover in a CHIP premium assistance program.

To estimate costs for wraparound of non-covered services and OOP costs for physical and mental health costs for individual commercial plans, we assumed the state’s expenses would be similar to what is currently paid for children in the Temporary Assistance for Needy Families-Medical (TANF) program and children eligible under the poverty level medical category (PLM),¹³ who have major medical third party resources. Therefore, claims from TANF and PLM children with major medical third party resources were used.

¹⁰ 2017 is the earliest feasible implementation date for the program

¹¹ ACA §1301(a)(1)(C) requires that QHPs “charge the same premium rate for QHP plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent.”

¹² The projected 2017 SLCSP rates for Oregon range from a low of \$1,428 PMPY (Bend) to a high of \$1,572 PMPY (Medford); the median rate is \$1,524.

¹³ <http://www.oregon.gov/oha/healthplan/tools/OHP%20Rate%20Group%20categories.pdf>

The data period used to estimate physical and mental health costs was July 2012 through June 2014. Per member per year (PMPY) estimates were derived from the claims data, demographically adjusted to reflect less newborn-related costs in the CHIP population than in TANF and PLM, and trended forward to 2017 using a 3.4% Medicaid trend rate that aligns with the Oregon's 2012 Medicaid waiver. The OOP wraparound costs to the state were estimated by reimbursing the full value of cost sharing claims, at commercial rates, instead of limiting claims to Oregon's Medicaid reimbursement rate.

The estimated annual premium for an individual level plan was \$1,572, which on average pays about 70% of the costs of all claims.¹⁴ We further assumed that approximately 10% of the premiums are for administrative expenses, resulting in total estimated medical costs of \$2,021 ($\$1,572 \times 90\% / 70\%$), and the plan would pay \$1,415 ($\$1,572 \times 90\%$). The difference in cost sharing, or the cost to the state to cover the child's OOP costs, is \$606 PMPY.

The cost to wrap services (i.e. benefits) available in OHP that are not provided in the individual commercial plans is \$456 PMPY. Currently, clients with major medical third-party resource (TPR) still enroll in a Medicaid dental care organization (DCO) as their TPR is unlikely to cover dental. The dental wraparound costs were estimated using CCO rates. The dental wraparound costs could be significantly more if a standalone commercial dental plan is purchased through the Marketplace. The total wraparound costs the state would have to pay for both services and OOP costs would be \$1,062 PMPY.

Table 2 (see next page) lists the comparison of program costs between the direct CHIP program and premium assistance for individual plans both in and outside of the Marketplace. For premium assistance, two admin rates were used: the current CHIP admin rate of 6.7%, and 10%, which is the maximum allowable admin rate for CHIP. It is highly unlikely that a premium assistance program would be able to achieve Oregon's current direct CHIP admin rate of 6.7%, due to the added administrative complexity for operating such a program. This is supported by FHIAP's historical administrative costs for premium assistance, which fluctuated between 9-14% of total program costs.¹⁵ Assumptions relating to program take-up were not made as they would require considerable modeling beyond what was needed to determine cost effectiveness for a premium assistance program.

¹⁴ Refers to the actuarial value of 70% for Silver plan as specified by the ACA. A health plan will pay 70% of health care expenses, while the enrollee themselves will pay 30% through some combination of deductibles, copays, and coinsurance.

¹⁵ Unpublished FHIAP program data from 2000-2009.

Table 2. Cost Comparison of Direct CHIP Program to Premium Assistance Program for Individual Plans, PMPY, Projected for CY 2017

	Direct CHIP Program (Oregon Health Plan)	Premium Assistance for Individual Plans In and Outside the Marketplace¹⁶
Eligible Population	16,458	
Benefits	Oregon Health Plan	Essential Health Benefits
Premium	\$1,968	\$1,572 ¹⁷
Wraparound Cost	N/A	\$1,062
Program Admin	\$141	\$189-\$293*
Total Program Cost (PMPY)	\$2,109	\$2,824-\$2,927

**Program admin for premium assistance was calculated at 6.7% and 10%.*

Employer Sponsored Insurance Coverage Option

Due to variation in ESI plans and limited data availability of data, program estimates for this coverage option were not feasible. One of the main obstacles is that small employers or those with less than 50 employees¹⁸ offering non-grandfathered plans, are required to offer the essential health benefits, while large employers (>50 employees) are not, making it difficult to compare ESI benefits to direct CHIP benefits. Based on an analysis of ESI in Oregon by the State Health Access and Data Assistance Center (SHADAC), the projected average annual premium for family ESI coverage in Oregon in CY 2016/2017 is \$19,237, with families paying an average of 23% of the premium costs, or \$5,140.^{19,20} The average ESI deductible for an Oregon family for the same time period is projected to be \$3,846.²¹

Taking into account the average premium costs and deductibles that a family in Oregon would have to pay for ESI coverage, it is unlikely ESI plans would be cost effective to the state under premium assistance. Recent national analyses^{22,23} support this assessment, indicating there has been general decline in the availability of affordable ESI and an increase in employee cost sharing—further reducing a state’s ability to meet the federal

¹⁶ The individual plan rates for plans sold through Marketplace are same as the rates for the same plans outside of the Marketplace, by company.

¹⁷ SLCSP rates for Oregon range from low of \$1,428 PMPY (Bend) to high of \$1,572 PMPY (Medford); the median rate is \$1,524.

¹⁸ ACA §1402

¹⁹ SHADAC analysis of Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey - Insurance Component (MEPS – IC) 2004,2005,2008,2009,2012 & 2013.

²⁰ For the MEPS IC survey, "family coverage" is any coverage other than single and employee-plus-one. Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, survey respondents are asked to report costs for a family of four.

²¹ SHADAC analysis of Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey - Insurance Component (MEPS – IC) 2004,2005,2008,2009,2012 & 2013.

²² Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act. Kaiser Commission on Medicaid and the Uninsured (March 2013).

²³ Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., Kenward, K. (2014). Health benefits in 2014: Stability in premiums and coverage for employer-sponsored plans. *Health Affairs*, 33(10), 1851-1860.

cost effectiveness requirement for a CHIP premium assistance program. For these reasons, there’s likely to be considerable need for subsidization of enrollee costs in ESI. Further analysis of ESI as a viable option for premium assistance is necessary to make a conclusive determination.

Summary of Cost Effectiveness Analysis

After taking into account total premium assistance program costs—premiums, wraparound and admin expenses—this analysis finds that there would be a net cost to the state to offer this coverage option. Results in Table 3 suggest that Oregon would have to allocate additional state funds, approximately \$714-\$818 PMPY per enrollee, to establish a CHIP premium assistance program.

Table 3. Cost Effectiveness of Premium Assistance Compared to Direct CHIP Coverage, PMPY, Projected for CY 2017	
Direct CHIP Program Cost	\$2,109
Premium Assistance Program Cost for Individual Plans In and Outside the Marketplace	\$2,824-\$2,927
Cost Effective (PMPY) Surplus/(Deficit)	(\$714-\$818)

Alternatively, in order to generate savings in an effort to meet the federal cost effectiveness requirements, Oregon would have to restructure key features of its existing CHIP program by waiver (e.g. reduce benefits, and/or establish monthly premiums beyond the maximum OOP cost limit of 5%).

Conclusion

While CMS has indicated that offering a voluntary CHIP premium assistance program to a subset of the population is federally permissible, several factors led OHA to conclude that such a program not feasible at this time. In agreement with the MAC, the OHA finds that, while these programs offer some benefits, they are often complex and costly to administer, and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and Marketplace continue to stabilize.

Further, Oregon’s post-ACA, 2015 coverage environment is very different than in previous years. Approximately 350,000 children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through OHP than what is generally available in the commercial market. The majority of children enrolled in Medicaid/CHIP are also served by innovative care delivery models via CCOs and patient-centered primary care homes. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon’s priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim. Lastly, the coverage option(s) modeled for premium assistance were not found to be cost effective.

The Oregon Health Authority does not recommend establishing a CHIP premium assistance program for children served by OHP. If there is legislative interest in pursuing this option,

OHA recommends further research and analysis to ensure that coverage options, enrollment systems, child-specific benefits, issues of affordability, and provider network alignment are critically examined and that the important gains achieved through Oregon's success with enrolling low-income children in OHP coverage are protected.

Appendix A: Summary of CHIP in Oregon, 2014

Summary of CHIP in Oregon, 2014

Eligibility Levels	Ages 0-1: >185-300% FPL Ages 1-18: >138-300% FPL
Enhanced FMAP	74.84% in FY 2015 ²⁴ ; projected 97.25% (with 23% ACA bump) in FY 2017, although funding beyond 2015 currently unknown.
Waiting Period	None (the period of uninsurance was reduced from two months to zero, effective 8/23/13).
Eligibility and Enrollment	Eligibility levels in Oregon for CHIP were revised based on 2014 federal poverty levels and reflect Modified Adjusted Gross Income (MAGI) ²⁵ converted income standards that include a five-percentage point of the FPL disregard.
Five-Year Waiting Period for Lawfully Residing Children	Oregon does not have a waiting period for lawfully present children.
Benefits	OHP <i>Plus</i> (full Medicaid w/EPSDT coverage per Prioritized List), with specified enhanced dental and vision coverage.
Cost-sharing	No premiums and copays; 5% aggregate cap on cost-sharing as a percent of family income.
Delivery System	Coordinated Care Organizations (CCOs), Fee-for-service (FFS), Fully Capitated Health Plan (FCHP), or Indian Health Services (IHS).
Continuous Eligibility for 12months	Oregon allows children to retain coverage for 12 months, regardless of whether their family income changes during that time period.

²⁵ The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security; does not include income from gifts, inheritance, Survivors Benefits, some other income sources are partially excluded; does not consider property, savings accounts, etc. for eligibility determination.

MEMORANDUM

DATE: January 6, 2015
TO: Oregon Health Authority, Medical Assistance Programs
FROM: Oregon Medicaid Advisory Committee
RE: Senate Bill 1526: Options and Considerations for Premium Assistance in Oregon's Children's Health Insurance Program

Senate Bill 1526 (2014) charges the Oregon Health Authority (OHA) with assessing the feasibility of using Children's Health Insurance Program (CHIP) federal matching funds for state expenditures to subsidize commercial insurance premiums for children in families with incomes between 200-300% of the federal poverty level (FPL), commonly referred to as premium assistance.

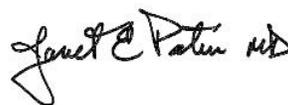
In the fall of 2014, Oregon's Medicaid Advisory Committee (MAC) was tasked by OHA to examine the issue of a voluntary premium assistance program, per SB 1526, and advise the Authority. The Committee reviewed federal regulations and guidance, assessed Oregon's health coverage and reform landscape, and considered the state's historical experience with premium assistance programs. The Committee then examined the benefits and challenges of a CHIP premium assistance program, viewed through the lens of CHIP beneficiaries and their families, the State, Coordinated Care Organizations (CCOs), the commercial market/Marketplace, and providers.

While the Committee identified some benefits, they recognize such programs are complex, costly to administer, and may add to consumer confusion, particularly as the Oregon Health Plan (OHP) eligibility and enrollment systems and Marketplace are still stabilizing. Further, the post-2014 coverage environment is very different, as most Oregon children up to 300% FPL have access to high quality, no-cost coverage and richer benefits through the OHP than what is generally available in the commercial market. OHP enrollees are also served by innovative care delivery models via CCOs. Lastly, per SB 1526, the option to enroll in premium assistance would only be available to a very small fraction of children in OHP. For these reasons, it is unclear how offering premium assistance to a limited number of low-income families aligns with Oregon's priorities that include ensuring all children are healthy and kindergarten-ready, and achieving an integrated and coordinated health care delivery system in support of the triple aim.

Based on the Committee's work, it advises OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time and that the state reassess future opportunities to improve Oregon's CHIP program after the status of the program's federal funding is resolved by Congress.



Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee



Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Background

Premium assistance programs aim to offer low- and moderate-income families access to affordable commercial health insurance coverage. These programs provide eligible beneficiaries additional coverage options, and may support whole family coverage, by allowing all members of a family to remain in a single commercial plan and be served by the same provider network, regardless of their coverage type.

States have varied experiences with implementing such programs through Medicaid and CHIP.²⁶ States that offer CHIP premium assistance programs are required to provide “comparable coverage” and ensure that children do not have greater out-of-pocket costs (premiums and cost sharing) than under direct CHIP coverage through Title XXI of the Social Security Act. States must fill benefit gaps that exist between commercial plans and CHIP benefits and wrap consumer out-of-pocket costs, to the extent that they exceed CHIP levels, if premium assistance is offered. States must also ensure that the program is cost effective, that is, the cost of covering an individual through premium assistance must be no more than providing “comparable coverage” than in the direct CHIP program.²⁷

Prior to 2014, Oregon supported a variety of coverage options for children under 19 years of age, including Medicaid, CHIP and several premium assistance programs through Healthy Kids. Oregon’s premium assistance programs were available in a variety of formats, but in general, subsidized both employed sponsored insurance (ESI) as well as certain individual plans for children in families up to 300% FPL. Due to ACA coverage expansions, these programs ended December 31, 2013. Starting in 2014, children in Oregon in families up to 300% FPL receive comprehensive, no-cost coverage through the Oregon Health Plan (OHP).

Program Design Considerations for CHIP Premium Assistance in Oregon

In order to assess issues relating to the design and implementation of a CHIP premium assistance program in Oregon, the Committee reviewed the general structure for the program based on current federal guidelines and taking into account the state’s health coverage landscape. Table 1 provides an overview.

²⁶ Kaiser Commission on Medicaid and the Uninsured. Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act. March 2013

²⁷ U.S.C. 1397ee(c)(3)(A)

Table 1. Program Design Considerations for CHIP Premium Assistance in Oregon

Program Element	Requirements and Options
Benefits	State must provide “comparable coverage” to direct CHIP benefits, and fill in gaps between commercial plans and CHIP benefits
Premiums and Cost Sharing	State must ensure children in premium assistance do not have greater out-of-pocket costs than those with direct CHIP, and wrap consumer out-of-pocket costs to the extent they exceed CHIP levels
Carriers/ Delivery System	Commercial coverage options that may be subsidized include: <ul style="list-style-type: none"> - QHPs, including CCOs offering certified QHPs - Individual plans available outside the Marketplace - Commercial plans offered by employers <i>* Provider networks between OHP and the commercial markets vary</i>
Employer Contribution	Optional; historically, has been a requirement in past Oregon ESI premium assistance programs
Administering Entity	Oregon Health Authority
Program Administration	At a minimum, administrative capability would need to be developed for: <ul style="list-style-type: none"> - Eligibility determination and enrollment - Tracking of benefits and consumer out-of-pocket costs - Education and outreach, customer service, etc. - Coordination with plan administration
Financing	<ul style="list-style-type: none"> - FY 2015 federal match rate = 74.84%²⁸ - FY 2017 federal match rate = 74.25% (without ACA 23% bump); 97.25% (with 23% ACA bump)²⁹
Cost Effectiveness³⁰	The State’s cost of covering an individual through premium assistance must be the same or less than providing “comparable coverage” to the individual in the direct CHIP program; must include the cost of providing wraparound coverage and administrative costs; can be applied on an individual or aggregate basis.
Federal Budget Neutrality	If the state seeks a federal waiver to implement the program, the program must be budget neutral to the federal government, meaning the costs must not exceed what they would have been without the premium assistance demonstration.
Federal Authority	Several options for states interested in offering premium assistance coverage for children currently eligible for CHIP: CHIP State Plan options; 1115 Demonstration Waiver; or Innovation Waivers (starting in 2017, ACA provides states the flexibility to apply for federal “Innovation Waivers”).

²⁸ FY 2015: [Federal Register, January 21, 2014 \(Vol 79, No. 13\), pp. 3385-3388.](#)

²⁹ The ACA extends CHIP through most of 2015 and beginning October 1, 2015 the already enhanced CHIP federal matching rate will increase by 23 percentage points, not to exceed 100%. The enhanced federal matching rate continues until September 30, 2019.

³⁰ See P.L. 111-3 and P.L. 111-148 §10203(b)(1). An exception to this lies in the 1905(a) option, which does not include a statutory reference to cost effectiveness, however recent regulatory guidance mentioned above includes a cost effectiveness definition similar to the statutory definition described here.

CHIP Premium Assistance: Programmatic Benefits and Challenges

The Committee considered the potential structure for a CHIP premium assistance program in Oregon and identified benefits and challenges viewed through the lens of CHIP beneficiaries and their families, the State, CCOs, the commercial market/Marketplace, and providers. The table below is not an exhaustive list of benefits and challenges.

Table 2. Benefits and Challenges for CHIP Premium Assistance in Oregon

Stakeholder	Benefits	Challenges
Consumers	<ul style="list-style-type: none"> • Offers voluntary participation and choice of health plans • Safeguards benefits and consumer out-of-pocket costs and affordability • Fosters whole family coverage • Depending on design, may help consumers maintain continuity across plans and providers based on IAP eligibility 	<ul style="list-style-type: none"> • Creates an additional coverage option which may add consumer confusion • Equity issue: Per terms of SB 1526 not all CHIP children would have access to premium assistance, only those from 200-300% FPL • Unknown impact on access to health care providers, including care coordination and continuity
State	<ul style="list-style-type: none"> • Prior experience in offering premium assistance programs 	<ul style="list-style-type: none"> • Complexities with program administration; need to ensure comparable benefits and affordability to direct CHIP coverage • Increase in provider reimbursement may lead to higher PMPM charges; state could face increased costs • A performance and quality infrastructure similar to OHP's is not currently in place statewide in the commercial market • State responsible for start-up and ongoing administrative costs • Requires federal approval, and state legislative and budget approval • Federal cost effectiveness and budget neutrality are difficult to achieve
CCOs	<ul style="list-style-type: none"> • None identified unless certified as QHPs 	<ul style="list-style-type: none"> • Enrollment in CCOs could decline, potentially affecting risk pool
Commercial Plans	<ul style="list-style-type: none"> • More covered lives • PA through Marketplace could encourage more CCOs to offer certified QHPs 	<ul style="list-style-type: none"> • Oregon's Marketplace is still stabilizing • Complex plan administration if a separate CHIP look-alike plan is needed • Different enrollment periods between CHIP and the commercial market • Voluntary nature of program creates potential risk volatility for participating carriers as individuals could disenroll/reenroll at any time
Providers	<ul style="list-style-type: none"> • Enhanced provider reimbursement relative to OHP payment rates 	<ul style="list-style-type: none"> • Encourage consumers to switch providers more frequently; providers' patient panels could be less stable

Although CHIP premium assistance programs may offer some advantages—consumer choice, while maintaining benefit coverage and consumer affordability comparable to CHIP—the Committee concluded that these programs are often complex in design, face considerable implementation barriers, including costly administration, and may add to consumer confusion.

A recent synthesis of research on the impact of the Medicaid and CHIP programs found that beneficiaries experience improved access to care, utilization, and financial protection. Research also indicates that these programs are positively associated with the quality of care children receive, and that parents value the programs.³¹ In Oregon, the MAC acknowledges the success of Healthy Kids, which has brought affordable comprehensive coverage to over 100,000 children through Medicaid and CHIP.³² The Committee also noted that the benefit coverage for children in the OHP is also more generous than the essential health benefits (EHBs) benchmark plan offered through the Marketplace.³³ Nearly 90% of OHP members are served through innovative care delivery models via CCOs, and as of March 2014, nearly 80% of CCO members were enrolled in a patient-centered primary care home.³⁴ Overall, it is unclear at this time whether or to what degree establishing a CHIP premium assistance program leverages current statewide health reform initiatives, advances spread of the coordinated care model and supports triple aim goals.

In addition to weighing the benefits and challenges of a premium assistance program, the Committee considered the program in the context of Oregon’s existing coverage landscape and health care market trends. In Oregon and nationally, commercial market trends show a general decline in availability of ESI, increases in employee cost sharing, and expanding use of high deductible health plans. These trends make it increasingly difficult for states to meet the federal cost effectiveness requirement of a premium assistance program through ESI.^{35,36}

Conclusion

The Committee advises that Oregon’s Medicaid and CHIP eligibility and enrollment systems as well as its Marketplace are still stabilizing. It is unclear how offering premium assistance to a limited number of low-income families aligns with the Oregon’s priorities. These include ensuring all children in Oregon are healthy and Kindergarten ready, and achieving

³¹ Paradise, J. The Impact of the Children’s Health Insurance Program (CHIP): What Does the Research Tell Us? Kaiser Family Foundation. July 2014.

³² <http://www.oregonhealthykids.gov/healthykids/history.html>

³³ Wakely Consulting Group. Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans. July 2014.

³⁴ Oregon Health Plan Section 1115 Annual Report. Demonstration Year: 12, 7/1/2013–6/30/201³⁴ FY 2015: [Federal Register, January 21, 2014 \(Vol 79, No. 13\), pp. 3385-3388.](#)

³⁴ The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security; does not include income from gifts, inheritance, Survivors Benefits, some other income sources are partially excluded; does not consider property, savings accounts, etc. for eligibility determination.

an integrated and coordinated health care delivery system in support of the triple aim for all Oregonians. The Committee advises the OHA that a premium assistance program for Oregon's CHIP population is not feasible at this time, and that future consideration may warrant further deliberation by interested stakeholders. The Committee recommends Oregon consider future opportunities to improve Oregon's CHIP program be reassessed after the status of the program's federal funding is resolved by Congress. Thank you for your consideration.

Medicaid Advisory Committee Members (*as of Jan. 2015)

Karen Gaffney, MS – Co-Chair, *Lane County health care executive, Trillium CCO Board Member*

Janet Patin, MD – Co-Chair, *physician, Columbia Pacific CCO Board Member*

Romnee Auerbach, MS, ANP, PMHNP-BC – *health care provider*

Rhonda Busek, MBA – *Interim Director, Medical Assistance Programs, OHA*

Carol Criswell, BA – *parent, patient advocate*

Kay Dickerson, BA – *OHP member, patient advocate*

Kristen Dillon, MD, FAAFP – *physician, Columbia Gorge CCO Board Member*

Alyssa Franzen, DMD – *dental provider; Dental Director, Care Oregon*

Leslie Sutton, JD – *children & disability advocate, Oregon Council on Developmental Disabilities*

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

Prepared for the Medicaid Advisory Committee

Current as of March 20th

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	Passed both chambers March 18 th and awaiting Governor's signature.
HB 2421	Makes mental health drugs subject to Practitioner-Managed Prescription Drug Plan. Requires cost of mental health drugs to be included in global budgets of coordinated care organizations. Requires coordinated care organization to temporarily continue to provide mental health drug to member who is in course of treatment with drug.	Would include mental health medications in CCO global budgets.	Public hearing held on February 11 th . OHA continuing to discuss with CCOs and mental health advocates
House Bills			
HB2204	Repeals sunset on hospital assessment; support the continuation of the hospital assessment to fund the Oregon Health Plan and enhanced reimbursement for assessment paying hospitals	Funding for the Oregon Health Plan	Referred to Health Care Committee with subsequent referral to Revenue.
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.	Public hearing held on February 13 th .
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.	Public hearing held on February 9 th .
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	Public hearing held on March 2 nd .
HB 2696	Requires OHA to collaborate with CCOs to develop uniform audit processes and forms.	Potentially lessen the administrative burden for CCOs.	Public health held on Feb. 18
HB 2697	Requires OHA to adopt consistent, uniform policies and procedures for provision and reimbursement of mental	See description for HB 2696.	Public health held on Feb. 18

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

Prepared for the Medicaid Advisory Committee

Current as of March 20th

Bill	Summary	Relationship to MAC/OHP	Current Status
	and physical health services in medical assistance program. Requires authority to convene advisory committee to advise authority in adoption of policies and procedures		
HB 2878	Establishes task force to investigate barriers and identify strategies to address health insurance coverage.	Taskforce could potentially include Oregon residents eligible for Medicaid coverage.	Feb. 11 th : Referred to Health Care with subsequent referral to Ways and Means
HB 2934	Requires OHA to submit blueprint for Basic Health Plan to CMS by December 31, 2015	MAC issued recommendation on BHP in 2014.	Public hearing held, March 3th.
HB2950	OHA to develop member handbook template, assign single case identification number to households receiving medical assistance, share contact information regarding members of CCO with organization and monitor hold times for calls made to authority by CCOs. Specifies requirements regarding processes for application, renewal and redetermination of medical assistance eligibility	Could improve customer service experience for OHP members; reduce administrative burden related to Medicaid eligibility.	Public hearing held on March 18 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	Department of Consumer and Business Services to adopt rules for participation of prominent carriers in Primary Care Transformation Initiative implemented by OHA. Specifies criteria for initiative. Requires authority to convene primary care payment reform committee to advise and assist in development of initiative	Would establish a multi-payer primary care collaborative. Collaborative to support primary care providers, including providers that serve OHP.	Public hearing scheduled, March 23rd.
SB 440	Requires Oregon Health Policy Board to establish Health Plan Quality Metrics Committee to develop health		

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

Prepared for the Medicaid Advisory Committee

Current as of March 20th

Bill	Summary	Relationship to MAC/OHP	Current Status
	outcome and quality measures for CCOs and plans offered by Public Employees' Benefit Board and Oregon Educators Benefit Board.	Could affect the Metrics and Scoring Committee.	Public hearing held, March 18th.
SB609	OHA to convene learning collaborative to develop payment method to support provision of care through patient centered primary care homes. Specifies membership of collaborative. OHA to request federal approval necessary to implement payment method for medical assistance program.	See description for SB 231.	Public hearing scheduled, Senate Health, March 23rd.
SB631	Establishes Health Care for All Oregon Board to develop, implement and have oversight of Health Care for All Oregon Plan to be administered by OHA.	Would provide publicly funded, comprehensive, quality, patient-centered, equitable and affordable health care to all Oregonians	Referred to Senate Health Committee, Feb. 12th.
SB 773	Requires CCOs to continue to provide health services to child meeting specified criteria who moves outside of geographic area served by CCO. Requires CCO serving geographic area where child relocates to enroll child no later than 30 days after child establishes residence in new geographic area.	Would help provide continuity of coverage for child eligible for OHP.	Referred to Senate Health Committee, March 3rd.
SB 791	Requires OHA to establish procedures to validate network capacity of CCOs.	Potentially impact OHA and CCOs.	Public hearing scheduled for March 30 th .
SB 832	Requires OHA to provide grants for integrating mental health and physical health services to CCOs that meet standards prescribed by authority. Prohibits CCOs from restricting members' access to mental health services. Permits patient centered primary care homes to use billing codes applicable to mental health services provided in primary care and urgent care settings. Requires metrics and scoring committee to adopt quality measure based on percentage of coordinated care organization members participating in PCPCHs that offer	Would prohibit CCOs from restricting access to mental health services for OHP enrollees.	Referred to Human Services and Early Childhood, March 6 th .

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

Prepared for the Medicaid Advisory Committee

Current as of March 20th

Bill	Summary	Relationship to MAC/OHP	Current Status
	integrated behavioral health care.		
SB 892	Requires OHA to adopt procedures to facilitate CCO assisting member of organization with renewal of eligibility for medical assistance.	Would potentially impact eligibility and enrollment in OHP.	Referred to Senate Health Care Committee, March 6th

DRAFT

OHA Transformation Center

The Oregon Health Authority's Transformation Center serves as the hub of innovation and learning for Oregon's health system in support of the triple aim: better health and better care at lower costs for all Oregonians. The Transformation Center is building a network of learning and connecting communities so innovation in one region can spread quickly to the rest of the state – and eventually, beyond. In other words, the center “helps good ideas travel faster.”

The goals of the Transformation Center are to:

- Champion and promote health system transformation in partnership with coordinated care organizations (CCOs), providers, payers and communities;
- Build an effective continuous learning network for CCOs and their providers; and
- Foster the spread of transformation beyond Medicaid.

The Center offers learning collaboratives and technical assistance, and convenes key health system conversations. With more than 80 percent of Oregon providers seeing Medicaid patients, these practices and strategies are able to be spread across the health system. The Center's work can be categorized into seven areas of transformation, which are described below. A number of cross-cutting strategies extend across all of the areas.

Leadership development

Leadership from the very top drives health system transformation. Transformation Center activities that foster leadership include:

- **Council of Clinical Innovators Fellows Program:** a statewide, multidisciplinary cadre of emerging innovation leaders who are actively working with local project teams to implement health system transformation projects in their communities.
- **Statewide CCO Learning Collaborative:** a monthly learning collaborative for CCO medical directors, dental directors, behavioral health directors and quality improvement coordinators to facilitate peer-to-peer learning and networking; learn about best practices; and help advance innovative health system transformation strategies, which are currently focused on the required CCO incentive metrics.
- **Quality Improvement Community of Practice:** a group of quality improvement leaders from each CCO receiving training and knowledge to enhance their leadership role.
- **CCO Community Advisory Council Learning Community:** includes a leadership development component (see below).

Community engagement

Achieving health requires focusing on the “upstream” factors that influence health outcomes, or the social determinants of health. Transformation Center activities that foster connections between upstream, community-based organizations and the health system include the following:

- **CCO Community Advisory Council Learning Community:** regular meetings that support leadership and organizational development needs and facilitate information sharing among community advisory council members from across the state.

- **Community health improvement plan review and implementation support:** Center staff review plans – which are focused on the entire community’s health, not just a CCO’s Medicaid members – to ensure contractual requirements are met, identify priorities and strategies, and connect CCOs with technical supports for implementation.
- **Connections between CCOs and “upstream” partners in early learning, public health and housing:** the Center serves as a connector between CCOs and partners focused on promoting health through upstream strategies such as Early Learning Hubs, local public health departments and housing organizations.
- **Patient and member engagement:** in conjunction with recommendations from the Individual Responsibility and Health Engagement Work Group, the Center is developing supports for CCOs to use in implementing evidence-based patient and member engagement strategies.

Clinical delivery system redesign

The Center is working towards facilitated improvement, implementation and dissemination of technical support in the clinical delivery system. Transformation Center activities that support redesign of the clinical delivery system include:

- **Complex Care Learning Community:** periodic gatherings of clinical practice leaders and staff from CCOs and other health system partners working to improve health outcomes for members requiring complex care.
- **Flexible Services Learning Community:** the Center will soon launch a learning community that will allow CCOs to share information and learn about best practices related to the implementation of flexible services.
- **Primary care infrastructure development:** the Center’s Director of Clinical Innovation ensures alignment between the center, the OHA Patient-Centered Primary Care Home program and the Patient-Centered Primary Care Home Institute housed at the Quality Corporation in assisting primary care providers.
- **Project ECHO:** the Center is engaged in various efforts to implement and spread Project ECHO (Extension for Community Healthcare Outcomes), an evidence-based program that builds primary care capacity to meet critical specialty clinical community health needs using videoconferencing technology to connect primary care providers with specialty providers.
- **Provider resiliency and vitality:** the Center is investigating the development of support systems to mitigate the stresses experienced by clinician caregivers as they simultaneously provide care and experience health care reform changes.
- **Health information technology consultation:** the Center provides ongoing consultation to OHA’s Office of Health Information Technology to ensure the office is connected with the CCOs’ clinical delivery reform efforts.
- **CCO Clinical Advisory Panels:** the Center is initiating a statewide clinical advisory panel environmental scan to help network and connect the clinical advisory panels with relevant activities and partners.

Integration of care

The integration of physical, mental and dental care is an area for which many CCOs need support. The Transformation Center’s work in this area includes:

- **Behavioral and mental health integration:** the Center is assessing the extent to which behavioral/mental health has been integrated with physical health care, including successes and barriers to further integration, and identifying how OHA might best support integration efforts.

- **Oral health integration:** the Center has provided venues for oral health presentations at convenings and learning community meetings, and is exploring additional ways to support oral health integration within CCOs and across the delivery system.

Promoting health equity

Promoting health equity and addressing health disparities is an essential step toward meeting the triple aim. The Transformation Center's work to promote health equity within CCOs and other health system partners is focused in the following areas:

- **Health Equity Learning Community:** co-convened learning community between the Transformation Center and the Office of Equity and Inclusion that offers learning and sharing opportunities for committed health equity champions within CCOs.
- **Traditional health worker support:** the Transformation Center completed a survey to assess barriers to CCOs' and health providers' use of traditional health workers and plans to host a learning experience to help CCOs address the identified barriers.

Financial alignment

Payment provides the incentives to drive change. A key element of the coordinated care model is paying for outcomes and health. The Transformation Center's support of alternative payment methods includes:

- Developing technical assistance opportunities for CCOs and other payers to develop alternative payment methods.
- Incorporating a discussion about payment methodology within other Transformation Center learning communities.

Accountability and transparency

The 33 required Medicaid metrics, 17 of which are tied to incentive payments, have become a platform by which the CCOs have focused their transformation efforts. Sharing outcomes with each other and the public creates accountability not just within their CCO or community, but scales this to the entire state, creating a healthy incentive for more widespread and rapid improvement. The Transformation Center has supported this work through the following activities:

- As mentioned above, the monthly Statewide CCO Learning Collaborative has focused on individual incentive measures and sharing practices and processes among CCOs.
- The Center's Director of Clinical Innovation serves as a clinical resource to the director and staff of OHA's Office of Health Analytics.

Transformation Center cross-cutting strategies

The Transformation Center engages in strategies that extend across all of the areas identified above. Examples include the following:

- **Innovator Agents:** Innovator Agents serve as a single point of contact between OHA and their CCOs, supporting OHA's internal transformation efforts, innovation within their CCOs, and connections between their CCOs' and community stakeholders.
- **Transformation Center Technical Assistance Bank:** outside consultants and experts from OHA are available to help CCOs and their community advisory councils meet their health system transformation goals.

- **Coordinated Care Model Summit:** annual convening of hundreds of health system stakeholders – from CCOs and beyond – focused on sharing and learning about concrete, innovative strategies for moving health system transformation forward.
- **Transformation Fund projects:** the Center manages the \$27 million Transformation Fund grant awards, which resulted from \$30 million the Oregon Legislature awarded to CCOs during the 2013 legislative session to support health system innovation (the Office of Health Information Technology manages the remaining \$3 million to spread the adoption of health information technology in Oregon).
- **Transformation Plan analysis:** the Center reviews the CCOs' Transformation Plans and updates, and uses the analysis to inform Center programs and to make connections between CCOs and other parts of OHA.
- **Good Ideas Bank:** an online resource of innovative CCO projects and programs to promote work happening within CCOs with health system partners within and outside of Oregon.
- **Groupsite:** an online tool for staff and representatives of CCOs and allied health organizations, community advisory councils and OHA to collaborate, network and share best practices.
- **Promote partnerships between health system transformation partners and funders:** the Center fosters connections between local and national funders interested in supporting Oregon's health system reform efforts with CCOs and their community advisory councils.

Medicaid Advisory Committee Charter

Approved by Oregon Health Authority on March 25th, 2015

I. Authority

Oregon is required by federal law to have a committee that advises the Oregon Health Authority (OHA) about the health and services offered through Medicaid. The Medicaid Advisory Committee (MAC) is mandated by state statute to advise OHA on the policies, procedures, and operation of the Oregon Health Plan (OHP) that affect OHP enrollees and their families.¹ ORS 414 explicitly states that the committee is to advise the Directors of the OHA and the Department of Human Services (DHS) on:

- Medical care, including mental health and alcohol and drug treatment and remedial care;
- Operation and administration of programs provided through Medicaid; and
- Determination of health care and services covered; quality and costs; affordability; and consumer engagement.

The committee's charter shall expire at the discretion of the OHA Director on or before Dec 2016 and serves to complement existing statutory authority.

II. Membership

In accordance with ORS 414.211, the Governor appoints members for two years with the option to reappoint for a second term. Membership includes representatives from the following entities:

- A physician licensed and allied health care professionals
- Two members of health care consumer groups that include Medicaid recipients
- Two OHP members
- Directors of the Oregon Health Authority and Human Services or designee(s)

III. Scope and Deliverables

The MAC is responsible for developing and advising policy recommendations at the request of the Governor, the Legislature and OHA. OHA explicitly directs the Committee to support the following functions:

- *Monitoring*: provide oversight and review of Oregon's administration of its Medicaid program.
- *Advising*: serve as an advisory body to OHA on issues relevant to those served by OHP as described in state and federal policy, and as requested.
- *Policy Development*: participate in Medicaid policy development by making recommendations to the OHA that are reflected as appropriate in program policies and procedures, statute, rule, or other governing protocols.
- *Reporting*: publish an annual letter that highlights key issues related to the operation of OHP that affect OHP enrollees and their families, and provide a list of pertinent reports developed by the committee.

¹ 42 CFR 431.12; ORS [414.211-227](#)

IV. Committee Principles

In the past, the Committee has adhered to a set of principles to guide its decision-making and recommendations in an effort to support OHA's Triple Aim of better health, better care and lower costs for OHP members. The principles, listed below are to be revisited, biannually, and revised to reflect external environmental changes.

- Promote coverage options that maximize quality, affordable and equitable benefit coverage, ensure access and continuity of care, and result in the lowest net level of churn for OHP members;
- Consider the health and support needs of diverse subpopulations, including but not limited to parents, women, children, persons with disabilities, communities experiencing health inequities, and residents in rural and frontier areas, among others served by OHP; and
- Balance consumer needs with the need for financial viability and operational self-sufficiency in the state Medicaid program, the health care delivery system, and other health insurance markets, as appropriate.

V. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA Leadership
- State Medicaid (OHP) Leadership
- Oregon Health Policy Board
- Oregon Legislature

The ability of the Committee to fulfill its statutory duties as outlined in section III is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

VI. Resources

Internal staff resources include the following:

- Executive Sponsors: OHA Chief of Policy; OHA Chief Medical Officer; OHA MAP Director, and State Medicaid (OHP) Leadership
- Staff support:
 - Office for Oregon Health Policy and Research (lead)
 - OHA Director's Office
 - Medical Assistance Programs



Medicaid Advisory Committee Proposed Calendar for 2015

Introduction

Oregon is required by federal law to have a committee that advises the Oregon Health Authority (OHA) and Medical Assistance Program (MAP) about the health and medical care services for recipients of the Oregon Health Plan (OHP). For the past decade, and as outlined in federal statute, Oregon's Medicaid Advisory Committee (MAC) has successfully participated in policy development, oversight, and review of Oregon's administration of its Medicaid program, as well as formulated recommendations to state agencies and committees.

Proposed 2015 Committee Schedule

In 2015, it will be important for the MAC to remain flexible and responsive to support the evolving needs of OHA in its administration of the Oregon Health Plan, particularly resulting from Oregon's 2014 expansion of Medicaid. This document outlines an initial list of potential topics for the committee to assess in 2015. The work plan also outlines opportunities for the committee to fulfill its responsibility to review and provide input on maintenance of programs and services supported by OHA and MAP. The list of informational updates will be finalized based upon discussions among committee members on March 25, 2015g (see Table A, pgs. 2-3).

Ongoing Advisory Role and Function of the MAC

The MAC will continue to serve in an advisory role and track both State and Federal movement on health care reform initiatives and provide guidance as it pertains to the Medicaid population and to relevant advisory and governing bodies in 2015, including review of Oregon's health system transformation effort.

Please see committee charter for additional information.

Table A: 2015 Meeting Schedule

Below is the proposed committee schedule for 2015.

Meeting Date	Location	Policy Develop Areas: TBD	Informational Learning/Updates
Jan.28 th	Salem	<ul style="list-style-type: none"> Finalize memo on SB 1526 	<ul style="list-style-type: none"> OHP Enrollment and Redeterminations – Linda Hammond, OHA OHP and CCOs – Rhonda Busek, OHA CMS OHP Quarterly report – Janna Starr, OHA 2015 Legislative Session Preview, Brian Niebuurt, OHA Oregon’s Health IT and HIE Efforts – Susan Otter
February: No meeting			
March 25 th	Salem	<ul style="list-style-type: none"> Adopt draft charter Identify potential policy topics of interest 	<ul style="list-style-type: none"> OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA 2015 Legislative Update – Brian Niebuurt OHA Ombudsperson – Ellen Pinney Transformation Center: Update on Community Advisory Councils (CACs) *Invited: Health Share CAC
April 22 nd	Salem	<ul style="list-style-type: none"> Introduce 12-Month Continuous Eligibility for Adults 	<ul style="list-style-type: none"> OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA CMS OHP Quarterly report – Janna Starr, OHA Metrics and Scoring Committee Update – Health System Transformation 2014 Mid-Year Performance Report DHS Overview – Agency Staff *Invited: Trillium CAC and Yamhill CAC
May: No meeting			
June 24 th	Salem	<ul style="list-style-type: none"> Review Policy Considerations for 12-Month Continuous Eligibility for MAGI Adults; cost-benefit analysis 	<ul style="list-style-type: none"> OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA OHA Ombudsperson – Ellen Pinney 2015 Legislative Update – Staff Patient-Centered Primary Care Home (PCPCH) Program – Nicole Merrithew OHA Addictions and Mental Health Services: Behavioral Health Integration *Invited: Cascade Health Alliance CAC, Family Care, and Columbia Pacific CAC
July 22 nd	Salem	<ul style="list-style-type: none"> Finalize Recommendations to OHA on 12-Month Continuous Eligibility for Adults 	<ul style="list-style-type: none"> OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA Early Learning Council/Health Policy Board Joint Subcommittee Health System Transformation 2015 Mid-Year Performance Report

Meeting Date	Location	Policy Develop Areas: TBD	Informational Learning/Updates
			<ul style="list-style-type: none"> • Health Care Workforce Committee Update, Cathryn Cushing, OHA • <i>*Invited:</i> Intercommunity Health Network CAC, EOCCO CAC, and Willamette Valley CAC
August: No meeting			
Sept. 23 rd	Salem	<ul style="list-style-type: none"> • Policy topic: TBD 	<ul style="list-style-type: none"> • OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA • OHA Ombudsperson – Ellen Pinney • OHA Dental Director – Bruce Austin • CMS OHP Quarterly report – Janna Starr • Coordinated Care Model Alignment Work Group • Health Evidence Review Commission (HERC) – Darren Coffman, Director • <i>*Invited:</i> Umpqua Health Alliance CAC and Western Oregon CAC
Oct. 28 th	Salem	<ul style="list-style-type: none"> • Policy topic: TBD 	<ul style="list-style-type: none"> • OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA • OHA Office of Equity and Inclusion; Health Equity Policy Review Committee • Alternative Payment Methodologies and FQHCs – Invited Guest • Transformation Center: Update on CCOs and Community Advisory Councils (CACs) • <i>*Invited:</i> Columbia Gorge CAC and Central Oregon CAC
November: No meeting			
Dec. 9 th	Salem	<ul style="list-style-type: none"> • Policy topic: TBD • Review MAC work plan for 2016 	<ul style="list-style-type: none"> • OHP Enrollment, Redeterminations and CCOs – Rhonda Busek, OHA • OHA Ombudsperson – Ellen Pinney • 2015: Year in Review • <i>*Invited:</i> Jackson Care Connect CAC and AllCare CACs

Oregon Health Plan

Section 1115 Quarterly Report



10/1/2014 – 12/31/2014

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

Demonstration Quarter (DQ): 2/2015

Federal Fiscal Quarter (FQ): 1/2015



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I. Introduction

A. Letter from the State Medicaid Director

From October through December 2014, 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 December 2014, there were 535 recognized Patient Centered Primary Care Home (PCPCH) clinics in the state, surpassing Oregon’s goal of 500 by 2015. The proportion of CCO members enrolled in a PCPCH continues to increase, ranging from 97.8 to 60.9 percent across CCOs.
- **Lever 2: Implementing alternative payment methodologies (APMs)** – The CCO Metrics and Scoring Committee selected the 2015 benchmarks for most CCO incentive measures. OHA also worked with CCOs to improve reporting of APMs and flexible services.
- **Lever 3: Integrating physical, behavioral and oral health care** – The Transformation Center and Oregon Health Sciences University (OHSU) completed a statewide environmental scan of behavioral health integration activities, best practices and barriers to integration.
- **Lever 4: Increased efficiency in providing care** – The percent of recent graduates who enroll as Oregon Medicaid providers has greatly increased, partly due to Oregon’s efforts to reach out for additional providers to prepare for the 2014 Medicaid expansion. The Traditional Health Worker (THW) program met its goal to train 300 THWs by December 31.
- **Lever 5: Implementation of health-related flexible services** – CCOs submitted their flexible services policies and procedures for OHA review and feedback. CCOs will receive feedback in the first calendar quarter of 2015. If they choose, CCOs can revise their procedures based on this feedback and resubmit in March 2015.
- **Lever 6: Innovations through the Transformation Center** – The Transformation Center hosted the Coordinated Care Model Summit in December. Health care leaders from throughout the state were in attendance, and the CCOs presented their work in many of the sessions. In an internal evaluation of the Center’s learning collaboratives, 88.2 percent of respondents found the sessions *valuable* or *very valuable* to their work.

One vital test of whether the OHP demonstration is meeting the goals of *lower cost, better care* and *better health* is the quality and access test, which determines whether our transformation efforts are making the quality of care and access to care better or worse.

- During this quarter, OHA presented three sets of quality and access test results for Demonstration Year (DY) 12, the first year that this test applies.
- In all three sets of test results, Oregon demonstrates over 100 percent improvement over the 2011 baseline.

This test is one of many that we are proud to see the OHP demonstration pass, and we hope for continued future successes.



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
 10/1/2014 – 12/31/2014
 Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)
 Demonstration Quarter (DQ): 2/2015
 Federal Fiscal Quarter (FQ): 1/2015

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	Yes	Yes	Yes	Renewals deferred; ongoing system and process improvements; decision to move to FFM and eventually to Kentucky-like system
B. Benefits				
C. CCO Complaints and Grievances				
D. Quality of care – CCO / MCO / FFS				
E. Access				
F. Provider Workforce				
G. CCO networks				

Detail on impacts or interventions

Oregon moved to the Federally Facilitated Marketplace (FFM) during this quarter. OHA coordinated with CCOs, providers and other stakeholders to promote education about the move to HealthCare.gov and the new website at OregonHealthCare.gov, which helps Oregonians determine the best way to apply for health coverage; and about use of the FFM eligibility confirmation letter as interim proof of OHP eligibility (*i.e.*, until the FFM members are enrolled in Oregon’s eligibility system).

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.

Due to staffing changes, OHA was unable collect all plan complaints, grievances, appeals and hearing information for in time for this quarterly submission. OHA will submit an updated report with this information no later than March 13, 2015.

Oregon Health Plan Quarterly Report

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
ELIGIBILITY AND ENROLLMENT					
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.					
b) Plan unresponsive, not available or difficult to contact for appointment or information.					
c) Provider's office too far away, not convenient					
d) Unable to schedule appointment in a timely manner.					
e) Provider's office closed to new patients.					
f) Referral or 2nd opinion denied/refused by provider.					
g) Unable to be seen in a timely manner for urgent/ emergent care					
h) Provider not available to give necessary care					
i) Eligibility issues					
j) Client fired by provider					
k) Availability of specialty provider					
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior					
b) Plan rude or inappropriate comments or behavior					
c) Provider explanation/instruction inadequate/incomplete					
d) Plan explanation/instruction inadequate/incomplete					
e) Wait too long in office before receiving care					
f) Member dignity is not respected					
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.					
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity					
i) Lack of coordination among providers					
CONSUMER RIGHTS					
a) Provider's office has a physical barrier					
b) Abuse, physical, mental, psychological					
c) Concern over confidentiality					
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.					
e) No choice of clinician					
f) Fraud and abuse					

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)					
i) Differential treatment for Medicaid clients					
j) Lack of adequate or understandable NOA					
k) Not informed of consumer rights					
l) Complaint and appeal process not explained					
m) Denied member access to medical records					
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.					
b) Testing/assessment insufficient, inadequate or omitted					
c) Medical record documentation issue					
d) Concern about prescriber or medication or medication management issues					
e) Unsanitary environment or equipment					
f) Lack of appropriate individualized setting in treatment					
QUALITY OF SERVICE					
a) Client feels unsafe/uncomfortable					
b) Delay, quality of materials and supplies (DME) or dental					
c) Lack of access to ENCC for intensive care coordination or case management services					
d) Benefits not covered					
CLIENT BILLING ISSUES					
a) Co-pays					
b) Premiums					
c) Billing OHP clients without a signed Agreement to Pay					

Trends related to complaints and grievances

As mentioned above, OHA will assess trends once all complaint and grievance information is collected, and provide an updated report to include this information no later than March 13, 2015.

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

As mentioned above, OHA will provide an updated report to include appeals and hearings information no later than March 13, 2015.

Category	CCO Appeals						Contested Case Hearings from CCO Appeals					
	Total		Overturned at plan level		Decisions Pending		Total		Overturned at hearing		Decisions Pending	
	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
a) Denial or limited authorization of a requested service												
b) Single PHP service area, denial to obtain services outside the PHP panel												
c) Termination, suspension or reduction of previously authorized covered services												
d) Failure to act within the timeframes provided in §438.408(b)												
e) Failure to provide services in a timely manner, as defined by the State												
f) Denial of payment for a service rendered												
TOTALS												

NOTE: Not all plans are currently using same reporting categories, which results in large range variations in the above categories. OHA is working with plans to align these categories.

Contested case hearings information

The following charts represent hearings information for cases that were initiated through the State’s Fair Hearings process.

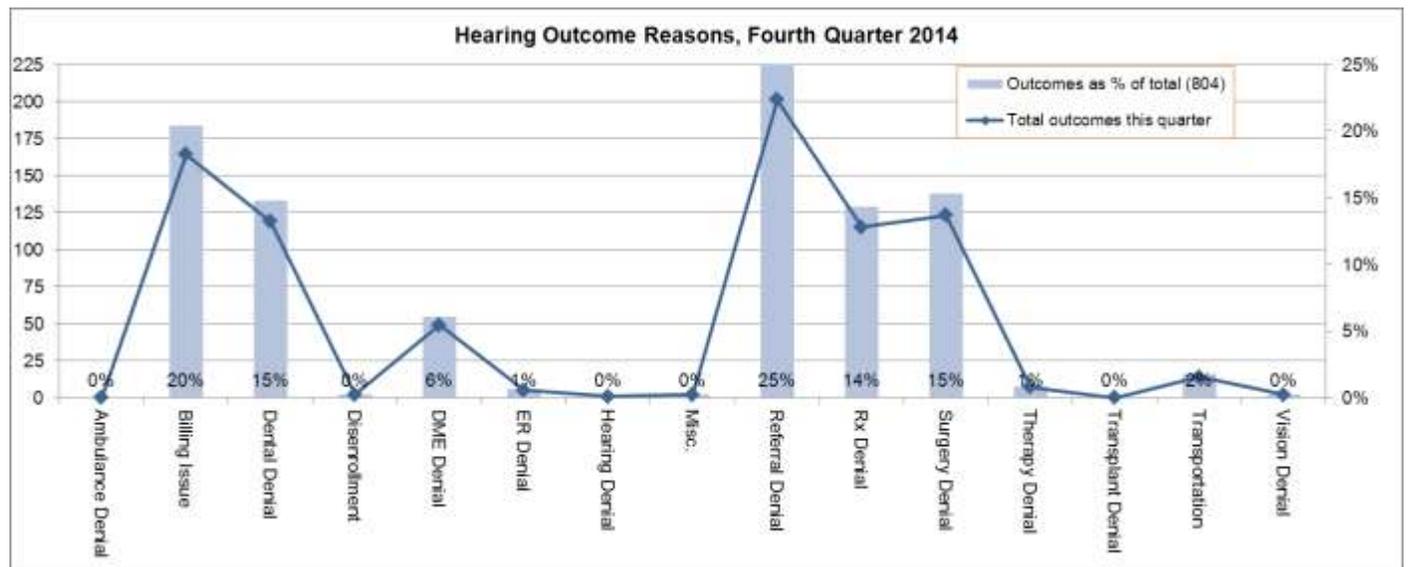
- They reflect hearing requests submitted to OHA by members of the following plans.
- They do not reflect appeal requests submitted to plans.

Plan Name	Total Received	Average Enrollment*	Per 1000 Members
Coordinated Care Organization requests			
AllCare Health Plan, Inc.	31	48,114	0.6443
Cascade Health Alliance	30	15,921	1.8843
Columbia Pacific CCO, LLC	9	25,919	0.3472
Eastern Oregon CCO, LCC	57	45,777	1.2452
FamilyCare CCO	80	112,402	0.7117
Health Share of Oregon	123	228,837	0.5375
Intercommunity Health Network	43	53,765	0.7998
Jackson Care Connect	14	28,343	0.4939
Kaiser Permanente OR Plus, LLC	6	2,125	2.8235
PacificSource Community Solutions	105	51,438	2.0413

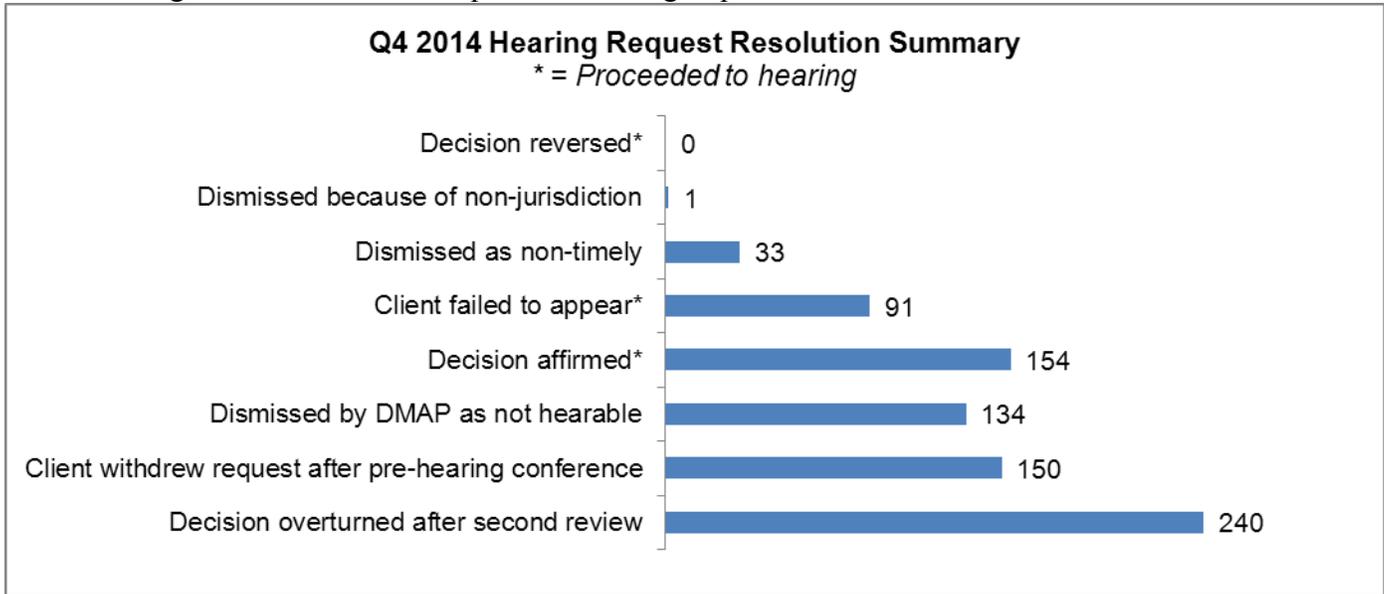
Plan Name	Total Received	Average Enrollment*	Per 1000 Members
PacificSource Community Solutions – Gorge		12,395	
PrimaryHealth of Josephine County CCO	14	10,845	1.2909
Trillium Community Health Plan	53	73,718	0.7190
Umpqua Health Alliance, DCIPA	46	25,831	1.7808
Western Oregon Advanced Health	20	20,082	0.9959
Willamette Valley Community Health	108	95,176	1.1347
Yamhill County Care Organization	10	21,153	0.4727
Dental Care Organization requests			
Access Dental Plan, LLC		1,911	0.0000
Advantage Dental	5	25,538	0.1958
Capitol Dental Care Inc.		15,103	0.0000
Care Oregon Dental		2,017	0.0000
Family Dental Care		1,892	0.0000
Managed Dental Care of Oregon		1,991	0.0000
ODS Community Health Inc.	4	8,319	0.4808
Willamette Dental Group PC		2	0.0000
Fee-for-service (FFS) requests			
	31	226,568	0.1368
Total	789	1,225,071	0.6440

Trends

The following chart shows trends for contested case hearings for this quarter. As stated above, this information only reflects hearing requests submitted to OHA; it does not reflect requests submitted to plans.



The following chart shows how the quarter’s hearing requests were resolved.



D. Implementation of 1% withhold

During this quarter, DMAP analyzed encounter data received for completeness and accuracy for the subject months of March through May 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 For the first year, this will be 99% and NOT include the 1% withhold, which is reflected under incentives agreement (or policy)	X	X
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

Metric	Frequency	
	Quarterly	Annually
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)	47	100	0	6
Personal Health Navigators (PHN)	0	5	0	1
Peer wellness/support specialists	48	238	0	16
Other THW	4	11	0	1 (Doula)
Total Certified	99	354	0	24

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

Training Program	Total number trained statewide		Cumulative trained by THW Type				
	Current quarter	To date	CHW	PHN	Peer Support	Peer Wellness	Other (doula)
Multnomah County Community Capacitation Center	24		✓				
Lane Community College	8		✓				
Central Oregon Community College	13		✓				
Mental Health America/Peer Link	12				✓		
Peer Services Consulting	10						
Addictions Counselor Certification Board of Oregon	7				✓		
Central City Concern	11				✓		
Project Able	22				✓		
Cascadia Behavioral Health	20					✓	
1st – 3rd Quarter Totals	-	469	222	2	214	17	14
4th Quarter Totals	-	127	45	0	62	20	0
Total Trained Since 2013	-	596	267	2	276	37	14

Approved training programs

Approved Training 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				✓	
Portland Community College				✓	
Project ABLE				✓	
Recovery and Beyond				✓	
Rogue Community College	✓				
Willamette Family Treatment Services				✓	
Total approved training programs	CHW 7	PHN 1	Peer Wellness 2	Peer Support 14	Other (doula) 1

Training programs pending approval:

Mental Health America Oregon Peer Wellness and Peer Support Programs

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

System integration

During the current quarter, we continued to coordinate system-level activities within (OHA, and with the Department of Human Services and the Community College Workforce Development Agency (CCWD). There are shared and similar complex THW goals legislatively required of each of the state agencies. OEI's

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goal is to coordinate these efforts to prevent duplication of the work, share lessons learned, engage the THW Commission for advisory purposes, and spread the THW model.

- Partnering with OHA Transformation Center, THW Commissioners helped to shape a statewide THW survey that assessed the value of THWs in the current delivery system. The survey was fielded among CCOs in all 15 regions. The results from this survey are to be shared on the OHA Transformation Center website in 2015.
- The THW Commission is working closely with Rogue Community College to develop and field their statewide THW needs assessment. The assessment will evaluate payment models, pay rates, utilization of THWs and employment trends. Previous funding level for this assessment limited the scope of the assessment to Community Health Workers (CHW). With encouragement from the THW Commission, the CCWD agreed to utilize unobligated grant funding to increase the amount of Rogue Community Colleges' contract to broaden the scope of the survey to include all THW worker types. The assessment is to be completed along with a comprehensive report by June 2015.

Training, certification and hiring of THWs

Oregon has met its goal to train 300 THWs by December 31, 2015. Due to an increase in OEI staffing capacity to process THW applications, this quarter OEI was able to certify 78 percent of all THW trainees in the same quarter, compared to 44 percent in the previous quarter. Relative to Oregon's workforce development investment in CHW training opportunities through local community colleges, 17 of the 21 individuals trained by the community college's CHW training programs also received certification.

In 2015, the training focus will shift to ensuring the incumbent workforce has access to an Incumbent Worker Assessment as a pathway to certification.

- Multnomah County Community Capacitation Center is in the process of developing this tool for CHWs.
- The THW Commission will complete its 2014-2015 work plan with the development of this tool for all THW worker types seeking certification.

Diversity of the workforce

More than 39 percent of this quarter's THW trainees are people of color. Other data reveals that 100 percent of THW training program participants had at least a high-school or equivalent education; 54 percent had some college-level course work; and 26 percent have bachelor's degrees or above.

THW presentations

- October 28, 2014 OHA Ombuds Advisory Council
- November 19, 2014 Chronic Disease and Self-Management Plenary Session
- December 4, 2014 Coordinated Care Model Summit THW Breakout Session

Meetings with stakeholders

- October 2, 2014 AMH Peer Delivered Services Workgroup
- October 3, 2014 THW System Coordination Meeting
- October 10, 2014 Cross Agency Health Related Workforce Group
- October 20, 2014 ORCHWREC Research Project Meeting
- October 21, 2014 CHW Program Site Visit in Enterprise, Oregon
- October 22, 2014 CHW Program Site Visit in La Grande, Oregon
- October 24, 2014 Oregon Community Health Workers Association
- October 27, 2014 THW Commission Meeting
- November 5, 2014 Community Health Worker Diverse and Talented Conference

- November 6, 2014 Care Oregon
- November 6, 2014 AMH Peer Delivered Services Workgroup
- November 6, 2014 THW Compensation Workgroup
- November 7, 2014 Cross Agency Health Related Workforce Group
- November 10, 2014 THW System Coordination-Rogue Community College
- November 17, 2014 THW Commission Meeting
- November 19, 2014 ORCHWREC Research Project Meeting
- December 1, 2014 Urban League of Portland CHW Meeting
- December 4, 2014 Office of Equity and Inclusion Annual Meeting
- December 10, 2014 THW Systems Integration Subcommittee
- December 15, 2014 THW Commission
- December 15, 2014 ORCHWREC Research Project Meeting
- December 16, 2014 SIMergy Webinar CHW Roles
- December 19, 2014 THW System Coordination-Rogue Community College

Health professional graduates participating in Medicaid

OHA periodically receives information about medical school, physician assistant, nurse practitioner, and dentistry program graduates from Oregon Health and Sciences University (OHSU). In accordance with STC 57.b.iii, we match this information with Medicaid provider enrollment data to ascertain what proportion of those graduates go on to serve Medicaid clients. OHA received an updated graduate file from OHSU in late 2014 and results for the following graduate cohorts are shown below:

- First-time match results for 2013-14 graduates in medicine, advanced practice nursing, dentistry, and physician assistant studies; and
- Second-run match results for 2012-13 graduates in the fields of nursing, dentistry, and physician assistant studies programs. An initial match for this cohort was conducted in late 2013 and results were included in the quarterly report covering October-December 2013. We conducted a second match recently to determine whether more of these graduates had become Medicaid providers as time goes on.

Cautions

It is important to note the limitations of this tracking method before reviewing the results. The primary limitation is that a “no match” result could mean one of several things:

- The graduate has left Oregon; or
- The graduate is still in Oregon but is not currently working as a direct care provider (e.g. working in policy or academia) or is not working at all (perhaps pursuing further education, or raising a family, or seeking a job but not yet employed); or
- The graduate is working in direct care and seeing Medicaid patients under the auspices of an enrolled clinic or CCO, and so is not enrolled individually as a Medicaid provider; or
- The graduate is working in direct care but not seeing Medicaid patients.

The advantage of this method—as discussed with school officials—is that it is likely to produce better results over time than a survey of graduates, because survey response rates would likely be low and the school’s ability to provide accurate contact information for graduates would deteriorate quickly over time.

Results

Proportion of 2012-2013 graduates enrolled as Oregon Medicaid providers

Field	January 2014	January 2015
Nursing (adv. practice)	0%	60.0%
Physician Assistant	N/A - data were not available	50.0%
Dentistry	3%	40.5%
Medicine*	100%	N/A – did not re-run since residencies generally last for minimum of 3 years

Proportion of 2013-2014 graduates enrolled as Oregon Medicaid providers

Field	January 2015
Nursing (adv. practice)	33.3%
Physician Assistant	50.0%
Dentistry	32.4%
Medicine*	100%

Discussion

The most recent match indicates that a substantial number of OHSU graduates go on to serve Medicaid beneficiaries. Among the most recent graduating cohort (2013-14), 50 percent of physician assistant (PA) graduates and about 33 percent of dentistry and advanced practice nursing graduates are enrolled Medicaid providers. 100 percent of recent medicine graduates whose residency training is in Oregon are working at institutions registered as Medicaid facilities.

When we conducted a second match of the 2012-13 graduate cohort, we found a much higher proportion of graduates enrolled as Medicaid providers than in the initial match. 60 percent of advanced practice nursing graduates, 50 percent of PA graduates, and 40 percent of dentistry graduates from 2012-13 are currently enrolled as Medicaid providers in Oregon. We suspect that this higher match rate is attributable both to increased time since graduation and to the substantial efforts of Oregon’s Medicaid program to enroll additional providers in advance of Medicaid expansion.

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
Trillium CCO closed until 12/31/2014	None	11,000 FFS members remain FFS	1	0
Non emergent medical transportation (NEMT) integration <ul style="list-style-type: none"> • AllCare 10/1/2014 • CHA 10/1/2014 • Jackson Care Connect 10/1/2014 	Integrated NEMTs	New brokerage (Ready Ride) for AllCare members	3	50,000 AllCare members
NEMT integration saw no change				

Changes in CCO/MCO networks for CHA and Jackson Care Connect (their NEMT brokerage remained the same).	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members

Rate certifications July-December 2014 rates	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
	-	-	16	-

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

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

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

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Member Medicare eligibility added to 834 enrollment file	-	Plans receive accurate detail about their medical coverage	All	All Medicare-eligible members
New search criteria added to MMIS Managed Care Capitation panel, allowing more timely response to CCO inquiries	-	-	All	-

G. Transformation Center

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

Key highlights from this quarter:

Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee

The Transformation Center facilitated two sessions in this period, where Innovator Agents served as small group discussion facilitators:

- One session focused on depression screening. It featured a presentation from a national expert on behavioral and mental health care in the primary care setting as well as presentations from three CCOs.
- Another session focused on alternative payment methodologies and Oregon's Incentive Metrics. It featured a presentation from a national expert on alternative payment methodologies and presentations from two CCOs.

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

Community Advisory Council Learning Collaborative

As noted in the last report, in response to feedback from the Community Advisory Council (CAC) Summit in May 2014, the CAC Steering Committee decided that this collaborative should meet quarterly in person rather than continue monthly online meetings.

- During this quarter, the Committee convened monthly to make recommendations for the learning collaborative's new quarterly meeting structure and topics; and to gather recommendations for CAC learning and networking for the Coordinated Care Model Summit in December.
- On October 27, 2014, the Transformation Center hosted the first in-person regional CAC learning collaborative meeting. Co-sponsored by Willamette Valley Community Health CCO and the Transformation Center, this meeting was held in conjunction with a provider training on health literacy and the culture of poverty.

To provide ongoing leadership development for the CACs, the Transformation Center hosted conference calls for the two new CAC leadership networks. One is for the CAC chairs and co-chairs, who are CAC members; the other is for the CCO CAC coordinators, who are primary staff of the CCOs. More information about CAC learning collaborative activities is available at <http://transformationcenter.org/learning-collaborative/cac/>.

As noted below, on December 3 and 4, 2014, the Transformation Center hosted the Coordinated Care Model Summit. At this event, the Transformation Center hosted roundtable discussions for CAC members on five topics pertinent to their work. The Transformation Center also hosted dinners with facilitated discussions for general CAC members, CCO CAC Coordinators and CAC Chairs/Co-Chairs.

Health Equity Learning Collaborative

In response to requests from CCOs, the Transformation Center and Office of Equity and Inclusion convened a new learning collaborative focused on promoting health equity for CCOs. The goals are to share promising practices on advancing health equity and to build a support network across CCOs. The Health Equity Learning Community launched this quarter with a breakfast at the Coordinated Care Model Summit. 25 people attended, representing over half of the CCOs. Starting next quarter, the Transformation Center will launch regular meetings that focus on topics such as "Identifying Health Disparities by Using Metrics and CAHPS Data" and "Organizational Cultural Competence and Language Access."

Quality Improvement Community of Practice

At the CCM Summit, the Transformation Center convened the first meeting of this group of quality improvement and measurement leads within CCOs.

- To facilitate connections across CCOs, the Transformation Center shared a spreadsheet of the 115 Transformation Fund projects organized by theme.
- Attendees were also invited to participate in a three-month IHI online training, *Leading Quality Improvement: Essentials for Managers*. This training begins February 2015, and the Transformation Center is covering the enrollment fee for one person per CCO.

In December, an online forum was launched for CCO and OHA quality improvement portfolio and project managers. The forum will provide a space to network, collaborate and share best practices for quality improvement and measurement.

Council of Clinical Innovators

In October, the Clinical Innovation Fellows program held a day-long, in-person meeting focused on health equity, public narrative and Trillium CCO's behavioral health integration. Ten fellows and two faculty also participated in a spokesperson training by OHA's Public Health Division. In November, the group held an online meeting focused on community health and CACs.

In December, all fellows and faculty attended the CCM Summit. Fellows participated in the poster session, which highlighted their innovation projects. The group also convened to discuss summit learnings and meet with Eric Coleman, a summit plenary speaker from the University of Colorado Anschutz Medical Campus.

Throughout this quarter, each fellow met monthly with their faculty mentor, both individually and in small groups, to receive support on project implementation. More information about the Council of Clinical Innovators is available at www.transformationcenter.org/ccli.

Transformation Center CCO Technical Assistance Bank

As a result of requests from CCOs and their CACs for technical assistance in key areas to help foster health system transformation, the OHA Transformation Center began offering CCOs and their CACs the opportunity to receive such assistance starting October 1, 2014:

- The Transformation Center has contracted with outside consultants who will provide 35 hours of free consultation to each CCO. The designated 35 hours include 10 hours of consultation to support CACs and other community-based work and will be accessible through September 2015.
- This technical assistance is in addition to the support and technical assistance CCOs already receive through other parts of OHA.

To continue to provide this support after September 2015, the Transformation Center plans to release a Request for Proposals (RFP) next quarter for consultants to contract as technical assistance providers through September 2016. Through the Innovator Agents, the Transformation Center has solicited feedback from CCOs to inform the RFP process. The Transformation Center also 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 Wellbeing Team to ensure coordination of OHA technical assistance for the topics listed below.

TA Bank technical assistance topics:

- Alternative payment methods
- Behavioral health integration
- Community advisory council (CAC) development
- Community health improvement plan (CHIP) implementation and evaluation
- Early Learning
- Health equity
- Health information technology
- Oral health integration
- Patient- and family-centered health engagement
- Primary care transformation, including patient-centered primary care homes
- Program Evaluation
- Public health integration
- Quality improvement and measurement
- Other topics upon request

TA Bank projects through January 2015:

CCO	Topic	Hours requested
AllCare	CAC member engagement	33
Eastern Oregon CCO	LCAC member engagement	6
FamilyCare	CAC development, CHIP implementation	15
Intercommunity Health Network	Measurement	7
Jackson Care Connect	CAC development, CHIP implementation	TBD
PacificSource Central Oregon	Measurement	25
PrimaryHealth Josephine County	CAC member engagement	TBD
PrimaryHealth Josephine County, Jackson Care Connect, AllCare	Health Literacy	3
Trillium	Program evaluation	15
Willamette Valley Community Health	Health equity	4
	Total anticipated hours	108

Innovator Agent-led Tiger Teams

Innovator Agents continued to lead OHA internal transformation through Tiger Teams, which were formed to address key internal areas within the agency. Innovator Agents were the lead staff for teams working towards integrating adult mental health residential into the global budget, rate setting, rules promulgation, and contracts. The Director of OHA was the Executive Sponsor, the Transformation Center’s Director was the Tiger Team Project Director, and OHA Sub-Cabinet approved completion of all chartered deliverables. Tiger Teams completed their work in December of this quarter.

Coordinated Care Model Summit

On December 3 and 4, 2014, the Transformation Center held a two-day summit titled *Oregon’s Coordinated Care Model: Inspiring Health System Innovation*. The goal of the summit was to connect and engage stakeholders and share best health transformation practices. CCOs, CAC members, providers, community stakeholders, health leaders, consumers, lawmakers, policymakers, health plan representatives and funders came together to share concrete, innovative strategies for implementing health system transformation.

Oregon Governor John Kitzhaber, M.D. provided opening remarks to kick off a series of presentations that included inspiring speakers such as Don Berwick, M.D., former Administrator for the Centers for Medicare and Medicaid Services and founding CEO of the Institute for Healthcare Improvement. Berwick challenged attendees to focus on cooperation and remaking the delivery system. Four CCOs told their stories of success implementing aspects of the coordinated care model. The second day highlighted upstream strategies, social determinants of health, the national health care landscape, and patient engagement.

88 percent of evaluation respondents plan to implement at least one innovative practice they learned about at the summit. Most common topic areas for follow-up included: collaboration or connections, patient engagement, peer supports, or social determinants of health. 91 percent agreed they made new connections with colleagues and other organizations they plan to follow up on. In particular, respondents valued remarks provided by Drs. Kitzhaber and Berwick, as well as their insights on how Oregon’s work is connected to and, in many respects, leads the national health transformation movement. Comments included: “As a presenter on alternative payment methodologies, it was gratifying to hear what other CCOs are doing and to feel much more confident that my CCO is on the right track.”

The convening of the Public Health and CCOs

In conjunction with the CCM Summit, the Transformation Center and the OHA Public Health Division hosted a hands-on, facilitated discussion about opportunities for CCOs and local public health departments to work together to improve community health. Innovator Agents were members of the Steering Committee and facilitated some of the small-group discussions. Participants learned from CCO and local public health colleagues, engaging in regional discussions focused on maternal and child health, early learning and chronic disease prevention.

Traditional Health Worker (THW) survey

As recommended by the HB 2859 Task Force on Individual Responsibility and Health Engagement, the Transformation Center was tasked to:

- Conduct a formal assessment to identify barriers to the use of THWs, and
- Develop strategies to address barriers, foster engagement and support partnerships between THWs, community-based organizations and CCOs.

This fall, the Transformation Center initiated the first phase of a formal assessment to identify barriers to CCO use of THWs. A survey was developed in coordination with the Office of Equity and Inclusion and the THW Commission and distributed to all CCOs. The Transformation Center is currently exploring ways to support CCO utilization of THWs based on the current findings and survey results. The THW survey results and recommendations for next steps will be released by the Transformation Center in Spring 2015.

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 other OHA divisions such as Public Health and OHA’s Child Health Director and her Child Well-being Team.
Promising practices identified	Coordination between the Innovator Agents and other OHA divisions are valuable ways to share information. For example, Public Health was responsible for fielding a survey of CCOs’ tobacco-cessation benefits, and used their meeting time to come up with a strategy for working with the IAs to obtain this information from the CCOs.
Participating CCOs	16
Participating IAs	8

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, IAs provided invaluable support in helping design and execute the Coordinated Care Model support, and the various learning experiences (e.g., the launch of the Quality Improvement Community of Practice) that were part of that event.
Promising practices identified	Ensuring IA engagement with learning collaborative development is key to ensuring the content meets CCO needs, and the right people from each CCO participate.
Participating CCOs	16
Participating IAs	8

Assisting and supporting CCOs with Transformation Plans

Summary of activities	IAs provided support to their CCOs in getting ready to create their new Transformation Plans for 2015-2017, which are due early 2015. In addition, the Transformation Center staff worked with the IAs to develop guidance for the CCOs' Community Health Improvement Plan updates (due June 30, 2015).
Promising practices identified	Since CCOs are in different stages of development, each IA's role is different. Some IAs provide internal support for CCOs' transformation, whereas others focus more on identifying solutions and addressing barriers within OHA.
Participating CCOs	16
Participating IAs	8

Assist CCOs with target areas of local focus for improvement

Summary of activities	IAs supported their CCOs as they engaged in conversations with state agencies, local public health representatives (especially at the CCM Summit, see above), and Early Learning Hub staff. The conversations addressed aligning upstream prevention efforts between CCOs and these entities. IAs also assist with behavioral health integration, oral health, alternative payment methodology, non-emergency medical transportation, cultural competency, and data collection.
Promising practices identified	IAs 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	Through their Tiger Team work completed this quarter, IAs addressed a number of system issues related to improved communications with OHA and came up with recommendations to solve them.
Promising practices identified	Tiger Teams have proved to be a very effective model of identifying system issues and creating solutions. Embedding IAs within OHA teams strengthened IA relationships with other OHA staff, greatly improving communication.
Participating CCOs	16
Participating IAs	8

Communications with other Innovator Agents

Summary of activities	IAs continue to work together on internal transformation, sharing information on promising practices to promote through in-person and electronic communication.
Promising practices identified	The IAs work as a team, sharing and benefitting from the expertise each IA brought to their job as well as their unique CCO experiences. They regularly meet as a team twice via phone each week, and once monthly for a day-long in-person meeting. In addition to these regularly scheduled meetings, they communicate frequently via email, phone, and periodically in person, as needed.
Participating CCOs	16
Participating IAs	8

Community Advisory Council activities

Summary of activities	See CAC Learning Collaborative summary .
Promising practices identified	<ul style="list-style-type: none"> ■ Reducing in-person gatherings of the two CAC leadership groups (Chairs/Co-Chairs, and CAC Coordinators) to two times a year (the CAC Summit and the CCM Summit). ■ Expanding CAC Steering Committee membership to all CAC Coordinators and one CAC member per CAC. ■ Eliminating the previous six-month rotation schedule for CAC Steering Committee membership.
Participating CCOs	CCO participation varied at each event, with a range of five to 13 CCOs represented.
Participating IAs	IA participation also varied depending on the event, with on average one to two IAs participating at each event.

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	The CCO Technical Assistance Bank provides customized resources to assist CCOs in adapting innovations. About half of the CCOs’ requests have been for resources to support their CAC development, which ultimately increases stakeholder and community engagement. In addition, a number of requests have come in to foster health equity and metrics/ measurement.
Promising practices identified	Each CCO has distinct priorities and initiatives to support innovation in different areas of transformation. In addition to offering learning collaboratives that reach broad groups of participants, it has been important for the Transformation Center to offer customized technical assistance to meet CCOs’ diverse needs.
Participating CCOs	16
Participating IAs	8

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

Summary of activities	The Transformation Center trained new staff in order to more appropriately and consistently capture data within the Issue Tracker. Innovator Agents used the Issue Tracker to identify themes for forming Tiger Teams.
Promising practices identified	Issues collected within the Issue Tracker were important foundational information for the Tiger Teams.
Participating CCOs	16
Participating IAs	8

Information sharing with public

Summary of activities	IAs continue to present to a large variety of stakeholders, sharing information on CCO or OHP? enrollment, health equity data, leadership opportunities, and local partnership opportunities with CACs and community partners.
Promising practices identified	Communicating with CACs is a good way to more broadly disseminate information to community members. Both the Transformation Center program staff and the IAs use this approach to disseminate information to the public
Participating CCOs	16
Participating IAs	8

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	-

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.
Web link to Innovator Agent quality data	-

Measure 3: Innovations adopted

Data published for current quarter? Type?	See Good Ideas Bank, an online searchable database of innovative ideas in health system transformation. In early 2015, the Transformation Center plans to revamp the Good Ideas Bank to make it more robust and usable.
Web link to Innovator Agent quality data	http://transformationcenter.org/good-ideas-bank/

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 grants the CCOs received in Fall 2013 have led to the implementation of over 100 innovative projects across all CCOs. The primary Transformation Fund project areas include health information technology, patient-centered primary care (including behavioral health integration in primary care settings), and managing complex care patients.
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?	In their progress reports and milestone reports to OHA, CCOs report solid progress. They report on 8 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	-

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.

Measure 6: CCO Transformation Plan implementation

Data published for current quarter? Type?	Transformation Plans are on track, as evidenced by CCO milestone reports . As noted above, the Technical Assistance Bank 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 TA resources by selecting the topics of most interest and need.
Web link to Innovator Agent quality data	-

Measure 7: Learning Collaborative effectiveness

Data published for current quarter? Type?	Evaluation results from Transformation Center learning collaborative can be found in Section V, Table 9.
Web link to Innovator Agent quality data	-

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.
Web link to Innovator Agent quality data	-

H. Legislative activities

Nothing to report this quarter.

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
Willamette Valley Community Health	Findings in EQRO report	10/1/2014	CCO developed Action Plan to correct findings	Action Plan received and approved 10/10/2014	-	Re-evaluate progress in January 2015

V. Evaluation activities and interim findings

In this quarter, Mathematica completed the initial draft report of its independent midpoint evaluation of the waiver. Per the Special Terms and Conditions (STCs) of the waiver, OHA submitted this draft report (along with additional information requested) to CMS on December 23, 2014. After CMS comments are received, OHA will have 60 days to work with Mathematica on any needed amendments and submit the final report to CMS.

The Transformation Center’s Coordinated Care Model Summit, held in December (see [Section G](#) for details on the summit), included a session on early evaluation findings of the Coordinated Care Model in Medicaid. Researchers from Oregon Health and Sciences University (OHSU) and the Providence Center for Outcomes Research and Education (CORE) presented findings from their work in this area. Mathematica also presented some of their preliminary qualitative findings.³ The session was both well-attended and well-received.

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:	In this quarter, the PCPCH program continued planning for future evaluation efforts as well as working on its annual report. This report will include findings from the initial Portland State University evaluation of the program. The formal reports for the initial evaluation of the program (discussed in previous quarterly reports) will be published in 2015.
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³ CORE and OHSU’s findings have been discussed in previous quarterly reports (Q2 and Q3 2014, respectively). In addition, per the STC’s, CMS was informed of Mathematica’s presentation prior to the Summit.

<p>Interim findings:</p>	<p>As of December 2014, there were 535 recognized clinics in the state (surpassing Oregon’s goal of 500 by 2015).</p> <p>OHA’s goal is to enroll 100 percent of CCO members in a PCPCH. The statewide baseline (for 2012) for this measure is 51.8 percent.</p> <ul style="list-style-type: none"> ■ CCO mid-year performance metrics (see Appendix E) show that the proportion of CCO members enrolled in a PCPCH has continued to increase from the baseline (to 80.4 percent in September 2014, ranging from 97.8 to 60.9 percent across CCOs). ■ It is noteworthy that this increase occurred during a time when Medicaid enrollment increased significantly due to the Patient Protection and Affordable Care Act. ■ It is also promising that there was a large improvement in terms of PCPCH enrollment for the poorest-performing CCO on this measure in each period. The poorest-performing CCO in calendar year 2013 had 41.8 percent of its members enrolled in a PCPCH, while in September 2014 the poorest-performing CCO had 60.9 percent of its members enrolled in a PCPCH.
<p>Improvement activities:</p>	<p>Oregon’s Patient-Centered Primary Care Institute provides technical support and transformation resources to practices statewide, including learning collaborative opportunities.</p> <p>In this quarter, the Institute conducted three 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 31 participants.</p> <p>The Institute also held five webinars:</p> <ul style="list-style-type: none"> ■ National Health Service Corps and Other Programs – Tools to Support Providers and Expand Oregon’s Health Care Workforce (attended by 20 people) ■ PCPCH Site Visits: What to Expect (attended by 64 people) ■ Patient-Centered Primary Care Home Program Overview (attended by 40 people) ■ Scrubbing and Huddling (attended by 48 people) ■ Coming Out of the Shadows: Addressing Substance Use in Primary Care (attended by 39 people) <p>Webinar attendees were asked to rate the quality of the webinars on a scale ranging from 1 (poor) to 5 (excellent). Responses were 4 or above on all webinars.</p>

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

<p>Evaluation activities:</p>	<p>OHA worked with the Oregon Association of Hospitals and Health Systems (OAHHS) to provide hospitals with support and guidance on Oregon’s hospital incentive measure program, the Hospital Transformation Performance Program (HTPP). This work included launching a webpage devoted to the program at http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx, publishing additional supporting documentation, and holding several webinars about the program (see the HTTP Web page and Appendix E for more detail).</p> <p>In this quarter the CCO Metrics Technical Advisory Workgroup (TAG) and the CCO Metrics and Scoring Committee also met, and metrics continued to be refined (see Appendix E for detail):</p> <ul style="list-style-type: none"> ■ The CCO Metrics and Scoring Committee selected the 2015 benchmarks for most incentive measures. ■ The Technical Advisory Group finalized the 2015 measure specifications.
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<p>Interim findings:</p>	<p>Internal analysis of the July-September 2014 CCO financial reports shows a slight decrease in the proportion of all plan payments that are non-fee-for-service (non-FFS):</p> <ul style="list-style-type: none"> ■ In July-September, non-FFS payments are 57.3 percent of all plan payments. In the previous quarter, non-FFS payments were 59.4 percent of all plan payments. ■ This is still an increase over January-March 2014, the first period in which this was tracked (at that time, the proportion of non-FFS payments was 52.5 percent). ■ Non-FFS payment arrangements include salary (2.1 percent), capitation (29.3 percent), and Other payment arrangements (26.0 percent). <p>Note: These data should be treated as preliminary as OHA is working with the CCOs to improve reporting of APMs and flexible services.</p>
<p>Improvement activities:</p>	<p>The November statewide learning collaborative for CCO Medical Directors and Quality Improvement Coordinators focused on exploring the link between payment methodologies and improving quality of care through measurement. Michael Bailit, of Bailit Health Purchasing (which OHA retained to be available to assist CCOs in setting up APMs), presented.</p> <p>OHA contracted with the Center for Evidence-Based Policy at OHSU (the Center) to prepare materials to assist CCOs with implementation of APMs. The final report will be available in the next quarter. In addition, OHA is currently working with the Center to develop plans for next steps in providing technical assistance to CCOs to design and adopt APMs.</p> <p>The state-sponsored Coordinated Care Model summit included a break-out session in which a selection of CCOs presented on their experiences implementing APMs.</p>

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

<p>Evaluation activities:</p>	<p>In partnership with OHSU, the Transformation Center continued work on an environmental scan of behavioral health integration activities across the state. The goals of the project are to assess:</p> <ul style="list-style-type: none"> ■ The extent of integration implementation; ■ The strategies and resources used; ■ Successes and barriers to further development; and ■ How OHA might best support these efforts. <p>Current findings are below.</p>
<p>Interim findings:</p>	<p>Initial findings from the environmental scan show that:</p> <ul style="list-style-type: none"> ■ While there has been extensive integration activity statewide, penetration of integrated care varies, with smaller and rural practices facing the most challenges. ■ The general components of integrated care are known and are being adapted according to how services are organized in each community. ■ The most frequently cited challenges to integration include reimbursement complexity and confusion; regulatory siloes; information sharing barriers; and workforce development. <p>Five of the CCO incentive measures relate to integration. The midyear report (comparing the 2011 baseline to July 2013-June 2014) includes data for four of the measures. The data continue to show progress on all four, though this varies across the CCOs:</p>

	<ul style="list-style-type: none"> ■ SBIRT increased from 0.0 to 4.5 percent, below the 13.0 percent benchmark⁴ (ranging from 0.1 to 15.7 percent across CCOs). ■ Follow-up after hospitalization for mental illness increased from 65.2 to 68.3 percent, which is just under the benchmark of 68.8 percent (ranging from 44.2 to 77.3 percent across CCOs). ■ Follow-up care for children initially prescribed ADHD medications continued to exceed the benchmark (57.7 percent versus a 51.0 percent benchmark), though this varied by CCO (from 49.3 to 80.0 percent). This measure has been dropped from the incentive measure set for 2015, though OHA will continue to monitor and report on this measure as part of the Quality and Access Test. ■ Mental and physical health assessments for children in DHS custody improved from 53.6 to 66.9 percent, but remained well below the benchmark (90.0 percent). Rates across CCOs varied significantly, from 50.0 to 97.2 percent.
Improvement activities:	<p>Flowing in part from the Transformation Center’s environmental scan, an OHA work group has been organized to address questions around barriers to behavioral health information sharing (e.g., federal and state regulations, EMR limitations, and provider misconceptions). A similar work plan is being explored to address reimbursement issues.</p> <p>Work continues on Oregon’s Adult Medicaid Quality Grant. The learning collaborative supported by this grant focuses on “reverse” integration (bringing primary care into behavioral health settings).</p> <ul style="list-style-type: none"> ■ 10 mental health and chemical dependency treatment settings participate in this collaborative, for which there have been two webinars, three in-person learning sessions, and ongoing practice coaching. ■ In December 2014, CMS approved a 12-month extension for this grant. During 2015 OHA will provide more intensive practice coaching and training in care coordination, data management, and shared decision-making aimed at building capacity to implement the four core attributes of a behavioral health home as defined by SAMHSA.

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:	<p>In this quarter Mathematica completed the draft report of the independent midpoint evaluation of the waiver, which OHA submitted to CMS in December. The report will be finalized upon receipt of CMS comments on the draft.</p>
Interim findings:	<p>The data in Appendix E show CCO progress on quality measures from July 2013 – June 2014 compared to baseline data from 2011 (these will be published in the next quarter).</p> <p>Promising findings:</p> <ul style="list-style-type: none"> ■ Decreases continue in emergency department (ED) visits; hospitalizations for chronic conditions; and hospital readmissions. ■ Increases continue in PCPCH enrollment; primary care expenditures; developmental screening; and follow-up after hospitalization for mental illness. While still far below the benchmark statewide, screening for risky drug or alcohol behavior (SBIRT) doubled from calendar year 2013. <p>Areas for improvement:</p> <ul style="list-style-type: none"> ■ Access to primary care providers (PCP) for children and adolescents (measured

⁴ Benchmarks noted are those for 2014.

	<p>as the proportion with a visit with a PCP) declined and was below the benchmark for all ages.</p> <ul style="list-style-type: none"> ■ While immunizations among children under age two and adolescents increased from the baseline, they are still below the benchmark and no CCO has achieved the benchmark for either measure. ■ While below the benchmark of 41.0 percent (lower is better), the obesity rate among CCO enrollees increased from 36.6 percent in 2010 to 39.6 percent in 2012. However, most CCOs did not form until August or September 2012, so this may not reflect CCO impact. ■ Tobacco use among CCO enrollees increased from 31.1 percent in 2011 to 34.1 percent in 2013, exceeding the benchmark of 25.0 percent (a lower number is better for this measure). No CCO achieved the benchmark on this measure, and tobacco use rates were worse than the benchmark for all races and ethnicities except among Hispanic/Latino and Asian Americans. ■ Chlamydia screening decreased from 59.9 to 57.4 percent during the reporting period (below the 64.0 percent benchmark). Only one CCO achieved the benchmark. These data are under review.
<p>Improvement activities:</p>	<p>In December 2014, the OHA Public Health Division and Transformation Center facilitated a half-day meeting for leadership from local public health authorities (LPHAs) and CCOs, immediately preceding Oregon’s Coordinated Care Model Summit.</p> <ul style="list-style-type: none"> ■ The purpose of this meeting was to engage LPHA and CCO administrators in robust conversations about ways they can better collaborate, specifically with regard to maternal and child health promotion and chronic disease prevention. ■ Nearly all of Oregon’s 34 LPHAs and 16 CCOs were represented, and through OHA staff-facilitated regional conversations, participants left the meeting with a draft work plan for how to continue their efforts in the future. <p>OHA’s Office of Health Information Technology (OHIT) staff completed a series of on-site meetings with each CCO. The aim of the meetings was to ensure that state IT initiatives align with and support CCO needs. OHIT is producing a summary document about these meetings, along with detailed individual profiles of each CCO’s health information technology use. This will be part of a broader environmental scan on the status of health information technology and exchange across the state.</p> <p>OHA recently launched 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.</p> <ul style="list-style-type: none"> ■ 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).

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

<p>Evaluation activities:</p>	<p>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.</p>
<p>Interim findings:</p>	<p>None at this time.</p>

Improvement activities:	<p>CCOs submitted their flexible services policies and procedures for OHA review and feedback in October. CCOs will receive feedback in the first calendar quarter of 2015. If they choose, CCOs can revise their procedures based on and resubmit in March 2015.</p> <p>In addition, the Transformation Center is working with OHA Medical Assistance Programs to develop a learning collaborative for CCOs to share best practices related to implementation and reporting of flexible services.</p>
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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:	<p>The formative evaluation of the Transformation Center continued this quarter, with the external evaluation team observing a range of Transformation Center meetings and events. They also interviewed Community Advisory Council (CAC) leaders and participants to identify how the Transformation Center could better support the needs of this audience.</p> <p>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. The evaluation team will present their CAC interview findings to Transformation Center staff in the next quarter.</p> <p>Findings from the Transformation Center’s ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.</p>
Interim findings/ Improvement activities:	<p>The Transformation Center hosted the Coordinated Care Model summit in December. Health care leaders from throughout the state were in attendance, and the CCOs presented their work in many of the sessions (see Section G for more).</p> <p>The Transformation Center now hosts seven external learning collaboratives (an eighth internal learning collaborative for the CCO Innovator Agents also exists):</p> <ol style="list-style-type: none"> (1) Statewide CCO learning collaborative focused on incentive metrics; (2) Learning collaborative for CCO Community Advisory Council members; (3) Complex care collaborative; (4) Institute for Healthcare Improvement for CCO Transformation Fund Portfolio Managers collaborative; (5) The Council of Clinical Innovators; (6) Health Equity learning collaborative (new this quarter); and, (7) Quality Improvement Community of Practice (new this quarter). <p>The Health Equity learning collaborative was created at the request of CCOs, and is a partnership between the Transformation Center and OHA’s Office of Equity and Inclusion.</p> <p>The Quality Improvement Community of Practice was launched during a breakfast at the Coordinated Care Summit in December. It is not included in the evaluation data presented below, but will be included in future reports.</p> <p>From October – December 2014 the Transformation Center held 11 learning collaborative sessions for the external learning collaboratives, attended by an average of 24 people.</p> <ul style="list-style-type: none"> ■ The roles of attendees are as follows: 18 percent clinical; 31 percent administrative or operational lead; 12 percent QI/QA staff; the remainder hold other roles.

	<ul style="list-style-type: none"> ■ The sessions were a mix of teleconferences, in-person sessions, and webinars. Topics ranged from <i>Community Health</i> to <i>APMs and Incentive Metrics</i>. <p>Results from the Transformation Center’s internal evaluation of the effectiveness of the learning collaboratives shows that:</p> <ul style="list-style-type: none"> ■ 88.2 percent of respondents found the session valuable or very valuable to their work. ■ 50.7 percent of respondents say they will attend future sessions. <p>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. Based upon this feedback, the Transformation Center has included future programming aimed at addressing those needs. For example:</p> <ul style="list-style-type: none"> ■ Based on feedback from the first Health Equity Learning Collaborative session, the Transformation Center is creating a survey to capture CCO practices related to health equity. ■ The Transformation Center is also in the process of developing a <i>CAC 101</i> PowerPoint presentation on health system transformation to assist in CAC member engagement and training.
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VI. Public Forums

Public comments received

During this quarter, the Metrics and Scoring Committee received public testimony regarding benchmark setting for effective contraceptive use, adoption of HIV as an incentive measure, and general considerations for incentive measure selection.

You can find the Committee’s meeting material, including all public testimony received, on the Committee’s Web page at <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

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	October 2014	November 2014	December 2014
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,009,918	972,030	995,928
Title XXI funded State Plan	76,368	69,816	68,292

Enrollment	October 2014	November 2014	December 2014
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	10/31/2014	11/30/2014	12/31/2014

*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%	1,662	3,949	-10.53%	-37.48%
		Pregnant Women FPL > 170%	909	2,213	-6.49%	-19.36%
	Title 21	SCHIP FPL > 170	32,243	72,421	-9.29%	30.80%
Optional	Title 19	PLM Women FPL 133-170%	13,979	31,819	-1.55%	-5.67%
	Title 21	SCHIP FPL < 170%	65,254	147,005	25.78%	2.93%
Mandatory	Title 19	Other OHP Plus	456,186	1,077,026	-6.94%	-6.88%
		MAGI Adults/Children	669,104	1,670,560	30.61%	0.00%
		MAGI Pregnant Women	10,538	27,124	26.34%	0.00%
QUARTER TOTALS			1,249,875			

* 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	
October	931,298	881,136	1,623	1,604	51,812	3,055	56,477	4,648
November	978,405	831,019	1,474	1,656	50,341	2,737	53,809	4,480
December	999,496	852,528	1,369	1,550	52,087	2,733	54,782	4,493
Qtr Average	969,733	854,894	1,489	1,603	51,413	2,842	55,023	4,540
		88.16%	0.15%	0.17%	5.30%	0.29%	5.67%	0.47%

*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

In this period, OHA continued reporting on 2014 data, selected the 2015 measures and benchmarks, and finalized measure specifications for 2015.

This quarterly report includes the final 2013 results and updated data for a rolling 12-month window (July 2013 – June 2014) for the 17 CCO incentive measures, 33 quality and access test measures, and additional core performance measures.

This quarterly report also includes the results of the Demonstration Year (DY) 12 test for quality and access, as conducted by OHA’s contractor, the Oregon Health Care Quality Corporation.

During this reporting period OHA worked with the Oregon Association of Hospitals and Health Systems (OAHHS) to provide hospitals with support and guidance on Oregon’s hospital incentive measure pool, the Hospital Transformation Performance Program (HTPP). This work included launching a Web page devoted to the program (see <http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>), publishing additional supporting documentation, and holding several webinars about the program (detailed below).

CCO incentive metrics updates

CCO reporting and validation:

- During this reporting period, OHA launched 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. 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 11 claims-based incentive measures and will be expanded to include additional measures and cost and utilization data in future releases.
- OHA will be publishing the next public report on the measures on January 14, 2015. The report will be available online at: <http://www.oregon.gov/oha/metrics/>.
- During this reporting period, OHA continued to work with its contractor, the Oregon Health Care Quality Corporation to validate measures for multiple measurement periods. See the Validation Update and DY 12 Test sections below for additional details.

2015 CCO incentive measure and benchmark selection

During this reporting period, the Metrics & Scoring Committee finalized the selection of CCO incentive metrics and benchmarks for the third measurement year, 2015. The measures and benchmarks are provided below and available online at <http://www.oregon.gov/oha/analytics/CCOData/2015%20Benchmarks.pdf>.

2015 Measures	2015 Benchmarks
Adolescent well care visits	62.0% <i>2014 national Medicaid 75th percentile (administrative data only)</i>
Alcohol and drug misuse (SBIRT)	12% <i>Metrics Technical Advisory Workgroup recommendation, weighted to accommodate inclusion of adolescents.</i>
Ambulatory care: emergency department utilization	39.4/1,000 member months <i>2014 national Medicaid 90th percentile</i>
CAHPS composite: access to care	87.2% <i>2014 national Medicaid 75th percentile; weighted average of adult and child rates.</i>
CAHPS composite: satisfaction with care	89.6% <i>2014 national Medicaid 75th percentile; weighted average of adult and child rates.</i>
Colorectal cancer screening	47.0% <i>Metrics & Scoring Committee consensus</i>
Controlling hypertension	64.0% <i>2014 national Medicaid 75th percentile</i>
Dental sealants on permanent molars for children	20.0% <i>Metrics & Scoring Committee consensus; based on national EPSDT data and Healthy People 2020 goals</i>
Depression screening and follow up	25.0% <i>Metrics & Scoring Committee consensus</i>
Developmental screening	50.0% <i>Metrics & Scoring Committee consensus</i>
Diabetes: HbA1c poor control	34.0% <i>2014 national Medicaid 75th percentile</i>
Effective contraceptive use	50.0% <i>Metrics & Scoring Committee consensus</i>
Electronic Health Record adoption	72% <i>Metrics & Scoring Committee consensus</i>
Follow up after hospitalization for mental illness	70.0% <i>2014 national Medicaid 75th percentile</i>
Mental, physical, and dental health assessments for children in DHS custody (foster care)	90.0% <i>Metrics & Scoring Committee consensus</i>
Patient Centered Primary Care Home enrollment	N/A – sliding scale. Goal: 100 percent of members enrolled in a Tier 3 PCPCH.
Timeliness of prenatal care	90.0% <i>2014 national Medicaid 75th percentile</i>

All 2015 measure specifications were finalized and posted online in December 2014 at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>.

Statewide chart review and year one proof of concept data

OHA has adopted a multi-pronged approach to build CCO capacity related to reporting on the three CCO incentive measures that require electronic medical record data. In 2013, CCOs were required to submit a Technology Plan and proof of concept data to receive the associated quality pool payments for these three measures. The objective of the Technology Plan was to describe how the CCOs will build the capacity to collect and report on these three measures from EHRs, and the proof of concept data demonstrated this

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capacity. Requirements for data submissions will increase in future years. As the 2013 proof of concept data submission was the first time CCOs had extracted this type of data and the first time OHA had looked to this type of data for performance measurement, additional validation of the proof of concept data is necessary.

OHA has completed a comparative analysis of the 2013 statewide chart review data for the three clinical incentive measures collected by OHA's contracted EQRO, Acumentra Health, with the year one proof of concept data extracted from electronic health records by CCOs. Due to validity issues, OHA calculated a performance rate for the proof of concept data using a subset of the data with consistent parameters that also passed a validity check.

Findings include similar performance rates for the hypertension measure, with 63.43 percent for the proof of concept data subset and 61.83 percent for the chart review data. The performance rate for the diabetes measure was almost double for the proof of concept data subset compared to the chart review data, with respective rates of 30.85 percent and 15.63 percent.

Most surprising were the calculated performance rates for the depression screening measure. The proof of concept data subset came in with a rate of 47.73 percent compared to the 1.44 percent for the chart review data. Additional analysis is needed, however, OHA's hypotheses for the differences include:

- The chart review process was able to validate the use of a *standardized, age-appropriate tool* for screening and exclude these encounters from the numerator. While there is also an expectation for the proof of concept data submission to utilize a standardized, age-appropriate tool it was more difficult to validate in this data set.
- The proof of concept data submission was based on a convenience sample from the CCOs. In many cases, CCOs (appropriately) looked to practices that were high performers in this area and also able to report on the measure data.
- The performance rate for the proof of concept rate was calculated based on a subset of the total data submissions. It is possible that this subset represents a grouping of the highest performing practices within the subset.

Measure development updates

During this reporting period, OHA fielded the *2014 Physician Workforce Survey*. Results were used to calculate the provider access questions (one of the 33 quality and access measures) and data is provided in the measures matrix below.

During this reporting period, OHA also finalized specifications for one of the remaining core performance measures: low birth weight. New data for low birth weight and obesity prevalence are provided in the core performance measures matrix below.

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, prior to the calculation of the DY 12 test (see below). This has been an ongoing process, with Q Corp calculating and validating the 2011 baseline, calendar year 2013, the "dry run" period (July 2012 – June 2013), and the first year of the test (July 2013 – June 2014). To date, the following validation activities have occurred:

Validation of measures computed with administrative claims

There are 22 measures that are computed using administrative claims data. As of February 5, 2015, 15 of the 22 measures have been fully validated and signed off for the DY 12 test. Validation status for all time periods is shown in the table below.

Time Period	Baseline	Dry Run	CY 2013	Year One Test
Measures Signed Off (as of 2/5/15)	19	19	17	15
Total Measures	22	22	22	22

Q Corp staff reviewed all of the OHA programming code used to produce the measures. First, they compared the code to measure specifications to ensure the correct algorithms were being used to identify numerator and denominator populations. Then they recommended corrections to coding errors, which OHA incorporated.

Q Corp also conducted a parallel test of the 2011 baseline measures produced by OHA. Q Corp maintains a multi-payer claims database which includes Medicaid data provided by OHA. Q Corp computed the CCO metrics using this data to provide a reconciliation point for the metrics produced by OHA.

Validation of non-claims based measures

In addition to the claims-based measures described above, Q Corp also validated several measures that are produced by OHA that do not use administrative claims. They include:

- Childhood immunization status
- Early elective delivery (EED)
- Immunization for adolescents
- Mental and physical health assessments for children in DHS custody
- Patient-centered primary care home (PCPCH) enrollment

For each of these measures, Q Corp evaluated the methodology and/or calculations used to determine measure results. Q Corp provided “Validation Summary” documents for each of these measures that detailed their validation process and summarized their findings.

Hospital metrics updates

Implementation of HTPP, Oregon’s hospital incentive measure program, continued in this quarter. OHA created and published documentation on how OHA would administer the program, including detailed specifications for each measure, quality pool payment distribution, calculation of improvement targets, and guidance on baseline data submission.

In addition, OHA partnered with OAHHS to provide additional technical assistance to hospitals. This included four webinars on topics ranging from an in-depth look at the measure specifications to technical assistance on implementing the SBIRT (Screening, Brief Intervention, and Referral to Treatment) process in the Emergency Department. All supporting documentation, as well as the slides and recordings from all webinars are available on the program’s official Web page (<http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>), which was launched in October.

In the next quarter hospitals will submit baseline data for the first year of the program (covering September 2013 – October 2014).

Committee and workgroup updates

The **CCO Metrics & Scoring Committee** met in October and November 2014. Meeting materials are available online at <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

- In October, the Committee reconsidered the adoption of tobacco use prevalence as a CCO incentive measure and agreed to postpone this measure until 2016. The Committee also selected the 2015 benchmarks for the majority of measures.

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- In November, the Committee set the final benchmark (for Effective Contraceptive Use), modified the challenge pool measures for 2015 (removed PCPCH Enrollment as a challenge pool measure and replaced with Developmental Screening), and established their 2015 meeting schedule.

The **CCO Metrics Technical Advisory Workgroup (TAG)** also met in October and November 2014. Meeting materials are available online at www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx.

- In October, the TAG received a demonstration of the new automated metrics reporting tool (“dashboard”) and continued to discuss the draft 2015 measure specifications.
- In November, the TAG finalized the 2015 measures specifications and considered recalculation of baseline data to reflect changes in specifications, to allow for meaningful comparisons.

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

DY 12 quality and access test

Under STC 52 and 54 of Oregon’s 1115 demonstration waiver, OHA must conduct a quality and access test in each program year that the state achieves its cost control goal. This test will determine whether the state’s health system transformation efforts have caused the quality of care and access to care experienced by state Medicaid beneficiaries to worsen.

The test consists of two parts: part 1 is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex counterfactual comparison that will only be undertaken if the state fails part 1 in a given program year.

For the first two years, part 1 of the test is passed if a composite score for the quality and access metrics remains constant or improves as compared to the historical baseline. Part 1 of the test consists of a single aggregate indicator constructed using the 33 agreed upon quality and access measures (although individual measures can be excluded from the composite with good reason). The test result is based on the difference between aggregate performance in the demonstration year and the baseline period (calendar year 2011). For the full methodology for this test, see Oregon’s Accountability Plan, online at <http://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf>.

This section provides the results of Oregon’s DY 12 test. DY 12 is the first year Oregon’s quality and access test applies. A “dry run” of the test for DY 11 was provided in previous quarterly reports.

DY 12 test results

OHA presents three sets of DY 12 test results for CMS consideration, depending on the level of independence in the measure production underlying the composite score and the number of measures included. Regardless of which option selected, Oregon demonstrates aggregated improvement over the 2011 baseline on the selected quality and access measures.

The DY 12 Test Score is a composite score that represents the average percent improvement in all measurement rates included in the composite (as compared to the historical baseline).

DY 12 Test #	Description	# of Measures Included (of 37 ⁵)	DY 12 Test Score
1	<p>Q Corp conducted this test entirely, independently calculating and validating all measures included in the composite.</p> <p>However, because Q Corp can only independently calculate claims-based measures, less than half of the measures were included in the composite.</p>	15	153.7%
2	<p>Q Corp and OHA jointly conducted this test.</p> <p>Q-Corp independently calculated and validated the 15 claims-based measures included in the composite; OHA calculated the remaining non-claims based measures.</p>	25	114.3%
3	<p>OHA conducted this test entirely; OHA produced all measures included in the composite.</p> <p>Slight differences in the code and data used between OHA and Q Corp result in different results for the individual claims-based measures, although the overall trend in improvement is similar. This iteration of the test also includes the remaining claims-based measures that Q Corp has not finished validating (these remaining measures were excluded from the previous two iterations of the test).</p> <p>OHA produced all other data reported in Appendix E.</p>	29	103.5%

See the [DY 12 Quality and Access Test Composite Tables](#) for the specific results, included measures, and rationale for exclusions under each result.

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 below, as are high and low CCO performance on each measure where possible. Updates provided in red.

⁵ Note measures with multiple rates are treated as separate measures in the composite scoring, resulting in more than the 33 quality and access test measures. For example, the measure Ambulatory Care: Outpatient and Emergency Department Utilization is treated as two measures for the purposes of the composite.

Core Performance Measures by Race/Ethnicity - June 2013 – May 2014

As part of the dashboard reporting under development with OHA/CORE, additional measures and additional stratifications will be added in future quarterly reports.

CORE Performance Measures	White, non-Hispanic	African-American, non-Hispanic	American Indian / Alaska Native, non-Hispanic	Asian American, non-Hispanic	Hawaiian / Pacific Islander, non-Hispanic	Hispanic / Latino
Ambulatory care: ED utilization	54.3/1,000 mm	67.7/1,000 mm	63.3/1,000 mm	21.1/1,000 mm	41.4/1,000 mm	35.2/1,000 mm
Developmental screening	36.9%	36.1%	32.5%	34.3%	32.0%	31.2%
Follow up after hospitalization for mental illness	69.5%	52.1%	55.2%	62.9%	42.9%	73.2%

Hospital Transformation Performance Program (HTPP) Measures Matrix

See [Appendix E](#).

Appendix E: Oregon Measures Matrix

NOTE: Measures with an asterisk (*) are those that are reported quarterly. All others are reported annually.

This quarterly report includes the final 2013 results for the 17 CCO incentive measures and 33 quality and access “test” measures, as well as a new rolling 12-month window (July 2013 – June 2014) for all claims-based measures and two non-claims based measures.

Updates from last quarter’s report are indicated in track changes.

Focus Area	Measure Sets					Quality and Access ‘Test’		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access ‘Test’ Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 – July 2014
Improving behavioral and physical health coordination	*Alcohol or other substance misuse (SBIRT)	√	√			√	0.02%	13%	MN method	13%	State: 0.02% High CCO: 0.22% Low CCO: 0.0%	State: 2.0% High CCO: 8.7% Low CCO: 0.0%	State: <u>4.5%</u> High CCO: <u>15.7%</u> Low CCO: <u>0.1%</u>
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0%	MN method with 3% floor.	68.0%	State: 65.2% High CCO: 88.9% Low CCO:	State: 67.6% High CCO: 81.0% Low CCO:	State: <u>68.3%</u> High CCO: <u>77.3%</u> Low CCO: <u>44.2%</u>

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										57.1%	51.2%		
	Screening for clinical depression and follow-up plan (NQF 0418)	√	√	√		√	0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	n/a	<u>N/A</u>
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				53.6%	90%	MN method with 3% floor.	90%	State: 53.6% High CCO: 67.7% Low CCO: 35.7%	State: 63.5% High CCO: 100% Low CCO: 23.1%	<u>State: 66.9%</u> <u>High CCO: 97.2%</u> <u>Low CCO: 50.0%</u>
	*Follow-up care for children prescribed ADHD meds (NQF 0108)	√				√	Initiation: 52.3% C&M: 61.0%	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 th percentile	MN method	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 th percentile	Initiation: 52.3% High CCO: 88.9% Low CCO: 33.3% C&M:	Initiation: 53.3% High CCO: 70.8% Low CCO: 43.5% C&M:	<u>Initiation: 57.7%</u> <u>High CCO: 80.0%</u> <u>Low CCO: 49.3%</u> <u>C&M will be available in.</u>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										State: 61.0% High CCO: 100% Low CCO: 29.4%	State: 61.6% This measure cannot be reported at the CCO level for 2013.	a future report.	
Improving perinatal and maternity care	*Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	65.3% using admin data only.	69.4% 2012 National Medicaid 75 th percentile: (adjustment factor applied to account for difference between admin data and hybrid rates)	MN method with 3% floor.	69.4% 2012 National Medicaid 75 th percentile: (w/ adjustment factor)	State: 65.3% High CCO: 77.0% Low CCO: 47.7%	State: 67.3% High CCO: 78.3% Low CCO: 56.0%	OHA will report on this measure when hybrid data are available following the end of the CY 2014 measure period.
	*Prenatal and postpartum care: postpartum care rate			√		√	40.0% using admin	43.1% 2012 National	n/a	n/a	State: 40.0%	State: 33.4%	OHA will report on this

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 – July 2014
	(NQF 1517)						data only	Medicaid 75 th percentile (adjustment factor applied)			High CCO: 47.1% Low CCO: 22.6%	This measure cannot be reported at the CCO level for 2013.	June 2013 – July 2014 measure when hybrid data are available following the end of the CY 2014 measure period.
	PC-01: Elective delivery (NQF 0469) <i>Lower score is better.</i>	√		√		√	10.1%	5% or below.	MN method with 1% floor.	5% or below.	State: 10.1% High CCO: 14.9% Low CCO: 7.2%	State: 2.6% High CCO: 4.3% Low CCO: 0.2%	N/A
Reducing preventable re-hospitalizations	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90 th	MN method with 3% floor.	68.0% 2012 National Medicaid	State: 65.2% High CCO:	State: 67.6% High CCO:	State: 68.3% High CCO:

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013
-tions							percentile		90 th percentile	88.9%	81.0%	<u>77.3%</u>
	<p>*Ambulatory Care: Outpatient (OP) and Emergency Department (ED) utilization.</p> <p><i>Lower score is better for ED utilization.</i></p>	√	√		√	√	ED: 61.0/1,000mm OP: 364.2/1,000mm	ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National Medicaid 90 th percentile	MN method with 3% floor. ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National Medicaid 90 th percentile	ED State: 61.0/1,000mm High CCO: 86.2/1,000mm Low CCO: 55.4/1,000mm OP State: 364.2/1,000mm High CCO: 412.3/1,000mm Low CCO:	ED State: 50.5/1,000mm High CCO: 74.3/1,000mm Low CCO: 31.6/1,000mm OP State: 323.5/1,000mm High CCO: 345.7/1,000mm Low CCO:	<u>ED State: 48.1/1,000mm</u> <u>High CCO: 69.1/1,000mm</u> <u>Low CCO: 33.1/1,000mm</u> <u>OP State: 304.3/1,000mm</u> <u>High CCO: 349.8/1,000mm</u> <u>Low CCO: 250.6/1,000mm</u>

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										296.6/ 1,00mm	267.4/1,000mm	<u>mm</u>	
	*Plan all-cause readmission (NQF 1768) <i>Lower score is better.</i>		√		√	√	12.3%	10.5% Average of Commercial and Medicare 75 th percentiles	n/a	n/a	State: 12.3% High CCO: 14.6% Low CCO: 8.7%	State: 11.7% High CCO: 13.6% Low CCO: 6.6%	State: <u>11.5%</u> High CCO: <u>14.4%</u> Low CCO: <u>7.3%</u>
Ensuring appropriate care is delivered in appropriate settings	*Ambulatory Care: Outpatient and ED utilization <i>Lower score is better for ED utilization.</i>	√	√		√	√	ED: 61.0/ 1,000mm OP: 364.2/ 1,000mm	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 th percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 th percentile	ED State: 61.0/ 1,000mm High CCO: 86.2/ 1,000mm Low CCO: 55.4/ 1,000mm OP State:	ED State: 50.5/1,000mm High CCO: 74.3/1,000mm Low CCO: 31.6/1,000mm OP State:	<u>ED</u> State: <u>48.1/1,000mm</u> High CCO: <u>69.1/1,000mm</u> Low CCO: <u>33.1/1,000mm</u> <u>OP</u> State: <u>304.3/1,000</u>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										364.2/1,000mm High CCO: 412.3/1,000mm Low CCO: 296.6/1,000mm	323.5/1,000mm High CCO: 345.7/1,000mm Low CCO: 267.4/1,000mm	June 2013 - July 2014 mm High CCO: 349.8/1,000mm mm Low CCO: 250.6/1,000mm mm	
Improving primary care for all populations	Colorectal cancer screening 2011 and 2013 measure specifications modified to identify unique members receiving colorectal cancer screening in 12 month period, reported per 1,000 member months (mm). 2014 measure will use HEDIS hybrid specifications	√			√	15.8/1,000mm using admin data only.		n/a 3% improvement only	n/a 3% improvement only	State: 15.8/1,000 mm admin data only. High CCO: 21.3/1,000 mm Low CCO: 5.1/1,000 mm	State: 11.4/1,000 mm High CCO: 15.7/1,000 mm Low CCO: 7.2/1,000 mm	OHA will report on this measure when hybrid data are available following the end of the CY 2014 measure period.	

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013
Patient-Centered Primary Care Home Enrollment	√				√	51.8% (2012)	100% (Tier 3)	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	State: 51.8% (2012) High CCO: 94.4% (2012) Low CCO: 3.7% (2012)	State: 78.6% High CCO: 95.6% Low CCO: 41.8%	State: <u>80.4%</u> High CCO: <u>97.8%</u> Low CCO: <u>60.9%</u>
* Developmental screening in the first 36 months of life (NQF 1448)	√	√		√	√	20.9% using admin data only.	50% Metrics & Scoring Committee consensus	MN method.	50% Metrics & Scoring Committee consensus	State: 20.9% High CCO: 67.1% Low CCO: 0.2%	State: 33.1% High CCO: 62.7% Low CCO: 16.8%	State: <u>35.2%</u> High CCO: <u>64.4%</u> Low CCO: <u>20.1%</u>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
*Well-child visits in the first 15 months of life (NQF 1392)					√	√	68.3%	77.3% 2012 National Medicaid 90 th percentile	n/a	n/a	State: 68.3% High CCO: 81.3% Low CCO: 45.0%	State: 60.9% High CCO: 75.3% Low CCO: 33.3%	State: 60.4% High CCO: 76.8% Low CCO: 50.0%
*Adolescent well-care visits (NCQA)		√			√	√	27.1% (admin data only)	53.2% 2011 National Medicaid 75 th percentile (admin data only)	MN method with 3% floor.	53.2% 2011 National Medicaid 75 th percentile (admin data only)	State: 27.1% High CCO: 31.9% Low CCO: 20.7%	State: 29.2% High CCO: 43.4% Low CCO: 20.5%	State: 29.3% High CCO: 39.3% Low CCO: 20.3%
Childhood immunization status (NQF 0038)					√	√	66.0% (Combo 2)	82.0% 2012 National Medicaid 75 th percentile (combo 2)	n/a	n/a	State: 66.0% High CCO: 73.1% Low CCO:	State: 65.3% High CCO: 74.5% Low CCO:	State: 67.6% High CCO: 77.0% Low CCO: 56.9%

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										58.0%	49.0%		
Immunization for adolescents (NQF 1407)					√	√	49.2% (Combo 1)	70.8% 2012 National Medicaid 75 th percentile (combo 1)	n/a	n/a	State: 49.2% High CCO: 57.2% Low CCO: 31.6%	State: 52.9% High CCO: 60.3% Low CCO: 29.6%	State: <u>55.3%</u> High CCO: <u>64.1%</u> Low CCO: <u>34.7%</u>
Appropriate testing for children with pharyngitis (NQF 0002)					√	√	73.7%	76.0% 2012 National Medicaid 75 th percentile	n/a	n/a	State: 73.7% High CCO: 90.7% Low CCO: 41.9%	State: 72.8% High CCO: 90.4% Low CCO: 36.7%	State: <u>73.4%</u> High CCO: <u>87.0%</u> Low CCO: <u>35.7%</u>
Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)				√	√	1: 50.0% of adult tobacco users on Medicaid reported being	2012 National Medicaid benchmark 90 th percentile: Component 1:	n/a	n/a	State: 1: 50.0% 2: 24.0% 3: 22.0% High CCO:	State: 1: 55.0% 2: 28.9% 3: 23.6% High CCO:	<u>N/A</u>	

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
						advised to quit by their Dr; 2: 24.0% reported their Dr discussed or recommended medications with them; 3: 22.0% reported their Dr discussed strategies to quit smoking with them (CAHPS 2011)	81.4%	Component 2: 50.7%			1: 61% 2: 34% 3: 27%	1: 61.5% 2: 41.9% 3: 30.1%	
Deploying care teams to	*Ambulatory Care: Outpatient and ED	√	√		√	√	ED: 61.0/	ED: 44.1 / 1,000mm	MN method with 3% floor.	ED: 44.1 / 1,000mm	ED State: 61.0/	ED State: 50.5/1,000	ED State: 48.1/1,000

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013
improve care and reduce preventable of unnecessarily costly utilization by super users	utilization					1,000mm OP: 364.2/1,000mm	OP: 439/1,000mm 2011 National Medicaid 90 th percentile		OP: 439/1,000mm 2011 National Medicaid 90 th percentile	1,000mm High CCO: 86.2/1,000mm Low CCO: 55.4/1,000mm OP State: 364.2/1,000mm High CCO: 412.3/1,000mm Low CCO: 296.6/1,000mm	mm High CCO: 74.3/1,000mm Low CCO: 31.6/1,000mm OP State: 323.5/1,000mm High CCO: 345.7/1,000mm Low CCO: 267.4/1,000mm	<u>mm</u> <u>High CCO: 69.1/1,000mm</u> <u>Low CCO: 33.1/1,000mm</u> <u>OP State: 304.3/1,000mm</u> <u>High CCO: 349.8/1,000mm</u> <u>Low CCO: 250.6/1,000mm</u>
Addressing discrete health	Controlling high blood pressure (NQF 0018)	√		√		0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	N/A	N/A

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of resources, including CHW.	*Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	67.2%	80% 2012 National Medicaid 75 th percentile	n/a	n/a	State: 67.2% High CCO: 73.1% Low CCO: 55.2%	State: 70.1% High CCO: 74.2% Low CCO: 61.5%	State: <u>74.5%</u> High CCO: <u>80.4%</u> Low CCO: <u>66.3%</u>
	*Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	78.5%	86% 2012 National Medicaid 75 th percentile	n/a	n/a	State: 78.5% High CCO: 86.4% Low CCO: 63.6%	State: 79.3% High CCO: 83.0% Low CCO: 76.8%	State: <u>82.7%</u> High CCO: <u>85.3%</u> Low CCO: <u>75.6%</u>
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	N/A	N/A
	*PQI 01: Diabetes, short term complication admission rate (NQF		√	√		√	192.9 / 100,000 member	10% reduction from baseline	n/a	n/a	State: 192.9 Low CCO:	State: 211.5 Low CCO:	State: <u>174.9</u> Low CCO:

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013
	0272) <i>Lower is better</i>					years				109.0 High CCO: 360.8	16.7 High CCO: 417.3	<u>57.6%</u> <u>High CCO: 370.6%</u>
	*PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) <i>Lower is better</i>		√	√	√	454.6 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 454.6 Low CCO: 292.5 High CCO: 821.1	State: 308.1 Low CCO: 42.9 High CCO: 602.6	<u>State: 234.0</u> <u>Low CCO: 103.7</u> <u>High CCO: 447.3</u>
	*PQI 08: Congestive heart failure admission rate (NQF 0277) <i>Lower is better</i>		√	√	√	336.9 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 336.9 Low CCO: 177.2 High CCO: 611.9	State: 247.0 Low CCO: 101.4 High CCO: 411.4	<u>State: 223.7</u> <u>Low CCO: 86.0</u> <u>High CCO: 408.5</u>
	*PQI 15: Adult asthma admission rate		√	√	√	53.4 / 100,000 member	10% reduction	n/a	n/a	State: 53.4	State: 43.6	<u>State: 32.5</u>

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013
	(NQF 0283) <i>Lower is better</i>					years	from baseline			Low CCO: 16.1 High CCO: 180.3	Low CCO: 0.0 High CCO: 70.2	<u>Low CCO: 0.0</u> <u>High CCO: 54.4</u>
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√	√	Access to Care OR adult baseline: 79% OR child baseline 87% OR average: 83%	2012 National Medicaid adult 75 th percentile: 83.63% 2012 National Medicaid child 75 th percentile: 90.31% National average: 86.97%	Access to Care OR adult baseline: 79% OR child baseline 88% OR average: 83.5%	Access to Care 2012 National Medicaid adult 75 th percentile: 83.63% 2012 National Medicaid child 75 th percentile: 90.31% National average: 86.97%	Access to Care Adult: 79% Child: 87% Avg: 83% High CCO: 85% Adult: 85% Child: 94% Avg: 90% Low CCO: 73% Adult: 73% Child: 81%	Access to Care Adult: 80.1% Child: 87.1% Avg: 83.6% High CCO: 88.3% Avg: 88.3% Low CCO: 80.4% Avg: 80.4%	<u>N/A</u>

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
										Avg: 81%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√				<i>Note: OHA cannot report on all CCOs for this measure – CAHPS 2011 was sampled for old managed care orgs – not current CCOs.</i>			
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	59.9%	63.0%	n/a	n/a	State: 59.9% High	State: 54.4% High	State: <u>57.4%</u> High CCO:

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
							percentile			CCO: 65.8%	CCO: 62.3%	<u>64.7%</u>	
										Low CCO: 49.6%	Low CCO: 41.5%	<u>Low CCO: 46.6%</u>	
	*Cervical cancer screening (NQF 0032)			√	√	56.1%	74.0% 2012 National Medicaid 75 th percentile	n/a	n/a	State: 56.1%	State: 53.3%	<u>State: 55.8%</u>	
										High CCO: 59.8%	High CCO: 58.9%	<u>High CCO: 61.8%</u>	
										Low CCO: 47.5%	Low CCO: 40.5%	<u>Low CCO: 42.9%</u>	
	*Child and adolescent access to primary care practitioners (NCQA)				√	12-24 mos 97.4%	12-24 mos 98.2%	n/a	n/a	12-24 mos State: 97.4%	12-24 mos State: 96.4%	<u>State: 12-24 mos: 95.1%</u>	
						25 mos – 6 years 86.2%	25 mos – 6 years 91.6%			High CCO: 99.0%	25 mos-6 years State: 84.3%	<u>25 mos – 6 years: 83.2%</u>	
						7-11 yrs 88.2%	7-11 yrs 93.0%			Low CCO: 96.2%		<u>7-11 years: 86.7%</u>	
						12-19 yrs 88.9%	12-19 yrs			25 mos – 6 years	7-11 yrs State:	<u>12-19</u>	

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
						All ages 88.5%	91.7% All ages n/a 2011 National Medicaid 75 th percentile			State: 86.2% High CCO: 88.8% Low CCO: 83.5% 7-11 yrs State: 88.2% High CCO: 91.4% Low CCO: 86.0% 12-19 yrs State: 88.9% High CCO: 92.3% Low CCO: 86.9% All ages State: 88.5%	87.2% 12-19 yrs State: 87.6% All ages State: 87.0% CCO data not available for 2013.	<u>June 2013 - July 2014</u> <u>years:</u> <u>87.3%</u> <u>All ages:</u> <u>86.4%</u>	

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
	<p>Provider Access Questions from the Physician Workforce Survey:</p> <p>1) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely closed, open with limitations, and no limitations).</p> <p>2) Do you currently have Medicaid/OHP patients under your care?</p> <p>3) What is the current payer mix at your primary practice?</p>				√	<p>In 2012:</p> <p>86.3% of Oregon's physicians accepted new Medicaid patients with no or some limitations</p> <p>86.9% of physicians have Medicaid patients.</p> <p>Medicaid/OHP represented 17% of current</p>	TBD	n/a	n/a	<p><u>In 2012:</u></p> <p>1) 86.3%</p> <p>2) 86.9%</p> <p>3) 17%</p> <p>Baseline revised to include all providers, not just PCPs.</p> <p>This measure cannot be reported by CCO.</p>	N/A. OHA is fielding a physician workforce survey in 2014 to be able to report on this measure.	<p><u>In 2014:</u></p> <p>1) 94.3%</p> <p>2) 88.9%</p> <p>3) 23%</p>	

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
							payer mix at primary practice.						
	Screening for depression and follow up plan (see above)												
	*SBIRT (see above)												
	*Mental and physical health assessment for children in DHS custody (see above)												
	*Follow-up care for children on ADHD medication (see above)												
	*Timeliness of prenatal care (see above)												
	Colorectal cancer screening (see above)												

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
	PCPCH enrollment (see above)												
	*Developmental screening by 36 months (see above)												
	*Adolescent well child visits (see above)												
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Satisfaction with Care 2012 National Medicaid adult 75 th percentile: 83.19% 2012 National Medicaid child 75 th percentile: 84.71% National average:	Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Satisfaction with Care 2012 National Medicaid adult 75 th percentile: 83.19% 2012 National Medicaid child 75 th percentile: 84.71% National	Adult: 76% Child: 80% Avg: 87% High CCO: Adult: 81% Child: 86% Avg: 83% Low CCO: Adult: 65% Child:	Adult: 82.1% Child: 84.1% Avg: 83.1% High CCO: Avg: 88.2% Low CCO: Avg: 79.5%	N/A

Focus Area	Measure Sets					Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Final CY 2013	June 2013 - July 2014
							83.95%		average: 83.95%	72% Avg: 70%			
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							
Meaningful Use	EHR adoption See revised documentation online at www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx	√				√	28.0%	49.2% <i>2014 Federal benchmark for Medicaid.</i>	Minnesota Method	49.2%	State: 28.0% High CCO: 35% Low CCO: 12%	State: 59.0% High CCO: 77.2% Low CCO: 46.0% <i>As of April 2014</i>	State: <u>62.7%</u> High CCO: <u>100%</u> Low CCO: <u>52.1%</u> <u>As of Sept 2014</u>

*These measures are reported quarterly

**The Minnesota Department of Health’s Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year’s results and the performance target goal to qualify for incentive payments. For example, a health plan’s current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan’s baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment. Additional details on the MN method are available online at www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf.

Hospital Transformation Performance Program (HTPP) Measures Matrix

Hospital Measures	Waiver Measure Sets			Target Calculations		Targets		Reporting Mechanism
	Aligns with CCO Incentive	Aligns with State Quality & Access Test	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
Alcohol and drug misuse, screening, brief intervention, and referral for treatment (SBIRT) in the ED	√	√		Measure set broken down as follows: 1. Alcohol and Other Drug Use Screening in the ED – Patients in ED age 12+ screened for alcohol and other substance use using an age-appropriate, validated instrument. 2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who received a brief intervention.	Measure set broken down as follows: 1. Alcohol and Substance Use Screening in the ED – All ED patients age 12+. 2. Alcohol and Other Drug Use Brief Intervention Provided – ED patients age 12+ who screen positive for unhealthy alcohol or drug use.	1. MN method with a 3 percentage point floor 2. N/A – reporting only	1. Alignment with CCO benchmark (12%) 2. N/A – reporting only	OAHHS will collect and report to OHA
Follow-up after hospitalization for mental illness (modified NQF 0576)	√	√		Number of discharges for Medicaid members enrolled in a CCO at hospital of interest: <ul style="list-style-type: none"> • Age 6+ • Hospitalized for treatment of selected mental health 	Number of discharges from acute inpatient settings (including acute care psychiatric facilities) at hospital of interest for Medicaid members enrolled in a CCO: <ul style="list-style-type: none"> • Age 6+ 	MN method with 3 percentage point floor	Alignment with CCO benchmark (National Medicaid 90 th percentile, 68.8%)	OHA MMIS – OHA will calculate rates for this measure through encounters/claims

Hospital Measures	Waiver Measure Sets			Target Calculations		Targets		Reporting Mechanism
	Aligns with CCO Incentive	Aligns with State Quality & Access Test	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
				disorders <ul style="list-style-type: none"> With an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of discharges 	<ul style="list-style-type: none"> Who were hospitalized for treatment of selected mental health disorders 			
Hospital-Wide All-Cause Readmissions		√		Number of readmissions, defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date.	Number of all inpatient discharges (for patients of all ages)	MN method with a 1 percentage point floor	State 90 th percentile for all hospital types	OAHHS will calculate and report to OHA
Hypoglycemia in inpatients receiving insulin (American Society of Health Systems Pharmacist Safe Use of Insulin measure)			√	Number of inpatients with hypoglycemia (blood glucose of 50mg per dl or less)	Number of inpatients receiving insulin during the tracked time period	MN method with 1 percentage point floor	7% or below	OAHHS will collect and report to OHA
Excessive anticoagulation with Warfarin (Institute for Safe Medication Practices measure)			√	Number of patients experiencing excessive anticoagulation (INR > 6)	Number of inpatients receiving warfarin anticoagulation therapy during tracked period	MN method with 1 percentage point floor	5% or below	OAHHS will collect and report to OHA
Adverse Drug Events due to opioids (Institute for Safe Medication Practices measure)			√	Number of patients treated with opioids who also received naloxone	Number of patients who received an opioid agent during tracked period	MN method with 1 percentage point floor	5% or below	OAHHS will collect and report to OHA

Hospital Measures	Waiver Measure Sets			Target Calculations		Targets		Reporting Mechanism
	Aligns with CCO Incentive	Aligns with State Quality & Access Test	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
HCAHPS, Staff always explained medicines (NQF 0166) ⁶			√	<p>Number of patients answering 'always' to Q16 and Q17:</p> <p>Q16: Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?</p> <p>Q17: Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?</p>	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor	National 90 th percentile (72%, April 2014)	OAHHS will collect and report to OHA
HCAHPS, Staff gave patient discharge information (NQF 0166) ²			√	<p>Number of patients answering 'Y' to Q19 and Q20:</p> <p>Q19: During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?</p> <p>Q20: During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?</p>	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor	National 90 th percentile (90% in April 2014)	OAHHS will collect and report to OHA

6 Note that the Child HCAHPS survey is under development. Therefore, Shriner's Hospital for Children is unable to field an HCAHPS survey. Instead, it uses the Press Ganey Inpatient Pediatric Survey. Shriner's performance on staff providing discharge information is therefore assessed against a similar question included in the Press Ganey Inpatient Pediatric Survey. The Press Ganey survey does not have a question about staff explaining medications, so Shriner's is not eligible for the HCAHPS staff explaining medication measure.

Hospital Measures	Waiver Measure Sets			Target Calculations		Targets		Reporting Mechanism
	Aligns with CCO Incentive	Aligns with State Quality & Access Test	Hospital Specific (Not CCO)	Numerator	Denominator	Improvement from Baseline Target	Benchmark	
CLABSI in all tracked units (modified NQF 0139)			√	Total number of CLABSI in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	Total number of central line days in all tracked units (adult ICU, pediatric ICU, NICU, and adult, pediatric, medical, surgical, and medical/surgical wards)	TBD MN method	TBD after review of baseline data from Year 1 of program	OAHHS will collect and report to OHA
CAUTI in all tracked units (modified NQF 0754)			√	Total number of healthcare-associated CAUTIs in all tracked units as defined or accepted by NHSN.	Total number of catheter days for all patients that have an indwelling urinary catheter in all tracked units as defined or accepted by NHSN.-	TBD MN method	TBD after review of baseline data from Year 1 of program	OAHHS will collect and report to OHA
Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits			√	<p>1. Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months</p> <p>2. Number of care guidelines completed for patients with 5+ ED visits in past 12 months who did not previously have a care guideline</p>	<p>1. Number of patients with five+ ED visits in the past 12 months</p> <p>2. Number of patients without a care guideline with five+ ED visits in the past 12 months</p>	<p>1. TBD</p> <p>2. N/A – reporting only</p>	<p>1. TBD after review of baseline data from Year 1 of program</p> <p>2. N/A – reporting only</p>	OAHHS will collect and report to OHA