

# Oregon Health Plan

## Section 1115 Quarterly Report



4/30/2015 – 6/30/2015

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

Demonstration Quarter (DQ): 4/2015

Federal Fiscal Quarter (FQ): 3/2015





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## I. Introduction

### A. Letter from the State Medicaid Director

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

- **Lever 1: Improving care coordination** – As of June 2015, there were 565 recognized Patient Centered Primary Care Home (PCPCH) clinics in the state. This represents over 50 percent of the estimated number of primary care clinics in Oregon. Providence Center for Outcomes Research and Education (CORE) analyzed written reports from PCPCH Program site visits, which demonstrated progress in care coordination, continuity of care, and comprehensive, whole-person care.
- **Lever 2: Implementing alternative payment methodologies (APMs)** –OHA and coordinated care organization (CCO) representatives revised the CCO Financial Report (Exhibit L). The revised report, will allow CCOs to report detailed breakout of non-fee-for-service (non-FFS) payments by APM for 2016. The Center for Evidence-based Policy (CEbP) also fielded an APM Readiness Assessment tool to help CCOs evaluate the readiness of providers and other stakeholders to implement APMs.
- **Lever 3: Integrating physical, behavioral and oral health care** – The Oregon Rural Practice-based Research Network at OHSU (ORPRN) began data collection for its evaluation of the Behavioral Health Home Learning Collaboratives efforts to help organizations integrate primary care into behavioral health settings. Integration of OHA Medical Assistance Programs and Addictions and Mental Health Divisions into a single Health Systems Division will also support efforts to integrate physical, oral and mental health care.
- **Lever 4: Increased efficiency in providing care** –All 16 CCOs have also made health information technology investments to support increased information exchange across providers and help them provide care that aligns with the level of support the patient needs. The number of Traditional Health Workers (THWs) also continues to increase.
- **Lever 5: Implementation of health-related flexible services** – This quarter, the Transformation Center interviewed 10 CCOs about their use of flexible services. Through these interviews, the Transformation Center found flexible services usually address chronic conditions. Examples include gym memberships, pool passes, rental assistance and incentives to increase adolescent well-child visits. To follow up this work, OHA is planning a future learning collaborative for flexible services.
- **Lever 6: Innovations through the Transformation Center** – The formative evaluation of the Transformation Center continued in this quarter, with a focus on assessing the implementation of the Community Advisory Councils' (CACs) Community Health Improvement Plans, to help guide the Center's support of the CACs. CCOs and other health system transformation champions in Oregon presented 43 innovative projects at the Oregon Health System Innovation Café on June 8-9.

On June 24, 2015, OHA published a public report comparing calendar year 2014 performance on the CCO incentive, quality and access test, and core performance measures with 2013 performance and 2011 baseline. The report is available online at: [www.oregon.gov/oha/metrics](http://www.oregon.gov/oha/metrics) and shows large improvements for OHP members thanks to the coordinated care model.

*Leslie Clement, M.P.A*  
*Interim State Medicaid Director*

**B. Demonstration description**

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

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

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

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

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

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

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

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

- **Workforce:** To support the new model of care within CCOs, Oregon established a loan repayment program for primary care physicians who agree to work in rural or underserved communities in Oregon, and will complete training for 300 community health workers by 2015. As mandated by House Bill 3396 (2015 Regular Session), Oregon will do further evaluation and research to determine how to best recruit and retain health care providers to practice in rural and medically underserved areas of the state.

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, [Public Health Modernization](#) and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.

- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.
- **Reducing the growth in Medicaid spending:** The state has agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

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

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

## C. State contacts

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## II. Title

Oregon Health Plan Section 1115 Quarterly Report  
 4/1/2015 – 6/30/2015  
 Demonstration Year (DY): 13 (7/1/2014 – 6/30/2015)  
 Demonstration Quarter (DQ): 4/2015  
 Federal Fiscal Quarter (FQ): 3/2015

## III. Events affecting health care delivery

### A. Overview of significant events across the state

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

#### Detail on impacts or interventions

No report this quarter.

### B. Complaints and grievances

#### Table 2 – Complaints and grievances

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

The following chart shows CCO complaint totals and rates per 1,000 members for the reporting period.

Data for two plans is not included in this table. We will submit an updated report that includes all plans' data when it is available.

Complaint or grievance type	Number reported
<b>ACCESS TO PROVIDERS AND SERVICES</b>	
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	419
b) Plan unresponsive, not available, difficult to contact for appointment or information.	30
c) Provider's office too far away, not convenient	10
d) Unable to schedule appointment in a timely manner.	123

<b>Complaint or grievance type</b>	<b>Number reported</b>
e) Provider's office closed to new patients.	24
f) Referral or 2nd opinion denied/refused by provider.	29
g) Unable to be seen in a timely manner for urgent/ emergent care	20
h) Provider not available to give necessary care	242
i) Eligibility issues	29
j) Client fired by provider	28
k) Availability of specialty provider	9
<b>TOTAL:</b>	<b>963</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>963</b>
<b>RANGE REPORTED BY CCOS</b>	<b>1-461</b>
<b>INTERACTION WITH PROVIDER OR PLAN</b>	
a) Provider rude or inappropriate comments or behavior	291
b) Plan rude or inappropriate comments or behavior	21
c) Provider explanation/instruction inadequate/incomplete	218
d) Plan explanation/instr. Inadequate/incomplete	89
e) Wait too long in office before receiving care	60
f) Member dignity is not respected	35
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.	8
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	3
i) Lack of coordination among providers	29
<b>TOTAL:</b>	<b>754</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>754</b>
<b>HIGH RANGE REPORTED BY CCOS</b>	<b>3-285</b>
<b>CONSUMER RIGHTS</b>	
a) Provider's office has a physical barrier	14
b) Abuse, physical, mental, psychological	8
c) Concern over confidentiality	24
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	63
e) No choice of clinician	24
f) Fraud and abuse	13
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	10
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)	0
i) Differential treatment for Medicaid clients	17
j) Lack of adequate or understandable NOA	3
k) Not informed of consumer rights	23
l) Complaint and appeal process not explained	41
m) Denied member access to medical records	3
<b>TOTAL:</b>	<b>243</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>243</b>
<b>RANGE REPORTED BY CCOS</b>	<b>0-106</b>
<b>CLINICAL CARE</b>	
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	153
b) Testing/assessment insufficient, inadequate or omitted	40
c) Medical record documentation issue	17
d) Concern about prescriber or medication or medication management issues	114
e) Unsanitary environment or equipment	16
f) Lack of appropriate individualized setting in treatment	21
<b>TOTAL:</b>	<b>361</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>361</b>

Complaint or grievance type	Number reported
<b>RANGE REPORTED BY CCOS</b>	<b>3-163</b>
<b>QUALITY OF SERVICE</b>	
a) Provider office unsafe/uncomfortable	86
b) Delay, quality of materials and supplies (DME) or dental	63
c) Lack of access to ENCC for intensive care coordination or case management services	15
d) Benefits not covered	18
<b>TOTAL:</b>	<b>182</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>182</b>
<b>RANGE REPORTED BY CCOS</b>	<b>2-107</b>
<b>CLIENT BILLING ISSUES</b>	
a) Co-pays	5
b) Premiums	13
c) Billing OHP clients without a waiver	174
<b>TOTAL:</b>	<b>192</b>
<b>PENDING:</b>	<b>0</b>
<b>RESOLVED:</b>	<b>192</b>
<b>RANGE REPORTED BY CCOS</b>	<b>2-180</b>
<b>OTHER REPORTED ISSUES</b>	
Other (unspecified)	35
Transportation	334
<b>GRAND TOTAL</b>	<b>2695</b>
Enrollment numbers as of 4/30/2015	827,617
Rate per 1000 members (range reported by CCOs)	0-5

**Trends related to complaints and grievances**

No report this quarter.

**Interventions**

No report this quarter.

**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**

As stated above, data for two plans is not included in this report, so we will submit a revised report that includes all plans’ data when it becomes available.

Outcome type	Number reported
<b>APPEALS REPORTED BY CCOS</b>	
a) Denial or limited authorization of a requested service.	1610
b) Single PHP service area, denial to obtain services outside the PHP panel	11
c) Termination, suspension or reduction of previously authorized covered services	34
d) Failure to act within the timeframes provided in § 438.408(b)	1
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	539
<b>Total</b>	<b>2195</b>
<b>Appeals per 1000 members (range reported by CCOs)</b>	<b>0-4.70</b>
<b>Number overturned at plan level</b>	<b>556</b>
<b>Appeal decisions pending</b>	<b>14</b>
<b>Number of hearings requested</b>	<b>868</b>
<b>Overturned prior to hearing</b>	<b>234</b>

Outcome type	Number reported
<b>Overturn rate</b>	<b>26.9%</b>
<b>Hearing decision pending</b>	<b>70</b>
<b>Hearing requests per 1000 members (range reported by CCOs)</b>	<b>0-2.25</b>
<b>NOAS ISSUED</b>	
a) Denial or limited authorization of a requested service.	26632
b) Single PHP service area, denial to obtain services outside the PHP panel	177
c) Termination, suspension or reduction of previously authorized covered services	303
d) Failure to act within the timeframes provided in § 438.408(b)	1
e) Failure to provide services in a timely manner, as defined by the State	5
f) Denial of payment, at the time of any action affecting the claim.	24240
<b>Total</b>	<b>51358</b>
<b>NOAs per 1000 members</b>	<b>938.94</b>
<b>APPEALS OVERTURNED AT PLAN LEVEL</b>	
a) Denial or limited authorization of a requested service.	427
b) Single PHP service area, denial to obtain services outside the PHP panel	2
c) Termination, suspension or reduction of previously authorized covered services	3
d) Failure to act within the timeframes provided in § 438.408(b)	0
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	124
<b>Total overturned</b>	<b>556</b>
<b>Range reported by CCOs</b>	<b>0-116</b>
<b>Total appeals</b>	<b>2195</b>
<b>Overturn rate</b>	<b>3.27%</b>
<b>DECISION PENDING AT PLAN</b>	
a) Denial or limited authorization of a requested service.	14
b) Single PHP service area, denial to obtain services outside the PHP panel	0
c) Termination, suspension or reduction of previously authorized covered services	0
d) Failure to act within the timeframes provided in § 438.408(b)	0
e) Failure to provide services in a timely manner, as defined by the State	0
f) Denial of payment, at the time of any action affecting the claim.	0
<b>Total</b>	<b>2</b>

### Contested case hearings

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

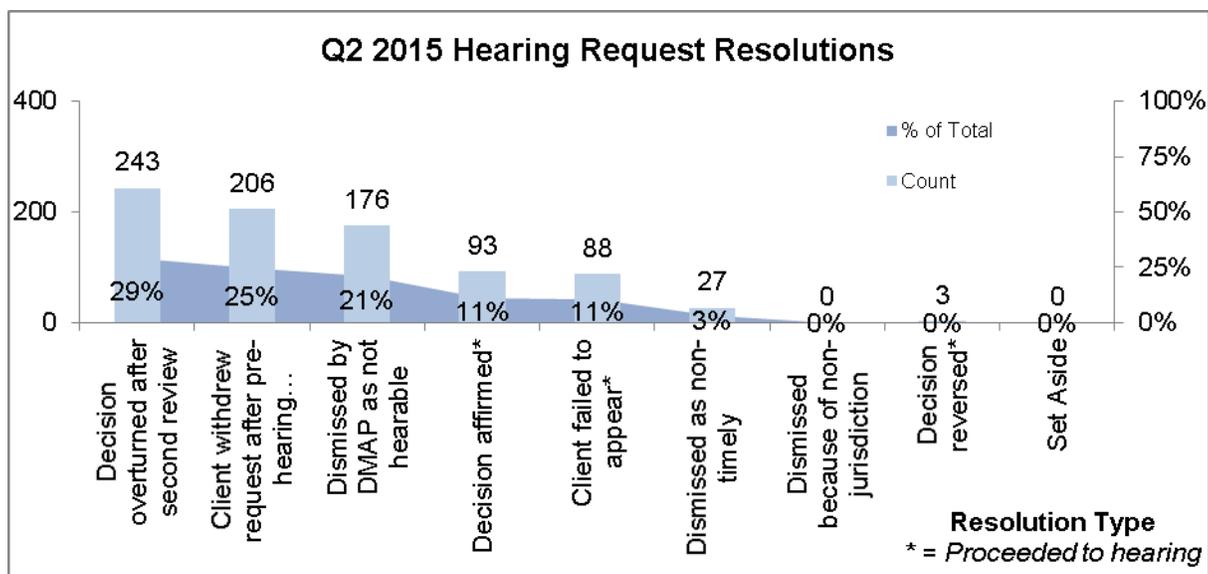
Plan Name	Total hearing requests received	Average plan enrollment *	Per 1000 members
ALLCARE HEALTH PLAN, INC.	37	50,916	0.7267
CASCADE HEALTH ALLIANCE	40	17,147	2.3328
COLUMBIA PACIFIC CCO, LLC	25	26,899	0.9294
EASTERN OREGON CCO, LLC	91	49,448	1.8403
FAMILYCARE, CCO	103	127,701	0.8066
HEALTH SHARE OF OREGON	134	244,407	0.5483
INTERCOMMUNITY HEALTH NETWORK	51	57,531	0.8865
JACKSON CARE CONNECT	16	30,368	0.5269
KAISER PERMANENTE OR PLUS, LLC	5	1,990	2.5126
PACIFCSOURCE COMM. SOLUTIONS	68	55,171	1.2325
PACIFCSOURCE COMM. SOLUTIONS - GORGE		13,389	0.0000
PRIMARYHEALTH JOSEPHINE CO CCO	7	11,747	0.5959
TRILLIUM COMM. HEALTH PLAN	53	93,522	0.5667
UMPQUA HEALTH ALLIANCE, DCIPA	41	27,160	1.5096
WESTERN OREGON ADVANCED HEALTH	22	20,807	1.0573

Plan Name	Total hearing requests received	Average plan enrollment *	Per 1000 members
WILLAMETTE VALLEY COMM. HEALTH	121	102,341	1.1823
YAMHILL CO CARE ORGANIZATION	11	23,517	0.4677
ACCESS DENTAL PLAN, LLC		2,008	0.0000
ADVANTAGE DENTAL	1	25,298	0.0395
CAPITOL DENTAL CARE INC	1	15,428	0.0648
CARE OREGON DENTAL		2,137	0.0000
FAMILY DENTAL CARE		2,046	0.0000
MANAGED DENTAL CARE OF OREGON		2,102	0.0000
ODS COMMUNITY HEALTH INC	2	7,994	0.2502
FFS	48	234,104	0.2050
<b>Total</b>	<b>877</b>	<b>1,225,071</b>	<b>0.7159</b>

The following chart shows the outcomes of the hearings completed this quarter.

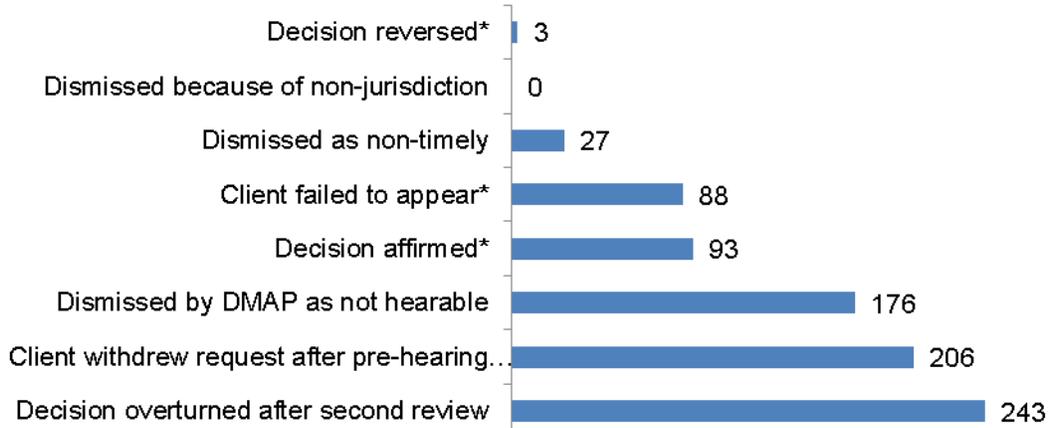
Outcome	Count	% of Total
Decision overturned after second review	243	29%
Client withdrew request after pre-hearing conference	206	25%
Dismissed by DMAP as not hearable	176	21%
Decision affirmed	93	11%
Client failed to appear	88	11%
Dismissed as non-timely	27	3%
Dismissed because of non-jurisdiction	0	0%
Decision reversed	3	0%
Set aside	0	0%
<b>Total outcomes</b>	<b>836</b>	

Trends



**Q2 2015 Hearing Request Resolution Summary**

\* = Proceeded to hearing



**Interventions**

No report this quarter.

**D. Implementation of 1% withhold**

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

**Table 3 – Summary**

Metric	Frequency	
	Quarterly	Annually
Actual amount paid of monthly PMPM capitation rate broken out by:	X	X
■ Average/mean PMPM		
■ Eligibility group		
■ Admin component		
■ Health services component		

Metric	Frequency	
	Quarterly	Annually
For the first year, this will be 99% and NOT include the 1% withhold, which is 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)

THW Program	Total number certified statewide		Number of approved training programs	
	Current Qtr.	Cumulative	Current Qtr.	Cumulative
<b>Community Health Workers (CHW)</b>	28	155	0	7
<b>Personal Health Navigators (PHN)</b>	0	5	0	2
<b>Peer wellness/support specialists</b>	48	219	0	18
<b>Other THW</b>	1	23	0	1 (Doula)

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

Two training programs submitted documentation for approval in this quarter; however, the curricula did not meet the approval standards so approvals were denied. Each program was provided recommendations for improvements and invited to resubmit.

Between April and June 2015, training programs reported that 197 THWs were trained. The racial/ethnic breakdown trainees are as follows:

- African American/Black: 20
- American Indian/Alaska Native: 9
- Asian: 5
- Hispanic/Latino: 44
- Pacific Islander: 1
- White: 68
- Other: 6

- Decline to Answer: 43

### THW presentations and meetings

- April 6: Miracles Club
- April 10: ACCBO; Empowerment Clinic
- April 23: Providence
- May 1: International Center for Traditional Childbirth
- May 4: Health Share of Oregon (CCO)
- June 9: OHA Transformation Center Innovation Café
- June 17-19: Rogue Community College THW Conference

### THW-related policy

The Oregon Legislature passed House Bill 2024 during the 2015 Legislative session, which requires OHA to work with CCOs and dental care organizations (DCOs) to develop certification requirements for THWs to provide dental health education and dental disease prevention services. OHA will initiate rulemaking in late August 2015.

### Other Workforce-related policy

The 2015 Legislative Session also saw the passage of House Bill 3396, requiring the Oregon Health Policy Board to study and evaluate the effectiveness of existing financial incentive programs offered in the state and to address new types of programs to recruit and retain health care providers to practice in rural and medically underserved areas, including financial assistance via loans, grants or subsidies, as well as retirement plan options and tax subsidies.. While the Medicaid Primary Care Loan Repayment Program was not granted continuing funding by the Legislature, HB 3396 does establish the Health Care Provider Incentive Fund to assist qualified health care providers who have committed to serving medical assistance recipients in rural or medically underserved areas of the state per the Health Policy Board's recommendations.

### Health professional graduates participating in Medicaid

No new results to report this quarter.

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

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

Changes in CCO/MCO networks	Effect on		Number affected	
	Delivery system	Members	CCOs	CCO members
CCO Columbia Pacific ended coverage in 5 ZIP codes in Coos County, effective 5/1/2015.	Improved access to services	Members transferred to Trillium CCO	2	2200 members
Care Oregon, last FCHP under contract, terminated effective 5/1/2015.	None	Members were transferred to Willamette Valley CCO	1	2750 members

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

Enrollment/disenrollment	Effect on	Number affected
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## Oregon Health Authority

	Delivery system	Members	CCOs	CCO members
No issues	-	-	-	-

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

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

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

### G. Transformation Center

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

#### Key highlights from this quarter:

##### ***Statewide CCO Learning Collaborative for the Quality and Health Outcomes Committee***

The Transformation Center facilitated two sessions for the statewide CCO learning collaborative in this period. Sessions focused on:

- Leading change, a workshop with Ed O’Neil, a national leadership development expert who provided a leadership framework for change work, helped participants develop skills related to the framework, and discussed strategies on how CCOs could work together more effectively.
- Clinical and community interventions to reduce tobacco use, with presentations from CCOs, county health departments, and dental care organizations.

More information is available at <http://www.oregon.gov/oha/Transformation-Center/Pages/CCO-Learning-Collaborative.aspx>

##### ***Oregon Health System Innovation Café***

On June 8-9, 2015, the Transformation Center hosted the Oregon Health System Innovation Café in Salem to bring together CCOs and other health system transformation champions in Oregon for peer-to-peer learning and collaborative conversation about innovative projects addressing complex care, behavioral health integration, traditional health workers, health information technology and telehealth. Forty-three projects were presented during rotating small-group table discussions. Keynote presenters included Ed Wagner, Director Emeritus of the MacColl Center for Health Care Innovation, and David Labby, Project Director of the Health Commons Grant and Chief Medical Officer of Health Share of Oregon. Three funders participated in a panel and OHA Director Lynne Saxton closed the event.

Response to the small group discussion format was very positive, and the Transformation Center will continue to help this work move forward. Materials and presentation slides are available at <http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx>.

### **Quality Improvement Community of Practice**

The Transformation Center supported the enrollment of each CCO's quality improvement or measurement lead in a three-month IHI online training, Leading Quality Improvement: Essentials for Managers, which launched in February and ended in June. This in-depth virtual program gave participants skills to focus their staff's efforts, better manage their portfolio of projects, and improve processes to more effectively achieve their organization's strategic goals.

The nine sessions of the IHI training built a knowledge base from which we will go deeper in the upcoming six months with a customized coaching program tailored specifically to the needs in Oregon. This monthly webinar program that will begin in July focuses on peer-to-peer learning, with the cohort consisting only of CCO and OHA colleagues. At each session a participant presents a case study for the group to discuss and share lessons learned. The curriculum for the series is being developed with input from the participants, and there will be multiple opportunities throughout to give further input and shape the sessions.

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

During the reporting period, the Transformation Center hosted monthly conference calls for the two CAC leadership networks – one for the CAC chairs and co-chairs (who are CAC members) and one for the CCO CAC coordinators (who are primary staff of the CCOs) – to provide ongoing leadership development for the CACs. Guest presenters from OHA's Early Learning Division and the Public Health Division were invited to participate on the calls, share their work and highlight available resources to support CACs.

In addition, the Transformation Center convened the CAC Steering Committee bimonthly during this time to make recommendations about the design of the CAC Learning Collaborative and to help plan the CAC Summit, which took place on June 3-4 and brought together 186 participants from across the state, including 112 CAC members and 26 CAC Coordinators/CCO staff. The Summit goals were to allow participants to:

- Discover strategies for effectively engaging Oregon Health Plan members on CACs to ensure a successful experience for both the members and councils;
- Identify current health disparities and resources that exist to ensure health equity for all Oregonians;
- Connect with and learn from other CAC members; and
- Celebrate and recognize the amazing work accomplished to date.

Highlights from the event included a pre-conference Motivational Interviewing workshop, a Race for Health Equity opening exercise, engaging and interactive breakout sessions, community health improvement plan roundtable discussions, networking meetings; a photo booth capturing images of CAC members across the state; and nutritious food, which followed the USDA dietary guidelines and was sponsored by the Oregon Health Authority Public Health Division's Tobacco Prevention & Education Program. More information is available at: <http://www.oregon.gov/oha/Transformation-Center/Pages/CAC-Learning-Community.aspx>.

During the reporting period, and in response to CAC leadership requests, the Transformation Center developed a presentation that CACs across the state can use to inform and educate CAC members. The presentation includes 1) slides and 2) a recorded webinar using these slides. This recorded webinar is available at <https://www.youtube.com/watch?v=Hz0s4zHtveM>.

### **Health Equity Learning Collaborative**

During this quarter the Transformation Center hosted the second and third sessions of the Health Equity Learning Collaborative. The sessions were co-hosted by Trillium Community Health Plan and Eastern Oregon CCO in Eugene and Portland, respectively.

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- The April meeting focused on organizational cultural competence and language access. The National Health Law Program joined a panel of local experts from Asian Pacific American Network of Oregon and Central City Concern.
- The June session hosted at the Oregon Latino Health Equity Conference highlighted engaging diverse communities with a focus on Latinos. Speakers from Families USA and Minnesota based Otto Bremer Foundation joined the panel.

Meeting materials are available at <http://www.oregon.gov/oha/Transformation-Center/Pages/Health-Equity-Learning-Community.aspx>.

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

This quarter, the Clinical Innovation Fellows program wrapped up its pilot year with two online meetings, one in-person meeting, the graduation of the pilot cohort and the selection of the second cohort.

In April, the online meeting focused on alternative payment methods, and the May meeting focused on health literacy. The in-person meeting in June included leading into the future, group presentations and reflections on accomplishments. Each fellow continued to meet monthly with their faculty mentor, both individually and in small groups. The Transformation Center also held a graduation celebration, which included presentations by the Oregon Health Authority director and one of the fellows and a poster session. About 60 people attended, including many CCO and OHA leaders.

In May, fellows submitted final reports describing the outcomes of their projects and feedback on their fellowship experience. Every fellow indicated the program was valuable or very valuable in their growth as a leader and in supporting their work. The most helpful aspects of the program were networking, project implementation and management skills, and mentoring. Every fellow implemented a project during the fellowship year, either as proposed (7 fellows) or with considerable changes (6 fellows). Twelve projects are expected to be sustained after the fellowship ends. As one fellow said, “My confidence is enhanced because the program allowed us to develop a systematic process to take an idea from beginning to end.” Another fellow said, “Without the support of the CCI program... I would not have applied for these [additional] opportunities to share my work with a wider audience.”

Also in May, the council announced the second cohort of Clinical Innovation Fellows, who will begin the program in July.

More information about the Council of Clinical Innovators is available at [www.transformationcenter.org/cci](http://www.transformationcenter.org/cci).

### ***Transformation Center CCO Technical Assistance Bank***

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance in key areas to help foster health system transformation. In addition to support and technical assistance provided by other parts of OHA, each CCO was designated 35 hours of free consultation from outside consultants on contract with the Transformation Center. The designated 35 hours include 10 hours of consultation to support CACs and other community-based work and will be accessible through September 2015.

CCOs that do not use all 35 hours of technical assistance by September 2015 will forfeit their remaining hours. Starting October 2015, there will be a new allocation of yet to be determined hours per CCO for use until September 2016.

As of June 2015, the Transformation Center had received 19 TA Bank requests from CCO, for a total of 262 anticipated TA hours upon completion of those requests.

- Sixty percent of these requests focused on CAC development, including the community health assessment and community health improvement plan.
- Other requests focused on health equity, quality improvement and measurement, program evaluation and alternative payment methods.
- TA Bank evaluation results for four of ten completed TA projects show that 100% of CCOs rated the TA as very valuable (75%) or valuable (25%), and 100% of CCOs rated the TA as very effective (75%) or effective (25%) (see charts below).

To continue to provide technical assistance through September 2016, the Transformation Center has released a Request for Applications (RFA) for consultants to contract as technical assistance providers. The Transformation Center received feedback from CCOs through the Innovator Agents to inform the RFA process. The Transformation Center has also requested the Innovator Agents work with their CCOs to advertise the RFA to potential contractors that might be a good fit with the Technical Assistance Bank.

The RFA has resulted in five new contractors available to provide technical assistance on a variety of topics. The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

**TA Bank technical assistance topics:**

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

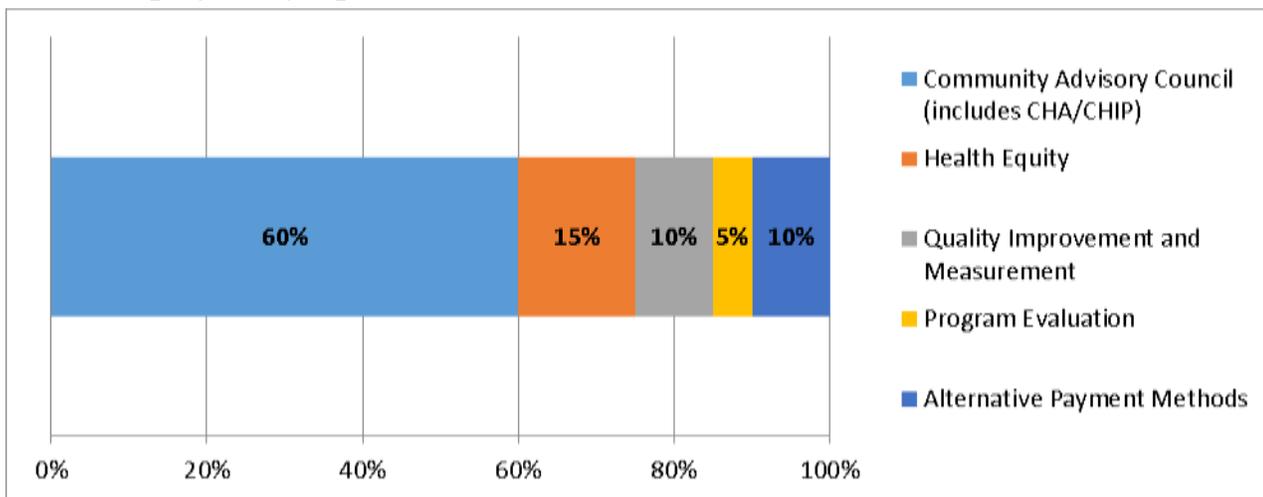
\*Topics added to the Technical Assistance Bank during the RFA development process.

**TA Bank projects through June 2015:**

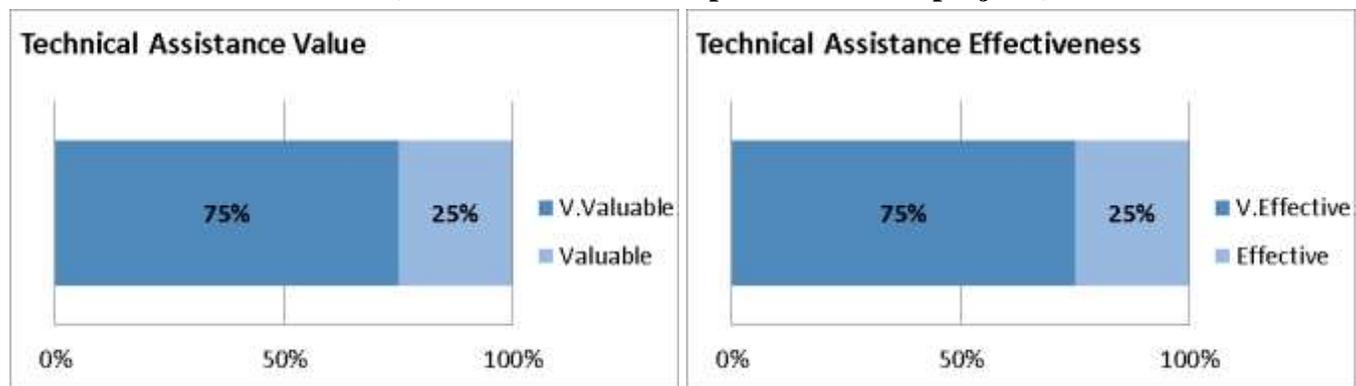
CCO	Topic	Hours Requested
1. Willamette Valley Community Health	Health equity	4
2. Intercommunity Health Network	Measurement	11
3. FamilyCare	CAC development, CHIP implementation	16
4. PacificSource Central Oregon	Measurement	25
5. Eastern Oregon CCO	CAC member engagement	5
6. AllCare	CAC member engagement	32
7. PrimaryHealth Josephine County	CAC member engagement	11
8. PrimaryHealth Josephine County, Jackson Care Connect, AllCare	Health literacy	10.5
9. Jackson Care Connect	CAC development, CHIP implementation	8.5
10. Trillium Community Health Plan	Health program evaluation	7
11. Western Oregon Advanced Health	CHIP development	15

CCO	Topic	Hours Requested
12. Intercommunity Health Network	Alternative payment method training	9.5
13. Columbia Pacific CCO	CHIP implementation	19
14. Cascade Health Alliance	CAC member engagement	10.5
15. Health Share	Health equity	25
16. Willamette Valley Community Health	CAC member engagement	16
17. Trillium	Community Health Assessment	7
18. Eastern Oregon CCO	CHIP implementation	30
19. Willamette Valley Community Health	Alternative payment methods	TBD
Total Anticipated Hours:		262

**TA Bank projects by topic:**



**TA Bank evaluation results (for four out of ten completed TA Bank projects):**



**Coordinated Care Model Summit**

The Transformation Center plans to hold its third coordinated care model summit on November 17, 2015, titled “Oregon’s Coordinated Care Model: Highlighting Outcomes and Promoting Excellence in the Coordinated Care Model.” The goals of the summit are to highlight outcomes and lessons learned, support excellence in coordinated care model implementation, and inspire future innovation in Oregon and beyond. CCOs, other public and private health care purchasers, providers and clinicians, CCO CAC members, community stakeholders, health leaders, lawmakers, policymakers and funders will come together to share outcomes and lessons learned from innovative strategies for implementing health system transformation.

A call for proposals was completed to elicit high-quality, results-oriented presentations. A draft agenda will be available in August and the breakout sessions during the conference will focus on the following topics:

- Behavioral Health Integration
- Culturally Competent Health Care Workforce
- Empowering Patients to Improve Health
- Engaging the Community to Improve Health
- Health Information Technology
- Oral Health Integration
- Opioids
- Patient Experience of Care
- Patients Requiring Complex Care Management
- Social Determinants of Health
- Trauma-Informed Care (includes Adverse Childhood Experiences)

**Health Equity and Health & Early Learning Conferences**

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

The OHA Office of Equity and Inclusion is hosting a conference that focuses exclusively on the implementation of health equity, diversity and inclusion policies and strategic equity initiatives throughout Oregon’s health system. The conference will bring together OHA leadership, CCOs and health systems; providers and health care stakeholders; Community-based Organizations; community stakeholders; and other organizations and groups that address Social Determinants of Health to focus on these key areas:

- Upstream approaches to achieving health equity;
- Community-led decision-making for organizational change and policy;
- Social Determinants of Health and opportunities for collaboration throughout the State; and
- Developing equity leadership skills among executives, administrators, providers and clinicians in Oregon’s health system.

The OHA Child Well-being Team and the Early Learning Division of the Oregon Department of Education are inviting CCO and Early Learning Hub representatives to come together to:

- Identify collaborative opportunities to support early learning and children’s health;
- Inspire and strengthen cross-sector connections; and
- Learn about existing CCO/Hub initiatives, projects and policies that can be replicated in other regions of Oregon.

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

**Innovator Agent learning experiences**

Summary of activities	The Transformation Center convenes Innovator Agents for monthly in-person meetings to share information and learn from others in OHA as well as outside experts. Meetings this quarter had a cultural competence/health equity focus, including the Intercultural Development Inventory (an inter-active cultural competence evaluation) and a joint training with three other OHA units on health equity. Additionally Innovator Agents met with Early Learning staff, CCO Contracts staff, and the OHA State Dental Director to share information and strategize how to continue work towards health system transformation.
Promising practices identified	These meetings allow Innovator Agents to build and sustain relationships with executive leadership across OHA. The Innovator Agents meet with the OHA Director each month to share her vision for the role of the Innovator Agents in

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	the new OHA organizational structure and how OHA will continue to support the CCOs.
Participating CCOs	16
Participating IAs	9

### Learning collaborative activities

Summary of activities	The Innovator Agents attended the Oregon Health System Innovation Café and the CAC Summit. Key areas of innovation shared during the Innovation Cafe included: opioid prescribing and pain management, creation of a trauma informed clinic, and a colorectal cancer screening initiative.
Promising practices identified	Innovator Agent engagement with learning collaborative development is key to ensuring that innovative CCO projects are identified and shared at learning collaborative events.
Participating CCOs	16
Participating IAs	9

### Assisting and supporting CCOs with Transformation Plans

Summary of activities	Innovator Agents provided support to their CCOs in writing their 2015-2017 Transformation Plans. The Innovator Agents assisted the CCOs in developing their Transformation Plan updates for the 2013-2015 contracts, and included developing strategies to get robust stakeholder input. The updates were due to the OHA in June and are now under review by the OHA.  In addition, the Innovator Agents provided guidance to the CCOs and their CACs for their community health improvement plan progress reports (due June 30, 2015).
Promising practices identified	Innovator Agents provide internal support for CCOs' transformation, including a more focus more on identifying solutions and addressing barriers within OHA.
Participating CCOs	16
Participating IAs	9

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

Summary of activities	Innovator Agents supported conversations between their CCOs and state and local public health representatives related to Targeted Case Management and Maternity Case Management. They also assist with local Oregon Health Plan outreach efforts by coordinating with community application assisters. Innovator Agents continue to assist with behavioral health integration, oral health, alternative payment methodology, non-emergency medical transportation, cultural competency and data collection.  In addition, Innovator Agents connect CCOs with statewide resources for pain management, effective contraceptive use, and access to A&D residential treatment.
Promising practices identified	Innovator Agents are an instrumental liaison between their CCOs and their communities, and the role is uniquely situated to provide value in this area.
Participating CCOs	16
Participating IAs	9

### Communications with OHA

Summary of activities	Innovator Agents meet regularly with leaders across OHA to strategize on how to collaborate and to stay informed about OHA programs and policies. For example, this quarter the Innovator Agents met with the Application Advisory
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	<p>Group as an opportunity to bring community stakeholder issues to the attention of the OHA.</p> <p>Innovator Agents communicate routinely with Medical Assistance Programs and Addictions and Mental Health staff on specific issues and concerns. Innovator Agents assisted in developing a collaborative of CCO dental coordinators.</p>
Promising practices identified	Regular and frequent communication with the Medicaid Assistance Program and Addictions and Mental Health helps the Innovator Agents support continuous quality improvement efforts within OHA related to Oregon's health system transformation implementation.
Participating CCOs	16
Participating IAs	9

**Communications among Innovator Agents**

Summary of activities	Innovator Agents continue to work together on internal transformation, sharing information on promising practices to promote spread through in-person and electronic communication.
Promising practices identified	The Innovator Agents work as a team, sharing and benefitting from the expertise each Innovator Agent brings to their job as well as their unique CCO experiences. They meet as a team twice each week by phone, and once monthly for a day-long in-person meeting. In addition to these regularly scheduled meetings, they communicate frequently via email and phone and periodically in person, as needed.
Participating CCOs	16
Participating IAs	9

**Community advisory council activities**

Summary of activities	<p>The Innovator Agents attended the CAC Summit in June 2015. The 2015 Summit focused on health equity and was well attended.</p> <p>The Innovator Agents continue to regularly attend CAC meetings for their CCOs. The Innovator Agents are also attending CAC CHIP work group meetings as these projects move forward.</p>
Promising practices identified	Many CACs allocate agenda time at CAC meetings for Innovator Agents to update the council on OHA-related items. This helps to build open communication with CAC members and OHA and increases CAC members' knowledge about Medicaid policies and organization change occurring within OHA.
Participating CCOs	16
Participating IAs	All 9 Innovator Agents attend the CAC meetings associated with their CCO(s).

**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	<p>Innovator Agents regularly gather feedback from CCOs and present issues to OHA leadership for problem solving. For example, this quarter the Innovator Agents provided feedback to the Medical Assistance Program on CCO challenges related to maternity applications, lactation support and flexible services.</p> <p>In addition assistance was provided on the implementation of eReferrals to the</p>
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	statewide Quitline, increase referrals and participation in the Living Well Chronic Disease self-management programs and the adoption of a Diabetes Prevention Program.
Promising practices identified	Each CCO has distinct priorities and initiatives to support innovation in different areas of transformation. Innovator Agents inform the development of learning collaboratives on key topic areas, such as alternative payment methodologies, that are designed to support CCOs in adapting innovations.
Participating CCOs	16
Participating IAs	9

**Database implementation (tracking of CCO questions, issues and resolutions to identify systemic issues)**

Summary of activities	The Issue Tracker is being revised to capture additional information about Innovator Agent presentations.
Promising practices identified	The Issue Tracker continues to be helpful for documenting issues and steps toward resolution.
Participating CCOs	16
Participating IAs	9

**Information sharing with public**

Summary of activities	<p>Innovator Agents continue to present to a large variety of stakeholders and share information on enrollment, health equity data, leadership opportunities and community partnership opportunities with their community advisory councils and community partners.</p> <p>In addition, the Innovator Agents work with local DHS field offices, within their regions, and Area Agencies on Aging, Aging and People with Disabilities, the Early Learning Hubs and CCO Clinical Advisory Panels.</p>
Promising practices identified	<p>Communicating with community advisory councils and CHIP workgroups are a good way to more broadly disseminate information to community members.</p> <p>Innovator Agents routinely share news stories to OHA communications to share best practices at CCOs, such as behavioral health APMs, a community health worker hub working with high utilizers and a community paramedicine project.</p>
Participating CCOs	16
Participating IAs	9

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

**Measure 1: Surveys rating IA performance**

Data published for current quarter? Type?	N/A: Plans for qualitative interviews with CCO stakeholders are forthcoming in early 2015.
Web link to Innovator Agent quality data	-

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

Data published for current quarter? Type?	Innovator Agents provide a connection between the CCOs and OHA for issues and questions as they arise and keep them apprised of important meetings and events. The Innovator Agents communicate often around these issues to determine if they are isolated or have become systemic and then track them through to resolution. As barriers appear, Innovator Agents often have those who are critical to overcoming them strategize either during
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	the weekly phone calls or during the monthly in-person meeting.
Web link to Innovator Agent quality data	-

**Measure 3: Innovations adopted**

Data published for current quarter? Type?	<p>Many innovative practices have been adopted and several were shared at the Innovation Café held in June 2015. CCOs, practitioners and OHA staff came together to share innovations that have been implemented and have demonstrated positive results. Innovator agents regularly share innovative ideas they learn about with their CCOs.</p> <p>The OHA Office of Health Analytics and the Transformation Center are contracting with the Providence Center for Outcomes Research and Education to code and populate an internally searchable database of current CCO projects and initiatives from the CCO Transformation Plans, Quality Improvement Plans, Transformation Fund projects and Community Health Improvement Plans. This internal database will provide a single data source to identify innovative ideas in health system transformation.</p>
Web link to Innovator Agent quality data	<p>Projects presented at the Innovation Café are available at:  <a href="http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx">http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx</a></p>

**Measure 4: Progress in adopting innovations<sup>1</sup>**

Data published for current quarter? Type?	<p>CCOs and other health system transformation champions in Oregon presented 43 innovative projects addressing complex care, behavioral health integration, traditional health workers, and health information technology and tele-health at the Oregon Health System Innovation Café on June 8-9.</p> <p>The highly interactive two-day meeting centered around informal small-group table discussions on the projects promoting collaborative conversation and peer-to-peer learning. Participants had the opportunity to engage in multiple discussions across the four topic areas.</p>
Web link to Innovator Agent quality data	<p>Projects presented at the Innovation Café are available at:  <a href="http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx">http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx</a></p>

**Measure 5: Progress in making improvement based on innovations<sup>1</sup>**

Data published for current quarter? Type?	<p>The CCOS continue to show improvement in a number of areas of care despite a large increase in members over the past year. CCOs have implemented numerous innovative practices that have decreased emergency room visits and hospital readmissions, increased developmental screenings and increased screening for alcohol and other substance use.</p> <p>Improvement in these areas of care has been a result of innovative practices including better training of providers, alternative payment methods, and collaboration with early learning hubs. During this time, the CCOs have demonstrated an ability to keep costs down and meet its commitment to reduce spending by 2% per member per year.</p>
Web link to Innovator	<p>Oregon’s Health System Transformation 2014 Final Report is available at:</p>

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

Agent quality data	<a href="http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf">http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf</a>
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**Measure 6: CCO Transformation Plan implementation**

Data published for current quarter? Type?	CCOs are successfully implementing their transformation plans and have submitted their Transformation Plans for 2015-2017 and their final benchmark reports for 2013-2015. Most CCOs with the assistance of their Innovator Agents have accessed the Technical Assistance Bank to help them achieve the goals of their transformation plans. The Technical Assistance Bank has provided a range of consultants who can provide CCOs technical assistance in areas including, but not limited to, member engagement, alternative payment methods, and health equity and literacy.
Web link to Innovator Agent quality data	Transformation Plan Reports available online: <a href="http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx">http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx</a>

**Measure 7: Learning collaborative effectiveness**

Data published for current quarter? Type?	<p>An increasing number of stakeholders participate in the Transformation Center’s learning collaboratives. For example, stakeholder participation in the Statewide CCO Learning Collaborative has maintained quarter one 2015 gains with an average of 77 attendees at the five sessions in the first two quarters of 2015 (compared to an average of 70 participants in 2014 and 61 participants in 2013).</p> <p>Participant evaluations for the first two quarters of 2015 indicate a similar percent of participants who found sessions valuable or very valuable (88% in 2015 compared to 90% in 2014) and a slight decrease in the percent who planned to take action based on the learning collaborative (49% in 2015 compared to 52% in 2014).</p>
Web link to Innovator Agent quality data	-

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

Data published for current quarter? Type?	<p>Innovator agents continue to work collaboratively with CCOs to help improve their metrics. In 2014, all CCOs showed improvements in some number of measures and 13 out of 16 CCOs earned 100 percent of their quality pool payments in 2014.</p> <p>Overall the state showed large improvements in the areas of decreased emergency department visits, decreased rate of hospital admissions for chronic obstructive pulmonary disease, patient-centered primary care home (PCPCH) enrollment continues to increase, and strong improvement to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure.</p>
Web link to Innovator Agent quality data	Oregon’s Health System Transformation 2014 Final Report is available at: <a href="http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf">http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf</a>

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

**H. Legislative activities**

Please see the [Medical Assistance Programs Legislative Summary](#) for a review of this quarter’s activities.

**I. Litigation status**

Nothing to report this quarter.

**J. Two-percent trend data**

See [Appendix C](#).

**K. DSHP terms and status**

See [Appendix D](#).

**IV. Status of Corrective Action Plans (CAPs)****Table 8 – Status of CAPs**

No report this quarter.

**V. Evaluation activities and interim findings**

In this quarter, Mathematica Policy Research delivered its final midpoint evaluation of Oregon’s Medicaid demonstration waiver and presented the results to CMS. The evaluation assessed OHA’s and CCOs’ activities to transform Medicaid and analyzed whether specific measures of access to care and quality of care could be attributed to the demonstration.

In addition, Providence Center for Outcomes Research and Education (CORE) delivered a baseline study on the extent of health care transformation among CCOs and other health care organizations. CORE also began work on a separate project to identify specific activities each CCO is carrying out to transform the delivery system through a review of CCOs’ transformation plans, progress reports, and other documents.

Evaluation of OHA’s PCPCH program also continued, and OHA made progress on internal data collection regarding alternative payment methodologies, health information technology, and flexible services.

**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:***

As part of its evaluation efforts, the PCPCH Program is looking in-depth at 15 to 30 recognized clinics considered to be top-performing or exemplary practices. Researchers will interview key staff at each practice to determine which aspects of the PCPCH model are most important to successful practice transformation. In this quarter, practices were recruited for this work and interview protocols were refined.

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Also in this quarter, Providence Center for Outcomes Research and Education (CORE) delivered an analysis of written reports from PCPCH Program site visits to 57 PCPCHs in 2013 and 2014. The report summarizes how well PCPCHs perform on core attributes and identifies best practices among PCPCHs.

### ***Interim findings:***

As of June 2015, there were 565 recognized clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents over 50% of the estimated number of primary care clinics in Oregon.

PCPCH enrollment is a CCO incentive metric. The statewide baseline (for 2012) for this measure is 51.8%.

- Updated CCO performance metrics (see Appendix E) show that the proportion of CCO members enrolled in a PCPCH has continued to increase from the 2012 baseline of 51.8% to 81.0% as of December 2014, ranging from 60.7% to 99.0% across CCOs.
- It is notable that CCOs have sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act.

In its analysis of reports from PCPCH Program site visits, CORE found evidence of progress in the areas of care coordination, continuity of care, and comprehensive whole-person care:

- Nearly all sites have a designated care coordinator. External coordination with referral and specialty care clinics appears high.
- Many sites are able to share information in real time with outside providers, and nearly half reported successful two-way communication with outside providers.
- Half of all sites used a pre-visit plan where providers and staff would "huddle" to discuss patient needs prior to scheduled appointments.

### ***Improvement activities:***

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

In this quarter, the Institute conducted four in-person sessions for its learning collaboratives. These sessions focused on patient experience of care, improving access, and patient-centered communication. Each session was attended by an average of 21 participants.

The Institute also held four webinars:

- Medication Assisted Treatment of Substance Use Disorders (23 attendees)
- Shifting Towards Trauma-Informed Care (30 attendees)
- Referral Tracking & Care Coordination (48 attendees)
- Depression Screening & SBIRT for Adolescents (109 attendees)

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

### ***Evaluation activities:***

In this quarter, OHA finalized the 17 CCO incentive measures for CY 2014 and paid out the second quality pool. In addition, OHA finalized Year 1 data for the Hospital Transformation Performance Program (HTPP), published results, and paid the Year 1 quality pool based upon the first data submissions. See Appendix E for details.

Also in this quarter, a work group composed of OHA staff and CCO representatives drafted a revised version of the CCO financial report (Exhibit L). The current version of this report is used to calculate percentage of plan payments that are non-fee-for-service (see Interim Findings below). The revised report includes a

detailed breakout of non-FFS payments by APM type, including sub-capitation, performance bonus, risk sharing, and risk withhold. CCOs will begin using the new report on January 1, 2016, and will report detailed breakout of non-FFS payments by APM on an annual basis.

In addition, OHA continued internal evaluation of the Federally Qualified Health Center (FQHC) APM Pilot in this quarter. The pilot includes three FQHCs that started the pilot in March 2013 (Phase I FQHCs) and an additional five FQHCs that joined the pilot in late 2014 (Phase II FQHCs). For the evaluation, OHA tracks several metrics on a quarterly basis, including a subset of CCO incentive measures. OHA is also evaluating the value of non-billable innovative patient engagement strategies for each FQHC's attributed population. These include telephone visits, online portal communications, coordinating transitions in care settings, and assisting patients with accessing community resources. In addition to tracking metrics and innovative patient engagement strategies, OHA is building an APM Total Cost of Care dashboard to share with FQHCs. OHA's Office of Health Analytics has produced a prototype of the dashboard and anticipates finalizing it by December 2015.

### **Interim findings:**

Internal analysis of the most recent quarterly CCO financial reports (for January – March 2015) shows that 47.9% of all plan payments are non-fee-for-service (FFS). This is a decline of 3.5% from the previous quarter, in which 51.4% of plan payments were non-FFS. As noted above, OHA continues to work with CCOs on improving APM reporting.

For the FQHC pilot, quality metrics indicate that the pilot is associated with improved quality of care for Phase I FQHCs and maintenance of quality of care at a steady level for Phase II FQHCs. Regarding innovative patient engagement strategies, the evaluation indicates that FQHCs have increased the number of services they are providing to their patient populations, and that access for each health center's attributed patient population has been made easier and more convenient.

### **Improvement activities:**

Following a November 2014 learning collaborative that focused on the link between payment methodologies and improving quality of care, one CCO requested technical assistance on APMs from Bailit Health Purchasing. In addition, OHA contracted with the Center for Evidence-based Policy at OHSU (CEbP) to provide technical assistance to CCOs with developing and implementing APMs. Assistance provided by CEbP will consist of focused work with two to three CCOs and more general resources and webinars for the remaining CCOs and other payers and providers.

In this quarter, two CCOs began the process for receiving technical assistance with APMs from OHA's Technical Assistance Bank. In late April, a senior consultant from Bailit began working with Intercommunity Health Network (IHN) on a presentation for IHN's leadership to help increase their understanding of APMs and help them assess APM options. The senior consultant will deliver the presentation in the next quarter. Also in this quarter, Willamette Valley Community Health submitted a request for technical assistance with identifying opportunities for implementing new APMs, and with improving existing APMs. To provide technical assistance, Bailit will identify existing APMs using staff and stakeholder interviews and document and data review, and will prepare a report documenting its findings and recommendations.

Also in this quarter, CEbP fielded an APM Readiness Assessment tool to help CCOs evaluate the readiness of providers and other stakeholders to implement APMs. CEbP received 67 responses from 14 CCOs. Analysis of the responses is underway. In addition, CEbP began developing a draft application plan and materials for a request for applications for technical assistance. CEbP anticipates releasing the request for applications for selection of TA sites in August and selecting sites in fall.

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

#### ***Evaluation activities:***

The Behavioral Health Home Learning Collaborative (BHHLIC) is supported by Oregon's Adult Medicaid Quality Grant and assists organizations that are integrating primary care into their behavioral health settings. The Oregon Rural Practice-based Research Network at OHSU (ORPRN) began data collection for its evaluation of the project, including both qualitative and quantitative components. In this quarter, ORPRN began analyzing two sets of the Behavioral Health Integration Capacity Assessment (BHICA) for each of the participating sites. A third set will be completed in December to track changes in organizational capacities over the course of the Collaborative. In addition, ORPRN began conducting interviews and focus groups to learn how team members at each site understand how behavioral health homes fit within the PCPCH model. The collaborative's activities with sites will conclude in December 2015 and the evaluation will be completed by the end of January 2016.

#### ***Interim findings:***

Five of the CCO incentive measures relate to physical and behavioral health care integration. The narrative below compares progress on the measures from the 2011 baseline to calendar years 2013 and 2014 (see Appendix E for details). Of the four measures with data available in calendar years 2013 and 2014, three measures improved between those years. However, only two of the five measures were above their benchmark targets for 2014.

- SBIRT (screening for unhealthy drug and alcohol use) increased from the 0.0% baseline in 2011 to 7.3% in CY 2014, an increase from 2.0% in CY 2013 but below the 13.0% benchmark target for 2014. SBIRT ranged from 0.0% to 19.8% across CCOs in CY 2014.
- Follow-up after hospitalization for mental illness increased from the 65.2% baseline in 2011 to 66.7% in CY 2014, a slight decrease from 67.6% in CY 2013 and below the 68.8% benchmark target for 2014. The measure ranged from 48.4% to 77.0% across CCOs.
- Screening for clinical depression and follow-up plan was 27.9% in 2014, exceeding the 25.0% benchmark target for 2014. The measure ranged from 3.3% to 68.1% across CCOs, with some of the variation likely due to challenges capturing data from electronic health records.
- Mental and physical health assessment within 60 days for children in DHS custody increased from the 53.6% baseline in 2011 to 70.0% in CY 2014, an increase from 63.5% in CY 2013 but below the 90.0% benchmark target for 2014. The measure ranged from 60.8% to 100.0% across CCOs.
- Follow-up care for children initially prescribed ADHD medications increased from the 52.3% baseline in CY 2011 to 57.7% in CY 2014, an increase from 53.3% in CY 2013 and above the 51.0% benchmark target for CY 2014. The measure ranged from 45.6% to 70.3% across CCOs. Note that this measure has been dropped from the incentive measure set for 2015 (though OHA will continue to monitor and report on this as part of the quality and access test).

#### ***Improvement activities:***

The Behavioral Health Home Learning Collaborative (BHHLIC) works with organizations that are integrating primary care into their behavioral health settings. It includes regular practice coaching, in-person learning sessions, and webinars. Under a no-cost extension of Oregon's Adult Medicaid Quality Grant, the BHHLIC was extended for an additional year. Six of the 10 original organizations continued to participate in the second year, and three new organizations joined in March 2015.

- Based on feedback from the first year, the amount of practice coaching available to participating agencies was doubled and a second vendor was contracted to provide training in care management and cross-training to familiarize behavioral health practitioners with care management guidelines for diabetes and hypertension.

- In this quarter, the BHHLC continued practice coaching, conducted an additional learning session, and provided care management training.
- Four of the nine organizations participating in Year 2 now provide integrated physical health services within the behavioral health facility to a growing panel of patients. Other sites are making progress toward increasing physical health services through co-location or care coordination with partners.
- The BHHLC will continue practice coaching, learning sessions, and webinars through December 2015.

As part of OHA's reorganization, OHA will consolidate Medical Assistance Programs (MAP), the unit responsible for the Oregon Health Plan, with Addictions and Mental Health (AMH) into a new division called Health Systems. The new structure reflects the transformed environment in which CCOs are responsible for integrating physical, oral, and mental health care (see Section 4 below for additional information about the reorganization).

### **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:*

#### **Midpoint evaluation of Oregon's Medicaid Section 1115 Demonstration**

Mathematica Policy Research (MPR) delivered its final midpoint evaluation of Oregon's Medicaid demonstration waiver and presented the results to CMS. The evaluation assessed the extent to which OHA and CCOs supported and implemented activities to transform Medicaid, and analyzed whether changes in specific measures of access to care and quality of care could be attributed to the demonstration.

#### **Assessing the spread of coordinated care in Oregon**

Providence Center for Outcomes Research and Education (CORE) delivered a baseline study assessing the spread of the coordinated care model among CCOs, commercial health plans, hospitals, and provider organizations. CORE used results from a 2015 survey to measure the extent of each organization's implementation of the coordinated care model in 11 domains, and interviewed a subset of organizations to provide context for survey results. CORE received survey responses from 12 of the 16 CCOs.

#### **CCO document analysis**

CORE began work on a project to identify and categorize specific activities each CCO is carrying out to transform the delivery system. The project leverages documents that CCOs submit to OHA under their contracts and Transformation Fund grant agreements, including:

- 2013 – 2015 transformation plans and progress reports
- 2015 – 2017 transformation plans
- Community health improvement plans submitted 2014 and progress reports
- Performance improvement project plans
- Transformation fund grant proposals and grant progress reports

The research team is in the process of reviewing the documents submitted by each CCO, summarizing distinct activities and progress carrying out activities described in the documents, and categorizing activities by transformation area, scope (number of members and geographic area affected), type, and other attributes.

At the conclusion of the project in September 2015, CORE will deliver a coded data set that can be expanded as new documents are submitted, and an analytic report describing where CCOs are focusing their efforts, what kinds of successes and challenges CCOs are experiencing, and the extent to which activities undertaken

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by CCOs are likely to result in improved quality, access, experience of care, health status, and reduced cost growth. The data set and report will be used by OHA to evaluate CCOs' transformation activities, assess contract compliance, identify and spread promising practices, and better support CCOs.

### **Tracking “spillover” from Medicaid’s coordinated care model**

Oregon Health & Science University’s Center for Health Systems Effectiveness (CHSE) delivered a plan to determine whether the effects of Medicaid transformation “spill over” to non-CCO patients. This may occur if clinics that are working to improve care management and coordination for Medicaid patients also adopt these improvements for other patients. CHSE will analyze claims and encounter data to determine whether change in outcomes for Medicaid patients are associated changes in quality and utilization for non-Medicaid patients. In addition, CHSE will compare claims-based measures of spillover for specific CCOs and health plans with survey-based measures of transformation from CORE. CHSE will deliver a final report by September 2016.

### *Interim findings:*

#### **Evaluation findings from contractors**

Through the midpoint evaluation, MPR found that OHA and CCOs made significant progress implementing transformation activities:

- OHA facilitated transition of the Medicaid delivery system from managed care entities to CCOs, implemented global budgets and CCO incentive payments, and created the Transformation Center, innovator agents, and learning collaboratives to spread innovations.
- CCOs contracted with appropriate mental health, addiction services, and alcohol treatment providers to integrate physical health, behavioral health, and addiction services, expanded PCPCH enrollment, and collaborated with communities to conduct community health assessments.

MPR also identified areas of transformation where more work remained for OHA and CCOs:

- For OHA, more work remained in the areas of reassessing its administrative structure, implementing a certification process for non-traditional health workers, and defining effective approaches to promote use of flexible services (since data were collected, OHA has identified a new administrative structure, established a certification process for non-traditional health workers, and initiated planning for a flexible services learning collaborative).
- At the time data were collected, CCOs were still in the design and early testing stages for alternative payment methodologies (APMs), implementation of health information technology (HIT), and strategies to address cultural and linguistic diversity and eliminate disparities.

MPR found few statistically significant changes in measures of access and quality associated with the introduction of CCOs, with significant changes concentrated in the area of improving primary care. MPR concluded that a longer observation period following the introduction of CCOs in mid-2012 is needed to make robust conclusions about the effect of CCOs on outcomes.

Consistent with MPR’s midpoint evaluation, CORE found that CCOs are most transformed in the areas of integrated care, care coordination, and community engagement, and less transformed in areas of APMs and data sharing within and across organizations. To assess spread of the coordinated care model over time, CORE will re-administer the survey to CCOs and other organizations in spring 2016.

#### **Measures of efficient and effective care collected by OHA**

From calendar year 2013 to calendar year 2014, key measures of efficient and effective care improved (see Appendix E for details):

- Emergency department visits decreased from 74.3 per 1,000 member months in CY 2013 to 64.7 per 1,000 member months in CY 2014.
- Hospital admissions per 100,000 member years for diabetes (short term complications) and chronic obstructive pulmonary disorder decreased by 32% and 17%, respectively.
- Hospital readmissions within 30 days for any cause decreased from 11.7% in CY 2013 to 11.4% in CY 2014.
- Rates of important screenings and preventive health services increased from CY 2013 to CY 2014. These include developmental screening in the first 36 months of life, adolescent well-care visits, childhood immunization status, appropriate testing for children with pharyngitis, and HbA1c screening for people with diabetes.

Rates in two areas for improvement noted in the last quarterly report (access to primary care providers for children and adolescents and immunization among children and adolescents) declined slightly from CY 2013 to CY 2014. In the quarter following this reporting quarter, immunization for children was adopted as an CCO incentive measure. This will likely lead to improvement and additional support from OHA.

OHA will continue to monitor these areas and work with CCOs on improvement activities (see Improvement activities below).

### ***Improvement activities:***

#### **Sustainable Relationships for Community Health (SRCH) Program**

In February 2015, OHA's Public Health Division awarded five grants to local consortia consisting of coordinated care organizations (CCOs), local public health authorities, and chronic disease self-management program providers. From February through September 2015, grantees will participate in a series of three institutes designed to establish improved referral and programmatic relationships to improve health outcomes for pre-diabetes, diabetes, and hypertension.

After the first two institutes, grantees created a multi-year plan and implementation plans around quality improvement for closed-loop referrals and payments/reimbursements for self-management programs, using tools and best practices for provider engagement and data collection. Grantees improved efforts around data collection and measurement concepts; identified relevant performance measures; and identified tools for developing data collection and measurement plans.

During the third institute, grantees will establish new processes for data sharing across organizations and establish a shared vision for commitment. Grantees will create joint agreements and coordinate key performance indicators to implement the work related to pre-diabetes, diabetes, and hypertension moving forward. These efforts are funded by the Centers for Disease Control and Prevention, and align with Oregon's CCO incentive measures and statewide performance improvement project.

#### **Summary of Health Information Technology (HIT) initiatives**

OHA's Office of Health Information Technology (OHIT) staff completed a series of on-site meetings with each CCOs to ensure that state HIT initiatives align with and support CCO needs. OHIT produced a summary document along with a detailed HIT profile for each CCO. This work is part of a broader ongoing environmental scan on the status of health information technology and exchange across the state.

The on-site meetings confirmed that all 16 CCOs made HIT investments to facilitate health care transformation in their communities. Nearly all CCOs are pursuing or implementing health information exchanges and care coordination tools, as well as population management or data analytics tools. CCOs reported early successes in achieving goals such as (1) increased information exchange across providers to support care coordination; (2) making new data available to providers to assist with identifying patients most

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in need of support or services and to help providers target their care appropriately; and (3) improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.

In addition to their current implementation efforts, CCOs are pursuing additional or improved HIT tools or strategies including (1) connecting providers to HIT/HIE through integration with their EHR workflows; (2) moving from administrative/claims-based case management and analytics to incorporating and extracting clinical data from provider's EHRs; (3) incorporating behavioral health, long-term care, and social services information; and (4) investing in new tools for patient engagement and telehealth.

### **CCO metrics “dashboards”**

OHA continues to release regular quality metric progress reports for CCOs utilizing the automated metric reporting tool (“dashboard”) developed by CORE. This tool was instrumental in allowing CCOs to efficiently validate OHA's final 2014 metrics results by allowing users to view overall results and drill down to member-level detail in a single file.

The dashboard currently includes all claims-based CCO incentive measures and a limited number of quality and access measures. The dashboards will continue to be expanded to include additional measures as well as historical trend analysis capabilities.

### **OHA reorganization**

At the beginning of 2015, OHA began an agency-wide reorganization to better deliver results in a transformed health care environment. In this quarter, OHA identified a new structure that consolidates 18 operational units into seven functional divisions that report to the OHA Director. This includes consolidation of Medical Assistance Programs (MAP), the unit responsible for the Oregon Health Plan, and Addictions and Mental Health (AMH) into the Health Systems division. The new structure reflects the transformed environment in which CCOs are responsible for integrating physical, oral, and mental health care.

### **Public Health Modernization**

In July 2015, the Oregon Legislature passed [House Bill 3100](#), which implements recommendations made by the [Task Force on the Future of Public Health Services](#) in the September 2014 report titled, "Modernizing Oregon's Public Health System". The overall goal of the modernization is to ensure everyone in Oregon has access to foundational public health protections. The program includes:

- A new governance structure for Oregon's public health system, the Public Health Advisory Board, will be appointed by the Governor;
- Clear, measurable definitions for the foundational capabilities and programs for public health will be developed using best practice research and feedback from stakeholders;
- State and local health departments will assess the extent to which they currently provide the foundational capabilities and programs;
- Local health departments will determine the most appropriate governance structure for the jurisdiction they serve, so they can successfully implement the foundational capabilities and programs;

With communities and partners, state and local health departments will develop plans to implement the foundational capabilities and programs, based on the findings from their assessments.

For more information, go to: <https://public.health.oregon.gov/About/TaskForce/Pages/index.aspx>.

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

### ***Evaluation activities:***

In this quarter, OHA's Transformation Center conducted interviews with CCOs about their use of flexible services, including successes, challenges, and information that would be helpful from a flexible services learning collaborative. As of mid-June, the Transformation Center had collected data for 10 CCOs.

### ***Interim findings:***

Among CCOs interviewed, the Transformation Center found that flexible services usually address chronic conditions. Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interest in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.

### ***Improvement activities:***

In order to leverage findings from CCO interviews, OHA is planning for a flexible services learning collaborative in fall 2015.

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

### ***Evaluation activities:***

The formative evaluation of the Transformation Center continued in this quarter, with a focus on assessing the implementation of the Community Advisory Councils' (CACs) Community Health Improvement Plans, to help guide the Center's support of the CACs. The team continues to analyze the data in real-time and debrief with the Transformation Center routinely to share emerging findings and to refine the direction of the evaluation.

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

### ***Interim findings/ Improvement activities:***

In this quarter, the Transformation Center continued work on its seven external learning collaboratives. From April through June 2015, five of the learning collaboratives met, including one new learning collaborative (the Innovation Café). A total of 12 formal sessions occurred, attended by an average of 57 people per session. This represents an increase from an average of 33 people per session in the previous quarter.

- Across all sessions, the roles of attendees were: 19% clinical, 23% administrative or operational lead, 10% quality improvement or quality assurance, 1% financial, and 47% in other roles.
- Sessions included three teleconferences, two webinars, and seven in-person sessions.
- Session topics included alternative payment models, clinical and community interventions to reduce tobacco use, and engaging diverse communities, with a focus on Latinos.

Across all sessions, 94% of respondents found the session valuable or very valuable to their work and 49% of all respondents said they would take action at their organization as a result of attending the learning collaborative session.

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The evaluation forms asked attendees to identify the most helpful aspects of each learning collaborative. Among the most helpful aspects from learning collaboratives this quarter, participants identified: hearing from other CAC members about member engagement strategies, learning about federal rules, hearing about new and innovative interventions, and sharing strategies that have been successful.

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## VI. Public Forums

### Public comments received

#### Medicaid Advisory Committee

No comments received this quarter.

#### Oregon Health Policy Board

Linda Dugan, Health Insurance Agent in Astoria, wanted the Board to be aware that the Federal Exchange is not updating life changes in a timely manner and this could cause issues for those who are incorrectly receiving OHP benefits. There was no public testimony in May or June.

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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.](#)

#### 2. State reported enrollment tables

Enrollment	April 2015	May 2015	June 2015
<b>Title XIX funded State Plan</b> Populations 1, 3, 4, 5, 6, 7, 8, 12, 14	1,083,100	1,083,087	1,059,781
<b>Title XXI funded State Plan</b>	69,291	68,658	54,132
<b>Title XIX funded Expansion</b> Populations 9, 10, 11, 17, 18	NA	NA	NA
<b>Title XXI funded Expansion</b> Populations 16, 20	NA	NA	NA
<b>DSH Funded Expansion</b>	NA	NA	NA
<b>Other Expansion</b>	NA	NA	NA
<b>Pharmacy Only</b>	NA	NA	NA
<b>Family Planning Only</b>	NA	NA	NA

<b>Enrollment current as of</b>	4/30/2015	5/31/2015	6/30/2015
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*\*Numbers reflect final movement in enrollment reporting systems of CHIP children with incomes to 138% FPL to Medicaid.*

## 3. Actual and unduplicated enrollment

## Ever-Enrolled Report

POPULATION			Total Number of Clients	Member Months	% Change from Previous Quarter	% Change from Previous Year
Expansion	Title 19	PLM Children FPL > 170%	858	2,010	-15.38%	-122.73%
		Pregnant Women FPL > 170%	689	1,677	2.61%	-39.19%
	Title 21	SCHIP FPL > 170	19,271	50,118	1.56%	-81.27%
Optional	Title 19	PLM Women FPL 133-170%	13,522	32,969	18.33%	-0.64%
	Title 21	SCHIP FPL < 170%	58,705	157,191	1.45%	21.09%
Mandatory	Title 19	Other OHP Plus	277,007	770,935	-2.62%	-77.69%
		MAGI Adults/Children	813,246	2,201,103	8.16%	49.88%
		MAGI Pregnant Women	14,498	32,117	16.81%	65.18%
<b>QUARTER TOTALS</b>			<b>1,197,796</b>			

\* 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
April	1,081,835	944,706	1,225	1,044	38,309	2,595	57,521	3,930
May	1,079,418	942,961	1,150	1,005	35,580	1	55,810	3,936
June	1,050,178	920,099	1,320	1,015	35,618	1	53,127	3,956
Qtr Average	1,070,477	935,922	1,232	1,021	36,502	866	55,486	3,941
		87.43%	0.12%	0.10%	3.41%	0.08%	5.18%	0.37%

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

\*\*CCOA = CCO provides physical, dental and mental health services

CCOB = CCO provides physical and mental health services.

CCOE = CCO provides mental health services only.

CCOG = CCO provides dental and mental health services.

## Appendix B. Neutrality reports

## 1. Budget monitoring spreadsheet

[Attached separately.](#)

## 2. CHIP allotment neutrality monitoring spreadsheet

[Attached separately.](#)

## Appendix C. Two-percent trend reduction tracking

[Attached separately.](#)

## Appendix D. DSHP tracking

[Attached separately.](#)

## Appendix E. Oregon Measures Matrix

Attached separately. In this reporting period, OHA finalized the 17 CCO incentive and 33 state performance measures for CY 2014 and paid out the second quality pool. This is the first time state and CCO level EHR-based data are available for the three clinical quality measures. This quarterly report includes an overview of the validation process to reach final data, the final 2014 performance at both state and CCO levels for the 17 CCO incentive measures and 33 quality and access test measures, 2014 performance by race and ethnicity, and the results of the second quality pool distribution.

Also in this reporting period, OHA finalized Year 1 (baseline) data for the Hospital Transformation Performance Program (HTPP), published results, and paid the Year 1 quality pool, which in this first year was pay-for-reporting; to qualify for quality pool payments in Year 2 of HTPP, hospitals will have to achieve benchmarks or improvement targets. .

### CCO Incentive Metrics Updates

#### CCO Reporting and Validation

- During this reporting period, OHA provided final CY 2014 metrics to CCOs utilizing the automated metric reporting tool (“dashboard”) developed by OHA’s contractor, the Center for Outcomes Research and Education (CORE) at Providence. All claims-based incentive measures were provided in dashboard format. The dashboards were instrumental in facilitating CCO validation of the 2014 measure results.
- During this reporting period, OHA worked with its contractor, the Oregon Health Care Quality Corporation, to complete validation of all measures for the baseline, dry run, CY 2013 and Year One Test measurement periods. Validation also commenced for the CY 2014 measurement period. See the Validation Update below for additional details.

#### Public Reporting

##### 2014 Performance Report

On June 24, 2015, OHA published a public report comparing calendar year 2014 performance on the CCO incentive, quality and access test, and core performance measures with 2013 performance and 2011 baseline. The report is available online at: [www.oregon.gov/oha/metrics](http://www.oregon.gov/oha/metrics).

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

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

Overall, the coordinated care model showed large improvements in the following areas for the state’s Oregon Health Plan members:

- Decreased emergency department visits. Emergency department (ED) visits for people served by CCOs have decreased 22 percent since 2011 baseline data. While some of the improvements seen may be due to national trends, CCOs have implemented a number of best practices for reducing emergency department utilization rates, such as implementing the use of emergency department navigators. One such program now includes referrals to a patient-centered primary care home for

patients who do not have a primary care provider, as well as referrals to dental services, drug and alcohol services, and intensive management for patients that have had 3 or more ED visits in the last 6 months.

- Decreased hospital admissions for short-term complications from diabetes. The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 26.9 percent from the 2011 baseline.
- Decreased rate of hospital admissions for chronic obstructive pulmonary disease. The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 60 percent from the 2011 baseline.
- Patient-centered primary care home (PCPCH) enrollment continues to increase. Coordinated care organizations continue to increase the proportion of members enrolled in a patient-centered primary care home – indicating continued momentum even with the new members added since January 1, 2014. PCPCH enrollment has increased 56 percent since 2011. Additionally, primary care costs continue to increase, which means more health care services are happening within primary care rather than other settings such as emergency departments.
- Strong improvement to the Screening, Brief Intervention, and Referral to Treatment (SBIRT) measure. This measures the percentage of adult patients (ages 18 and older) who had appropriate screening and intervention for alcohol or other substance abuse. Two coordinated care organization have exceeded the benchmark, a great accomplishment given the statewide baseline of almost zero. Initiation of alcohol and drug treatment has also increased. However, engagement of treatment has held steady, indicating room for improvement.

Other measures in this report that highlight room for improvement include cervical cancer and chlamydia screenings for women. The changes in these screening rates may be due to changes in national guidelines reported in 2012, which recommended women wait 3 to 5 years between Pap tests and do not have their first Pap test until age 21.

### **2014 Quality Pool**

OHA made its second annual quality pool payments to CCOs in June 2015 (see table E1 below). Under the coordinated care model, OHA held back three percent of the monthly payments to CCOs, which were put in the common quality pool. To earn their full payment for CY 2014, CCOs had to meet the benchmark or improvement target on at least 12 of the 17 incentive measures (including EHR adoption), and have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from the quality pool formed the challenge pool. To earn challenge pool funds, CCOs had to meet the benchmark or improvement target on a subset of four measures: depression screening and follow up plan, diabetes HbA1c poor control, SBIRT, and PCPCH enrollment.

In summary: 13 of the 16 CCOs earned 100 percent of their quality pool. One CCO earned 60 percent and the remaining two earned 80 percent. CCOs were able to earn more than 100 percent of their quality pool once the challenge pool funds were distributed; the table below shows distribution with and without the challenge pool.

**Table E1: 2014 Quality Pool Distribution by CCO**

<b>Coordinated Care Organization</b>	<b>Number of measures met (of 17)</b>	<b>Percent of quality pool funds earned (without challenge pool)</b>	<b>Percent of quality pool funds + challenge pool funds earned</b>	<b>Total dollar amount earned</b>
AllCare Health Plan	11.7	80%	83%	\$ 6,170,421
Cascade Health Alliance	11.7	80%	84%	\$ 1,423,801
Columbia Pacific	13.9	100%	104%	\$ 4,247,607
Eastern Oregon	12.6	100%	103%	\$ 6,847,819
FamilyCare	13.8	100%	105%	\$ 17,157,018
Health Share of Oregon	16.8	100%	105%	\$ 34,592,657
Intercommunity Health Network	9.9	60%	62%	\$ 5,310,493
Jackson Care Connect	13.8	100%	103%	\$ 4,704,838
PacificSource - Central Oregon	12.9	100%	104%	\$ 8,177,907
PacificSource - Gorge	13.0	100%	105%	\$ 1,872,161
PrimaryHealth of Josephine County	16.0	100%	105%	\$ 1,601,588
Trillium	13.6	100%	103%	\$ 12,658,814
Umpqua Health Alliance	12.9	100%	104%	\$ 4,491,875
Western Oregon Advanced Health	12.8	100%	103%	\$ 3,449,486
Willamette Valley Community Health	14.9	100%	104%	\$ 2,802,864
Yamhill CCO	12.7	100%	105%	\$ 2,981,967

**Year Two Clinical Quality Measures**

During this reporting period, all 16 CCOs successfully submitted their year two data for the Clinical Quality Measures. The year two data was used to calculate statewide and CCO level rates, which were published in the 2014 final report (see above).

**Measure Validation Updates**

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

The status of validation of the 22 measures that are computed using administrative claims data is shown below for each measurement period.

<b>Time Period</b>	<b>Baseline</b>	<b>Dry Run</b>	<b>CY 2013</b>	<b>Year One Test</b>	<b>CY 2014</b>	<b>Year Two Test</b>
<b>Measures Signed Off (as of 12/31/15)</b>	19	19	17	15	TBD	TBD
<b>Measures Signed Off (as of 3/31/15)</b>	20	20	20	19	TBD	TBD
<b>Measures Signed Off (as of 6/31/15)</b>	22	22	22	22	6	TBD
<b>Total Measures</b>	22	22	22	22	22	22

## Hospital Metrics Updates

Implementation of HTPP, Oregon's hospital incentive measure program, continued in this quarter with the publication of the baseline report and first issuance of quality pool payments.

In the first year of HTPP (for the measurement period October 2013 – September 2014), hospitals could qualify for quality pool payments by submitting baseline data adhering to OHA guidelines and measure specifications. The official data submissions were made in the previous quarter. OHA then worked with hospitals to address any questions about the baseline data submitted and confirmed whether it adhered to OHA guidelines. Overall, all participating hospitals successfully submitted baseline data for over 90 percent of the measures for which they were eligible.

On April 20, the HTPP baseline year report was published (it can be found online at: [www.oregon.gov/oha/metrics/pages.aspx](http://www.oregon.gov/oha/metrics/pages.aspx)).

For this first year, a total of \$150 million in funds from a quality pool were awarded based on the successful submission of baseline data adhering to OHA guidelines and measure specifications for the 11 measures. A two-phase distribution method determined amounts awarded. In the first phase, all participating hospitals were eligible for a \$500,000 "floor" payment if they achieved at least 75 percent of the measures for which they were eligible (achieved meant successfully submitting baseline data). All hospitals achieved this, resulting in \$14 million in payments to hospitals from phase one. In the second phase, the \$136 million in remaining funds went to a pool that was distributed on a measure-by-measure basis. Overall, hospitals succeeded in reporting most or all of the data required for payment. See table E2 below for total payments distributed; Addendum3 below provides details of the baseline performance on each measure.

**Table E2, Year 1 HTPP Quality Pool Distribution by Measure (Phase 2)**

Measure	Measures weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
CAUTI in all tracked units	9.38%	\$12,750,000	28
CLABSI in all tracked units	9.38%	\$12,750,000	28
Adverse drug events due to opioids	6.25%	\$8,500,000	28
Excessive anticoagulation with Warfarin	6.25%	\$8,500,000	28
Hypoglycemia in inpatients receiving insulin	6.25%	\$8,500,000	28
HCAHPS: Staff always explained medicines * #	9.38%	\$12,750,000	27
HCAHPS: Staff gave patient discharge information #	9.38%	\$12,750,000	28
Hospital-wide all-cause readmissions	18.75%	\$25,500,000	28
Follow-up after hospitalization for mental illness	6.25%	\$8,500,000	28
SBIRT: Screening for alcohol and other substance misuse in the ED *	6.25%	\$8,500,000	17
EDIE: Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits **	12.50%	\$17,000,000	26
<b>Total</b>	<b>100.00%</b>	<b>\$136,000,000</b>	

### Committee and Workgroup Updates

The **CCO Metrics & Scoring Committee** met twice during this period. In May, the Committee received updates and in-depth analyses of several measures, and refined frameworks for the selection and retirement of measures. In June, the Committee began discussion around potential CCO incentive measures for CY 2016. Meeting materials are available online at: <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>.

Also in June, three new Committee members were appointed: one CCO representative, one measurement expert, and one members at large. In addition, three existing Committee members were reappointed to continue serving for an additional 1-year term. An updated Committee roster is available online at: [http://www.oregon.gov/oha/analytics/Documents/MetricsScoringCommitteeRoster\\_updatedAugust2015.pdf](http://www.oregon.gov/oha/analytics/Documents/MetricsScoringCommitteeRoster_updatedAugust2015.pdf)

During this period, Senate Bill 440 was passed by the Oregon Legislature. This bill establishes a Health Plan Quality Metrics Committee charged with identifying an aligned menu of measures to be used by coordinated care organizations and health plans offered by the Public Employee Benefits Board, the Oregon Educators Benefits Board, and the insurance exchange. The Metrics and Scoring Committee will become a subcommittee of this larger body.

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

- In April, the TAG received an update on the 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) survey and provided input on a potential tobacco prevalence measure that is being considered by the Metrics and Scoring Committee.
- In May, the TAG continued discussion of a tobacco prevalence measures and provided feedback on draft specifications which utilize Meaningful Use attestation reports.
- In June, the TAG learned about one CCO's efforts around the *Mental and physical health assessment within 60 days for children in DHS custody* measure; received an update on Year 3 Clinical Quality Measures; and provided feedback on *Dental sealants* measure specifications and 2014 chart review processes.

The **Hospital Performance Metrics Advisory Committee** met three times during this reporting period. Meeting materials are available online here: <http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx>.

- On May 1, the Committee received an update on the state legislative session and process for discussions with CMS about the proposed extension of HTPP; and reviewed the baseline year report.
- On May 29, the Committee finalized benchmarks for Year 2, and began discussion about program structure and potential measures for Year 3.
- On June 26, the Committee continued discussion about Year 3 and advised on program structure moving forward.

Also in June, two new Committee members were appointed, both representing CCOs. An updated Committee roster is available at: <http://www.oregon.gov/oha/analytics/HospitalMetricsDocs/HTPP-roster-July-2015.pdf>.

### Core Performance Measure Matrix

[Attached separately.](#)

### Hospital Transformation Performance Program (HTPP) Measures Matrix and Measures

[Matrix](#) and [measures](#) attached separately.

## Appendix F: Uncompensated Care Program

Nothing to report this quarter. OHA is currently implementing system updates to support collection of UCCP claim data.