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

Oregon Health Authority

Oregon HEALTH PLAN

Table of Contents

I. Introduction **2**
A. Letter from the State Medicaid Director 2
B. Demonstration description 3
C. State contacts 4
II. Title **5**
III. Events affecting health care delivery **5**
A. Overview of significant events across the state 5
B. Complaints and grievances 5
C. Appeals and hearings 9
D. Implementation of 1% withhold 12
E. Statewide workforce development 13
F. Table 5- Significant CCO/MCO network changes during current quarter 18
G. Transformation Center 19
H. Legislative activities 27
I. Litigation status 27
J. Two-percent trend data 27
K. DSHP terms and status 27
IV. Status of Corrective Action Plans (CAPs) **28**
Table 8 – Status of CAPs 28
V. Evaluation activities and interim findings **28**
Table 9 - Evaluation activities and interim findings 28
VI. Public Forums **34**
Public comments received 34
VII. Transition Plan, Related to Implementation of the Affordable Care Act **34**
VIII. Appendices **34**
Appendix A. Quarterly enrollment reports 34
Appendix B. Neutrality reports 35
Appendix C. Two-percent trend reduction tracking 36
Appendix D. DSHP tracking 36
Appendix E. Oregon Measures Matrix 36

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 an 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
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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	No	No	Yes	Yes
D. Quality of care – CCO / MCO / FFS	No	No	Yes	Yes
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.

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

Coordinated Care Organization	Total Complaints/ Grievances Received	Enrollment as of 12/31/2014	Per 1000 Members
AllCare Health Plan, Inc.	54	48,568	1.11
Cascade Health Alliance	41	17002	2.41
Columbia Pacific CCO, LLC	81	28068	2.89
Eastern Oregon CCO, LCC	51	44801	1.14
FamilyCare CCO	94	114,893	0.82
Health Share of Oregon	641	233802	2.74
Intercommunity Health Network	27	55498	0.49
Jackson Care Connect	58	30022	1.93
PacificSource Community Solutions	66	50876	1.30
PacificSource Community Solutions – Gorge	2	12244	0.16
PrimaryHealth of Josephine County CCO	4	11054	0.36
Trillium Community Health Plan	240	89237	2.69
Umpqua Health Alliance, DCIPA	19	25195	0.75
Western Oregon Advanced Health	98	20606	4.76
Willamette Valley Community Health	17	101726	0.17
Yamhill County Care Organization	31	23950	1.29

The following chart shows the total number of complaints and grievances by category, and the range of complaints and grievances received by CCOs for each category.

Complaint or grievance type	Number reported	Range reported by CCOs
ELIGIBILITY AND ENROLLMENT	2431	4-210
ACCESS TO PROVIDERS AND SERVICES		
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	106	1-42
b) Plan unresponsive, not available or difficult to contact for appointment or information.	26	0-16
c) Provider's office too far away, not convenient	24	0-13
d) Unable to schedule appointment in a timely manner.	55	0-21
e) Provider's office closed to new patients.	20	0-13
f) Referral or 2nd opinion denied/refused by provider.	25	0-8
g) Unable to be seen in a timely manner for urgent/ emergent care	12	0-3
h) Provider not available to give necessary care	46	0-15
i) Eligibility issues	13	0-5
j) Client fired by provider	21	0-7
k) Availability of specialty provider	4	0-3
INTERACTION WITH PROVIDER OR PLAN		
a) Provider rude or inappropriate comments or behavior	208	0-32
b) Plan rude or inappropriate comments or behavior	19	0-11
c) Provider explanation/instruction inadequate/incomplete	107	0-57
d) Plan explanation/instruction inadequate/incomplete	44	0-23
e) Wait too long in office before receiving care	21	0-14
f) Member dignity is not respected	31	0-13
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.	6	0-2
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	3	0-2
i) Lack of coordination among providers	24	0-5
CONSUMER RIGHTS		
a) Provider's office has a physical barrier	1	0-1
b) Abuse, physical, mental, psychological	4	0-1
c) Concern over confidentiality	22	0-13

Complaint or grievance type	Number reported	Range reported by CCOs
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	68	0-23
e) No choice of clinician	10	0-3
f) Fraud and abuse	1	0-1
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	7	0-2
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)	2	0-1
i) Differential treatment for Medicaid clients	12	0-6
j) Lack of adequate or understandable NOA	2	0-1
k) Not informed of consumer rights	1	0-1
l) Complaint and appeal process not explained	0	
m) Denied member access to medical records	3	0-1
CLINICAL CARE		
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	104	0-54
b) Testing/assessment insufficient, inadequate or omitted	40	0-15
c) Medical record documentation issue	18	0-5
d) Concern about prescriber or medication or medication management issues	123	0-46
e) Unsanitary environment or equipment	5	0-3
f) Lack of appropriate individualized setting in treatment	5	0-4
QUALITY OF SERVICE		
a)Client feels unsafe/uncomfortable	18	0-10
b) Delay, quality of materials and supplies (DME) or dental	41	0-14
c) Lack of access to ENCC for intensive care coordination or case management services	3	0-2
d) Benefits not covered	41	0-17
CLIENT BILLING ISSUES		
a) Co-pays	7	0-2
b) Premiums	0	0
c) Billing OHP clients without a signed Agreement to Pay	185	0-117

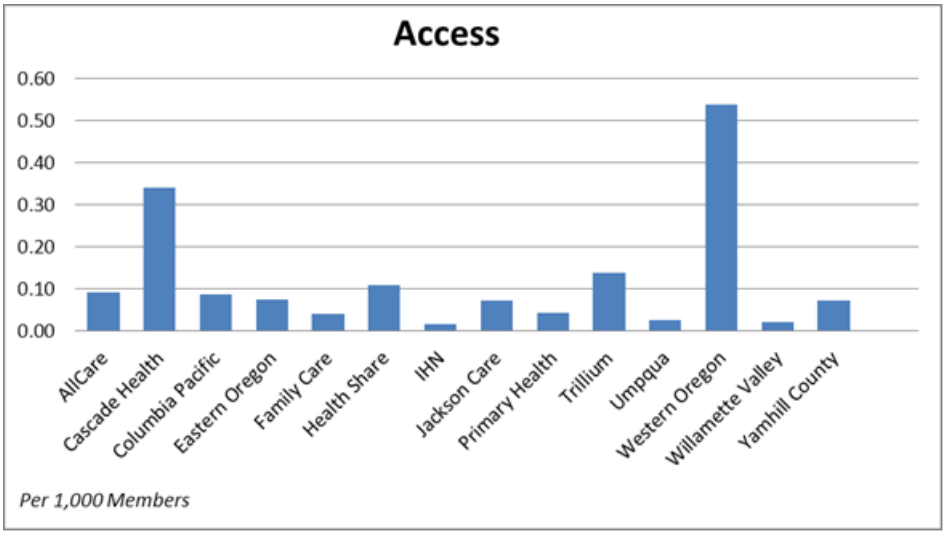
Trends related to complaints and grievances

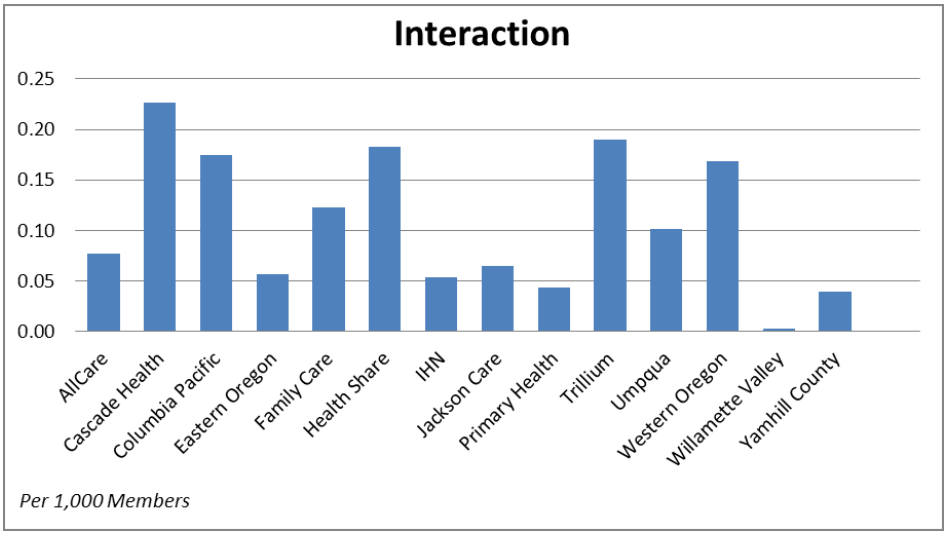
The last quarter of 2014 had a total complaint and grievance trend rate of 0.17 to 4.76 per 1000 members.

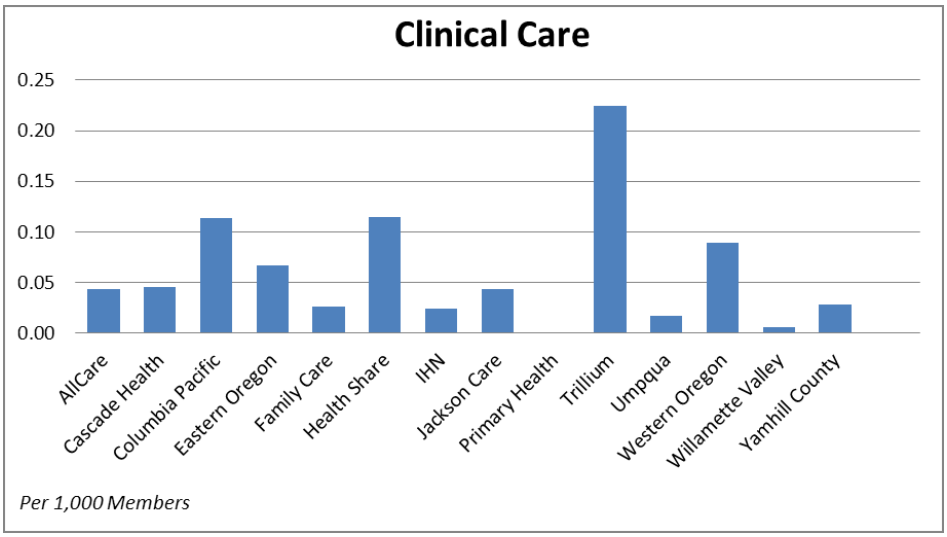
Areas of highest trend and range were seen in *Access to Provider and Services*, *Interactions with the Plan and Provider*, and *Clinical Care*. Sub category drivers under each of these categories included:

- Access to Provider and Services - Provider's office unresponsive, not available, difficult to contact for appointment or information
- Interactions with Providers and Plan - Provider rude or inappropriate comments or behavior
- Clinical Care - Concern about prescriber or medication or medication management issues

The following charts break down Access, Interaction and Clinical Care complaints and grievance rates by plan.





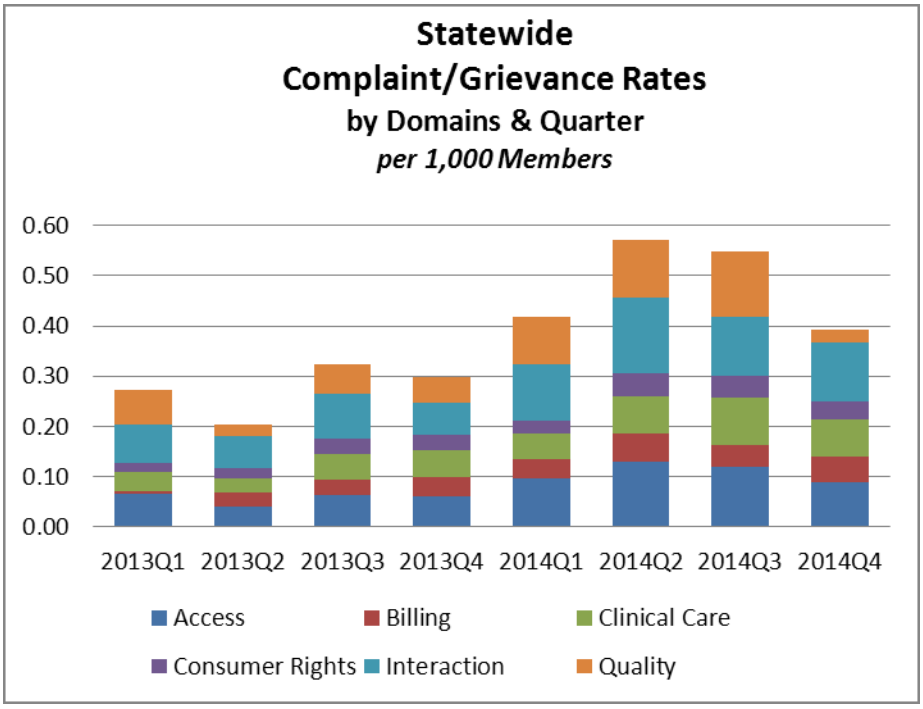


In reviewing the 4th quarter individual data, a review of the past seven quarters was included in the analysis.

As shown below, the overall number of complaints has increased over the last 5 quarters, which appears to align with the increase and movement of members:

- First, throughout 2013 as OHP enrollees were enrolled into CCOs, and
- Again through additional Medicaid expansion in the first and second quarter of 2014.

Beginning with the third quarter of 2014, there has been a decline in total complaints. Client movement among plans has stabilized and may be a factor in this decline.



Quality of care complaints had a spike during the beginning of 2014, but have declined in the last quarter of 2014. Hearings and quality of care reviews completed by the plans and the state have not identified trends in adverse events and negative outcomes related to quality of care complaints. Billing has remained at a steady range.

Interventions

To address access of care issues, several plans have initiated outreach efforts, worked with providers to open up primary care access and adjusted member services staffing to adjust to the increase in members. Two plans have had consistently high billings complaints. These plans are working with OHA to review their processes and address best practices going forward.

Access complaints reported by the plans have been reviewed and compared to calls entering into the state call system. Two plans had a potential discrepancy in the numbers reported and the state numbers received. OHA is working with these plans to address these differences to identify if access concerns are present.

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

The following chart lists the total appeals submitted by CCO members following receipt of CCO Notices of Action (NOAs). A breakdown, by reason and CCO, of all NOAs issued during the reporting period is attached separately.

	CCO Appeals						Contested Case Hearings from CCO Appeals					
	Total		Overturned at plan level		Decisions Pending		Total		Overturned at hearing		Decisions Pending	
Category	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
a) Denial or limited authorization of a requested service	1677	25-352	479	3-145	12	0-7	774	0-123	*See graph below		21	0-7
b) Single PHP service area, denial to obtain services outside the PHP panel	14	0-6	4	0-1	-	-	-	-	-	-	-	-
c) Termination, suspension or reduction of previously authorized covered services	65	0-57	10	0-6	-	-	-	-	-	-	-	-
d) Failure to act within the timeframes provided in §438.408(b)	0	0	0	0	-	-	-	-	-	-	-	-
e) Failure to provide services in a timely manner, as defined by the State	0	0	0	0	-	-	-	-	-	-	-	-
f) Denial of payment for a service rendered	296	0-96	76	0-30	-	-	-	-	-	-	-	-
TOTALS	2052	-	569	-	12	-	774	-	*	-	21	-

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.

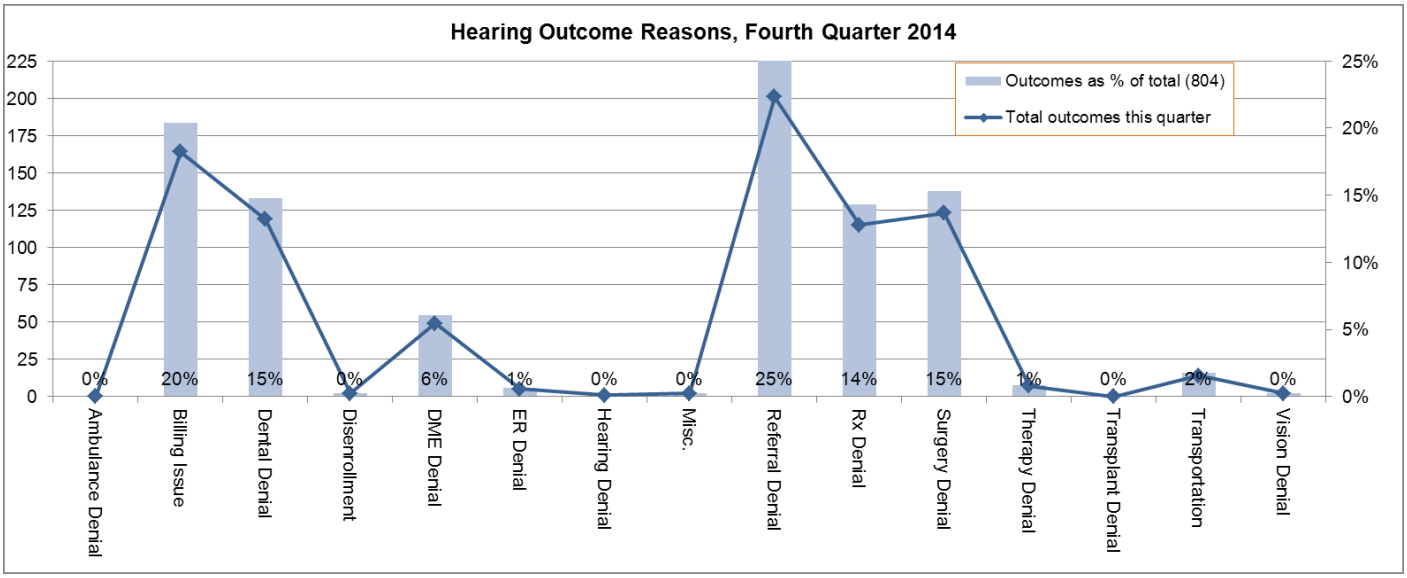
- They reflect hearing requests submitted to OHA by members of the following plans.
- They do not reflect appeal requests submitted to plans.

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

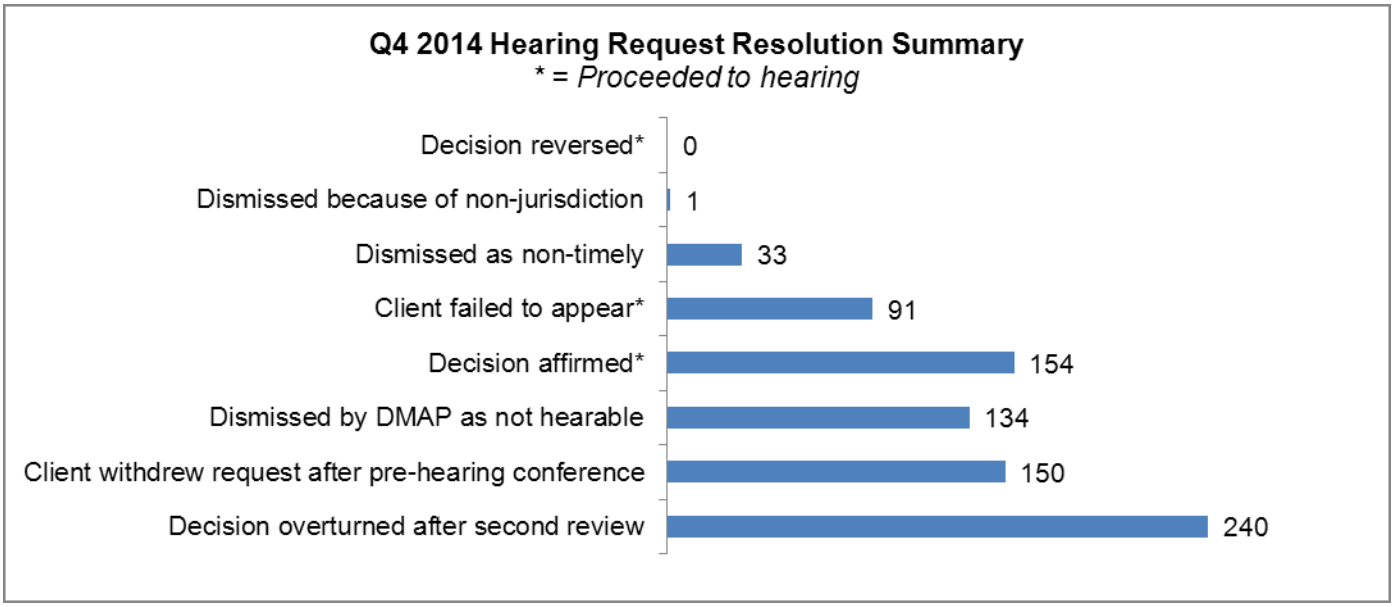
Plan Name	Total Received	Average Enrollment*	Per 1000 Members
Kaiser Permanente OR Plus, LLC	6	2,125	2.8235
PacificSource Community Solutions	105	51,438	2.0413
PacificSource Community Solutions – Gorge		12,395	
PrimaryHealth of Josephine County CCO	14	10,845	1.2909
Trillium Community Health Plan	53	73,718	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.



Interventions

A breakdown, by reason and CCO, of all NOAs issued during the reporting period is attached separately. OHA will be working with the CCOs to identify areas around NOAs that may help reduce the number of appeals and hearings requested by CCO members. For example, researching the individual drivers for each NOA category may help OHA and CCOs identify best practices.

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: ■ 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: ■ Total by CCO ■ Average/mean PMPM incentive ■ The over/under 100% of capitation rate by CCO and by average enrollee PMPM	X	X

Metric	Frequency	
	Quarterly	Annually
Best accounting of the flexible services provided broken out by: ■ Services that are not Medicaid state plan services but DO have encounter data (e.g., alternative providers) ■ Services that are not reflected in encounter data (e.g., air-conditioners, sneakers)	X	X
CCO sub-contractual payment arrangements – narrative ■ Description of innovative (i.e., non-FFS) reimbursement and incentive arrangements between CCOs and sub-contracted service delivery network		X
Encounter data analysis ■ 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

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 • AllCare 10/1/2014 • CHA 10/1/2014 • Jackson Care Connect 10/1/2014 NEMT integration saw no change	Integrated NEMTs	New brokerage (Ready Ride) for AllCare members	3	50,000 AllCare members

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

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

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

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

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

Other	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
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.

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/cci.

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 newTransformation 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	■ 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 innovations[1]

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 innovations[2]

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.

[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.

Interim findings:	As of December 2014, there were 535 recognized clinics in the state (surpassing Oregon's goal of 500 by 2015). 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. ■ 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.
Improvement activities:	Oregon's Patient-Centered Primary Care Institute provides technical support and transformation resources to practices statewide, including learning collaborative opportunities. In this quarter, the Institute conducted 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. The Institute also held five webinars: ■ 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) 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.

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

Evaluation activities:	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 programat 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). 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): ■ The CCO Metrics and Scoring Committee selected the 2015 benchmarks for most incentive measures. ■ The Technical Advisory Group finalized the 2015 measure specifications.

Interim findings:	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): ■ 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). Note: These data should be treated as preliminary as OHA is working with the CCOs to improve reporting of APMs and flexible services.
Improvement activities:	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. 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. The state-sponsored Coordinated Care Model summit included a break-out session in which a selection of CCOs presented on their experiences implementing APMs.

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

Evaluation activities:	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: ■ The extent of integration implementation; ■ The strategies and resources used; ■ Successes and barriers to further development; and ■ How OHA might best support these efforts. Current findings are below.
Interim findings:	Initial findings from the environmental scan show that: ■ 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. 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:

	■ SBIRT increased from 0.0 to 4.5 percent, below the 13.0 percent benchmark[4] (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:	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. 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). ■ 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:	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.
Interim findings:	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). Promising findings: ■ 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. Areas for improvement: ■ Access to primary care providers (PCP) for children and adolescents (measured

4 Benchmarks noted are those for 2014.

	as the proportion with a visit with a PCP) declined and was below the benchmark for all ages. ■ 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.
Improvement activities:	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. ■ 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. 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. 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. ■ 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

Evaluation activities:	Analysis of the CCO financial reports has shown a relatively low level of flexible service provision (though this varied across the CCOs). These data are being tracked each quarter to understand the level of flexible service provision at an aggregate level.
Interim findings:	None at this time.

Improvement activities:	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. 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.

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

Evaluation activities:	The formative evaluation of the Transformation Center continued 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. 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. Findings from the Transformation Center's ongoing, internal process for rapidly evaluating the effectiveness of its learning collaboratives are below.
Interim findings/ Improvement activities:	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). The Transformation Center now hosts seven external learning collaboratives (an eighth internal learning collaborative for the CCO Innovator Agents also exists): (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). 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. 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. From October – December 2014 the Transformation Center held 11 learning collaborative sessions for the external learning collaboratives, attended by an average of 24 people. ■ 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.

	■ The sessions were a mix of teleconferences, in-person sessions, and webinars. Topics ranged from *Community Health*" to *APMs and Incentive Metrics*. Results from the Transformation Center's internal evaluation of the effectiveness of the learning collaboratives shows that: ■ 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. 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: ■ 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 *CAC 101* PowerPoint presentation on health system transformation to assist in CAC member engagement and training.

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

		Coordinated Care				Physical Health	Dental Care	Mental Health
OHP Eligibles*		**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% *2014 national Medicaid 75th percentile (administrative data only)*
Alcohol and drug misuse (SBIRT)	12% *Metrics Technical Advisory Workgroup recommendation, weighted to accommodate inclusion of adolescents.*
Ambulatory care: emergency department utilization	39.4/1,000 member months *2014 national Medicaid 90th percentile*
CAHPS composite: access to care	87.2% *2014 national Medicaid 75th percentile; weighted average of adult and child rates.*
CAHPS composite: satisfaction with care	89.6% *2014 national Medicaid 75th percentile; weighted average of adult and child rates.*
Colorectal cancer screening	47.0% *Metrics & Scoring Committee consensus*
Controlling hypertension	64.0% *2014 national Medicaid 75th percentile*
Dental sealants on permanent molars for children	20.0% *Metrics & Scoring Committee consensus; based on national EPSDT data and Healthy People 2020 goals*
Depression screening and follow up	25.0% *Metrics & Scoring Committee consensus*
Developmental screening	50.0% *Metrics & Scoring Committee consensus*
Diabetes: HbA1c poor control	34.0% *2014 national Medicaid 75th percentile*
Effective contraceptive use	50.0% *Metrics & Scoring Committee consensus*
Electronic Health Record adoption	72% *Metrics & Scoring Committee consensus*
Follow up after hospitalization for mental illness	70.0% *2014 national Medicaid 75th percentile*
Mental, physical, and dental health assessments for children in DHS custody (foster care)	90.0% *Metrics & Scoring Committee consensus*
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% *2014 national Medicaid 75th percentile*

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

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.

- 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	Q Corp conducted this test entirely, independently calculating and validating all measures included in the composite. However, because Q Corp can only independently calculate claims-based measures, less than half of the measures were included in the composite.	15	153.7%
2	Q Corp and OHA jointly conducted this test. Q-Corp independently calculated and validated the 15 claims-based measures included in the composite; OHA calculated the remaining non-claims based measures.	25	114.3%
3	OHA conducted this test entirely; OHA produced all measures included in the composite. 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). OHA produced all other data reported in Appendix E.	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.

	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting		
Focus Area	**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 coordina-tion	*Alcohol or other substance misuse (SBIRT)	√	√			√	0.02%	13% Metrics & Scoring Committee consensus	MN method	13% Metrics & Scoring Committee consensus	State: 0.02% High CCO: 0.22% Low CCO: 0.0%	State: 2.0% High CCO: 8.7% Low CCO: 0.0%	State: 4.5% High CCO: 15.7% Low CCO: 0.1%
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90th percentile	MN method with 3% floor.	68.0% 2012 National Medicaid 90th percentile	State: 65.2% High CCO: 88.9% Low CCO:	State: 67.6% High CCO: 81.0% Low CCO:	State: 68.3% High CCO: 77.3% Low CCO: 44.2%

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	N/A
	*Mental and physical health assessment within 60 days for children in DHS custody	√	√				53.6%	90% Metrics & Scoring Committee consensus	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%	State: 66.9% High CCO: 97.2% Low CCO: 50.0%
	*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 90th percentile	MN method	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90th percentile	Initiation: State: 52.3% High CCO: 88.9% Low CCO: 33.3% C&M:	Initiation: State: 53.3% High CCO: 70.8% Low CCO: 43.5% C&M:	Initiation: State: 57.7% High CCO: 80.0% Low CCO: 49.3% C&M will be available in

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 75th percentile: (adjustment factor applied to account for difference between admin data and hybrid rates)	MN method with 3% floor.	69.4% 2012 National Medicaid 75th 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 75th percentile (adjustment factor applied)			High CCO: 47.1% Low CCO: 22.6%	This measure cannot be reported at the CCO level for 2013.	measure when hybrid data are available following the end of the CY 2014 measure period.
	PC-01: Elective delivery (NQF 0469) *Lower score is better.*	√		√		√	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-hospitaliza	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90th	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	June 2013 – July 2014
-tions								percentile		90th percentile	88.9% Low CCO: 57.1%	81.0% Low CCO: 51.2%	77.3% Low CCO: 44.2%
	*Ambulatory Care: Outpatient (OP) and Emergency Department (ED) utilization. *Lower score is better for ED utilization.*	√	√		√	√	ED: 61.0/ 1,000mm OP: 364.2/ 1,000mm	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90th percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90th 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: 50.5/1,000 mm High CCO: 74.3/1,000 mm Low CCO: 31.6/1,000 mm **OP** State: 323.5/1,00 0mm High CCO: 345.7/1,00 0mm Low CCO:	**ED** State: 48.1/1,000 mm High CCO: 69.1/1,000 mm Low CCO: 33.1/1,000 mm **OP** State: 304.3/1,000 mm High CCO: 349.8/1,000 mm Low CCO: 250.6/1,000

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	June 2013 – July 2014
											296.6/ 1,00mm	267.4/1,000mm	mm
	*Plan all-cause readmission (NQF 1768) *Lower score is better.*		√		√	√	12.3%	10.5% Average of Commercial and Medicare 75th 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: 11.5% High CCO: 14.4% Low CCO: 7.3%
Ensuring appropriate care is delivered in appropriate settings	*Ambulatory Care: Outpatient and ED utilization *Lower score is better for ED utilization.*	√	√		√	√	ED: 61.0/ 1,000mm OP: 364.2/ 1,000mm	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90th percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90th percentile	**ED** State: 61.0/ 1,000mm High CCO: 86.2/ 1,000mm Low CCO: 55.4/ 1,000mm **OP** State:	**ED** State: 50.5/1,000 mm High CCO: 74.3/1,000 mm Low CCO: 31.6/1,000 mm **OP** State:	**ED** State: 48.1/1,000 mm High CCO: 69.1/1,000 mm Low CCO: 33.1/1,000 mm **OP** State: 304.3/1,000

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	June 2013 – July 2014
											364.2/ 1,000mm High CCO: 412.3/ 1,000mm Low CCO: 296.6/ 1,00mm	323.5/1,000mm High CCO: 345.7/1,000mm Low CCO: 267.4/1,000mm	mm High CCO: 349.8/1,000 mm Low CCO: 250.6/1,000 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	June 2013 – July 2014
	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: 80.4% High CCO: 97.8% Low CCO: 60.9%
	* 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: 35.2% High CCO: 64.4% Low CCO: 20.1%

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 90th 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 75th percentile (admin data only)	MN method with 3% floor.	53.2% 2011 National Medicaid 75th 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 75th 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 75th 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: 55.3% High CCO: 64.1% Low CCO: 34.7%
	Appropriate testing for children with pharyngitis (NQF 0002)				√	√	73.7%	76.0% 2012 National Medicaid 75th 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: 73.4% High CCO: 87.0% Low CCO: 35.7%
	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 90th 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:	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
							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% Component 3: 56.6%			1: 61% 2: 34% 3: 27% Low CCO: 1:45% 2: 19% 3: 16%	1: 61.5% 2: 41.9% 3: 30.1% Low CCO: 1: 43.9% 2: 16.8% 3: 17.8%	
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	June 2013 – July 2014
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 90th percentile		OP: 439/ 1,000mm 2011 National Medicaid 90th 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/ 1,00mm	mm High CCO: 74.3/1,000 mm Low CCO: 31.6/1,000 mm **OP** State: 323.5/1,000mm High CCO: 345.7/1,000mm Low CCO: 267.4/1,000mm	mm High CCO: 69.1/1,000 mm Low CCO: 33.1/1,000 mm **OP** State: 304.3/1,000 mm High CCO: 349.8/1,000 mm Low CCO: 250.6/1,000 mm
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 75th 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: 74.5% High CCO: 80.4% Low CCO: 66.3%
	*Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	78.5%	86% 2012 National Medicaid 75th 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: 82.7% High CCO: 85.3% Low CCO: 75.6%
	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: 174.9 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	June 2013 – July 2014
	0272) *Lower is better*						years				109.0 High CCO: 360.8	16.7 High CCO: 417.3	57.6% High CCO: 370.6%
	*PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) *Lower is better*		√	√		√	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	State: 234.0 Low CCO: 103.7 High CCO: 447.3
	*PQI 08: Congestive heart failure admission rate (NQF 0277) *Lower is better*		√	√		√	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	State: 223.7 Low CCO: 86.0 High CCO: 408.5
	*PQI 15: Adult asthma admission rate		√	√		√	53.4 / 100,000 member	10% reduction	n/a	n/a	State: 53.4	State: 43.6	State: 32.5

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 0283) *Lower is better*						years	from baseline			Low CCO: 16.1 High CCO: 180.3	Low CCO: 0.0 High CCO: 70.2	Low CCO: 0.0 High CCO: 54.4
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%	**Access to Care** 2012 National Medicaid adult 75th percentile: 83.63% 2012 National Medicaid child 75th 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 75th percentile: 83.63% 2012 National Medicaid child 75th percentile: 90.31% National average: 86.97%	**Access to Care** Adult: 79% Child: 87% Avg: 83% High CCO: Adult: 85% Child: 94% Avg: 90% Low CCO: Adult: 73% Child: 81%	**Access to Care** Adult: 80.1% Child: 87.1% Avg: 83.6% High CCO: Avg: 88.3% Low CCO: Avg: 80.4%	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
											Avg: 81% *Note: OHA cannot report on all CCOs for this measure – CAHPS 2011 was sampled for old managed care orgs – not current CCOs.*		
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√							
	Chlamydia screening in women ages 16-24 (NQF 0033)			√	√	√	59.9%	63.0% 2012 National Medicaid 75th	n/a	n/a	State: 59.9% High	State: 54.4% High	State: 57.4% 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% Low CCO: 49.6%	CCO: 62.3% Low CCO: 41.5%	64.7% Low CCO: 46.6%
	*Cervical cancer screening (NQF 0032)			√		√	56.1%	74.0% 2012 National Medicaid 75th percentile	n/a	n/a	State: 56.1% High CCO: 59.8% Low CCO: 47.5%	State: 53.3% High CCO: 58.9% Low CCO: 40.5%	State: 55.8% High CCO: 61.8% Low CCO: 42.9%
	*Child and adolescent access to primary care practitioners (NCQA)				√	√	12-24 mos 97.4% 25 mos – 6 years 86.2% 7-11 yrs 88.2% 12-19 yrs 88.9%	12-24 mos 98.2% 25 mos – 6 years 91.6% 7-11 yrs 93.0% 12-19 yrs	n/a	n/a	**12-24 mos** State: 97.4% High CCO: 99.0% Low CCO: 96.2% **25 mos – 6 years**	**12-24 mos** State: 96.4% **25 mos-6 years** State: 84.3% **7-11 yrs** State:	**State:** **12-24 mos:** 95.1% **25 mos – 6 years:** 83.2% **7-11 years:** 86.7% **12-19**

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 75th 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.	years: 87.3% All ages: 86.4%

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
	Provider Access Questions from the Physician Workforce Survey: 1) To what extent is your primary practice accepting new Medicaid/OHP patients? (include: completely closed, open with limitations, and no limitations). 2) Do you currently have Medicaid/OHP patients under your care? 3) What is the current payer mix at your primary practice?					√	In 2012: 86.3% of Oregon's physicians accepted new Medicaid patients with no or some limitations 86.9% of physicians have Medicaid patients. Medicaid/ OHP represented 17% of current	TBD	n/a	n/a	In 2012: 1) 86.3 % 2) 86.9 % 3) 17% Baseline revised to include all providers, not just PCPs. This measure cannot be reported by CCO.	N/A. OHA is fielding a physician workforce survey in 2014 to be able to report on this measure.	In 2014: 1) 94.3% 2) 88.9% 3) 23%

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)												
	*Developmen-tal 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 75th percentile: 83.19% 2012 National Medicaid child 75th 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 75th percentile: 83.19% 2012 National Medicaid child 75th 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% *2014 Federal benchmark for Medicaid.*	Minnesota Method	49.2%	State: 28.0% High CCO: 35% Low CCO: 12%	State: 59.0% High CCO: 77.2% Low CCO: 46.0% *As of April 2014*	State: 62.7% High CCO: 100% Low CCO: 52.1% *As of Sept 2014*

*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 quality 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: • 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: • Age 6+	MN method with 3 percentage point floor	Alignment with CCO benchmark (National Medicaid 90th 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 • With an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of discharges	• 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 90th 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]			√	Number of patients answering 'always' to Q16 and Q17: **Q16:** Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? **Q17:** Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor	National 90th percentile (72%, April 2014)	OAHHS will collect and report to OHA
HCAHPS, Staff gave patient discharge information (NQF 0166)[2]			√	Number of patients answering 'Y' to Q19 and Q20: **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? **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?	Number of clients with number of valid responses >=2 for same domain	MN method with 2 percentage point floor	National 90th 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			√	1. Number of outreach notifications to primary care providers for patients with 5+ ED visits in past 12 months 2. Number of care guidelines completed for patients with 5+ ED visits in past 12 months who did not previously have a care guideline	1. Number of patients with five+ ED visits in the past 12 months 2. Number of patients without a care guideline with five+ ED visits in the past 12 months	1. TBD 2. N/A – reporting only	1. TBD after review of baseline data from Year 1 of program 2. N/A – reporting only	OAHHS will collect and report to OHA