

# Oregon Health Plan

## Section 1115 Quarterly Report



1/1/2014 – 3/31/2014

Demonstration Year (DY): 12 (7/1/2013 – 6/30/2014)

Demonstration Quarter (DQ): 3/2014

Federal Fiscal Quarter (FQ): 2/2014





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## I. Introduction

### A. Letter from the State Medicaid Director

Over 350,000 people joined the Oregon Health Plan (OHP) during this first quarter of Affordable Care Act (ACA) implementation, bringing us closer to our goal of improving health for all Oregonians. The Oregon Health Authority (OHA) also worked with dental care organizations (DCOs) and coordinated care organizations (CCOs) to integrate dental care into CCO service delivery for over 135,000 OHP households, helping us meet the goal of improving health care through increased coordination.

CCOs continue to meet the Administrative Performance standard in their reporting of accurate and complete encounter data, so that no 1% withholds occurred.

Statewide workforce development made great strides with the approval of several new training programs, and training of over 200 potential Traditional Health Workers (THWs). OHA's Office of Equity and Inclusion (OEI) continued extensive education to stakeholders about the THW program.

The number of new OHP members this quarter exceeded expectations, and OHA rose to meet the challenge of ensuring continuity of care for this new population. The Division of Medical Assistance Programs (DMAP) worked with CCOs/plans to make sure member enrollment did not exceed each CCO's capacity.

The Transformation Center also continued to support CCOs in the following ways:

- The CCO Learning Collaborative educated on developmental screening, and coordinated care for children in foster care.
- The Community Advisory Council Learning Collaborative provided guidance about community health improvement plans and language access for clients with Limited English Proficiency.
- The Complex Care Learning Collaborative focused on trauma-informed care.
- The IHI Improvement Science in Action Learning Collaborative launched, to help CCOs create and implement measures for Transformation Fund projects.
- Innovator Agents continued training, outreach and partnership with CCOs and OHA staff, collecting best practices and ideas for the Good Ideas Bank (formerly known as the Transformation Bank).

Work began on the midpoint evaluation of the current demonstration. This quarter, we also found that:

- As of March 2014, 502 Patient-Centered Primary Care Homes (PCPCHs) have been recognized statewide, exceeding our 2013 goal of 500 recognized PCPCHs.
- CCOs delivered their Year One Technology Plans to build their capacity to collect data for their three clinical metrics. 7 CCOs were approved this quarter.

In public forums held this quarter, major themes included collaboration, community, and pooling resources. It is a pleasure to see that within OHA and Oregon communities, the drive to improve the health of all Oregonians provides so much common ground.



*Judy Mohr Peterson, PhD.*

*Director, Division of Medical Assistance Programs, Oregon Health Authority*

## 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.

## Oregon Health Authority

- **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.

### C. State contacts

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## II. Title

Oregon Health Plan Section 1115 Quarterly Report  
1/1/2014 – 3/31/2014  
Demonstration Year (DY): 12 (7/1/2013 – 6/30/2014)  
Demonstration Quarter (DQ): 3/2014  
Federal Fiscal Quarter (FQ): 2/2014

### 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	No
B. Benefits	Yes	Yes	No	No
C. CCO Complaints and Grievances	No	No	No	Yes
D. Quality of care – CCO / MCO / FFS	No	No	No	Yes
E. Access	No	Yes	Yes	Yes
F. Provider Workforce	No	No	No	Yes
G. CCO networks	No	No	Yes	Yes

#### Detail on impacts or interventions

During this quarter, over 350,000 MAGI-eligible individuals enrolled in the Oregon Health Plan, bringing the total OHP population to more than 950,000 people, with 87 percent enrolled in a CCO (see [Appendix A](#) for enrollment details).

Effective January 1, 2014, the OHP Standard benefit package was eliminated. All OHP eligibles now receive OHP Plus benefits.

In March, OHA made a new [Service Denial Appeal and Hearing Request Form and Notice of Action template available to CCOs/plans](#). For other CCO Complaints and Grievances impacts and interventions, please see Tables 2 and 2.1.

For quality of care, OHA is working with remaining managed care organizations (MCOs) to evaluate access and impact on fee-for-service (FFS) clients across physical, behavioral health and dental care.

Due to the large number of newly-eligible CCO members, OHA has worked to address access to care concerns by collaborating with CCOs and providers on specific interventions; please see the narrative in [Section B](#) for details.

Provider workforce development continued with the approval of several training programs, with many traditional health workers (THWs) trained and progressing toward certification. Please see [Section E](#) for details on this progress.

During this quarter, more than 135,000 households receiving services from a dental care organization (DCO) moved to a CCO providing dental care. Please see [Table 5](#) for details about the specific network changes that took place to support this and other 2014 changes.

## 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.

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
ELIGIBILITY AND ENROLLMENT	1914	Yes <sup>1</sup>	1914	Yes*	1-340
<b>ACCESS TO PROVIDERS AND SERVICES</b>					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	71	No	73 <sup>2</sup>	No	2-34
b) Plan unresponsive, not available or difficult to contact for appointment or information.	22	No		No	0-9
c) Provider's office too far away, not convenient	18	No		No	0-10
d) Unable to schedule appointment in a timely manner.	80	Yes		Yes	0-24
e) Provider's office closed to new patients.	28	Yes		Yes	0-13
f) Referral or 2nd opinion denied/refused by provider.	13	No		No	0-6
g) Unable to be seen in a timely manner for urgent/ emergent care	8	No		No	0-2
h) Provider not available to give necessary care	47	Yes		Yes	0-27
i) Eligibility issues	24	Yes		Yes	0-13
j) Client fired by provider	19	No		No	0-5
k) Availability of specialty provider	47	No		No	0-32
<b>INTERACTION WITH PROVIDER OR PLAN</b>					
a) Provider rude or inappropriate comments or behavior	148	Yes		Yes	0-48
b) Plan rude or inappropriate comments or behavior	13	No		No	0-6
c) Provider explanation/instruction inadequate/incomplete	176	No		No	0-51
d) Plan explanation/instruction inadequate/incomplete	53	No		No	0-23
e) Wait too long in office before receiving care	15	No		No	0-4
f) Member dignity is not respected	19	No		no	0-9
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.	3	No		No	0-3
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	1	No		No	0-1

<sup>1</sup> Represents new eligibility from ACA expansion.

<sup>2</sup> Currently plans are reporting pends in aggregate.

Complaint or grievance type	Number reported	Trend(s) identified? Yes/No	Number resolved	Actions to prevent recurrence? Yes/No	Range reported by CCOs
i) Lack of coordination among providers	7	No		No	0-2
<b>CONSUMER RIGHTS</b>					
a) Provider's office has a physical barrier	2	No		No	0-2
b) Abuse, physical, mental, psychological	3	No		No	0-3
c) Concern over confidentiality	9	No		No	0-4
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	64	No		No	0-27
e) No choice of clinician	13	No		No	0-10
f) Fraud and abuse	2				0-1
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	9	No		No	0-2
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)	0	No		No	0
i) Differential treatment for Medicaid clients	3	No		No	0-1
j) Lack of adequate or understandable NOA	0	No		No	0
k) Not informed of consumer rights	0	No		No	0
l) Complaint and appeal process not explained	2	No		No	0-1
m) Denied member access to medical records	0	No		No	0
<b>CLINICAL CARE</b>					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	68	No		No	0-25
b) Testing/assessment insufficient, inadequate or omitted	41	No		No	0-13
c) Medical record documentation issue	17	No		No	0-6
d) Concern about prescriber or medication or medication management issues	70	No		No	0-32
e) Unsanitary environment or equipment	4	No		No	0-3
f) Lack of appropriate individualized setting in treatment	1	No		No	0-1
<b>QUALITY OF SERVICE</b>					
a) Client feels unsafe/uncomfortable	28	No		No	0-12
b) Delay, quality of materials and supplies (DME) or dental	47	No		No	0-2
c) Lack of access to ENCC for intensive care coordination or case management services	246	Yes		Yes	0-242
d) Benefits not covered	44	Yes-downward		Yes-downward	0-33
<b>CLIENT BILLING ISSUES</b>					
a) Co-pays	5	No		No	0-2
b) Premiums	0	No		No	0
c) Billing OHP clients without a signed Agreement to Pay	143	No		No	0-95

**Trends related to complaints and grievances**

Plans recorded a total of 1,631 complaints and grievances. Trend rates per 1000 members ranged 0.18 to 6.07, down from recent previous quarters.

The Oregon Health Authority Client Services Unit received 6,595 complaint or grievance calls. 3,812 were related to fee for service clients. The remaining calls were related to concerns from enrolled members. Enrollment/disenrollment requests, medical services access, and dental services access were the most frequent reasons for complaint or grievance calls.

- Due to the high number of newly-eligible members effective Jan. 1 through fast-track enrollment and Cover Oregon, the usual process for processing enrollment and eligibility information took longer to validate. As a result, many newly-eligible members needed to call OHA to verify their enrollment status.
- At the same time, the transition of more than 135,000 households from their dental plan to a coordinated care organization that covered dental care may have caused concerns for some non-established members.

Provider access (*i.e.*, provider office responsiveness, scheduling and interactions with provider offices) have remained the most frequent reasons for plan-reported complaints and grievances.

- Due to the high numbers detailed above, some newly-eligible members experienced a longer than usual wait time to access preventative or routine visits.
- Plans have been able to screen for urgent or emergent needs, as well as to reach out to members to inform them of the reasons for delay. Plans have not reported quality of care issues as a result of this delay, and have supported this triage component.
- Some newly-eligible members also found that they had enrolled in a CCO that did not contract with their existing primary care provider or other existing providers. OHA has worked with CCOs and Oregon’s medical provider associations to develop a process to help these members enroll in a CCO that would allow them to maintain continuity of care to the greatest extent possible.

**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**

Category	CCO Appeals						Contested Case Hearings from CCO Appeals					
	Total		Overturned at plan level		Decisions Pending		Total		Overturned at hearing		Decisions Pending	
	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
a) Denial or limited authorization of a requested service	1,253	0-28*										
b) Single PHP service area, denial to obtain services outside the PHP panel	23	1-14										

Category	CCO Appeals						Contested Case Hearings from CCO Appeals					
	Total		Overturned at plan level		Decisions Pending		Total		Overturned at hearing		Decisions Pending	
	#	Range	#	Range	#	Range	#	Range	#	Range	#	Range
c) Termination, suspension or reduction of previously authorized covered services	19	1-17										
d) Failure to act within the timeframes provided in §438.408(b)	0	0										
e) Failure to provide services in a timely manner, as defined by the State	0	0										
f) Denial of payment for a service rendered	223	1-131										
<b>TOTALS</b>	<b>1,518</b>	<b>10-358</b>	<b>432</b>	<b>1-102</b>	<b>27</b>	<b>0-7</b>	<b>669</b>	<b>4-126</b>	<b>186</b>	<b>0-47</b>	<b>173</b>	<b>0-20</b>

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.

**Trends**

- During this quarter, Appeals per 1,000 members ranged from 0.64 to 4.90. The overturn rates at the plan level range from 0.64 to 4.17.
- Hearings per 1,000 members ranged from 0.32 to 2.1. Of 589 hearing requests, 166 are overturned by the plan during the pre-hearing process.
- Billing, referral, pharmacy and surgical denials remain the highest categories. Billing categories have been decreasing over the last 3 quarters as we continue to educate clients and providers about Medicaid billing requirements.

Due to the continued high rate of appeal and hearings plan overturn rates, a focus review of utilization activities is being developed.

**D. Implementation of 1% withhold**

During the current quarter, DMAP analyzed encounter data received for completeness and accuracy for the subject months of May and June 2013. All CCOs met the Administrative Performance (AP) standard for both subject months and no 1% withholds occurred.

Future reports will contain the following information:

**Table 3 – Summary**

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

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

## E. Statewide workforce development

### Traditional health workers (THW)

**Table 4 - Traditional health workers (THW)**

	Total number certified* statewide		Number of approved training programs	
	Current quarter	Cumulative	Current quarter	Cumulative
Community Health Workers (CHWs)	0	0	3	6
Personal Health Navigators (PHNs)	0	0	0	1
Peer wellness/support specialists	0	0	3	16
Other THW	0	0	0	1 (doula)

\* Statewide THW registry is ready to launch April 8, 2014. So far, approximately 45 individuals have returned paper applications for processing. We are manually inputting those applications before announcing the registry’s public interface on the THW website. Two OEI staff members have received approval as Qualified Entity Designee (QED) to process THW criminal background checks with our background check unit.

As of March 2014, a total of two hundred and twenty-nine (229) THWs have been trained by the following OHA approved training programs:

Training Program Name	Total number trained statewide		THW Type			
	Current quarter	To date	CHW	Peer Support	Peer Wellness	Other (doula)
Northeast Oregon Network (NEON)	-	25	25			
Cascadia Behavioral Health	-	17			17	
Multnomah County Health Department	43	141	141			

Training Program Name	Total number trained statewide		THW Type			
	Current quarter	To date	CHW	Peer Support	Peer Wellness	Other (doula)
Miracles Club Inc. (Each One Teach One)	32	32		32		
International Center for Traditional Childbearing	14	14				14
Total trained	Current Quarter	To Date	CHW	Peer Support	Peer Wellness	Other (doula)
	89	229	166	32	17	14

**Regional distribution of certified THW training programs**

OHA has approved 25 training programs.

- Nineteen of those have provided training before this reporting period.
- Four programs are within the community college system and will begin training CHWs beginning April 2014.
- One program is pending approval: Foundations for Recovery (Peer Support Specialist).

Approved Training Program Name	THW Type				
	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
Northeast Oregon Network	✓				
Chemeketa Community College	✓				
Rogue Community College	✓				
Lane/Clackamas Community College	✓				
Central Oregon Community College	✓				
Portland Community College				✓	
Institute for Professional Care Education	✓				
Institute for Professional Care Education		✓			
International Center for Traditional Childbearing					✓
Cascadia Behavioral Health			✓		
Multnomah County Health Department	✓				
Addiction Certification Board of Oregon				✓	
Central City Concern				✓	
Cultivating a New Life through Community Connections			✓		
Empowerment Initiatives				✓	
Intentional Peer Support Program				✓	
Mental Health of America				✓	
National Alliance on Mental Illness				✓	
Oregon Family Support Network/Youth MOVE				✓	
Project ABLE				✓	

Approved Training Program Name	THW Type				
	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
Willamette Family Treatment Services				✓	
Miracles Club Inc				✓	
Eugene Relief Nursery				✓	
Oregon Behavioral Consultation and Training				✓	
Recovery and Beyond				✓	
Total approved	CHW	PHN	Peer Wellness	Peer Support	Other (doula)
	7	1	2	14	1

As part of the Governor's vision for healthcare reform, the Community Colleges Workforce Development Board (CCWD) was given \$673,800 in the budget to develop THW training. CCWD convened about 25 people including OEI program staff and THW leaders in January to determine the best use of these funds. An RFP was issued that closed on March 31, 2014. CCWD is working with OEI, the THW Commission, and other THW professionals to review the applications and provide comments that will ensure community colleges' CHW program models meet the expectations necessary for OHA approval and to ensure that the fidelity of the model is maintained.

**Relevant recruitment efforts or challenges**

	THW presentations	Meetings with stakeholders
<b>January 2014</b>	<ul style="list-style-type: none"> <li>■ January 26: International Center for Traditional Childbearing</li> <li>■ January 31: Community Colleges Workforce Development Board</li> </ul>	<ul style="list-style-type: none"> <li>■ January 16: OEI and AMH on Traditional Health Workers</li> <li>■ January 17: Meeting with ORCHWA</li> <li>■ January 19: Urban League of Portland's Community Health Worker Hub</li> <li>■ January 22: PSU, Adolescent Peer Support Research Project</li> <li>■ January 23: ORCHWERC (Cambia) - steering team meeting</li> <li>■ January 26: Oregon Black Nurses Association</li> <li>■ January 27: First THW Commission Meeting</li> <li>■ January 29: Miracles Club of Portland, African American Peer Support Peer Run Organization</li> <li>■ January 31: CCWD Community Health Worker education and training</li> </ul>
<b>February 2014</b>	<ul style="list-style-type: none"> <li>■ February 5: OHPB Workforce Committee-Workforce Diversity</li> </ul>	<ul style="list-style-type: none"> <li>■ February 6: Oregon Law Center; CHW Continuing Education</li> <li>■ February 6: OEI THW Business Review - Sprint 7</li> <li>■ February 7: OCN Nursing Equity Coalition meeting</li> <li>■ February 7: THW Rules and Requirements w/ Asian Health &amp; Service Center</li> <li>■ February 12: Mohr Peterson/Alexander - Urban League</li> <li>■ February 13: Urban League of Portland CHW Graduation, Key Note Speaker</li> <li>■ February 18: ORCHWA, CHW Policy meeting</li> <li>■ February 24: THW Commission Meeting</li> <li>■ February 26: Center for Community Capacitation</li> <li>■ February 27, 2014: Flexible Services Committee</li> </ul>

	THW presentations	Meetings with stakeholders
March 2014	<ul style="list-style-type: none"> <li>■ March 1: PCC Cascade Student Success Conference</li> </ul>	<ul style="list-style-type: none"> <li>■ March 4: Mother Tree (Doula Program) Information sharing re doula certification</li> <li>■ March 5: SIM Fed Evaluators</li> <li>■ March 6: OEI THW Business Review - Sprint 8</li> <li>■ March 20: Oregon Community Health Worker Assn – follow up re: Disease Self-Management</li> <li>■ March 11: Lane Community College CHW Program Training consultation</li> <li>■ March 12: Peer Services OHP Implementation Meeting</li> <li>■ March 13: OHA Transformation Center-CCO Learning Series/Collaborative</li> <li>■ March 24: THW Commission Training</li> <li>■ March 25: THW Commission Training</li> <li>■ March 27: CHW Consortium Steering Team Meeting</li> <li>■ March 28: Doula Certification &amp; Reimbursement Process information session for CBOs</li> </ul>

**Health professional graduates participating in Medicaid**

No new results to report this quarter, since few health professions programs have graduation dates in January – March. OHA will request updated data files from Oregon Health and Sciences University (OHSU) in late summer 2014 for an initial match of 2014 graduates against Medicaid provider enrollment data. At that time, the state also intends to re-run 2012 and 2013 dental, nursing, and physician assistant graduate data—results for these cohorts were describe in the previous quarterly report—to ascertain whether graduates are more likely become enrolled Medicaid providers as time goes on.

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

CCO enrollment had a significant increase as Oregon’s expansion population surpassed projections. DMAP has been actively working with plans regarding capacity levels, and one CCO has closed to new enrollment. DMAP has placed additional resources in that community to coordinate care for the fee for service population, and continue to work with the CCO to add enrollment as they increase capacity, which they are currently doing incrementally

Approval and contracting with new plans	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Pacific Source divided into two separately contracted organizations. Pacific Source Columbia Gorge became a CCO effective 1/1/14.	Wasco and Hood River Counties are now covered by the new Pacific Source CCO.	Members in Wasco and Hood River Counties moved to the new Pacific Source CCO	2	9,261 members moved to the new CCO (Columbia Gorge)  39,377 members remain in Pacific Source Central Oregon.

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Cascade Health Alliance closed to new enrollment effective 1/1/14.	NA	Newly-eligible clients placed in fee-for-service	1	850
Continued dental integration into CCOs effective 1/1/2014	Strengthen transformation and integration	Positive-access and coordination benefits	8	135,000 households

Rate certifications	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Approved rates implemented for 1/1/14 CCO contracts	NA	NA	NA	NA

Enrollment/disenrollment	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
Medicaid expansion became effective on 1/1/14. MAGI enrollees from the State-Based Marketplace (Cover Oregon) started benefits on 1/1/14 as well.	Increased total CCO enrollment by approximately 38% over December 2013 enrollment.	More members enrolled in CCOs	16	CCO enrollment as of March 2014 is 772,352.

CCO/MCO contract compliance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
None	NA	NA	NA	NA

Relevant financial performance	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
None	NA	NA	NA	NA

## G. Transformation center

The Transformation Center is continuing to provide assistance specific to CCOs through learning collaboratives, Innovator Agent support, and additional activities targeted towards community empowerment and leadership development. Highlights from this quarter include:

- A session of the Complex Care Learning Collaborative with over 275 attendees, the majority of whom served in clinical roles throughout the state.
- Work on systemic transformation also includes improving communication efforts across state agencies to ensure consistency and coordination.
- The Transformation Center is hiring two additional analysts and an Innovator Agent, who will serve the final CCO Cascade Health Alliance and work to coordinate communication with stakeholders across the state.

### Statewide CCO Learning Collaborative

The Statewide CCO Learning Collaborative provides CCOs a focus for improvement. The Transformation Center’s Director of Clinical Innovation facilitates monthly meetings for CCO medical and behavioral

health directors and quality improvement coordinators from around the state. Each gathering provides participants with specific examples of innovation and details on how high performance metrics can dovetail with the implementation of best practices and lessons learned.

Meetings this quarter focused on developmental screening, and mental and physical health assistance for children in foster care custody. Sessions explain how challenges were identified and overcome in communities across the state. The February session, which was scheduled to cover the foster care screening, was cancelled due to inclement weather and held in March.

### **Community Advisory Council Learning Collaborative**

The Transformation Center also continued its support of CCOs' Community Advisory Councils (CACs), which serve as CCO advisory bodies. With recommendations from a CAC steering committee, this learning collaborative is designed to showcase different types of available resources available to CACs, and give case examples to inspire and inform CAC work.

Because CACs are comprised of CCO members and community representatives, the Transformation Center brought a number of trainers to the learning collaborative this quarter in order to increase CAC members' knowledge. The February session focused on community health improvement plans, with over fifty participants. The March session addressed health equity with a presentation on language access for clients with limited English proficiency, with over forty participants.

### **Innovator Agent Learning Collaborative**

To support the work of Innovator Agents, the Transformation Center provided Innovator Agents with additional opportunities to learn from one another and experts in the field. The Transformation Center hired a consultant with expertise in governance, management processes, organization, team and leadership development and change management to help Innovator Agents identify strategies to support transformation internal to OHA.

The Transformation Center also hosted monthly in-person meetings for the Innovator Agents as well as two learning sessions hosted via webinar to increase their ability to spread innovation across the state.

- One webinar focused on innovative funding structures in Federally Qualified Health Centers (FQHCs) in Oregon. Craig Hostetler, Executive Director of the Oregon Primary Care Association (OPCA) discussed how OPCA has implemented alternative payment methodologies (APMs) in FQHCs, and provided examples that Innovator Agents could bring back to their region.
- In the second webinar, a representative from the Oregon Medical Association shared information about patient empowerment by providing them with information on the Choosing Wisely campaign.

### **Complex Care Learning Collaborative**

As part of the Complex Care Learning Collaborative, a huge success for the Transformation Center was a webinar attended by over 275 individuals on trauma-informed care. Participants learned how adverse childhood experiences can be attended to in the primary care setting, and how to implement trauma-informed care in an organization. The high attendance of this webinar indicates that clinical focus learning held in the early morning (7:30 a.m.) can help bring information in the field in a way that some in-person meetings cannot accomplish due to the nature of health care delivery systems across the state.

### **IHI Improvement Science in Action Learning Collaborative**

Another large-scale learning collaborative is the IHI Improvement Science in Action program, geared to assist CCOs in creating and implementing measurable objectives and performance measures for their Transformation Fund projects (last year, the state legislature allocated approximately \$30 million in

## *Oregon Health Authority*

Transformation Funds to support CCO innovation and further efforts to transform health care delivery in Oregon).

The series began in March with a series of webinars with faculty and will include an intensive three-day in-person meeting in Eugene this April. Over 20 teams have submitted charters ranging from hepatitis to behavioral health integration.

### **Good Ideas Bank**

Through the Innovator Agents and learning collaborative activities, the Transformation Center has been identifying, collecting and compiling information on innovative or promising health system transformation practices. The information will be housed within a searchable database on the Transformation Center website. At the end of this reporting period, over 70 projects had been collected. The searchable database is scheduled to go live in second half of 2014.

### **Plans for next quarter and beyond**

#### ***Council of Clinical Innovators***

The Transformation Center is in the process of convening a state Council of Clinical Innovators, which will be a statewide, multidisciplinary cadre of innovation leaders, consultants and mentors who are actively working with project teams to implement health system transformation projects in their local communities. Through their innovation projects and participation in a year-long learning experience, a select group of Clinical Innovation Fellows will develop and refine skills in leadership, quality improvement, implementation and dissemination science that creates a network of expertise supporting the Oregon coordinated care model.

#### ***Complex Care***

Due to popular demand, the Transformation Center will host a second day-long Complex Care Collaborative meeting in late April in Eugene, Oregon. Approximately 120 guests, including CCO leadership, providers and other health care professionals will gather to share ideas focused on complex care issues surrounding opioid use, behavioral health integration, and prenatal care. This opportunity will help participants learn about innovative new care models being implemented throughout the state.

#### ***Metrics Retreat***

Also in April, the Statewide CCO Learning Collaborative will consist of an intensive four-hour metrics retreat, where all 17 CCO metrics will be discussed in detail and supporting documentation will be shared to ensure that all program participants understand how the metrics are tracked, collected, and measured.

#### ***CAC Summit***

In May, the Transformation Center will host a CAC Summit, which will be a gathering of over a hundred CAC members from across the state. The Summit will provide:

- Opportunities to connect with and learn from other CAC members
- A forum for sharing CAC activities and overcoming challenges,
- Leadership skills training, including how to build constructive, functional advisory council, and resources, and
- Training in areas such as health equity and council development.

Community leaders from the OHA Public Health Division and Northwest Health Foundation will share updates and impressions on transformation activities, and CAC representatives will have an opportunity to

highlight their work. A significant portion of the event will facilitate learning on funding opportunities, community health assessments, and community health improvement plans.

**CCO Summit**

Finally, the Transformation Center will host the annual CCO Summit in October to celebrate the second year of transformation and inspire its spread throughout Oregon and beyond. Leaders from the CCOs, CACs, community partners, commercial payers and other experts will share relevant, practical information to support transformation moving forward.

Topics for breakout sessions will likely include behavioral health and dental integration, patient engagement, health equity, health information technology, payment reform, measurement and connections with early learning. In addition to leaders in Oregon, the agenda is being designed to appeal to health reform innovators from around the country and provide an opportunity to showcase the Oregon model.

**Table 6 - Innovator Agents – Summary of promising practices**

***Innovator agent learning experiences***

Summary of activities	(1) Consultation with Paul Krissel, consultant in governance (2) FQHC presentation from Oregon Primary Care Association (3) Choosing Wisely presentation from Oregon Medical Association
Promising practices identified	(1) OHA system change (2) Alternative payment methods best practices (3) Patient engagement strategies
Participating CCOs	-
Participating IAs	8  The presentations were attended by all 8 Innovator Agents and several OHA staff.

***Learning Collaborative activities***

Summary of activities	The Transformation Center continued two learning collaboratives this quarter for our CCO partners, which are regularly attended by the IAs: (1) Statewide Learning Collaborative for CCO Medical Directors (2) Community Advisory Council (CAC) Learning Collaborative. (3) Complex Care Learning Collaborative (trauma-informed care webinar) (4) IHI Improvement Science in Action Course
Promising practices identified	Appreciative inquiry on challenges overcome and how success was achieved was most beneficial. Participants gained a deeper understanding of: (1) performance metrics (2) patient centered care (3) trauma informed care (4) scoping a project and creating cycles of improvement
Participating CCOs	16
Participating IAs	8 (for IAs)  45 avg per meeting (for CACs) 50 avg per meeting (for CCOs) 275 (Complex Care meeting) 100 (IHI)

**Assisting and supporting CCOs with Transformation Plans**

Summary of activities	Innovator Agents are continuing to support their CCOs' Transformation Plans. One key role they play is ensuring positive communication among CCOs, OHA, and their external partners. In this way, Innovator Agents work with CCO and OHA leadership and collaborate with other Innovator Agents to problem solve and recommend next steps. In addition, Innovator Agent support includes working with CCO leadership to identify and resolve obstacles and implement system improvements related to health system transformation.
Promising practices identified	Innovator Agents are collecting promising practices from their CCOs for sharing with others across the state, to be shared in a "Good Ideas Bank", which will serve as a central repository for innovations adopted by CCOs to support the innovation spread.
Participating CCOs	16
Participating IAs	8

**Assist CCOs with target areas of local focus for improvement**

Summary of activities	The IHI training 'Improvement Science in Action' began this quarter, and allowed CCOs to develop a charter and system design for quality improvement projects.
Promising practices identified	Teams created Plan-Do-Study-Act (PDSA) cycles of improvement and learned how to scope a project to ensure long term spread.
Participating CCOs	16 (with over 100 attendees)
Participating IAs	8

**Communications with OHA**

Summary of activities	The Transformation Center continues to focus on streamlining communications and facilitating problem-solving between CCOs and OHA, work that will be led through the Innovator Agents and was supported by the consultant Paul Krissel. This quarter, Innovator Agents identified a number of system issues that will be the focus of work in early 2014. Communications with OHA included support to fast track expansion, coordinating foster children metrics, account rep. facilitation, case management enrollment, quality measures, metrics clarifications, new member applications, timelines for streamlining systems, public health partnerships, administrative rules support, midwife coordination, and guidance documentation.
Promising practices identified	Cross department problem solving about the flow of communication and sharing data is essential to CCO success.
Participating CCOs	16
Participating IAs	8

**Communications with other Innovator Agents**

Summary of activities	Weekly phone calls and monthly day-long in-person meetings, as well as weekly email communication.
Promising practices identified	IAs requested that communication be streamlined, organized, and sent at standard weekly intervals.
Participating CCOs	16
Participating IAs	8

**Community Advisory Committee activities**

Summary of activities	The Transformation Center’s CAC learning collaborative continued this quarter guided by a steering committee comprised of CAC members. Technical assistance was provided regarding communications and committee effectiveness.
Promising practices identified	Innovator Agent insight continued to facilitate effective collaboration and healthy partnerships.
Participating CCOs	16
Participating IAs	8

**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 (1) Good Ideas Bank and (2) IHI training both are designed to speed the rate of successful transformation.
Promising practices identified	Scoping a project to start small, being strategic about spread are critical to improving on metrics performance in the long term.
Participating CCOs	N/A
Participating IAs	N/A

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

Summary of activities	This CCO Issue Tracker database was launched this quarter, though the IAs are still learning how to use the system and ramping up to fully use it.
Promising practices identified	The issue tracker was used to identify a history of language preference discrepancies over time. Issues around language coding were identified.
Participating CCOs	N/A
Participating IAs	2

**Information sharing with public**

Summary of activities	Along with the Transformation Center website, Innovator Agents have made numerous presentations to groups of different community stakeholders to share information about the Center and IA roles.
Promising practices identified	Innovator Agents have given presentations to a number of unique audiences to spread transformation beyond CCOs, including a coalition of local public health officials and a number of advocacy groups
Participating CCOs	N/A
Participating IAs	4

Over the last quarter, Innovator Agents have strengthened relationships with their CCOs as well as the communities in which they operate. The support they provide now has expanded to assist CCOs in the work of continually adjusting to change. Support includes gentle guidance on specific areas, such as behavioral health and dental integration, to overarching perspective that helps CCOs remember the national scope of change that is occurring. In addition, Innovator Agents are working closely with other OHA staff to address CCO’s questions and concerns. For example, as reported in the previous quarter, Innovator Agents and the Account Representatives within the Division of Medical Assistance Programs have created “customer service teams” to improve the relationship between CCOs and OHA in support of CCO goals.

**Table 7 - Innovator Agents – Measures of effectiveness**

**Measure 1: Surveys rating IA performance**

Data published for current quarter? Type?	N/A (a survey will be fielded with CCOs to assess the effectiveness of the IA program during Q2 of 2014)
Web link to Innovator Agent quality data	N/A

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

Data published for current quarter? Type?	<ol style="list-style-type: none"> <li>(1) The Innovator Agents submitted another quarterly report to the Transformation Center that listed the work they were engaged in as well as CCO innovations adopted during the last quarter.</li> <li>(2) As mentioned above, the CCO Issue Tracker database is in the final stages of becoming fully functional.</li> <li>(3) Feedback on Innovator Agent meetings is gathered through surveys to refine services delivered.</li> </ol>
Web link to Innovator Agent quality data	N/A

**Measure 3: Innovations adopted**

Data published for current quarter? Type?	<ol style="list-style-type: none"> <li>(1) The Good Ideas Bank is in the final stages of development, with over 75 entries (i.e., innovative practices being adopted by CCOs) in the process of being formatted for entry, and will be uploaded to the Transformation Center website during the last half of 2014.</li> <li>(2) While not documented in data form, Innovator Agents have supported alternative payment methods for mental health integration, improving same day access to time-sensitive data, and working with CCOs and CACs on non-emergency medical transportation. Additionally, Innovator Agents are working on a pneumonia risk stratification tool and rule changes related to alternative payment methodology.</li> </ol>
Web link to Innovator Agent quality data	N/A

**Measure 4: Progress in adopting innovations\***

Data published for current quarter? Type?	CCOs are making solid progress in adopting innovations as evidenced through (1) the work with IHI and (2) the many ideas collected for the Good Ideas Bank.
Web link to Innovator Agent quality data	N/A

**Measure 5: Progress in making improvement based on innovations \***

Data published for current quarter? Type?	Current data on state mandated metrics show that all CCOs are on track.
Web link to Innovator Agent quality data	N/A

**Measure 6: CCO Transformation Plan implementation**

Data published for current quarter? Type?	Quarterly Progress Reports on Transformation Plans indicate that CCOs are on track. While each CCO is at a different level of transformation, each is also moving forward.
Web link to Innovator Agent quality data	N/A

**Measure 7: Learning Collaborative effectiveness**

Data published for current quarter? Type?	Measure of learning collaborative effectiveness are documented in the Section V Table 9, but in summary, collaborative2 are well attended and positively reviewed for effectiveness.
Web link to Innovator Agent quality data	N/A

**Measure 8: Performance on Metrics and Scoring Committee metrics**

Data published for current quarter? Type?	All Innovator Agents assist in internal planning to realign resources for internal metrics improvements, through consultation on investment strategies, contracts, care management reform, and clinical tools. Some IAs also met individually with PCPs and assisted with SBIRT trainings and other interventions to integrate mental health and primary care.
Web link to Innovator Agent quality data	<a href="http://www.oregon.gov/oha/Metrics/Pages/index.aspx">http://www.oregon.gov/oha/Metrics/Pages/index.aspx</a>

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

**H. Legislative activities**

**January 2014 budget rebalance**

In January, OHA presented its [budget rebalance](#) to the Oregon Legislative Assembly’s Interim Joint Committee on Ways and Means. This included requests for additional funding to support ACA expansion.

**Highlights from 2014 Regular Session**

**House Bill 4108: Durable Medical Equipment**

Requires OHA to contract with nonprofit organizations to operate pilot projects that would provide used durable medical equipment to medical assistance recipients. Appropriates \$75,000 GF to fund grants to qualified organizations. Pilot projects are required to serve Washington, Multnomah, Clackamas, Umatilla, Marion and Polk counties, but can be expanded as deemed appropriate.

**House Bill 4109: Basic Health Plan Study**

Requires OHA to commission an independent study of costs and impacts of operating a basic health program in Oregon. Specifies the parameters of the study: including; availability of federal funds; state expenses and costs, impact to the number of people enrolled through the Exchange; impact on health insurance rates; and expectations about cycling through the basic health program and coverage offered through the Exchange. Requires the report be submitted to the Legislative Assembly by November 30, 2014.

**House Bill 4124: Youth Suicide Intervention**

Establishes Youth Suicide Intervention and Prevention Coordinator in AMH. Requires update of Youth Suicide Intervention and Prevention Plan once every five years.

**Senate Bill 1526: CHIP Study**

Requires OHA to look into seeking federal approval of using CHIP \$ to subsidize costs of commercial insurance for kids between 200-300 FPL. Report due no later than September 15, 2014.

## Oregon Health Authority

### Senate Bill 1582: Temporary Medical Insurance Pool

Authorizes money from the OMIP account to fund the Temporary Medical Insurance Pool (TMIP), which extended through March 31 to ensure coverage of high risk individuals.

#### Other key initiatives:

<b>HB 5201 (Budget notes)</b>	Requires OHA to work with health systems, CCOs and health care providers to develop recommendations that ensure Medicaid clients have access to medically appropriate and necessary health services.	Report to Legislature	Before 2015 session
	Report on plans to appoint a state dental director as part of the agency's 2015-17 budget request. The report will include a position description outlining the duties of this position and the estimated costs to fill the position.	Report to Legislature	Sept. 1, 2014
	NAMI/ORPA report on implementation of MH housing partnership	Report to Legislature	May 2014, and subsequent E-Board meetings
	Update on Senior Mental Health Specialists SPA	Report to Legislature	May 1, 2014
	BMRC economic development workgroup	Report to Legislature	Sept. 1, 2014
	Sobering station pilot	Report to Legislature	During 2015 session
<b>SB 1560 (Telemedicine)</b>	Work group has been formed to discuss telehealth issues in advance of 2015 session; proposed legislation possible as a result	Participation on work group	Ongoing

### I. Litigation status

Nothing to report this quarter

### J. Two-percent trend data

See Appendix C. With the implementation of the ACA and our Medicaid expansion, the state has struggled with system and data issues. Because of these data issues, a number of significant corrections need to take place. Making the corrections is one of the state's highest priorities. The implications for the 2% test report and budget neutrality calculations are that they would be inaccurate for quarterly report ending March 31, 2014, if they were submitted using data that have not yet been corrected.

Instead of submitting these reports with inaccurate data, the state is submitting the quarterly report ending March 31, 2014, using projections for that quarter. OHA expects the data issues to be corrected in time to use actual expenditure data for the June quarterly report.

### 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
Managed Dental Plan	Encounter claim submissions	2/1/2014	Completed claims submitted timely	Has been submitting on a monthly basis per workplan	-	-

## V. Evaluation activities and interim findings

### Waiver midpoint evaluation

In February 2014, OHA approved the evaluation plan for an independent midpoint evaluation of the 1115 Demonstration (as required by CMS) by Mathematica Policy Research. The midpoint evaluation will assess the association between transformation activities and early outcomes in access and quality. The agreed evaluation plan is a multi-level, mixed-methods approach and is in three parts:

1. The formative evaluation component will utilize qualitative research methods to assess the extent to which OHA and the CCOs have supported and implemented transformation activities as specified in the Demonstration;
2. The summative evaluation component will build on the formative assessment and assess initial changes in outcomes that capture access and quality of care, patient experience, and health status;
3. The integration of results from the formative and summative evaluation components will enable an assessment of the relationship between the level of transformation and early outcomes.

Also in February, Mathematica hosted an informational webinar for stakeholders (including OHA and CCO leadership and staff); the webinar and slides can be accessed at [www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx](http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx).

### Data collection activities

The contractors began data collection activities soon after, as follows:

<b>Document reviews</b>	Document reviews commenced almost immediately, and a coding scheme was available for OHA information in March. Much of this work is already complete.
<b>Key informant interviews</b>	Mathematica completed telephone interviews with state staff representing various elements of OHA in March. Telephone interviews with key informants from the CCOs (CCO managers, fiscal administrators, providers, and community representatives) will begin in the next quarter.
<b>CCO Transformation Assessment Tool (CTAT)</b>	<p>The CTAT will be used to assess the degree to which individual CCOs have transformed.</p> <ul style="list-style-type: none"> <li>■ The CCOs will be categorized on a continuum of early, midstream, or advanced stages of transformation;</li> <li>■ Then the relationship between the level of transformation and outcomes will be analyzed at an aggregate level and by domain (e.g. on integration of physical health, mental health, and addictions).</li> </ul>

	<p>Initially completed by the CCOs, the CTATs will then be reviewed by each CCO's Innovator Agent, against the information from Mathematica's document reviews, and will also be discussed in interviews with key informants from the CCOs (to occur in the next quarter).</p> <p>Mathematica will use the totality of this information to finalize each CCO's level of transformation on the areas included in the tool.</p>
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**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:	<p>Work continued on the PCPCH evaluation effort comparing service utilization and expenditures for individuals in selected PCPCH practice sites one year prior and following PCPCH recognition with those in non-PCPCH settings over the same time periods. Results are expected in the next quarter.</p> <p>The PCPCH program launched a new online application system based on updated 2014 recognition standards. The application now includes many of the questions from a survey used for the formal evaluation of the program (the evaluation findings are forthcoming). Completion of these questions is optional, but the program hopes to use them for evaluation purposes.</p>
Interim findings:	<p>As of March 2014, 502 PCPCHs had been recognized statewide, exceeding the goal of 500 recognized PCPCHs by the end of 2014.</p> <p>The goal for CCOs with respect to PCPCH enrollment is that 100% of members will be enrolled in a PCPCH. The statewide baseline (for 2012) for this measure is 51.8%.</p> <ul style="list-style-type: none"> <li>■ Preliminary data covering calendar year 2013 indicate that 80.9% of CCO members were enrolled in a PCPCH, which continues the improvement seen in previous quarters (see Appendix E).</li> <li>■ While there is significant spread across the CCOs on this measure, it is promising that the poorest performing CCO has continued to increase at each data point: At the 2012 baseline, the poorest performing CCO had just 3.7% of members enrolled in a PCPCH, while the poorest performing CCO during calendar year 2013 was at 49.9%, a substantial improvement (see Appendix E).</li> </ul>
Improvement activities:	<p><a href="#">New PCPCH recognition criteria</a> went into effect on January 1, 2014. These standards are aimed at making the model more robust.</p> <p>Oregon's Patient-Centered Primary Care Institute continues to provide technical support and resources for transformation to practices statewide.</p> <ul style="list-style-type: none"> <li>■ Technical assistance topics over this quarter included webinars on brief intervention skills for primary care clinicians and behavioral health consultants in the primary care behavioral health model of care; building resiliency in the primary care home team; and, empanelment - what do you do after every patient has an assigned care team.</li> <li>■ In addition, the online learning modules for the 2014 PCPCH recognition standards were launched. Slides and audio recordings of each presentation are available at</li> </ul>

	<p><a href="http://www.pcpci.org/resources">http://www.pcpci.org/resources</a>.</p> <ul style="list-style-type: none"> <li>■ Planning and contract execution were completed in March 2014 for the next phase of technical assistance through the institute for primary care practices across Oregon.</li> </ul> <p>In this quarter, four positions were posted that will increase the PCPCH program's capacity to conduct site visits and provide additional technical assistance to clinics. Hiring for these positions is expected to be completed in the next quarter.</p> <ul style="list-style-type: none"> <li>■ These positions include two program analysts to verify the standards and measures attested to by clinics and to provide practice facilitation and coaching to clinics.</li> <li>■ In addition, two compliance specialist positions were posted; they will provide consultation, technical assistance and evaluation services to verify that recognized PCPCHs are meeting program requirements.</li> </ul>
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**Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes**

<p>Evaluation activities:</p>	<p>Work related to the CCO incentive measures continued in this quarter, as all CCOs submitted their Year One Technology Plans. At the end of the quarter, nine plans were accepted, and the quality pool advance related to acceptance of the Technology Plan was disbursed to seven CCOs. OHA anticipates approving the final six plans in mid-April (see Appendix E for more detail).</p> <p>The Metrics Technical Advisory Group, Metrics and Scoring Committee, and the Dental Metrics Workgroup met in this quarter. Metrics continued to be refined:</p> <ul style="list-style-type: none"> <li>■ The 2014 SBIRT measure specification was amended;</li> <li>■ 2014 benchmarks for colorectal cancer screening and diabetes: HbA1c poor control were established; and,</li> <li>■ A dental quality measure was adopted for the 2015 measurement year.</li> <li>■ OHA also provided updated and new guidance on the CCO incentive measures, and established a Metrics Technical Advisory Group website (<a href="http://www.oregon.gov/oha/Pages/metricsTAG.aspx">http://www.oregon.gov/oha/Pages/metricsTAG.aspx</a>). More detail on this work is available in Appendix E.</li> </ul> <p>In 2013, Oregon House Bill 2216, Section 1, established the nine-member Hospital Performance Metrics Advisory Committee appointed by the Director of the Oregon Health Authority.</p> <ul style="list-style-type: none"> <li>■ The Committee was tasked with identifying three to five performance measures and targets for hospitals to advance health system transformation, reduce hospital costs, and improve patient safety.</li> <li>■ The Committee's recommended performance standards will be used to determine incentive payments to DRG hospitals through 2015 from a share of Oregon's hospital assessment revenue.</li> <li>■ In this quarter the Committee held two meetings to select metrics for the Hospital Transformation Performance Program. The committee selected two measures: early elective deliveries and hospital-wide readmissions.</li> <li>■ At its final meeting in April, the Committee will select the remaining one to three metrics and finalize the measurement set.</li> </ul> <p>Information on the Committee, including presentations and meeting minutes, is available at <a href="http://www.oregon.gov/oha/Pages/http.aspx">www.oregon.gov/oha/Pages/http.aspx</a>.</p>
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Interim findings:	<p>Progress was made on the work that the Center for Evidence-based Policy at Oregon Health &amp; Sciences University is doing for OHA related to shared-risk multi-payer payment models. The Center conducted an evidence review of the effectiveness of APMs as well as interviews with 18 thought leaders across Oregon. The data are still being analyzed, but preliminary findings suggest that:</p> <ul style="list-style-type: none"> <li>■ APMs are effective in reducing utilization, costs, and improving care quality (most evidence is on pay-for-performance and shows it to be effective; studies of bundled payments and capitation also show evidence of effectiveness given certain conditions)</li> <li>■ Leaders are committed to implementing payment reform</li> <li>■ There is no ‘one size fits all’ model to payment reform (different models will work in different situations)</li> <li>■ Reform decisions need to be made at the local level and engage all citizens</li> <li>■ Specialists need to be at the table</li> <li>■ Metrics are important (but providers need control over the measured outcome, and are overwhelmed with current metrics and reporting requirements - so it may be beneficial to reduce this burden)</li> <li>■ Reforming payment methods will require other system changes (such as state and federal actuarial and accounting systems)</li> <li>■ Sharing experiences is essential (need to communicate successes and setbacks).</li> </ul> <p>The final report, expected by the end of the year, will include findings, models, tools and strategies for use in payment reform.</p>
Improvement activities:	<p>To further the use of APMs, Oregon has a workgroup tasked with developing recommendations on which rural (type A/B) hospitals should transition from cost-based reimbursements to rates negotiated with local CCOs.</p> <ul style="list-style-type: none"> <li>■ In March the workgroup agreed on final recommendations for submission to OHA’s Director’s Office.</li> <li>■ After applying the workgroup’s recommended decision criteria in April, it was decided that 18 hospitals would transition away from cost-based reimbursement (meaning they will need to negotiate with their CCOs), and 14 will continue to use a cost-based reimbursement method. This will be re-evaluated every two years.</li> </ul> <p>The report is available here: <a href="http://www.oregon.gov/oha/pages/rhri.aspx">http://www.oregon.gov/oha/pages/rhri.aspx</a>.</p>

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

Evaluation activities:	<p>Five of the 33 state performance measures relate specifically to behavioral health integration.</p> <ul style="list-style-type: none"> <li>■ Baselines, January-September 2013 performance data, and benchmarks have been finalized for three of these measures, and preliminary data for calendar year 2013 are available in Appendix E.</li> <li>■ In addition, in this quarter the Metrics and Scoring Committee agreed to adopt a benchmark for depression screening in June 2014, when proof of concept data from 2013 is available.</li> </ul>
Interim findings:	<p>Data for calendar year 2013 are available in Appendix E. However, these data only include encounters submitted through the beginning of February 2014, so are incomplete. Therefore, findings for the year will not be analyzed until data are finalized.</p> <p>However, data for the first nine months of 2013 (January – September 2013) show that performance related to integration is generally similar to baseline (though it should be</p>

	<p>noted that some metrics have a very small number of cases, so caution should be taken when interpreting these data). More time is needed to be able to assess any improvement from the baseline.</p>
Improvement activities:	<p>In January, the statewide learning collaborative for CCO Medical Directors and Quality Improvement staff focused on developmental screening.</p> <ul style="list-style-type: none"> <li>■ Experts from across the state shared how they overcame obstacles to accomplish significant clinical and system integration to improve developmental screening rates.</li> <li>■ In March, the focus was timely mental and physical health assessments for children in the custody of Oregon’s Department of Human Services, which is also a CCO incentive measure. A panel of OHA and DHS staff described the process that DHS and OHA are using to share accurate, up-to-date lists of children in DHS custody with CCOs.</li> <li>■ Also, representatives from two local communities presented their successful processes to improve assessments for this population.</li> </ul> <p>As CCOs begin their dental integration beginning July 1, the Transformation Center is talking with members of the various Dental Care Organizations about how to collaborate on opportunities to promote dental integration. In addition, OHA will be hiring a Dental Director to assist with this work.</p> <p>The Transformation Center completed planning for an environmental scan of behavioral health integration activities across the state, which will start in the next quarter. This will assist with targeting needed technical assistance to communities and the delivery system.</p> <p>Oregon was awarded a two-year Adult Medicaid Quality grant in 2012. As part of this, OHA will be facilitating a Behavioral Health Learning Collaborative with the aim of improving the integration of behavioral health with primary care, particularly within mental health and chemical dependency treatment settings. Applications for participation in the collaborative were due in February. Twenty-seven (27) applications were received, and eleven (11) were invited to participate. Notification of the decision was sent out to applicants on March 28th.</p>

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

Evaluation activities:	<p>As described in more detail above, in this quarter activities related to the Mathematica midpoint evaluation of the waiver included:</p> <ul style="list-style-type: none"> <li>■ Finalizing the evaluation plan;</li> <li>■ Hosting an informational webinar about the evaluation;</li> <li>■ Working on document reviews;</li> <li>■ Completing interviews with state staff; and,</li> <li>■ Creating and distributing the CTAT to the CCOs (for completion in the next quarter).</li> </ul>
Interim findings:	<p>Appendix E includes preliminary 2013 data on the CCO incentive measures and demonstration core measures. However, most of these data are incomplete; therefore, we will not discuss them here. These data should be finalized by the next quarterly report.</p>
Improvement activities:	<p>In this quarter OHA provided two progress reports on the incentive measures to the CCOs. These assist the CCOs in monitoring their progress in these areas, and in making interim process improvements as needed to improve performance.</p>

	<p>The State Innovation Model (SIM) funded Regional Health Equity Coalitions (RHECs) continue to work as advisors to CCOs' Community Advisory Councils and community partners on culturally relevant and specific strategies to reduce health disparities. During this reporting period, grant agreements were executed with each of the newest RHECs, and detailed project plans were developed with the help of OHA. In addition, a new site visit protocol was developed by OHA.</p> <p>Oregon's "Phase 1.5" HIE/HIT development, which aims to support immediate coordination between providers while building a foundation for statewide interoperability, continued in this quarter. Phase 1.5 includes six elements: state-level provider directory; incremental development of state-level patient index attributing patients to providers; statewide notification of emergency department and hospital visits; statewide direct secure messaging; statewide clinical quality data registry; and, technical assistance to providers. The HIT/HIE Development Strategy can be found <a href="#">on the HITOC website</a>.</p> <p>Oregon is establishing Early Learning Hubs, which are coordinating bodies pulling together resources for children and families in defined service areas.</p> <ul style="list-style-type: none"> <li>■ In the Hubs, all sectors that touch early childhood education, including health, have a common place to focus their efforts.</li> <li>■ Oregon's HB 2013 requires that services coordinated by the Hubs be aligned with those provided by CCOs and county public health departments.</li> <li>■ At the state level, there is a joint Early Learning Council/Health Policy Board subcommittee focused on integrating health care and early learning policies, sharing resources, and aligning goals.</li> <li>■ The first six Hub contracts were in the process of being negotiated and awarded in this quarter; of these, Yamhill Early Learning Hub is actually sponsored by the local CCO (see the <a href="#">Early Learning Council's February 2014 report to the Oregon Legislative Assembly</a>).</li> </ul> <p>Work continues with the SIM-funded Community Prevention Program, which in December awarded grants to four local partnerships of CCOs and local public health authorities. In this quarter, all four grantees focused on recruiting staff to manage these projects.</p>
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**Lever 5: Implementation of health-related flexible services aimed at improving care delivery, enrollee health, and lowering costs**

Evaluation activities:	An advisory workgroup of CCO representatives formed in late 2013 to make suggestions for tracking and reporting flexible services at the member-level. It held its first meeting in quarter 1 of 2014. The workgroup plans to have a reporting tool available by January 2015. Broader evaluation work related to the impact of flexible services on cost and quality will rely upon the data collected by this process.
Interim findings:	Will be available in future reports.
Improvement activities:	As noted above and in past quarterly reports, discussions on how the reporting of flexible services at the member-specific level can be incorporated as a part of overall CCO financial reporting are ongoing. OHA is also working on a process to publish the CCOs' aggregated quarterly flexible services reports.

**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**

<p>Evaluation activities:</p>	<p>To assist in process improvement, a system for rapidly evaluating the effectiveness of the learning collaboratives was piloted in this quarter.</p> <ul style="list-style-type: none"> <li>■ This process will consistently track attendance (including the roles of attendees) and will ask participants to respond to a standard set of questions after each event (e.g., value of the session in supporting their work, actions attendees plan to take as a result of the session, what attendees found most useful, and ideas for improvement). This will allow the Transformation Center to track satisfaction from session to session, and across learning collaboratives.</li> <li>■ There are also plans to survey collaborative members on a biannual basis in order to assess their opinions of the learning collaborative process overall.</li> <li>■ This process was piloted from February to March, and preliminary results are anticipated for the next quarterly report.</li> </ul> <p>Contract negotiations for an independent, formative evaluation of the Transformation Center continued during this period. It is hoped that the contract will be finalized in the next quarter.</p>
<p>Interim findings/ Improvement activities::</p>	<p>The Transformation Center is creating a Council of Clinical Innovators, which will be a statewide, multidisciplinary cadre of innovation leaders, consultants, and mentors who are actively working with project teams to implement health care transformation projects in their local communities.</p> <ul style="list-style-type: none"> <li>■ In the last quarter the Transformation Center solicited applications for its first cohort of Clinical Innovation Fellows.</li> <li>■ Fellows will work on a systems improvement project during the program (July 2014 – June 2015) and will participate in a year-long learning experience to develop and refine skills in leadership, quality improvement, implementation and dissemination science.</li> <li>■ The goal is to create a network of expertise supporting the coordinated care model. More detail can be found in Section G.</li> </ul> <p>From January to March 2014, the Transformation Center’s three external learning collaboratives<sup>3</sup> held five sessions, attended by an average of 98 people.</p> <ul style="list-style-type: none"> <li>■ They were a mix of webinars and in-person meetings, and focused on: developmental screening; community health improvement plans; trauma-informed care in primary care settings; health equity; and, physical and mental health assessment of children in the custody of Oregon’s Department of Human Services.</li> <li>■ Each learning collaborative is meant to lead to a cycle of improvements based on feedback during and after the session.</li> </ul> <p>In addition to the learning collaboratives, the Transformation Center hosts online</p>

<sup>3</sup> The fourth learning collaborative, for OHA’s Innovator Agents, differs from the three external collaboratives (the statewide CCO Learning Collaborative with CCO Medical Directors, Behavioral Health Directors, and Quality Improvement Coordinators; the Community Advisory Council Collaborative; and, the Complex Care Collaborative). It is an all-day, in-person gathering specifically for the Innovator Agents. They meet with account representatives from OHA’s Medical Assistance Programs, have updates from internal Medicaid officials, and work with a consultant on internal transformation projects. It is not aimed at external partners. Note, though, that the Transformation Center is collecting evaluation forms after each session for process improvement purposes.

learning communities via its Groupsite Web portal.

- These learning communities are online tools that allow staff and representatives of CCOs, Community Advisory Councils (CACs), and OHA to collaborate, network and share best practices.
- There are four subgroups on the Groupsite website: The CCO community (for the Statewide CCO learning collaborative focused on incentive metrics); the CAC community; the CAC Steering Committee; and, one for Transformation Center staff.
- Total membership of two of these online learning communities, the CAC and CCO Communities, are tracked on a monthly basis, as are the number of posts.
  - From January - March 2014, membership in the CAC learning community increased from 125 to 148 members, with the number of posts ranging from 9 to 21 in the first quarter of 2014.
  - Over this same time period the CCO learning community increased from 88 to 93 members, with three to four posts to the Groupsite per month.
- Plans for the next quarter include launching a complex care community, and setting up a community for the Council of Clinical Innovators (this won't launch until July, but is being set up in the next quarter).

Through the Innovator Agents and learning collaborative activities, the Transformation Center has been identifying, collecting and compiling information on innovative or promising practices in what is being called a 'Good Ideas Bank'. The information will be housed within a searchable database on the Transformation Center website. At the end of this reporting period, 131 projects had been collected. The searchable database is scheduled to go live in June 2014.

## VI. Public Forums

### Public meetings

- Oregon Health Policy Board: January 7, February 4, March 4
- Early Learning Council and Oregon Health Policy Board Joint Subcommittee: January 7
- Future of Public Health Services Task Force: January 21, February 19, March 19
- Healthcare Workforce Committee: February 5
- Medicaid Advisory Committee: January 22, February 26, March 26
- Metrics and Scoring Committee: January 31, February 21
- Public Employee Benefits Board: February 11

### Public comments received

#### Future of Public Health Services Task Force

##### *January 21, 2014*

One citizen appeared for public comment: Gloria Krahn, PhD, MPH from Oregon State University. Dr. Krahn thanked the task force for grappling with the large issues and funding streams in public health while addressing economic resources and the framework needing to be created. She asked them to consider adding metrics and data in order to track the work and suggested if gaps aren't done by public health they will not get done.

**February 19, 2014**

Gloria Krahn, PhD, MPH from Oregon State University appeared for public comment. She is interested in the workforce development process with regards to the Guiding Principles document and recommended that the Task Force consider the broad scope of Public Health that is rooted in community and working collaboratively.

**March 19, 2014**

<p><b>Kate O’Leary, Washington County Public Health:</b></p>	<p>The state MCH budget overview talked about some state general fund that state public health gets for nurse home visiting. At Washington County we get \$58,000 for that particular program. We use county general funds to increase the services to at risk children and families, including non-Medicaid eligible children. The local county reality looks very different than the state perspective. It is that kind of map that I hope you will be able to get across all of the counties so that you compare apples to apples to understand what is the landscape. I hope you do apply what are individual services and what are populations and policy kinds of work that happens with those investment because that is important to have. Then you will have the landscape of public health funding not just one part of the system.</p>
<p><b>Rebecca Austin, Lincoln County Public Health:</b></p>	<p>I am here also representing my public health advisory council and they want to bring the message to this committee that they are thrilled that there is a statewide conversation going on about public health. They are also watching what is going on in this committee and hoping that at some point they can give some input to the process.</p> <p>Also, they are very interested with meeting with the public health advisory council from neighboring counties, Linn and Benton County, and they have had a couple of meetings already and want to continue to do that because they feel it is important that we insert the public health discussion into health care transformation, or as we like to think of as health transformation going on in Oregon. I am very excited about that because I think that one of the functions that public health does is convene partners and collaborate across many different areas as well as different jurisdictions. I cannot tell you how thrilled I am being a resident of Lincoln County to have my partners in Linn and Benton County who are awesome. Keep your eye on this region of partners who are working fearlessly to engage their whole communities and improving the health of their populations.</p> <p>One example of that partnership is our tobacco programs. Smoking is by far our biggest problem in Lincoln County and we can see that in the rate of chronic disease in the community. We are working together with Benton and Linn to build a program so we can do the policy work that is going to have to happen in all of our communities to move this forward. In Benton, they have an epidemiologist which Linn or Lincoln will never have, so they lend that epi to us. In our little region we want to work together because we see how we can move forward to helping the community to be healthier.</p> <p>I am a public health nurse and one of our biggest challenges in workforce development is when we have to recruit for nurses. It is extremely difficult to recruit for your run of the mill nurse. And if you want to have the nurse have a specialty care in public health nursing which requires a bachelor or masters, it ups the difficulty. And if you want a public health nurse and a leader, it is almost impossible in the rural areas. I hope the workforce development person can take that message back to the universities and tell them we really need more public health nurses.</p>

<b>Joselyn Warren, Oregon State University:</b>	<p>As the vice chair of Linn County’s public health advisory committee I salute your comments about inclusion of the advisory committee at the local level. We would love to be able to comment. I am reporting back to my committee in a few weeks. We don’t have a school of nursing but workforce development is a mission of our college. We have the future policy analyst, the epi, the community health planners in this state and at this time we are also re-envisioning public health education at the university level so this might be a really great time to also think about what else we can do to prepare our students for a future in public health. That approach could be case based rather than experiential learning.</p> <p>I also want to say as far workforce development that OSU has a number of extension offices around the state and that could be a resource for providing continuing education. We can think about that also in terms of doing continuing education for our public health practitioners at the local level.</p>
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## Metrics and Scoring Committee

2/19/2014

Submitted by Suzanne Browning, Executive Director of the Kemple Memorial Children’s Dental Clinic in Bend.

### Regarding overall adoption of dental metrics:

Dental metrics should address each part of the triple aim. For example:

- Reducing Cost: finding ways to deliver preventative services in non-dental settings that do not require a higher end of the dental professional categories to be involved in the less technical / restorative / specialized dental procedures; creating a diversely skilled dental professional workforce to meet the needs and a best use recommendation for the needs of the community.
- Improving Health Outcomes: measuring oral health indicators consistently over time, setting goals for improvement, and incentivizing those who contribute to this outcome.
- Quality of Patient Experience with Care: develop a formalized customer service process, administered by an outside organization, to assess the quality of care and patient experiences.

### Regarding the sealant metric:

- This measure appears to incentivize “pay for treatment” rather than incentivizing the entire community to ensure that sealant education and application are happening. The metric would be more inspiring if it incentivized everyone in the community to see the percentage of sealants rise (measured via the OHA Smile Survey) using community resources collectively, rather than focusing on dental providers.
- Experience in Central Oregon has demonstrated that doing prevention work (applying fluoride and sealants) in non-dental settings in the community (such as Migrant Education Programs, Community Medical Centers, Head Start, WIC, School-Based Health Centers, Community Associations, etc…) has been very successful.
- This is also a best use workforce issue – preventative work done by the appropriate professionals. Oregon has taken great strides to create certifications for various levels of dental work / treatments. This work should be taken advantage of and everyone should be incentivized to champion prevention, oral health literacy, and preventative treatments in a variety of venues.
- See also the RWJF study on dental professionals working in non-dental settings to increase access to preventive oral health care. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/09/dental-professionals-in-non-dental-settings.html>

- Recommend setting a baseline as the current percentage of sealants observed; then measure the percentage of sealants regularly by having various groups (private and OHP providers, community health organizations, non-profit groups, etc...) consistently measure what they observe over time. Alternately, measure through dental chart review at various intervals.

**Regarding dental exams**

- The Central Oregon Oral Health Coalition has suggested a metric measuring the number of children near one year old that receive a dental exam, and a metric on the number of pregnant women who receive a cleaning, oral health instruction, and some instruction on the impact of their health on their new baby, and how to take care of the new baby / toddler teeth.
- Frequency of dental exams should be measured for children, adults, and especially seniors. Seniors in Central Oregon have very few services available to them to access dental care (as seen in the regional oral health coalition survey) – this is a very at risk group. A metric structured like the Adolescent Well Care Visit could easily be established.
- Incorporation of dental exam results in the primary care medical provider record could also be a metric. Dental information should be transmitted to the primary care medical provider to be integrated into the patient health profile, and measuring this would encourage more awareness of the importance of dental health to overall medical health. This metric might also encourage PCPs to encourage patients to see dentists and support care coordination.

**Regarding access and patient experience:**

- Access to appointments is an important issue for the Central Oregon Oral Health Coalition. With over 13,000 new Medicaid patients in Central Oregon, there is concern there will not be enough practitioners to handle the dental needs of those coming into the system. A metric to measure patient wait time for appointments should be included.
- There is a lot of anecdotal data locally regarding inability to get in to see the dentist, long wait times for cleaning, exams, and a perceived lack of response for emergencies. A comprehensive customer satisfaction survey process should be designed and fielded by an outside agency to monitor all OHP dental providers. A customer satisfaction incentive metric might help address challenges with access, treatment, and attitude.

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

No updates to the Transition Plan this quarter.

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## VIII. Appendices

### Appendix A. Quarterly enrollment reports

#### 1. SEDS reports

[Attached separately](#) (final report for October - December 2013 and preliminary report for current quarter).

#### 2. State reported enrollment tables

Enrollment	January 2014	February 2014	March 2014
Title XIX funded State Plan Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	775,608	807,165	853,975

Enrollment	January 2014	February 2014	March 2014
Title XXI funded State Plan	91,347	93,047	96,700
Title XIX funded Expansion Populations 9, 10, 11, 17, 18	NA	NA	NA
Title XXI funded Expansion Populations 16, 20	NA	NA	NA
DSH Funded Expansion	NA	NA	NA
Other Expansion	NA	NA	NA
Pharmacy Only	NA	NA	NA
Family Planning Only	NA	NA	NA

Enrollment current as of	1/31/2014	2/28/2014	3/31/2014
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### 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%	2,028	5,615	-12.67%	10.90%
		Pregnant Women FPL > 170%	962	2,616	-12.79%	-13.83%
	Title 21	SCHIP FPL > 170	34,564	99,238	35.45%	40.65%
Optional	Title 19	PLM Women FPL 133-170%	13,132	36,200	-12.48%	-19.66%
	Title 21	SCHIP FPL < 170%	45,927	129,661	-37.92%	-45.87%
Mandatory	Title 19	Other OHP Plus	497,295	1,419,319	1.95%	-0.63%
		MAGI Adults/Children	373,246	1,056,856	100.00%	100.00%
		MAGI Pregnant Women	3,480	9,925	100.00%	100.00%
<b>QUARTER TOTALS</b>			970,634			

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

#### OHP eligibles and managed care enrollment

OHP Eligibles*	Coordinated Care				Physical Health	Dental Care	Mental Health	
	CCOA**	CCOB**	CCOE**	CCOG**	FCHP	DCO	MHO	
January	821,221	467,130	207,650	13,294	24,574	3,484	258,736	4,300
February	854,288	497,979	216,147	13,525	24,898	3,442	270,472	4,278
March	901,108	517,455	221,568	13,634	25,072	3,409	275,365	4,326
Qtr Average	858,872	494,188	215,122	13,484	24,848	3,445	268,191	4,301
		57.54%	25.05%	1.57%	2.89%	0.40%	31.23%	0.50%

\*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 reporting period, OHA continued to produce preliminary 2013 “progress report” data at the state and CCO level, and continued to stratify those data by race and ethnicity. This quarterly report builds on the January – September 2013 data and provides a first look at January – December 2013 data for all measures where available. **These data are still preliminary and do not reflect state or CCO final performance for 2013.**

Year One Technology Plans were accepted and reviewed during this quarter; OHA paid the advance distribution of the 2013 quality pool related to this requirement.

OHA continued work on the quality and access “test” during this period: details on data validation performed by OHA’s contractor Oregon Health Care Quality Corporation and ‘dry run’ data are included in this report.

### CCO Incentive Metrics Updates

#### *Clinical Measures (Diabetes, Hypertension, and Depression)*

Year One Technology Plans that describe the CCOs plans to build capacity to collect and report on these three clinical metrics electronically were due to OHA on February 1, 2014. All 16 CCOs submitted their year one technology plans on time.

Once received, technology plans undergo a two-step approval process: 1) initial review for completeness and 2) secondary review for content. Thirteen of the 16 CCOs received a request for additional information or clarification during the secondary review. As of March 31<sup>st</sup>, all 16 plans have successfully passed the initial review and 9 plans have passed the secondary review. OHA projects approval for the final 6 organizations to occur in mid-April (see table below).

Additional details on the review process available online in the Year One Technology Plan Review Guide: <http://www.oregon.gov/oha/CCODData/Technology%20Plan%20Review%20Guide.pdf>

As per the November 2013 agreement with CMS, approval of the Year One Technology Plan results in an advance distribution of 75 percent of 3/17ths of their maximum quality pool. Seven CCOs were approved by March 31<sup>st</sup> with approval for the remaining CCOs anticipated by mid-April (see table below).

OHA also published guidance for CCOs outlining the requirements for reporting the proof of concept data on the three clinical metrics:

[www.oregon.gov/oha/CCODData/Year%20One%20Proof%20of%20Concept%20Data%20Submission%20Guidance.pdf](http://www.oregon.gov/oha/CCODData/Year%20One%20Proof%20of%20Concept%20Data%20Submission%20Guidance.pdf)

## Oregon Health Authority

The table below provides the amounts of the advance distribution and year one technology plan approval dates:

CCO	Advance Distribution for Year One Technology Plan (75% of 3/17ths of total quality pool)	Approved On
AllCare Health Plan	\$344,220	March 31, 2014
Cascade Health Alliance	\$44,118	Projected approval date: April 1, 2014
Columbia Pacific CCO	\$185,546	March 31, 2014
Eastern Oregon CCO	\$290,780	Projected approval date: April 14, 2014
FamilyCare	\$546,974	March 10, 2014
Health Share of Oregon	\$1,740,874	March 10, 2014
Intercommunity Health Network	\$416,235	March 31, 2014
Jackson Care Connect	\$233,255	March 31, 2014
PacificSource Community Solutions <sup>4</sup>	\$432,488	March 10, 2014
PrimaryHealth of Josephine County	\$132,353	Projected approval date: April 14, 2014
Trillium Community Health Plan	\$4,755,000	Projected approval date: April 14, 2014
Umpqua Health Alliance	\$216,880	Projected approval date: April 14, 2014
Western Oregon Advanced Health	\$136,944	Projected approval date: April 14, 2014
Willamette Valley Community Health	\$611,635	Projected approval date: April 1, 2014
Yamhill CCO	\$144,105	Projected approval date: April 14, 2014

The **Metrics Technical Advisory Workgroup (Metrics TAG)** continued to meet throughout this reporting period to address details of the incentive measure specifications and make connections across analytic activities. Topics addressed this quarter include:

- Feedback on the proof of concept data submission required format;
- Updates on the CAHPS and Medicaid Behavioral Risk Factor Surveillance System surveys;
- Updates on the revised USDOJ measures;
- Troubleshooting exclusion criteria and notification files for children entering DHS custody.

A webpage for the Metrics TAG was also established: [www.oregon.gov/oha/Pages/metricsTAG.aspx](http://www.oregon.gov/oha/Pages/metricsTAG.aspx)

The **Dental Quality Metrics Workgroup** met twice more during this quarter to address feedback from their presentation to the Metrics & Scoring Committee in December 2013 and prepare a revised recommendation for the Committee.

The workgroup presented their revised recommendation to the Committee in February 2014. The Committee adopted one of the recommended measures as a CCO Incentive Measure for 2015: sealants on

<sup>4</sup> While OHA has been reporting PacificSource Community Solutions data by their two regions (Central Oregon and Columbia Gorge) – PacificSource only had one contract and will only receive one quality pool payment for 2013.

permanent molars for children. The workgroup’s presentation is available online at:

[www.oregon.gov/oha/MetricsMeetingMaterials/February%202014,%202014%20Dental%20Materials.pdf](http://www.oregon.gov/oha/MetricsMeetingMaterials/February%202014,%202014%20Dental%20Materials.pdf)

The Committee also requested the workgroup bring back a third recommendation related to dental quality metrics for adults, particularly young adults (21 – 30) and pregnant women. The workgroup will meet again in April. All workgroup materials are available online at:

<http://www.oregon.gov/oha/Pages/DentalQualityMetrics.aspx>

The **Metrics & Scoring Committee** met in January and February 2014. In these meetings, the Committee adopted bylaws, adopted one additional code for the 2014 SBIRT measure specifications, and established 2014 benchmarks for colorectal cancer screening and diabetes: HbA1c poor control. The Committee agreed to adopt a benchmark for depression screening in June 2014, when proof of concept data from 2013 is available. See the updated 2014 benchmark table below.

The Committee also adopted one dental quality measure for 2015: sealants on permanent molars for children. The Committee will begin the process of selecting measures for 2015 in April.

CCO Incentive Measure	2013 Benchmark	2014 Benchmark	2014 Improvement Target
<b>Adolescent well care visits</b>	53.2% <i>2011 National Medicaid 75<sup>th</sup> percentile (admin data only)</i>	57.6% <i>2013 National Medicaid 75<sup>th</sup> percentile (admin data only)</i>	Minnesota method <sup>5</sup> with 3 percentage point floor.
<b>Alcohol and drug misuse (SBIRT)</b>	13% <i>Committee consensus.</i>	13% unless CCOs demonstrate higher performance in 2013. Review in Q1 2014.	Minnesota method with 3 percentage point floor.
<b>Ambulatory care: emergency dept. utilization</b>	44.4/1,000 member months <i>2011 National Medicaid 90<sup>th</sup> percentile</i>	44.6/1,000 member months <i>2013 National Medicaid 90<sup>th</sup> percentile</i>	Minnesota method
<b>CAHPS: Access to Care</b>	87% <i>Average of the 2012 National Medicaid 75<sup>th</sup> percentiles for adult and child rates.</i>	88% <i>Average of the 2013 National Medicaid 75<sup>th</sup> percentiles for adult and child rates.</i>	Minnesota method with 2 percentage point floor.
<b>CAHPS: Satisfaction with Care</b>	84% <i>Average of the 2012 National Medicaid 75<sup>th</sup> percentiles for adult and child rates.</i>	89% <i>Average of the 2013 National Medicaid 75<sup>th</sup> percentiles for adult and child rates.</i>	Minnesota method with 2 percentage point floor.
<b>Colorectal cancer screening</b>	n/a – improvement target only	47% <i>Committee consensus</i>	n/a
<b>Developmental screening</b>	50% <i>Committee consensus.</i>	50% <i>Committee consensus.</i>	Minnesota method.
<b>Depression screening and follow up plan</b>	n/a – CCO earned quality pool for this measure by submitted	TBD by Committee in June 2014	n/a

<sup>5</sup> Additional information about the Improvement Target methodology is available online at:

<http://www.oregon.gov/oha/CCODData/Improvement%20Targets%20--%20Revised%20September%202013.pdf>

CCO Incentive Measure	2013 Benchmark	2014 Benchmark	2014 Improvement Target
	technology plan and proof of concept data.		
<b>Diabetes: HbA1c poor control</b>	n/a – CCO earned quality pool for this measure by submitted technology plan and proof of concept data.	34% <i>2013 National Medicaid 75<sup>th</sup> percentile</i>	n/a
<b>Early elective delivery</b>	5% or below <i>Committee consensus.</i>	5% or below <i>Committee consensus</i>	Minnesota method with 1 percentage point floor.
<b>Electronic Health Record Adoption</b>	49.2% <i>Federal benchmark for EHR adoption by 2014.</i>	72% <i>Committee consensus, based on highest performing CCO in July 2013.</i>	Minnesota method with 3 percentage point floor.
<b>Follow up after hospitalization for mental illness</b>	68% <i>2012 National Medicaid 90<sup>th</sup> percentile</i>	68.8% <i>2013 National Medicaid 90<sup>th</sup> percentile.</i>	Minnesota method with 3 percentage point floor.
<b>Follow up for children prescribed ADHD medication (initiation rate)</b>	51% <i>2012 National Medicaid 90<sup>th</sup> percentile</i>	51% <i>2013 National Medicaid 90<sup>th</sup> percentile</i>	Minnesota method.
<b>Mental and physical health assessments for children in DHS custody</b>	90% <i>Committee consensus.</i>	90% <i>Committee consensus.</i>	Minnesota method with 3 percentage point floor.
<b>Patient Centered Primary Care Home (PCPCH) enrollment</b>	Goal: 100% of members enrolled in Tier 3 PCPCH	Goal: 100% of members enrolled in Tier 3 PCPCH	n/a
<b>Timeliness of prenatal care</b>	69.4% <i>2012 National Medicaid 75<sup>th</sup> percentile, admin data only.</i>	90% <i>2013 National Medicaid 75<sup>th</sup> percentile</i>	Minnesota method.

All Committee materials are available online at: <http://www.oregon.gov/oha/Pages/metrix.aspx>.

**CCO Incentive Measure Guidance**

OHA has revised one guidance document and provided a new one for the CCO incentive measures during this quarter. All documents are posted online at <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.

- Colorectal Cancer Screening Overview, revised January 2014
- Mental and Physical Health Assessments for Children in DHS Custody, March 2014.

**Remaining State Performance (Test) Measure Status:**

**Provider Access Questions from the Physician Workforce Survey:** OHA initially reported baseline data from the 2012 physician workforce survey on the percent of primary care providers that are accepting new Medicaid / Oregon Health Plan patients, and the percent of primary care providers that currently care for Medicaid / Oregon Health Plan patients.

As the physician workforce survey is not fielded annually, OHA is continuing to explore alternate data sources for this measure, including physician licensing survey data and adding questions to the provider survey being fielded in Oregon as part of the national State Innovations Model (SIM) grant evaluation.

### Public Reporting and Reporting to CCOs

OHA continued public reporting on many of the CCO incentive and state performance measures with the fourth Oregon Health Authority Health System Transformation Quarterly Progress report, released in early February 2014. This report expands on the data provided in the November 2013 report and includes state and CCO level data for January – September 2013 for many of the 33 state performance measures.

Highlights include:

- *Decreased emergency department visits.* Nine months of reporting shows that emergency department visits have decreased 13 percent from the 2011 baseline.
- *Decreased hospitalization for chronic conditions.* Nine months of reporting shows CCOs reduced hospital admissions for congestive heart failure by 32 percent, chronic obstructive pulmonary disease by 36 percent and adult asthma by 18 percent.
- *Increased primary care.* Nine months of reporting shows enrollment in patient centered primary care homes has increased 51 percent since 2012, the baseline year for that program. Twelve months of expenditure data show that spending for primary care is up by more than 18 percent.
- *Increased adoption of electronic health records.* Electronic health record adoption among measured providers has doubled. In 2011, 28 percent of eligible providers had EHRs. By September 2013, 58 percent of them had adopted EHRs.

The report is available online at: <http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf>. This report will be next published on July 1, 2014.

### Reporting to CCOs

OHA provided CCOs with two progress reports containing preliminary 2013 data during this reporting period.

- The January 17<sup>th</sup> report included January – September 2013 data on 9 of the 17 CCO incentive measures and an additional 11 state performance measures.
- The March 14<sup>th</sup> report included preliminary January – December 2013 data, using all encounter data received through February 11, 2014. This report included 11 of the 17 CCO incentive measures and an additional 11 state performance measures.

OHA also provided each CCO with lists of identified members who are being “counted” in each measure, to support data validation and quality improvement initiatives. This progress reporting allows CCOs to monitor their performance on the incentive measures and determine where quality improvement efforts need to be focused for 2014.

### Quality and Access Test Methodology Review

OHA and its contractor, the Oregon Health Care Quality Corporation (Q Corp) have been conducting a multi-directional validation process on the CCO incentive measures and state performance measures. The document included below describes Q Corp’s validation activities for these measures.

### Dry Run Results

The dry run results calculated by Q Corp and dropped into the composite methodology agreed upon in Attachment H of the waiver are also included in the report below (Appendix B).

**CCO Measure Production – Q Corp Validation Activities**  
**April 29, 2014**



The Oregon Health Authority (OHA) has contracted with the Oregon Health Care Quality Corporation (Q Corp) to provide consulting and validation for the incentive and quality and access test metrics that are being computed as part of the Coordinated Care Organization (CCO) implementation. These metrics are being produced to ensure the CCOs are improving the quality of care for their enrollees. This document will describe the steps taken by Q Corp to validate these measures.

**Consulting on Measure Specifications**

The OHA used standard measure specifications for the majority of the CCO metrics. However, the OHA Metrics & Scoring Committee approved a small number of deviations from the specifications. The majority of these deviations were prompted by a need to account for transformation activities within the CCOs; for example, innovative efforts to integrate physical and behavioral health. In other cases the deviations were incorporated to account for the transition from enrollment in the previous managed care organizations structure to the new CCO structure.

The OHA also developed custom specifications for the following performance measures:

- Alcohol and Drug Misuse (SBIRT)
- Colorectal Cancer Screening (rate/1000)
- Early Elective Delivery
- Electronic Health Record (EHR) Adoption
- Mental and Physical Health Assessments for Children in DHS Custody
- Patient Centered Primary Care Home (PCPCH) Enrollment

In these cases, there was no standardized measure available to assess performance in a specific category.

Q Corp staff reviewed all of the CCO measure specifications published by the OHA. The individual CCOs are using the specifications to track their performance internally, so it was essential to ensure the specifications provided explicit instructions that were not subject to interpretation. The primary focus of Q Corp's review was to ensure the specifications were clear and did not contain ambiguities regarding input data or metric methodology. The OHA incorporated Q Corp feedback regarding specification accuracy and clarity.

**Validation of Measures Computed with Administrative Claims**

There are twenty-two measures that are computed using administrative claims data. Q Corp has validated sixteen of these to date, and is currently in the process of validating the remaining six. Q Corp engaged in several activities to ensure the results reported by OHA were accurate.

Q Corp staff reviewed all of the OHA programming code used to produce the measures. The code was compared to measure specifications to ensure the correct algorithms were being used to identify numerator and denominator populations. Feedback on coding errors was provided to the OHA and recommended corrections were incorporated.

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

The parallel test was an iterative exercise. There were differences in the underlying source data that made it difficult to ensure the same population was included in both measure sets. The OHA provided a list of the member identifiers that were included in their baseline calculations. This list was matched to the Q Corp data set; 99.5% of the members on the OHA list were found in the Q Corp data. Q Corp computed the measures for this list of members to determine how closely they matched the measures produced by the OHA. Comparisons were made on numerators, denominators, and the overall rates. A variance of +/- 5% was considered acceptable. Appendix A contains the results of this parallel test.

**Note: The remainder of this document describes future work to be completed by Q Corp. Contents may change as the work is completed.**

#### Validation of Immunization Measures

There are two immunization measures included in the Test and Access measures that are reported to CMS:

- Childhood immunization status (NQF 0038)
- Immunization for adolescents (NQF 1407)

There are HEDIS specifications to calculate these two measures using administrative claims data. However, the use of administrative claims is often problematic due to the inaccurate capture of all immunizations in claims data sets. The OHA chose to use the HEDIS specifications to identify the denominator population for both of these measures. These two lists of patients were then sent to the Oregon Immunization Program to be matched against the immunization registry (ALERT). A file indicating which children had obtained immunizations was created, and was then used to calculate the measures.

Twelve health plans, the Oregon Health Authority, and Centers for Medicare & Medicaid Services (CMS) contributed administrative medical and pharmacy claims data to Q Corp for various Q Corp reporting initiatives. To validate the denominator, Q Corp used the Medicaid data in their aggregated data set to produce the two immunization measures. The resulting denominators were compared to the denominators produced by the OHA.

To validate the numerators, Q Corp will review the code used to compile the ALERT data to ensure the algorithm matches the HEDIS specifications. In addition, Q Corp will review the documentation of the process to ensure it is complete.

### **Validation of Clinical Measures**

There are three clinical measures included in the list for CCO incentive payments:

- Screening for clinical depression and follow-up plan (NQF 0418)
- Controlling high blood pressure (NQF 0018)
- Diabetes: HbA1c Poor Control (NQF 0059)

There are no incentive payments tied to performance on these measures for calendar year 2013. Instead, the CCOs submitted a Technology Plan that described the steps they would be taking to develop the capability to report these measures through clinical electronic health record (EHR) systems in the future. The CCOs will also submit proof of concept data in May of 2014 as part of this technology plan.

The OHA requested that Q Corp review the proof of concept data to ensure that it included the information outlined in the individual technology plans. The OHA also requested that Q Corp review the code from the EHR vendors where possible to ensure proof of concept data met meaningful use specifications.

### **Early Elective Delivery Rate**

The following modified approach to calculating the Early Elective Delivery rate was approved by the Metrics & Scoring Committee in August 2013.

To determine early elective delivery rates at the CCO level, OHA will:

1. Determine the number of women who delivered between 37 and 39 weeks for each CCO.
2. Categorized this data by birthing hospitals within each CCO.
3. Apply each hospital's overall rate for Early Elective Deliveries as they reported it to The Joint Commission or CMS for 2011 to the number of births for that hospital, creating a weighted average for each CCO.

If the hospital did not report a rate to either The Joint Commission or CMS in 2011, OHA will assume that the hospital's rate was equivalent to the state average and apply the state average to deliveries at those facilities when calculating the weighted average.

The OHA requested that Q Corp produce a document describing the pros and cons of the methodology to estimate the elective delivery rate. Q Corp will also validate the calculations produced by the OHA.

**Patient-Centered Primary Care Home Enrollment**

Patient-Centered Primary Care Home Enrollment is based on data the CCOs submit to the OHA on a quarterly basis. The CCOs are contractually required to report this information.

Q Corp will compare the PCPCH enrollment numbers that were self-reported by the CCOs to the data that has been collected by the PCPCH program. Q Corp will also review the results produced by the OHA to ensure the calculations were correct.

**EHR Adoption**

This measure determines the providers in a Coordinated Care Organization's (CCO) service area that qualified for incentive payments under the Medicaid, Medicare, or Medicare Advantage EHR Incentive Program for adoption or meaningful use of certified EHR technology, compared to an estimate of the providers in the CCO's network who were eligible to receive these payments.

Q Corp will validate the code produced by the OHA to ensure that all criteria have been applied correctly.

**Mental and Physical Health Assessment within 60 days for children in DHS custody**

The CCO incentive measure looks at whether a child who enters DHS custody and is placed in foster care and who is enrolled in a CCO receives appropriate assessment(s) within 60 days of OHA/DHS providing notification to the CCO that the child had entered DHS custody and been placed in foster care:

- A child who is 4 years of age or older as of the date of DHS custody is expected to receive both a physical health assessment and a mental health assessment within 60 days; and
- A child who is under 4 years of age as of the date of DHS custody is expected to receive a physical health assessment within 60 days.

Q Corp will validate the code that calculates the numerator for this measure.

Appendix A – Dry Run Results Validated as of April 29, 2014

Measure Names	Incentive Measure	Q&A Test Measure	Benchmark	2011 OHA Baseline (1/01/11-12/31/11)	Q Corp Dry Run (7/01/12-6/30/13)	Variation from Baseline
Alcohol or other substance misuse (SBIRT)	X	X	13.0%	0.02%	0.13%	0.11%
Ambulatory Care: Emergency Department Utilization (Visits per 1000)	X	X	44.4	61.0	59.9	(1.1)
Ambulatory Care: Outpatient Utilization (Visits per 1000)		X	439.0	364.2	398.8	34.6
Developmental screening in the first 36 months of life (NQF 1448)	X	X	50.0%	20.9%	24.4%	3.5%
Adolescent well-care visits (NQQA)	X	X	53.2%	27.1%	26.7%	-0.4%
Plan all-cause readmission (NQF 1768)		X	10.5%	12.3%	13.4%	1.1%
Appropriate testing for children with pharyngitis (NQF 0002)		X	76.0%	73.1%	70.9%	-2.2%
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		X	80.0%	67.2%	66.8%	-0.4%
Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)		X	86.0%	78.5%	78.6%	0.1%
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		X	N/A	192.9	240.7	47.8
PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		X	N/A	454.6	260.8	(193.8)
PQI 08: Congestive heart failure admission rate (NQF 0277)		X	N/A	336.9	253.1	(83.8)
PQI 15: Adult asthma admission rate (NQF 0283)		X	N/A	53.4	55.6	2.2
Chlamydia screening in women ages 16-24 (NQF 0033)		X	63.0%	59.9%	53.1%	-6.8%
Cervical cancer screening (NQF 0032)		X	74.0%	56.1%	56.2%	0.1%
Child and adolescent access to primary care practitioners (NQQA)		X	N/A	88.5%	86.1%	-2.4%
Age 12 months to 24 months		X	N/A	97.4%	95.2%	-2.2%
Age 25 months to 6 years		X	N/A	86.2%	83.3%	-2.9%
Age 7 years to 11 years		X	N/A	88.2%	86.2%	-2.0%
Age 12 years to 19 years		X	N/A	88.9%	86.7%	-2.2%
Childhood immunization status (NQF 0038)*		X	82.0%	66.0%	18.4%	-47.6%
Immunization for adolescents (NQF 1407)*		X	70.8%	49.2%	41.4%	-7.8%

\* Administrative data only used to validate denominators.

**Appendix B: Dry Run Results in Composite Methodology**

Using validated data as of April 29, 2014

Measure Names	Incentive Measure	Q&A Test Measure	Benchmark	Baseline Result	Q Corp Dry Run Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Alcohol or other substance misuse (SBIRT)	X	X	<b>13.0%</b>	0.02%	0.13%	0.11%	12.98%	0.8%	Y	
Follow-up after hospitalization for mental illness (NQF 0576)	X	X	<b>68.0%</b>	65.2%	52.5%	-12.70%	2.80%	-453.6%	N	Validation not complete.
Follow-up care for children prescribed ADHD meds (NQF 0108)										
Initiation Phase	X	X	<b>51.0%</b>	52.3%	63.8%	11.50%	-1.30%	-884.6%	N	Negative result with baseline exceeds benchmark
Continuation Phase		X	<b>63.0%</b>	61.0%	67.6%	6.60%	2.00%	330.0%	N	Validation not complete.
Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	X	X	<b>69.4%</b>	65.3%	58.6%	-6.70%	4.10%	-163.4%	N	Validation not complete.
Ambulatory Care: Outpatient and ED utilization										
ED Visits per 1000	X	X	<b>44.4</b>	61.0	59.9	(1.1)	(16.6)	6.6%	Y	
OP Visits per 1000		X	<b>439.0</b>	364.2	398.8	34.6	74.8	46.3%	Y	
Colorectal cancer screenings per 1000 members	X	X	<b>11.0</b>	10.7	8.6	(2.1)	0.3	-654.2%	N	Validation not complete.

Measure Names	Incentive Measure	Q&A Test Measure	Benchmark	Baseline Result	Q Corp Dry Run Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Developmental screening in the first 36 months of life (NQF 1448)	X	X	50.0%	20.9%	24.4%	3.50%	29.10%	12.0%	Y	
Adolescent well-care visits (NQQA)	X	X	53.2%	27.1%	26.7%	-0.40%	26.10%	-1.5%	Y	
Prenatal and postpartum care: Postpartum Care Rate (NQF 1517)		X	40.0%	31.6%	29.7%	-1.90%	8.40%	-22.6%	N	Validation not complete.
Plan all-cause readmission (NQF 1768)		X	10.5%	12.3%	13.4%	1.10%	-1.80%	-61.1%	Y	
Well-child visits in the first 15 months of life (NQF 1392)		X	77.3%	68.3%	42.1%	-26.20%	9.00%	-291.1%	N	Validation not complete.
Childhood immunization status (NQF 0038)		X	82.0%	66.0%		-66.00%	16.00%	-412.5%	N	OHA must provide data.
Immunization for adolescents (NQF 1407)		X	70.8%	49.2%		-49.20%	21.60%	-227.8%	N	OHA must provide data.
Appropriate testing for children with pharyngitis (NQF 0002)		X	76.0%	73.1%	70.9%	-2.20%	2.90%	-75.9%	Y	
Comprehensive diabetes care: LDL-C Screening (NQF 0063)		X	80.0%	67.2%	66.8%	-0.40%	12.80%	-3.1%	Y	

Measure Names	Incentive Measure	Q&A Test Measure	Benchmark	Baseline Result	Q Corp Dry Run Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)		X	86.0%	78.5%	78.6%	0.10%	7.50%	1.3%	Y	
PQI 01: Diabetes, short term complication admission rate (NQF 0272)		X	173.6	192.9	240.7	47.8	(19.3)	-247.8%	Y	
PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)		X	409.1	454.6	260.8	(193.8)	(45.5)	426.3%	Y	
PQI 08: Congestive heart failure admission rate (NQF 0277)		X	303.2	336.9	253.1	(83.8)	(33.7)	248.7%	Y	
PQI 15: Adult asthma admission rate (NQF 0283)		X	48.1	53.4	55.6	2.2	(5.3)	-41.2%	Y	
Chlamydia screening in women ages 16-24 (NQF 0033)		X	63.0%	59.9%	53.1%	-6.80%	3.10%	-219.4%	Y	
Cervical cancer screening (NQF 0032)		X	74.0%	56.1%	56.2%	0.10%	17.90%	0.6%	Y	
Child and adolescent access to primary care practitioners (NCQA)		X	93.6%	88.5%	86.1%	-2.40%	5.10%	-47.1%	Y	

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Measure Names	Incentive Measure	Q&A Test Measure	Benchmark	Baseline Result	Q Corp Dry Run Result	Diff Baseline to Current (Num)	Diff Target to Baseline (Den)	Translated Level of Performance	Include in Composite	Reason for Exclusion
Electronic Health Record Adoption	X	X	49.2%	28.0%		-28.00%	21.20%	-132.1%	N	OHA must provide data.
PCP Enrollment	X	X	100.0%	51.8%		-51.80%	48.20%	-107.5%	N	OHA must provide data.

**Number of Measures**  
**Included in Composite:** 16  
**Average Percent**  
**Improvement in Rate**  
**(Composite Score):** 2.9%

**Core Performance Measure Development**

OHA has continued development work on the core performance measures outlined in the waiver; 2011 baseline data and January – September 2013 data at the state level is included in the table below, as are high and low CCO performance on each measure where possible.

OHA anticipates being able to report data for the following outstanding measures beginning in May 2014: potentially avoidable emergency department utilization, medication reconciliation post-discharge, initiation and engagement in alcohol and drug treatment, mental health assessments for children in DHS custody, and low birth weight.

Core Performance Measures	2011 Baseline			Jan – Sept 2013 Progress			Data Source
	State Level	High CCO	Low CCO	State Level	High CCO	Low CCO	
<b>Member / patient experience of care (CAHPS or similar)</b>	Access to care: 83%  Satisfaction w/care: 78%	Access: 90%  Satisfaction: 83%	Access: 81%  Satisfaction: 70%	--	--	--	CAHPS
<b>Health and functional status among CCO enrollees</b>	Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (Excellent, Very Good): 23%	25.1%	15.8%	--	--	--	CAHPS
<b>Rate of tobacco use among CCO enrollees (lower rate is better)</b>	31%	42%	23%	--	--	--	CAHPS
<b>Rate of obesity among CCO enrollees (lower rate is better)</b>	37%	Baseline data not available at CCO level.	Baseline data not available at CCO level.	--	Data not available at CCO level.	Data not available at CCO level.	BRFSS
<b>Ambulatory care: outpatient and ED utilization (lower score is better)</b>	Outpatient (OP): 364.2/1,000 mm  Emergency department (ED): 61/1,000 mm	OP: 412.3/1,000 mm  ED: 86.4/1,000 mm	OP: 296.9/1,000 mm  ED: 41.4/1,000 mm	OP: 334.8/1,000 mm  ED: 53.1/1,000 mm	OP: 383.7/1,000 mm  ED: 77.3/1,000 mm	OP: 285.0/1,000 mm  ED: 34.0/1,000 mm	Claims
<b>Potentially avoidable ED utilization</b>	TBD	TBD	TBD	TBD	TBD	TBD	Claims
<b>Ambulatory care sensitive hospital admissions</b>	See PQI matrix below.	See PQI matrix below.	See PQI matrix below.	See PQI matrix below.	See PQI matrix below.	See PQI matrix below.	Claims
<b>Medication reconciliation post-discharge</b>	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Oregon Health Authority

Core Performance Measures	2011 Baseline			Jan – Sept 2013 Progress			Data Source
	State Level	High CCO	Low CCO	State Level	High CCO	Low CCO	
Plan All-Cause Readmissions (lower is better)	12.3%	14.6%	8.6%	11.3%	14.7%	5.9%	Claims
SBIRT	0.02%	0.22%	0.00%	0.7%	4.0%	0.0%	Claims
Initiation & Engagement in alcohol and drug treatment	TBD	TBD	TBD	TBD	TBD	TBD	Claims
Mental health assessment for children in DHS custody	56.0% (MH only, composite rate for mental health and physical health assessments reported in the full Measures Matrix below)	76.7%	23.0%	--	--	--	Claims + ORKIDS
Follow up after hospitalization for mental illness	65.2%	88.9%	57.1%	66.4%	81.3%	48.4%	Claims
Effective contraceptive use among women who are at risk of unintended pregnancy.	62.1%	Baseline data not available at CCO level.	Baseline data not available at CCO level.	76.5% (2012)	Data not available at CCO level.	Data not available at CCO level.	BRFSS
Low birth weight	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Developmental screening	20.9%	67.1%	0.2%	31.7%	61.9%	8.6%	Claims
Differences in these metrics between race/ethnic categories	OHA has reported 2011 baseline data by race/ethnicity for a number of measures. Baseline data are available in the Oregon Health Policy Board (OHPB) Health System Transformation quarterly progress report, available online here: <a href="http://www.oregon.gov/oha/Metrics/Pages/measures.aspx">www.oregon.gov/oha/Metrics/Pages/measures.aspx</a>			2013 data by race/ethnicity will be available in July 2014.			See above, plus enrollment data.

**PQI Matrix**

All rates per 100,000 member years. Lower rates are better. OHA anticipates updating the full PQI matrix in May 2014.

Prevention Quality Indicators (Lower is better)	2011 Baseline			Jan – Sept 2013 Progress		
	State Level	High CCO	Low CCO	State Level	High CCO	Low CCO
PQI 01: Diabetes short term complication rate	192.9	360.8	0.0	203.8	373.8	22.1
PQI 02: Perforated appendix	33.1	202.4	8.9	--	--	--
PQI 03: Diabetes long term complication rate	187.9	545.0	71.4	--	--	--

Prevention Quality Indicators (Lower is better)	2011 Baseline			Jan – Sept 2013 Progress		
	State Level	High CCO	Low CCO	State Level	High CCO	Low CCO
PQI 05: COPD	454.6	766.3	62.3	292.7	646.4	56.0
PQI 07: Hypertension	43.9	295.9	0.0	--	--	--
PQI 08: Congestive Heart Failure	336.9	611.9	177.2	229.3	385.2	82.8
PQI 10: Dehydration	120.9	358.1	45.1	--	--	--
PQI 11: Bacterial Pneumonia	388.5	626.0	195.0	--	--	--
PQI 12: Urinary Infection	211.0	464.2	32.5	--	--	--
PIQ 13: Angina	14.0	62.3	12.2	--	--	--
PQI 14: Diabetes Uncontrolled	19.5	45.1	6.3	--	--	--
PQI 15: Adult Asthma	53.4	180.3	11.9	43.8	59.6	0
PQI 16: Diabetes – Lower Extremity Amputation	24.0	80.2	0.0	--	--	--

**Appendix E: Oregon Measures Matrix**

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

[This quarterly report provides a first look at January – December 2013 data for all measures where available. Please note preliminary Jan – Dec 2013 data was run using all encounters submitted through February 11, 2014 and are incomplete. These rates do not reflect state or CCO final performance for 2013.](#)

Updates from Q1 2014 report are indicated in track changes.

Focus Area	Measure Sets						Quality and Access 'Test'		CCO Incentive Targets		Reporting			
	Measures	CCO Incentive Measures	1115 Demonstration Core Performance Measures	CMS Medicaid Adult Core Measures	CMS CHIPRA Core Measures	Oregon Quality & Access 'Test' Measures	2011 Baseline	2013 Benchmark	Improvement from Baseline Target	2013 Benchmark Target	Baseline CY 2011	Jan – June 2013	Jan – Sept 2013	Prelim Jan – Dec 2013
Improving behavioral and physical health coordination	*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: 0.10% High CCO: 0.38% Low CCO: 0.00%	State: 0.65% High CCO: 3.97% Low CCO: 0.00%	<a href="#">State: 1.75%</a> <a href="#">High CCO: 8.35%</a> <a href="#">Low CCO: 0.01%</a>
	* Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	State: 65.2% High CCO: 88.9% Low CCO: 57.1%	State: 64.6% High CCO: 90.9% Low CCO: 45.5%	State: 66.4% High CCO: 81.3% Low CCO: 48.4%	<a href="#">State: 67.2%</a> <a href="#">High CCO: 81.0%</a> <a href="#">Low CCO: 52.5%</a>
	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	n/a
	*Mental and physical health	√	√				53.6%	90% Metrics & Scoring	MN method with 3% floor.	90%	State: 53.6% High	n/a	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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	assessment within 60 days for children in DHS custody						Committee consensus			CCO: 67.7% Low CCO: 35.7%				
	*Follow-up care for children prescribed ADHD meds (NQF 0108)	√			√	√	Initiation: 52.3% C&M: 61.0%	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 <sup>th</sup> percentile	MN method	Initiation: 51% C&M: 63.0% Medicaid 2012 NCQA National 90 <sup>th</sup> percentile	Initiation: State: 52.3% High CCO: 88.9% Low CCO: 33.3% C&M: State: 61.0% High CCO: 100% Low CCO: 29.4%	Initiation: State: 49.2% High CCO: 85.7% Low CCO: 33.3% C&M data not available	Initiation: State: 54.1% High CCO: 73.0% Low CCO: 38.0% C&M: State: 61.7% CCO data not available.	<a href="#">Initiation: State: 52.2% High CCO: 68.8% Low CCO: 39.1%</a> C&M data not yet available.
Improving perinatal and maternity care	*Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)	√			√	√	65.3% using admin data only.	69.4% 2012 National Medicaid 75 <sup>th</sup> percentile: (adjustment factor applied to account for difference between admin data and hybrid rates)	MN method with 3% floor.	69.4% 2012 National Medicaid 75 <sup>th</sup> percentile: (w/ adjustment factor)	State: 65.3% High CCO: 77.0% Low CCO: 47.7%	Data not available	State: 69.0% CCO data not available	2013 data not yet available.
	*Prenatal and postpartum			√		√	40.0% using	43.1%2012	n/a	n/a	State: 40.0%	n/a	State: 31.6%	2013 data not yet

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	care: postpartum care rate (NQF 1517)						admin data only	National Medicaid 75 <sup>th</sup> percentile (adjustment factor applied)			High CCO: 47.1% Low CCO: 22.6%		CCO data not available	<a href="#">available</a>
	PC-01: Elective delivery (NQF 0469)	√		√		√	10.1%	5% or below.	MN method with 1% floor.	5% or below.	State: 10.1% High CCO: 14.9% Low CCO: 7.2%	n/a	n/a	2013 data not yet available
Reducing preventable re-hospitalizations	*Follow-up after hospitalization for mental illness (NQF 0576)	√	√	√	√	√	65.2%	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	68.0% 2012 National Medicaid 90 <sup>th</sup> percentile	State: 65.2% High CCO: 88.9% Low CCO: 57.1%	State: 64.6% High CCO: 90.9% Low CCO: 45.5%	State: 66.4% High CCO: 81.3% Low CCO: 48.4%	<a href="#">State: 67.2%</a> <a href="#">High CCO: 81.0%</a> <a href="#">Low CCO: 52.5%</a>
	*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 90 <sup>th</sup> percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	ED State: 61.0/ 1,000mm High CCO: 86.2/ 1,000mm Low CCO: 55.4/ 1,000mm State: 364.2/ 1,000mm	ED State: 55.2/ 1,000mm High CCO: 77.0 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 339.7/ 1,000mm	ED State: 53.1/ 1,000 mm High CCO: 77.3 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 334.8/ 1,000mm	<a href="#">ED State: 51.1 / 1,000 mm</a> <a href="#">High CCO: 74.1 / 1,000mm</a> <a href="#">Low CCO: 30.4 / 1,000mm</a> <a href="#">OP State: 319.3/ 1,000mm</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	Jan – June 2013	Jan – Sept 2013	Prelim Jan – Dec 2013
										High CCO: 412.3/ 1,000mm Low CCO: 296.6/ 1,000mm	High CCO: 394.8/ 1,000mm Low CCO: 292.3/ 1,000mm	High CCO: 383.7/ 1,000mm Low CCO: 285.0/ 1,000mm	High CCO: 339.8/ 1,000mm Low CCO: 294.7 / 1,000mm	
	*Plan all-cause readmission (NQF 1768) <i>Lower score is better.</i>		√		√	√	12.3%	10.5% Average of Commercial and Medicare 75 <sup>th</sup> percentiles	n/a	n/a	State: 12.3% High CCO: 14.6% Low CCO: 8.7%	State: 10.8% High CCO: 13.9% Low CCO: 5.7%	State: 11.3% High CCO: 14.7% Low CCO: 5.9%	State: 11.6% High CCO: 13.9% Low CCO: 6.2%
Ensuring appropriate care is delivered in appropriate settings	*Ambulatory Care: Outpatient and ED utilization <i>Lower score is better for ED utilization.</i>	√	√		√	√	ED: 61.0/ 1,000mm OP: 364.2/ 1,000mm	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/ 1,000mm 2011 National Medicaid 90 <sup>th</sup> 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: 296.6/	ED State: 55.2/ 1,000mm High CCO: 77.0 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 339.7/ 1,000mm High CCO: 394.8/ 1,000mm Low CCO: 292.3/ 1,000mm	ED State: 53.1/ 1,000mm High CCO: 77.3 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 334.8/ 1,000mm High CCO: 383.7/ 1,000mm Low CCO: 285.0/	ED State: 51.1/ 1,000mm High CCO: 74.1 / 1,000mm Low CCO: 30.4 / 1,000mm OP State: 319.3/ 1,000mm High CCO: 339.8/ 1,000mm Low CCO: 294.7 /

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
Improving primary care for all populations	Colorectal cancer screening Measure specifications modified to identify unique members receiving colorectal cancer screening in 12 month period, reported per 1,000 member months (mm)	√				√	15.8/1,000mm using admin data only.		n/a 3% improvement only	n/a 3% improvement only	15.8/ 1,000 mm admin data only. High CCO: 21.3/ 1,000 mm Low CCO: 5.1/ 1,000 mm	State: 10.2/ 1,000 mm High CCO: 13.0/ 1,000 mm Low CCO: 5.6/ 1,000 mm	State: 10.2/ 1,000mm High CCO: 12.8/ 1,000mm Low CCO: 6.4/ 1,000 mm	State: <a href="#">10.6 / 1,000mm</a>  <a href="#">High CCO: 13.8 / 1,000mm</a>  <a href="#">Low CCO: 6.3 / 1,000mm</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	Jan – June 2013	Jan – Sept 2013
Patient-Centered Primary Care Home Enrollment	√				√	51.8% (2012)	100% (Tier 3)	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	The % of dollars available to each CCO for this measure will be tied to the % of enrollees in PCPCH, based on formula.	State: 51.8% (2012) High CCO: 94.4% (2012) Low CCO: 3.7% (2012)	State: 70.8%	State: 78.1% High CCO: 92.0% Low CCO: 40.5%	State: <a href="#">80.9%</a> High CCO: <a href="#">95.6%</a> Low CCO: 49.9%
* 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: 17.1% High CCO: 48.0% Low CCO: 3.3%	State: 31.7% High CCO: 61.9% Low CCO: 8.6%	State: <a href="#">32.1%</a> High CCO: <a href="#">61.7%</a> Low CCO: 9.5%
*Well-child visits in the first 15 months of life (NQF 1392)				√	√	68.3%	77.3% 2012 National Medicaid 90 <sup>th</sup> percentile	n/a	n/a	State: 68.3% High CCO: 81.3% Low CCO: 45.0%	n/a	State: 48.3% High CCO: 63.7% Low CCO: 18.2%	State: <a href="#">61.6%</a> High CCO: <a href="#">75.0%</a> Low CCO: 34.3%
*Adolescent well-care visits (NCQA)	√			√	√	27.1% (admin data only)	53.2% 2011 National Medicaid 75 <sup>th</sup>	MN method with 3% floor.	53.2% 2011 National	State: 27.1% High CCO:	State: 12.3% High CCO:	State: 21.4% High CCO:	State: <a href="#">29.0%</a> 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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
							percentile (admin data only)		Medicaid 75 <sup>th</sup> percentile (admin data only)	31.9% Low CCO: 20.7%	17.4%  Low CCO: 8.7%	29.0% Low CCO: 15.6%	<a href="#">43.2%</a> Low CCO: <a href="#">20.3%</a>	
Childhood immunization status (NQF 0038)					√	√	66.0% (Combo 2)	82.0% 2012 National Medicaid 75 <sup>th</sup> percentile (combo 2)	n/a	n/a	State: 66.0% High CCO: 73.1% Low CCO: 58.0%	n/a	State: 68.5% CCO data not available	<a href="#">State: 65.3%</a> <a href="#">High CCO: 74.5%</a> Low CCO: 49.0%
Immunization for adolescents (NQF 1407)					√	√	49.2% (Combo 1)	70.8% 2012 National Medicaid 75 <sup>th</sup> percentile (combo 1)	n/a	n/a	State: 49.2% High CCO: 57.2% Low CCO: 31.6%	n/a	State: 55.9% CCO data not available	<a href="#">State: 52.9%</a> <a href="#">High CCO: 62.1%</a> Low CCO: 29.6%
Appropriate testing for children with pharyngitis (NQF 0002)					√	√	73.7%	76.0% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 73.7% High CCO: 90.7% Low CCO: 41.9%	n/a	State: 72.7% High CCO: 90.4% Low CCO: 36.7%	<a href="#">State: 72.7%</a> <a href="#">High CCO: 90.4%</a> Low CCO: 36.7%
Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)			√		√		1: 50.0% of adult tobacco users on Medicaid reported being advised to quit by	2012 National Medicaid benchmark 90 <sup>th</sup> percentile: Component 1: 81.4% Component 2: 50.7%	n/a	n/a	State: 1: 50.0% 2: 24.0% 3: 22.0%  High CCO: 1: 61% 2: 34%	n/a	n/a	2013 data not yet available

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
						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)	Component 3: 56.6%			3: 27% Low CCO: 1:45% 2: 19% 3: 16%				
Deploying care teams to improve care and reduce preventable of unnecessarily costly utilization by super users	*Ambulatory Care: Outpatient and ED utilization	√	√		√	√	ED: 61.0/1,000mm OP: 364.2/1,000mm	ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	MN method with 3% floor.	ED: 44.1 / 1,000mm OP: 439/1,000mm 2011 National Medicaid 90 <sup>th</sup> percentile	ED State: 61.0/1,000mm High CCO: 86.2/1,000mm Low CCO: 55.4/1,000mm OP State: 364.2/	ED State: 55.2/1,000mm High CCO: 77.0 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 339.7/	ED State: 53.1/1,000 mm High CCO: 77.3 / 1,000mm Low CCO: 34.0 / 1,000mm OP State: 334.8/	<a href="#">ED State: 51.1/1,000 mm</a> <a href="#">High CCO: 74.1 / 1,000mm</a> <a href="#">Low CCO: 30.4 / 1,000mm</a> <a href="#">OP State: 319.3/</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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
										1,000mm High CCO: 412.3/ 1,000mm Low CCO: 296.6/ 1,00mm	1,000mm High CCO: 394.8/ 1,000mm Low CCO: 292.3/ 1,000mm	1,000mm High CCO: 383.7/ 1,000mm Low CCO: 285.0/ 1,000mm	<a href="#">1,000mm High</a> <a href="#">CCO: 339.8/</a> <a href="#">1,000mm</a> Low CCO: 294.7 / 1,000mm	
Addressing discrete health issues (such as asthma, diabetes, hypertension) within a specific geographic area by harnessing and coordinating a broad set of resources, including CHW.	Controlling high blood pressure (NQF 0018)	√		√		√	0%	Reporting only in CY 2013.		0%	n/a	n/a	n/a	
	*Comprehensive diabetes care: LDL-C Screening (NQF 0063)			√		√	67.2%	80% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 67.2% High CCO: 73.1% Low CCO: 55.2%	n/a	State: 63.6% High CCO: 70.1% Low CCO: 48.6%	<a href="#">State: 70.6% High</a> <a href="#">CCO: 74.7%</a> Low CCO: 62.8%
	*Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)			√		√	78.5%	86% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 78.5%  High CCO: 86.4% Low CCO: 63.6%	n/a	State: 74.9% High CCO: 80.9% Low CCO: 58.6%	<a href="#">State: 79.9% High</a> <a href="#">CCO: 84.5%</a> Low CCO: 70.8%
	Diabetes: HbA1c Poor Control (NQF 0059)	√				√	0%	Reporting only in CY 2013.		Reporting only in CY 2013.	0%	n/a	n/a	n/a
	*PQI 01: Diabetes, short term		√	√		√	192.9 / 100,000 member	10% reduction from baseline	n/a	n/a	State: 192.9 Low CCO:	State: 196.2 Low CCO:	State: 203.8 Low CCO:	<a href="#">State: 204.3</a> <a href="#">Low CCO:</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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	complication admission rate (NQF 0272) <i>Lower is better</i>						years			109.0 High CCO: 360.8	0.0 High CCO: 414.8	22.1 High CCO: 373.8	<a href="#">16.7</a> High CCO: <a href="#">373.3</a>	
	*PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275) <i>Lower is better</i>		√	√		√	454.6 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 454.6 Low CCO: 292.5 High CCO: 821.1	State: 303.9 Low CCO: 35.3 High CCO: 550.4	State: 292.7 Low CCO: 56.0 High CCO: 646.4	<a href="#">State: 294.6</a> <a href="#">Low CCO: 42.9</a> High CCO: 430.2
	*PQI 08: Congestive heart failure admission rate (NQF 0277) <i>Lower is better</i>		√	√		√	336.9 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 336.9 Low CCO: 177.2 High CCO: 611.9	State: 219.9 Low CCO: 65.4 High CCO: 374.9	State: 229.3 Low CCO: 82.8 High CCO: 385.2	<a href="#">State: 235.8</a> <a href="#">Low CCO: 85.8</a> High CCO: 394.8
	*PQI 15: Adult asthma admission rate (NQF 0283) <i>Lower is better</i>		√	√		√	53.4 / 100,000 member years	10% reduction from baseline	n/a	n/a	State: 53.4 Low CCO: 16.1 High CCO: 180.3	State: 41.2 Low CCO: 0.0 High CCO: 71.9	State: 43.8 Low CCO: 0.0 High CCO: 59.6	<a href="#">State: 42.2</a> <a href="#">Low CCO: 0.0</a> High CCO: 57.3
Improving access to effective and timely care	CAHPS 4.0 – Adult questionnaire (including cultural)	√	√	√		√	Access to Care OR adult baseline: 79%	Access to Care 2012 National Medicaid adult	Access to Care OR adult baseline: 79% OR child baseline 88%	Access to Care 2012 National Medicaid	Access to Care Adult: 79% Child:	n/a	n/a	2013 data not yet available

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
competency and health literacy modules).						OR child baseline 87% OR average: 83%	75 <sup>th</sup> percentile: 83.63% 2012 National Medicaid child 75 <sup>th</sup> percentile: 90.31% National average: 86.97%	OR average: 83.5%	adult 75 <sup>th</sup> percentile: 83.63% 2012 National Medicaid child 75 <sup>th</sup> percentile: 90.31% National average: 86.97%	87% Avg: 83% High CCO: Adult: 85% Child: 94% Avg: 90% Low CCO: Adult: 73% Child: 81% Avg: 81% <i>Note: OHA cannot report on all CCOs for this measure – CAHPS 2011 was sampled for old managed care orgs – not current CCOs.</i>				
	CAHPS 4.0H (child version including Medicaid and	√	√		√	√								

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>	
children with chronic conditions supplemental items).															
Chlamydia screening in women ages 16-24 (NQF 0033)				√	√	√	59.9%	63.0% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 59.9% High CCO: 65.8% Low CCO: 49.6%	n/a	State: 54.8% High CCO: 63.2% Low CCO: 39.7%	<a href="#">State: 57.4%</a> <a href="#">High CCO: 65.7%</a> <a href="#">Low CCO: 43.1%</a>	
*Cervical cancer screening (NQF 0032)				√		√	56.1%	74.0% 2012 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	State: 56.1% High CCO: 59.8% Low CCO: 47.5%	n/a	State: 48.5% High CCO: 52.0% Low CCO: 35.7%	<a href="#">State: 53.5%</a> <a href="#">High CCO: 59.5%</a> <a href="#">Low CCO: 39.8%</a>	
*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% All ages 88.5%	12-24 mos 98.2% 25 mos – 6 years 91.6% 7-11 yrs 93.0% 12-19 yrs 91.7% All ages n/a 2011 National Medicaid 75 <sup>th</sup> percentile	n/a	n/a	12-24 mos State: 97.4% High CCO: 99.0% Low CCO: 96.2% 25 mos – 6 years State: 86.2% High CCO: 88.8% Low CCO:	n/a	12-24 mos State: 96.2% 25 mos – 6 years State: 82.7% 7-11 yrs State: 86.5% 12 – 19 yrs State: 86.8% All ages State:	2013 data not yet available

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
										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%		86.0% CCO data not available		
	Provider Access Questions from the Physician Workforce Survey: To what extent is your primary practice accepting new Medicaid/OH				√	In 2012: 85.0% of Oregon's physicians accepted new Medicaid patients with no or some limitations  81.7% of physicians	TBD	n/a	n/a	85.0% 81.7% TBD OHA cannot report this measure by CCO, but may be able to report regional variation in a	n/a	n/a	2013 data not yet available	

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	<p>P patients? (include: completely closed, open with limitations, and no limitations).</p> <p>Do you currently have Medicaid/OH P patients under your care?</p> <p>What is the current payer mix at your primary practice?</p>					have Medicaid patients. TBD				subsequent report.				
	Screening for depression and follow up plan (see above)													
	*SBIRT (see above)													
	*Mental and physical health assessment for children in DHS custody (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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	*Follow-up care for children on ADHD medication (see above)													
	*Timeliness of prenatal care (see above)													
	Colorectal cancer screening (see above)													
	PCPCH enrollment (see above)													
	*Developmental screening by 36 months (see above)													
	*Adolescent well child visits (see above)													
Addressing patient satisfaction with health plans	CAHPS 4.0 – Adult questionnaire (including cultural competency and health literacy modules).	√	√	√		√	Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average:	Satisfaction with Care 2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.19% 2012 National Medicaid child 75 <sup>th</sup> percentile:	Satisfaction with Care OR adult baseline: 76% OR child baseline: 80% OR average: 78%	Satisfaction with Care 2012 National Medicaid adult 75 <sup>th</sup> percentile: 83.19% 2012 National Medicaid	Adult: 76% Child: 80% Avg: 87% High CCO: Adult: 81% Child: 86%	n/a	n/a	2013 data not yet available

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	Jan – June 2013	Jan – Sept 2013	<a href="#">Prelim Jan – Dec 2013</a>
	CAHPS 4.0H (child version including Medicaid and children with chronic conditions supplemental items).	√	√		√	√	78%	84.71% National average: 83.95%		child 75 <sup>th</sup> percentile: 84.71% National average: 83.95%	Avg: 83% Low CCO: 65% Child: 72% Avg: 70%			
Meaningful Use	EHR adoption See revised documentation online at <a href="http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx">www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx</a>	√				√	28.0%	49.2% 2014 Federal benchmark for Medicaid.	Minnesota Method	49.2%	State: 28.0% High CCO: 35% Low CCO: 12%	State: 57.0% High CCO: 72.7% Low CCO: 37.1% As of July 2013	State: 58.8% High CCO: 78.2% Low CCO: 41.7% As of Nov 2013	<a href="#">State: 58.7% High CCO: 77.2% Low CCO: 46.1%</a> As of Feb 2014

## Oregon Health Authority

\*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/QIPReport051012final.pdf](http://www.health.state.mn.us/healthreform/measurement/QIPReport051012final.pdf).