IV. PROJECT NARRATIVE
Oregon State Innovation Models Testing Assistance Application

A. Description of the State Health Care Innovation Plan Testing Strategy

A.1. Model Purpose: Oregon has chosen to address today's health care challenges – increasingly unaffordable costs for businesses, consumers, and the state and incentives based on volume, not value – by changing the system to foster improved efficiency, value and health outcomes, with the goal of meeting the Triple Aim: better care, better health and lower costs. Instead of reducing provider payments, cutting eligibility, or reducing covered benefits to save money, Oregon has chosen a fourth pathway by transforming the delivery of health care through its Coordinated Care Model which will begin with Coordinated Care Organizations (CCOs) in Medicaid and then the underlying model will spread to public employees covered through the Public Employees Benefit Board (PEBB), Medicare for individuals who are dually eligible for Medicaid and Medicare, and commercial payers. These are critical next steps as the State prepares for sustainable expansions of coverage in the state's Health Insurance Exchange and in Medicaid in 2014.

The Coordinated Care Model grew out of recognition that the current structure of separate managed care organizations for physical, behavioral and oral health services creates a dizzying array of options and rules for enrollees. Separate managed care organizations have little incentive to encourage delivery system behaviors that improve health and quality of care or lower costs outside of their own silos or outside clinic or hospital walls and into the community. Oregon's Coordinated Care Model was developed through three years of intensive planning with key stakeholders: business, managed care organizations, consumers, public employee unions and advocacy organizations. In the year leading up to the authorizing legislation alone, the Oregon Health Authority (OHA) hosted 76 public meeting, including tribal consultations.

As we intend to move this new care model beyond just Medicaid, we need to test that we can achieve the quality improvement and cost reduction targets, and accelerate and spread the lessons learned across the delivery system. What we are essentially trying to do is change both the care model and the business model. We intend to realign incentives with the State's purchasing power now and as we move forward, so that our state employees, Medicare beneficiaries, and those purchasing qualified health plans on Oregon's Health Insurance Exchange ("the Exchange") have high quality, low cost options that are sustainable over time.

The Coordinated Care Model, as implemented initially in Medicaid through CCOs, begins to address health system shortcomings by focusing on the integration and coordination of physical, behavioral, and oral health care; by shifting to a payment system that rewards outcomes rather than volume; by aligning incentives across medical care and long-term care services and supports; and by partnering with community public health systems to improve health. CCOs are community-based entities governed by a partnership of providers of care, community members and entities taking financial risk for the cost of health care. While there are similarities between CCOs and Medicare Accountable Care Organizations, Oregon's CCOs are full risk-bearing entities and the model emphasizes a community responding to its unique health needs. Further, a CCO operates within a global budget that is designed to move from a fully-capitated model to a model wherein an increasing part of the budget is based on payment for outcomes. CCOs are the single point of accountability for health quality and outcomes in the population they serve and have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership. Through its 1115 waiver agreement, Oregon has committed to reducing the Medicaid per member per month cost trend by two percentage points while improving quality through implementation of this model.

Because the Coordinated Care Model allows for local flexibility, it is an ideal platform for further innovation and for replication to other payers and populations. OHA currently purchases health care for almost 850,000 people, or about one in four insured Oregonians, and this will increase by an estimated 200,000 people with the 2014 Medicaid expansion. By spreading this model to those who are dually eligible for Medicare and Medicaid, to state employees, and to the Health Insurance Exchange we will create a "tipping point" for transformation of Oregon's entire health care delivery system. This transformation can ensure real and sustainable improvements in health status, enhanced patient experience of care and lower costs. As noted in the attached Financial Analysis, Oregon expects to save a total of $372 million over the 3-year SIM demonstration period from these efforts, but these efforts set the stage for continued savings across the system.

To accelerate the implementation of reform, OHA plans to create a Transformation Center that will lead the way to a statewide "Rapid Learning Health System" to spread the model across payers and into the qualified health plans of the Exchange in 2014. The primary request in this application is to support the creation of this Center to coordinate testing the Coordinated Care Model, to accelerate transformation by disseminating best practices among CCOs and other health plans, to support rapid cycle improvement and to spread the model to state employees, Medicare and other payers across the state.

A.2. Scope of the Model: The Coordinated Care Model was implemented within the Medicaid population beginning August 1, 2012, thanks to first-in-the nation authority granted by the Centers for Medicare & Medicaid Services (CMS) on July 5, 2012. Currently, 13 Coordinated Care Organizations (CCOs) are certified and operational in 33 counties, covering 500,000 of the OHP members (See Map of CCO Service Area, Innovation Plan, Appendix H). By November

2012, CCOs will be certified in all of Oregon's 36 counties, serving an estimated 90% of the Medicaid population. Oregon's CCOs are establishing themselves in urban, small town, rural and frontier settings. The Medicaid/CHIP funding streams included in the CCO global budget will initially cover all services previously provided by managed physical and behavioral health care organizations, removing important barriers to effective integration and coordination of care. Additional services and funding streams such as non-emergency transportation and dental services will be incorporated in 2013 and 2014. CCOs will not directly provide long-term services and supports (LTSS); however, CCOs and the LTSS system will coordinate care and share both programmatic and financial accountability.

Beyond Medicaid, Oregon will test the Coordinated Care Model for additional payers, beginning with state employees and dually eligible individuals through a Medicare-Medicaid Financial Alignment Demonstration. A central focus will be on Oregon's Patient-Centered Primary Care Home (PCPCH) standards which are a core element around which other Coordinated Care Model elements are built. More than 280 clinics have been recognized as PCPCHs to date, 70 of which participate in the federal Comprehensive Primary Care Initiative (CPCI) program with payments from Medicaid, Medicare, and several private payers starting in November 2012 and many others through Medicaid under an ACA 2703 state plan amendment. Paying differently for primary care across multiple payers provides incentives for providers to invest in the practice changes necessary to enhance coordination and build relationships that are patient and family-centered. Oregon also seeks to spread the model to additional payers in 2014 by aligning contracting requirements and outcome metrics in qualified health plans on the Exchange with the Coordinated Care Model.

A.3. Description of Delivery System & Payment Models Tests: Oregon proposes to test the Coordinated Care Model's ability to meet the Triple Aim in three ways:

1. Assessing the success of the overall model in Medicaid, as outlined in the state's landmark 1115 waiver;
2. Assessing key payment, delivery system, and support elements individually to determine to what extent these elements contribute to the overall model's success; and
3. Testing the spread of the Coordinated Care Model to other payers and populations, specifically public employees and Medicare.

Oregon proposes to accomplish these tests utilizing the Transformation Center to drive change and coordinate activities across the OHA as well as in the community. Key elements of the Coordinated Care Model to be addressed are outlined below:

Community-driven accountability: Within Medicaid, CCOs are organized to encourage local flexibility and accountability. CCOs are community-driven entities with requirements for provider, community and consumer involvement in governance and in active Community Advisory Councils. A core requirement is that CCOs collaborate with local hospitals, public health agencies, social services organizations and others to conduct a community health needs assessment and develop a community heath improvement plan based on the needs and resources identified. This level of community involvement is intended to ensure that CCOs are responsive to local needs; they will also be held accountable through clear performance expectations, payment for outcomes and transparency in public reporting.

Payment designed to move from volume to value: *Medicaid CCO global budgets*. Designed to be as comprehensive as possible, CCO budgets will promote integration and coordination of care, economies of scale, and dedication of resources toward the most efficient forms of care,

and will discourage cost-shifting. To bolster CCO accountability and ensure that cost savings result from improved coordination and outcomes, rather than from withholding needed care, degrading quality, or simply cutting provider payment rates, Oregon's agreement with the federal government establishes a financial incentive for achieving performance benchmarks, including a fully at-risk quality pool starting in July 2013. Incentives will be tied to each CCO's performance on select quality, cost and access measures as well as electronic health record (EHR) adoption. Over time, the proportion of a CCO's global budget based on capitation is expected to decrease as the proportion based on performance incentives will increase with performance goals and incentives reflected in provider agreements. In our upcoming 2014 state employee RFP, the intent is to request risk-sharing strategies that could mirror these elements to manage healthcare trends and reward performance.

Alternative Payment Methodologies. CCOs are expected to use alternative payment methodologies (APMs) for provider compensation, in accordance with the principles of equity, accountability, simplicity, transparency, and affordability or cost containment. CCOs will have the flexibility to choose which APM(s) they implement. The state, through its Transformation Center, will collaborate with CCOs, providers and other stakeholders to support the adoption and spread of successful APM models in Medicaid as well as into the commercial market for state employees and future qualified health plans. APMs will be evaluated for their effectiveness in meeting the goals outlined above. The Transformation Center will offer technical assistance and implementation tools for a "starter set" of promising APM models, aligning with CMS's work to develop value-based purchasing models for Medicare and other APM efforts underway in the state. The starter set of promising APM models (also see the Innovation Plan) will include:

- Patient-Centered Primary Care Home (PCPCH) payments;

- Bundled payments, including case rates, fee-for-service (FFS) with risk-sharing, and episode payments;
- Risk and gain-sharing arrangements between health plans and their providers;
- Service agreements aligning incentives for specialty and primary care physicians;
- Quality bonuses or other performance incentives; and
- Accountable Care Organization (ACO) models.

LTSS financial alignment. In addition to these models, Oregon is developing strategies to align financial incentives and/or penalties for CCOs and LTSS to coordinate care and achieve desired outcomes for individuals they serve in common. Oregon's legislature excluded LTSS from CCO budgets, but Oregon has worked closely with stakeholders to develop strategies to share accountability and coordinate between CCOs and the LTSS system, including financial strategies. One promising coordination approach is the Congregate Housing with Services model, such as the one used in Vermont, where partnerships between health plans, housing providers, and LTSS providers can achieve positive health outcomes, address social determinants of health, increase member engagement, reduce health disparities, and save costs in communities or in Section 8 housing that serves mostly low-income, aged, and people with disabilities.

Redesigned, person-centered delivery system that reaches outside four walls. *Integration and coordination of benefits and services and PCPCHs*. Oregon's Coordinated Care Model integrates care across physical, behavioral and oral health, and has a strong focus on primary and preventive care and more effective care coordination, especially across transitions of care. Implementation of PCPCHs; proactive, collaborative care planning; collaborative community health needs assessments; use of evidence-based practices; widespread adoption of health information technology, and broader use of a new workforce (e.g., community health workers,

peer wellness specialists) are key strategies that the CCOs are expected to use to improve health and reduce health disparities.

Oregon's 280-plus PCPCHs focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient- and family-centered approach to all aspects of care. Many PCPCHs integrate physical and mental or behavioral health care onsite. CCOs are to develop a strong primary care system through a network of recognized PCPCH providers and bids for state employee January 2014 benefit year will need to demonstrate a similar intent to use PCPCHs. (See Section C for more information).

Community Collaboration. In recognition that health extends beyond a medical setting, key elements of our underlying model is population health and linkages to the community. Medicaid CCOs are a required to establish relationships with local community health and LTSS systems. Further, each CCO is required to establish a Community Advisory Council that will develop a community health needs assessment that specifically addresses health disparities. Spreading these elements of the Coordinated Care Model to state employees and Medicare beneficiaries can start to link the clinical care of these populations to community health and wellness as well.

Workforce development - Non-traditional health care workers and health care interpreters: Health Care Interpreters (HCIs) and Non-Traditional Health Care Workers (NTHWs), such as Community Health Workers, Peer Wellness Specialists, Patient Navigators, and other workers in specialized settings (doulas, home care workers) are an integral part of a CCO's team: they support adherence to treatment and care plans, coordinate care, support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention particularly for those experiencing health disparities. CCOs are required to incorporate NTHWs and HCIs in their service delivery model. Oregon has established core standards for several types

of NTHWs, and has committed to training 300 new community health workers by 2015. In addition, 150 HCIs will be trained and qualified by 2016. If testing proves these models to be successful, they can be spread to other populations including public employees and other payers.

Long-term care services and support systems alignment: Among the promising mechanisms identified to achieve system-wide alignment between CCOs and the LTSS system are: nurse practitioners making rounds to monitor individuals in nursing facilities, interdisciplinary care teams, shared care plans, sharing client level data between CCOs and LTSS systems, and bringing health services to individuals in their home or community-based care facility. OHA and the Oregon Department of Human Services (DHS) are in the process of implementing a shared accountability system with four components:

(1) Specific, contractual requirements for coordination between the two systems were implemented in 2012 for CCOs and LTSS local offices;

(2) All CCOs are required to have jointly-developed memoranda of understanding (MOUs) with the local LTSS field offices in their area that describe clearly defined roles and responsibilities;

(3) Reporting and transparency of performance metrics related to better coordination between the two systems; and

(4) Incentives and/or penalties linked to performance metrics applied to the CCO and the LTSS system.

Clinical standards, supports, and patient engagement: Oregon's Health Evidence Review Commission (HERC) is developing evidence-based decision tools that are grounded in extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes. Disseminated through the Transformation Center, these tools will provide guidance to providers

and CCO Clinical Advisory Panels in delivering clinically- and cost-effective care. These resources will also provide the PEBB Board, other health plans, providers and health systems the best available evidence for benefit design and APMs. Oregon will also support payers and providers with evidence-based approaches and tools for patient activation and informed decision-making. Expanding availability of clinical guidelines and patient engagement tools directly engages providers and patients in health systems transformation efforts.

Health Information Technology (HIT) and Health Information Exchange (HIE) supports: To ensure widespread adoption and meaningful use of EHRs, CCOs must meet baseline requirements for access to HIE for their providers and the quality pool that was established as a requirement of Oregon's Medicaid 1115 waiver will include financial incentives starting in 2013. Oregon has achieved one of the higher rates of EHR adoption in the nation. With State Innovation Model (SIM) investment, OHA intends to offer CCOs and providers tools to support care coordination beyond basic HIE and EHR use, namely: technical assistance to ensure that providers can use HIT effectively and access to innovative tools that improve person-centered care such as mobile devices, home monitoring tools, and tele-health technology. In addition, Oregon anticipates submitting an HIE funding request (HIT-IAPD) to CMS in 2012 for the technology needed to enable more sophisticated use of HIT/HIE across the state. Based on feedback from CCOs and stakeholders, Oregon will prioritize statewide development of real-time notifications of emergency department visits or hospital admissions, and a shared patient care plan tool for each CCO member to be used by their CCO, providers, caregivers, families and the patients themselves to truly coordinate care as a "team." Additional support from CMMI will accelerate adoption and use of these new tools.

Supports and tools to accelerate, magnify, and measure innovation: *Oregon Transformation Center (OTC)*. The Coordinated Care Model is leading-edge innovation for health care, and providers and payers will require support in adopting and adapting the new model. The Transformation Center is the state's strategy for implementing the model successfully and rapidly throughout the state and across all payers. The Center will work with payers, providers, community stakeholders and consumers to promote the successful implementation and spread of the CCM using data and analytic tools to improve care coordination and management, focused learning opportunities, technical support for alternative payment methodologies, and other tools. The Center will test CCM elements that contribute to quick and sustainable change and will facilitate rapid cycle feedback, allowing all parts of the system to assess and adjust reform strategies as needed. Stakeholders will be heavily involved in both the creation and ongoing work of the Center, and innovation will move bi-directionally between the State and CCOs (and other participating providers and health plans) to assure that transformation occurs at all levels.

Innovator Agents: In accordance with the terms of Oregon's waiver agreement, each CCO will be assigned an Innovator Agent (IA) by January 15, 2013. Two CCOs have already been assigned an IA. The IAs will serve as a single point of contact between the CCO and OHA, and will provide data-driven feedback to CCOs and assist their providers and Community Advisory Councils to develop strategies to support quality improvement and the adoption of innovations in care and gauge the impact of health systems transformation on community health needs. Support to build a full Transformation Center will provide the resources for IAs to connect communities, providers and CCOs to facilitate transformation in Medicaid.

Learning Collaboratives: The Center will convene and facilitate several learning collaborative (LCs), some for specific groups (e.g. clinicians) and others dedicated to particular

topics (e.g. integration of public health, reducing health disparities, adoption of PCPCH standards). For the most part, the LCs will be open to all payers and will create opportunities for peer-to-peer learning and networking, identifying and sharing information on evidence-based best practices and emerging best practices, and advancing innovative strategies in all areas of health care transformation. These LCs will be vital in order to accelerate and spread successful innovation to additional payers and future qualified health plans being readied for the Exchange.

Council of Clinical Innovators: The Oregon Transformation Center will develop a Council of Clinical Innovators who, along with the medical directors of the CCOs and other health plans, can serve as advisors and champions for the implementation of key innovations in the delivery and coordination of care. The Council will build upon strong partnerships created during the development of the Coordinated Care Model with Oregon's physician, specialty and other provider associations to spread transformation.

Conferences/workshops, *communications, outreach and networking*: The Transformation Center will develop multiple mechanisms for CCOs and other payers and stakeholders to learn and share information, including conferences and workshops; materials, such as research, policy and practice guides; and communication and outreach to support the Coordinated Care Model.

Technical assistance and infrastructure support: The Transformation Center will connect CCOs, other payers adopting elements of the Coordinated Care Model, and providers to expertise and technology resources that can offer assistance in effective delivery system reforms, use of health information technology, delivery of quality data, and alignment of financial incentives.

Regional Health Equity Coalitions (RHECs): OHA's Office of Equity and Inclusion will support the Transformation Center in advancing policies that promote health equity and address

social determinants of health. Through the RHECs, CCOs will have a bridge to communities that have been historically under-represented in health program and policy development, assistance in assuring representation of culturally and linguistically diverse communities on their governing board and Community Advisory Councils, and support to validate whether CCO's Community Health Improvement Plans are effective in addressing health disparities.

Bureaucracy busting: The Transformation Center will serve as the hub of innovation within OHA, working to streamline OHA systems and processes, reduce administrative burdens, and assist the agency in better coordinating the work of its different divisions in support of health system transformation.

Data and Analytics. The new model requires timely and actionable data to fuel the range of new payment and service delivery models being tested. OHA's Office of Health Analytics will support the Transformation Center to improve the quality and cost effectiveness of care. As a statewide aggregator of health care data and statistics, the Office of Health Analytics provides unique and valuable resources to drive change across the health care system. The Office leverages: all key health-related data sets containing claims/encounters; LTSS and other services and supports outside of CCOs; surveys including CAHPS and BRFSS; and integrated data sets such as the All-Payer All-Claims (APAC) database, and the Client Process Monitoring System (CPMS), which contains clinical data for mental health/chemical dependency treatment services.

Investment in data and analytic tools is crucial to enable testing of Oregon's Coordinated Care Model and to provide actionable data to: 1) improve the targeting and delivery of services; 2) support accountability mechanisms based on objective performance measurement; and 3) clear communication about performance, progress and opportunities for improvement. This will allow the State to use continuous improvement approaches in to monitor and spread the model.

A.4. Value Proposition and Improvement Objectives: The value proposition for the Coordinated Care Model is multi-factorial. As part of the recent 1115 waiver, the State committed to reducing the trend in per capita Medicaid expenditures by two percentage points by the end of the second year of the waiver, while maintaining standards of access and quality of care. The levers that will be used to achieve these improvements and savings reflect the key elements of the model: improved care management at all points in the system, with an emphasis on patient-centered primary care; APMs; integration of physical, behavioral, and oral health care with community health improvement; standards and accountability for safe and effective care; and testing, accelerating and spreading effective innovations through the state-coordinated Transformation Center.

Spreading key elements of the Coordinated Care Model, such as PCPCHs, to public employees can yield significant value as the rising cost of employee benefits are a significant aspect of state budgets. Aligning efforts across Medicare and Medicaid in our dually eligible population can similarly add additional value while improving health and the quality of care. Medicare beneficiaries and commercial populations receiving care from providers participating in Oregon's model will all benefit, regardless of payer, from better integrated and coordinated care. See Financial Analysis for further discussion of return on investment.

Oregon's Coordinated Care Model is essential to preparing Oregon's health care delivery system for the ACA coverage expansions through Medicaid and the Exchange. Most newly-insured individuals will have had limited coverage in the past and may only be familiar with expensive emergency room care. Oregon's Coordinated Care Model will provide these individuals and their families coordinated care through PCPCHs that are ready for their newly-

covered lives. All parties benefit: federal tax credits and state general fund go further if costs can be controlled, and access and quality of care across Oregon can be improved.

A.5. Evidence Base for Testing the Model / A.6. Theory of Action: The theory of action of Oregon's Coordinated Care Model features a delivery system with PCPCHs as a core feature, both for CCOs and for public employees and individuals eligible for Medicare and Medicaid. All the Coordinated Care Model elements are integrated around that core, most notably mental health and behavioral health services, support from non-traditional healthcare workers, payment methods that emphasize value over volume, community partnerships, and supports to accelerate transformation through rapid cycle feedback.

The medical home model, upon which Oregon's PCPCHs are built, is evidence-based and well-documented in literature. The key elements of primary care: accessible first contact care; continuity; coordination across persons' conditions, providers and settings; and comprehensive care that meets or arranges for most of a patient's health care needs, have long been recognized as the most efficient and cost effective delivery system intervention to improve a population's health status.[1,2] Redesign of primary care with addition of team based care, addition of quality and safety tools, evidence-based decision support, and care management, all supported by appropriate information technology and electronic health information exchange, have been associated with improved quality of care and patient experiences, as well as reductions in expensive hospital and emergency department utilization.[3,4,5]

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[1] Starfield B, Shi L, Macinko J. *Contribution of primary care to health systems and health*, Milbank Q. 2005;83:457-502

[2] Schoen, Cathy, et al., *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries*, *Health Aff*airs, Web exclusive (Oct. 31, 2007).

[3] Grumback K, Grundy P, *Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States.* Patient-Centered Primary Care Collaborative Nov. 16, 2010 (www.pcpcc.net)

[4] Reid RJ, et al, *Patient-centered medical home demonstration: a prospective quasi-experimental, before and after evaluation.* Am J Manag Care. 2009;15:71-87

In addition to PCPCHs, CCOs are required to integrate physical and behavioral health, employing one of the several models of integration that have been demonstrated to improve health and reduce cost.[6] Currently, delivery systems are inadequate and uncoordinated for individuals with co-occurring physical health conditions and mental health problems. Oregon has also invested in new workforce capacity by defining competencies for NTHWs, as described in A.3. There is abundant evidence supporting the effectiveness of such workers in promoting and supporting improved health outcomes and guiding care to the most efficient and cost effective place.[7]

Oregon's Coordinated Care Model emphasizes the adoption of payment methodologies that reward value rather than volume, such as APMs like bundled payments, global budgets, shared savings and others. Studies are beginning to show that bundled payments, risk and gain sharing arrangements including ACOs, and service agreements between primary and specialty physicians are reducing lengths of stay and unnecessary admissions and readmissions and hospital charges while not negatively impacting quality.[8] Similarly, carefully designed provider incentive schemes do show positive results.[9]

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[5] Tsai, A., et al, A Meta-analysis of Interventions to Improve Care for Chronic Illnesses, Am J Manag Care, 2005;11, (8)

[6] Agency for Healthcare Research and Quality. *Integrating Behavioral Health and Nutrition Services into Primary Care Clinics Significantly Reduces Mental Health–Related Hospitalizations for Staff-Model Health Maintenance Organization*. 2008 Rockville, MD http://www.innovations.ahrq.gov

[7] Oregon Health Policy Board Workforce Committee Non-Traditional Health Worker Subcommittee. *The Role of Non-Traditional Health Workers in Oregon's Health Care System* 2012.

[8] Agency for Healthcare Quality and Research, *Closing the Quality Gap Series: Bundled Payment: Effects on Health Care Spending and Quality*. 2012, August*:* http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/; Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care, Francois de Brantes et al, Robert Wood Johnson Foundation; MEDPAC, cited by Mechanic, Robert E. and Stuart H. Altman. "Payment Reform Options: Episode payment is a Good Place to Start, Health Affairs; Ketcham, Jonathan D. and Michael F. Furukawa. ―Hospital-Physician Gainsharing in Cardiology, Health Affairs. 803: 12. (May/June 2008); ("Issues in Physician Payment Policy", Report to the Congress: Medicare Payment Policy, March 2005; Diane Hasselman; Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care; Center for Health Care Strategies, Inc., March, 2009

[9] Commonwealth Fund, States in Action Newsletter. States in Action Archive: Medicaid Pay-for-Performance: Ongoing Challenges, New Opportunities. January/February 2007; Bailit Health Purchasing, LLC. Ensuring Quality Health Plans: A Purchaser's Toolkit for Using Incentives. National Health Care Purchasing Institute. May 2002.

As outlined in an article by Fisher and Shortell (2010),[10] Oregon proposes to create the Transformation Center to act as the infrastructure for transformation in the state that supports the rapid learning, timely correction of missteps and broad dissemination of successful innovations necessary to implement and continuously improve the Coordinated Care Model. Analytic capacity built into the functions of the Center will allow for rapid cycle improvement at all levels to swiftly correct policies and design decisions and keep the transformation moving forward.

A.7. Alignment and Coordination with other Federal Initiatives Operating in Oregon: The Coordinated Care Model incorporates a number of design elements that are the focus of other federal initiatives and Oregon is an active participant in many federal projects. Participation in these initiatives is building additional momentum for transformation in Oregon's health system and will enhance the Coordinated Care Model by providing infrastructure for reform and generating evidence about best practices. In many cases, federal opportunities will directly support spread of Coordinated Care Model elements to new payers or environments. The OHA oversees implementation of many of these projects and will be able to coordinate them with SIM activities to promote alignment and avoid redundancy or waste.

Some of the initiatives that align most closely with and that will help advance the Coordinated Care Model include: Oregon's PCPCH program (including ACA Section 2703 Health Homes SPA and the Comprehensive Primary Care Initiative); a proposal submitted to CMS for a Medicare-Medicaid financial alignment demonstration; participation in the Partnership for Patients program; Federally Qualified Health Center projects, including a grant through the Commonwealth Fund/Qualis/MacColl to transition Federally Qualified Health

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www.bailit-health.com/articles/NHCPI-healthplanstoolkit.pdf; Song, Z., Safran, D. G., Landon, B. E., et. al., The 'Alternative Quality Contract' based on a global budget, lowered medical spending and improved quality. Health Affairs. August 2012. 31:8. DOI:10.1377/hltaff.2012.0327

[10] Fisher E, Shortell S, *Accountable Care Organizations: Accountable for What, to Whom, and How*, JAMA. 2010;304(15):1715-1716

Centers (FQHCs) into patient-centered medical homes and a SPA submission to CMS for alternative payments; LTSS initiatives, including expansion of its Money Follows the Person program and partnering in the federal 811 housing grant application; and extensive investment in HIT through ONC/HHS, which will allow for the secure use and sharing of patient medical records electronically. Please see Innovation Plan Appendix F for more information on these and other federal initiatives in which Oregon is participating.

A.8. Plan for Sustainability: The health system transformation underway in Oregon has a high likelihood of success and sustainability after the 3-year testing phase. Oregon has invested the necessary time and resources to lay the groundwork for a strong foundation to advance the model in Medicaid by working with key stakeholders at the state level (including legislators, beneficiaries, health plans, providers, and advocacy organizations) and CMS (through its 1115 waiver and ACA 2703 Health Homes SPA).

Oregon has obtained federal approval to implement the model through CCOs for its Medicaid members, including an approved five-year, statewide Medicaid 1115 waiver demonstration and three pending State Plan Amendments. The 1115 waiver demonstration is underway and projections are that the Coordinated Care Model will generate both federal and state Medicaid savings, a crucial element of long-term sustainability. Support from the SIM funding opportunity will provide the upfront investment and framework that Oregon will be able to support and continue well beyond the 3-year testing phase by reinvesting a portion of the projected savings.

Oregon will sustain the investments made by CMMI in several ways: many of the staff, consultants and contractors will initiate activities but will ramp down or be eliminated over time. Some ongoing costs, including the Transformation Center, will eventually be funded in whole or

in part by the savings generated out of the model. Over time, the Center may transition to a public-private collaborative supported in part by fees from participating health sector entities.

A.9. Potential to Replicate the Model in Other States: The Coordinated Care Model shows great promise for replication in other states. State Medicaid/CHIP programs are vastly different and a one-size-fits-all approach often does not work; however, the model promotes flexibility and customization of reforms at both the state and regional levels, making it an ideal candidate to replicate in other states. As an example of a next evolutionary step for managed care, CCOs are particularly valuable as a model for states that already have a strong managed care system.

The CCO global budget with quality incentives is a payment structure that states with wide-scale Medicaid managed care penetration today could likely adopt readily, and these reforms can be implemented with existing Medicaid waiver and state plan amendment authorities. The payment and delivery system reforms that the Coordinated Care Model incorporates are valued by CMS and states alike and have broad application across multiple payers. Experience in spreading transformation to state employees is of vital interest to other states as they wrestle with the rising costs of providing benefits.

Oregon's geography and provider profile is diverse – the state is made up of urban, rural, small town, and frontier areas, some with domination of larger group practices or FQHCs, and others with single practices. The Coordinated Care Model promotes innovation and customization that recognizes these regional differences. Testing aspects of these models will allow other states to look at a "menu" of what works in a variety of communities, and adapt a model to their situation.

The proposed Transformation Center is an organizational resource that many states could adopt to assess and disseminate successful innovations to all payers, including Medicare and

commercial plans, and to providers. It may be a particularly valuable tool for states looking to use their Exchanges to support system improvements.

A.10. Geographic Area for Model Testing: As described in Section A.2, the Coordinated Care Model is being implemented statewide for Oregon's Medicaid population and OHA anticipates that 90% of the Medicaid population will be served through CCOs by November 2012, including urban, rural and frontier areas of the state. PCPCHs, the primary means by which CCOs will integrate and coordinate benefits and services, are also expanding; Oregon's 280 plus recognized PCPCHs are distributed widely across the state. Oregon is spreading the model to other payers and populations, also on a statewide basis; the state's goal is that, by mid-2016, 75% of all Oregonians will have access to PCPCHs and 80% of Oregon's primary care clinics will be recognized as PCPCHs.

State employees and their families are covered through Oregon's Public Employees' Benefit Board (PEBB), which serves approximately 134,000 members who will be able to choose plans that incorporate the Coordinated Care Model in 2014. Additionally, as part of Oregon's separate CMS financial alignment demonstration proposal, Oregon proposes to make Coordinated Care Model elements available to individuals dually eligible for Medicare and Medicaid (roughly 60,000 Oregonians).

A.11. Likelihood of success and potential risk factors: As noted under Section A.8, the Coordinated Care Model has broad support from stakeholders, executive leadership, the State legislature, and CMS. In 2011 and 2012, the Governor and legislative leadership enacted legislation to establish and implement the Coordinated Care Model statewide for Oregon Health Plan (OHP) members, including individuals eligible for both Medicare and Medicaid. House Bill 3650 and Senate Bill 1580 passed the state legislature with broad support; in fact, this past

March, SB 1580 passed an evenly divided House by 53-7. CCOs also have CMS' support in the form of approval for Oregon's Medicaid 1115 waiver amendment in July 2012.

Oregon gained buy-in for the Coordinated Care Model from key stakeholders across the state through a series of stakeholder committees, boards, councils and workgroups convened from 2007 through 2012, with over 76 public meetings in the year preceding the passage of our health system transformation-enabling legislation alone. (See Appendix C in the Innovation Plan for a full description). More than 300 Oregonians representing health plans, providers, beneficiaries, consumer advocacy groups and other key stakeholder groups participated in the strategic planning and development of Oregon's health system transformation agenda. As stated earlier, there was strong support for adopting the Coordinated Care Model – Oregon is just completing a $1 billion procurement in its Medicaid program for the 13 organizations successfully certified as CCOs. As described in Section E, Oregon continues to engage stakeholders as the Coordinated Care Model is rolled out and implemented.

As evidenced by the number of CCOs already certified and PCPCHs already recognized, the model has widespread engagement across Oregon and has passed the first set of hurdles associated with bringing a concept to implementation. The proposed Transformation Center will be a critical factor to the success of the model as implementation continues, since it will provide CCOs, providers, consumers, and communities with the examples and technical assistance they need to make reforms work and the information necessary for rapid-cycle improvement.

Strong data and analytics will also support the success of the Transformation Center. Oregon has long recognized the potential for improved data systems to contribute toward better health, and has initiated efforts to modernize information systems that support health care and other programs. In addition, Oregon will ensure streamlined access to the Exchange and interaction

with Medicaid information systems to develop capacity for robust analytics. In the special terms and conditions of Oregon's recent 1115 waiver approval, Oregon committed to accomplish quality improvement activities and payment reforms that are heavily reliant on clear, reliable and timely data collection and analysis.

Change and innovation at this scale are never without risks and capacity for transformation is an important one. Oregon's vision for health systems transformation calls for significant changes on an accelerated timeline. Providers, plans, consumers, and the state must all adopt new business models or shed outdated paradigms. The Transformation Center will mitigate the risk inherent in the transformation of complex systems by providing a structured path for sharing of best practices and robust data to support mid-course corrections and rapid cycle improvement strategies.

Oregon believes that the Coordinated Care Model is likely to be successful as we spread the model to other populations. For example, it is likely to be successful for state employees within Oregon's Public Employees' Benefit Board (PEBB) because of the steps already taken to incorporate key elements of the model and because PEBB and its health plan partners were involved as key stakeholders in the development of the model. Another of the risks identified is the model expansion to dually eligible individuals. The CMS methodology for payment rates under the Medicare-Medicaid financial alignment demonstration may not work for Oregon due in part to Oregon's high Medicare Advantage penetration and low FFS costs. However, if Oregon is unable to offer CCOs as integrated Medicare and Medicaid plans for dually eligible individuals, the state will still pursue alignment of care by other means, as described in Section A.3.

In addition, as is often true in a policy environment, there are multiple initiatives being implemented at the same time in the state – some state-sponsored, some health system-sponsored and some federally sponsored. It will be critical to our success that Oregon continues to track and collaborate with these multiple efforts where possible in order to best reach shared policy goals.

The risks that OHA will face are considerable but well understood. The transformation activities underway in Oregon create a very dynamic environment, and OHA will continually monitor the impact of different reforms (see Section VII) to make quick adjustments and corrections as well as build on experience.

A. 12. Current clinical quality and beneficiary experience outcomes and targets/ A.13. Current population health status and expected outcomes, by target population: Oregon's goal is to improve system performance in alignment with the Triple Aim. Linking improved clinical care with community health improvement outside clinical walls is a key aspect of Oregon's vision for the Coordinated Care Model. The following is a brief overview of Oregon's current performance and future goals on a few key indicators in each of the three Triple Aim domains; please refer to Sections VI and VII of the State Innovation Plan for more data, including information on health status and health care disparities in Oregon.

Better health: Oregon not infrequently does better than the nation as a whole on measures of health status but there is significant room for improvement, as well as important disparities to be addressed for some of the populations targeted for this proposal. While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general (37% vs. 17%).[11] Similarly, rates of overweight and obesity are slightly below national levels and have been relatively stable in recent years, but PEBB members are slightly more likely to be more obese than Oregon adults in

[11] Oregon Health Improvement Plan, 2010.

general (28% vs. 24%).[12] Almost half of adult Oregonians have a chronic disease and, while 80% of Oregonians overall report good or excellent health status; only 51% of those with a chronic condition report the same. Oregon intends to make measureable progress in these population health areas and has committed to tracking and publicly reporting rates of tobacco use, obesity and self-perceived health status as measures, among many others, of the success of health systems transformation.

Better care: The delivery system redesign and payment reforms in Oregon's Coordinated Care Model are expected to increase the quality of care and care coordination on a variety of indicators such as primary care-sensitive hospital admissions or initiation and engagement in drug and mental health treatment. With a person-centered care model and patient engagement tools, Oregon also intends to significantly improve the experience of care. Currently, about 66% of Medicaid recipients and 90% of state employees report being satisfied with how well their provider communicates and 56% of those receiving Medicaid-funded mental health services are satisfied with their level of participation in treatment planning. Strengthening coordination and communication across a member's primary care team, specialists and hospital providers, as required by Oregon's PCPCH standards, will help improve these figures and hence health outcomes.

Reduced costs: Lowering and containing the cost of care so that it is affordable for everyone is a key goal of Oregon's transformation efforts. Oregon has committed to CMS that it will reduce per capita Medicaid trend by 1 percentage point by July 2013 and 2 percentage points by July 2014. For state employees and dually eligible populations the ultimate goal is the same: a reduction in per capita spending trend while at least maintaining, if not improving, access and quality.

[12] Ibid.

A robust measurement and performance reporting strategy including initial and ongoing data collection, analysis, and follow up action is being developed to ensure that CCOs and the state are meeting Triple Aim goals. A core set of 16 quality measures is specified in the waiver (see Appendix E in the Innovation Plan for the full list) and includes:

- Appropriate care measures such as ambulatory care sensitive hospital admissions, potentially avoidable ED visits, and readmission rates;
- Measures of patient experience of care;
- Measures relevant to behavioral care integration; and
- Outcome measures such as tobacco use and obesity rates and health/functional status.

Access measures are also being identified. Improvement objectives for cost control have already been set in the form of the 2 percentage point per capita reduction commitment but benchmarks for performance improvement on measures of access and quality will be established this year by the state's statutorily created Metrics and Scoring Committee in consultation with CMS. As Oregon tests its model, similar robust measurement and performance reporting will be the key in spreading similar expectations to state employee plans and providers. Alternative payment relationships between the state and plans will need to be adjusted for the commercial plan populations, but the state's goal is to reduce the growth in health care spending across all payers. Investment in expertise and analytics will be valuable to Oregon in order to ensure and measure the impacts of that spread.

A.14. Other authorities needed / A.15. Contingency Plans: With legislative pieces already in place for the overall model and with Oregon's comprehensive, five-year 1115 waiver amendment granted in July, no further waiver authority is needed. Oregon is finalizing with CMS aspects of our waiver approval: incentive payments to CCOs, metrics and reporting

requirements, IA roles, flexible benefits, and details of the methodology for measuring the 2% trend reduction, due in early November. Oregon has an ACA 2703 Health Homes SPA in place to offer PCPCH payments for ACA-qualified individuals. In addition, Oregon currently has three SPAs (related to NTHWs, additional payments to primary care homes for non-ACA qualified individuals, and an alternative payment pilot for FQHCs) and a Medicare-Medicaid financial alignment demonstration proposal under consideration at CMS. Approval is expected on the SPAs by the end of the year. CMS has not yet had a chance to respond to Oregon's Medicare-Medicaid alignment proposal but, if the state and CMS are unable to come to a demonstration agreement, there are still avenues available to leverage the Coordinated Care Model to provide care for dually eligible individuals (see Section A.3). The OHA will work closely with Oregon's Exchange to align efforts as the requirements of qualified health plans are refined to aid transformation across Oregon's delivery system.

A.16. Other targeted improvements: Oregon's Coordinated Care Model is intended to provide a platform for moving beyond the walls of clinical care to community-level prevention and promotion of well-being. These kind of cross-sector collaborations are especially well-suited for local innovation and flexibility and Oregon has prioritized two areas of collaboration for the immediate future.

Addressing leading causes of poor health at the community-level: Oregon's public health system aims to make Oregon one of the healthiest states in the nation by 2017.[13,14] The Coordinated Care Model offers an optimal opportunity to bring the health care system and the public health system together to implement primary and secondary prevention strategies recommended by the US Preventive Health Services Task Force Guides to Community and

[13] Public Health Division, Oregon Health Authority. Oregon Public Health Strategic Plan: 2012-2017, 2012. In press.
[14] Public Health Division, Oregon Health Authority. Oregon's State Health Profile, 2012. In press.

Clinical Preventive Services.[15] Oregon therefore proposes to support a number of CCOs in partnering with their local public health authorities and other local organizations to decrease the leading causes of disease, injury, and death while also reducing the leading drivers of health care costs in their communities. Supported collaborations (approximately 5 per year) will use evidence-based clinical as well as community preventive strategies to address a specific health need, using a "flood the zone" approach. The goal is for communities to make lasting changes in practice and/or policy to support prevention. This will impact PEBB members and dually eligible individuals in these communities, but also spread to other Oregonians as community efforts align with the clinical delivery system around the Triple Aim.

Aligning health and education system reform: Oregon's Governor Kitzhaber has launched a significant process of reforming the state's education system from pre-K to the college level. The opportunity to align health and education system reform in Oregon can dramatically contribute to short- and long-term improvements in health outcomes for children and is a primary prevention strategy. The state has set a goal of universal kindergarten readiness among Oregon children, which is dependent on both health and education system innovations. Oregon's Early Learning Council recently adopted a statewide Kindergarten Readiness Assessment that will be broadly implemented in 2013. The Transformation Center will partner with the Early Learning Council to test innovative delivery models and collaborations at the community level between CCOs, education, and social service partners that result in improved kindergarten readiness to test this expansion of Oregon's model to link more closely with Oregon's education system.

A.17. Project processes and operational planning: 17a. Data collection and reporting: As described in Section VI, OHA has extensive plans for data collection and reporting for performance, continuous improvement, and evaluation of the Coordinated Care Model. In

[15] http://www.thecommunityguide.org/about/guide.html

Medicaid, CCOs are required to submit administrative and financial data and 2013 CCO contract amendments will include any additional reporting requirements related to quality, access, and cost performance metrics as determined by OHA and CMS. OHA will use SIM support to expand survey sampling under the CAHPS and BRFSS surveys. OHA will leverage existing partnerships with its External Quality Review Organization (Accumentra) to collect chart/record-level data and with its Chartered Value Exchange and Aligning Forces for Quality partner (Oregon Healthcare Quality Corporation) to produce CCO-level performance reports and validate performance metrics related to new CCO incentive payments beginning in July 2013.

In terms of data collection for other payers, Oregon's All-Payer All-Claims (APAC) data reporting program is operational, and contains claims and encounter data beginning in 2010 for all payers except Medicare FFS and plans with fewer than 5,000 covered lives in Oregon. The APAC database includes all state employees' PEBB data and Medicare Advantage data for plans meeting the covered lives threshold, and starting in 2013, all Dual Special Needs Plans will be included. For PCPCHs, OHA collects information at the clinic level in order to recognize clinics at the different tiers of PCPCH. In addition, the APAC includes a plan-provided indicator for individuals enrolled in primary care homes, which will enable analyses of administrative data for individuals served through medical homes. Oregon is partnering with Portland State University to collect data and evaluate the PCPCH program in Oregon, including an assessment of clinical quality, cost and efficiency of care, and experience of patients, providers, and staff.

17b. Provider payment systems: Because most CCOs are now operational, many of the contracting, beneficiary enrollment, payment, data submission, and administrative processes are already in place on the Medicaid side. With CMMI support, OHA anticipates providing software and analytic support to CCOs and other health plans who undertake APMs with their providers

(e.g., grouper software). Analytic support will allow the state to better evaluate the global budget and incentive program for continuous improvement as Oregon tests the model, and determine how to translate this payment methodology to commercial partner plans in PEBB.

17c. Model enrollment or assignment processes: Enrollment into CCOs began on August 1 with the certification of eight CCOs; on September 1, five more were certified and 76% of Medicaid beneficiaries were enrolled; by November 2012 OHA expects that close to 90% of Medicaid beneficiaries will be enrolled in a CCO. Oregon has a waiver in place allowing mandatory managed care enrollment for OHP, with some exceptions including dually eligible individuals and tribal members. Enrollees who have more than one CCO in their area will be enrolled in the CCO of their choice for up to 12 months, and may change plans at eligibility redetermination. First-time eligible individuals may change plans within 90 days of their initial plan enrollment. Enrollees may change plans or disenroll to FFS at any time with cause.

OHA is dedicated to strong beneficiary protections that ensure individuals' health and safety and high quality health and supportive services necessary to meet their needs, and will maintain existing beneficiary protections, including grievance and appeal rights, and will continue to meet CMS access requirements. Further protections include individualized care planning for individuals with special health care needs transitioning between enrollment categories and work on evidence-based care guidelines to ensure the right care is delivered in the right setting safely to all Oregonians.

Oregon's Public Employees' Benefit Board (PEBB) currently offers its members a PCPCH-based plan, and enrollees may choose and enroll in a PCPCH to avoid higher out of pocket costs. For the 2013 year, co-pays will be lowered for visits to providers in the statewide PPO that are PCPCHs. With the 2014 RFP, there will be continued incentives for participation.

Under Oregon's Medicare/Medicaid Alignment Demonstration proposal, CCOs would have the choice of applying to participate in the demonstration. For those CCOs in the demonstration, all dually eligible members of a CCO's affiliated Medicare Advantage plan would be rolled into their integrated Medicare/Medicaid Alignment demonstration plan, and dually eligible individuals who are FFS for Medicare would likely be passively enrolled into a demonstration plan in their area. All enrollees will have an opportunity to opt out prior to the start of the demonstration or to disenroll at any time.

17d. Contracting and administrative processes: Oregon will complete its CCO procurement process by November 2012. The RFP for PEBB's 2014 coverage year is under development and due to be completed by fall 2012. For the Medicare/Medicaid Alignment Demonstration, if successful, OHA expects to come to an arrangement with CMS by the end of 2012, with procurement in spring 2013 for a January 2014 start. CPCI contracts to pay differently for PCPCHs are in place with 70 clinics and six payers, including Medicaid and Medicare and are underway with a start date of November 2012.

To ensure smooth contracting and administrative processes throughout the startup and testing period of the SIM, Oregon seeks in its SIM request dedicated contracts and procurement staff and human resources staff to ensure that all resources are in place on time to fully implement the approaches and testing envisioned in this proposal.

17e. Continuous improvement analysis and performance optimization process: Section VI and Section A.17a above describe Oregon's plans for continuous improvement and performance optimization. Specific processes to support those plans include establishing the data infrastructure, access, and analytics tools to make full use of Oregon's current and new data sources, including:

- Data integration and architecture: OHA is focusing on data integration and alignment as many fragmented, legacy systems are still in place. The state has invested in the development of its All-Payer All-Claims database over the last two years, but current funding levels are not adequate for maximum use of this rich dataset. The state has also recently established a contractual partnership with the Oregon Health Care Quality Corporation (QCorp--an independent, non-profit, multi-payer health care quality organization and an RWJF Aligning Forces site). Finally, Oregon and the federal government have invested significantly in the development of a single eligibility platform between the Oregon Health Insurance Exchange and Medicaid to ensure seamless and continuous eligibility and enrollment processes.
- Access: The state's goal is that data will be integrated, linked and be accessible in a secure environment to provide something much closer to real-time monitoring of performance, visits, interactions, and communications. Providing appropriate data access to potential and current members, as well as providers, partners, citizens, and other researchers, supports the intent of building the expectation and the culture of coordinated care.
- Analytics and Informatics tools: OHA is working to enhance its current toolset to accommodate the sophisticated and complex assessment required to support transformation efforts and be of practical value to the CCOs and other partners. Oregon's model focuses on all elements of the health care delivery system becoming learning organizations.
- Infrastructure: 2012 hardware, including servers, archiving and disaster recovery tools, will support the functions described above.

17f. Other processes needed to complete delivery system reform: Oregon's delivery system reform is largely underway. However, with support from CMMI, OHA plans to build a robust Transformation Center with technical assistance and expertise particularly in payment

methodologies, expand capacity for data analytics, expand HIT/HIE resources and supports, and provide support to CCOs, PEBB plans, and other partners and providers engaging in new models of care.

17g. Project Management and governance structure/17h. Describe model staffing resources and roles: If successful in this proposal, Oregon's SIM grant project will be managed by the Office for Oregon Health Policy and Research (OHPR), with a dedicated Project Manager, and with OHPR Administrator, Jeanene Smith, MD, as the principle investigator and single point of accountability to CMMI for the SIM project. Dr. Smith has extensive experience managing complex projects and grants, and will be responsible for ensuring that the project is meeting the scope, budget, and timelines agreed to with CMMI, and will report to the Director of OHA and the OHA Chief of Policy on project progress and/or issues. The Project Manager will report directly to Dr. Smith, and will manage all aspects of the project, ensuring that OHA cooperates with CMMI monitoring plans and that reports, data, and other information requested by CMMI are submitted in a timely manner to allow for the evaluation of the project results.

The governance of the SIM project will include executive sponsorship of Tina Edlund, OHA Chief of Policy, with a Lean Project Management leadership team to monitor and make decisions. This leadership team will meet at least monthly through the 6-month implementation period, and at least quarterly thereafter. The team will include Ms. Edlund and Dr. Smith as well as executive representation from Medicaid, the Oregon Transformation Center, and the Office of Health Analytics. The tasks described in the project plan will be the responsibility of lead staff for each major area of work. The Project Manager will work with lead staff and will report on status, issues, and risks to the leadership team, as well as raise decisions impacting budget,

timelines, or scope. The Project Manager will provide regular updates to the OHA Cabinet and the Oregon Health Policy Board.

The Transformation Center will be responsible for carrying out most of the activities described in the project plan. The Center is a new office housed within the Oregon Health Authority, reporting to the OHA Chief of Policy. The Center and its director will staff a Transformation Steering Council, made up of representatives from CCOs, PEBB, Oregon's Health Insurance Exchange, commercial health plans, health systems, and providers to be convened jointly with OHA and DHS policy leaders. The Council will advise OHA and the Transformation Center on the implementation of the Coordinated Care Model and inform and assist in the model's acceleration and spread.

As described in the Project Plan (Section VII) and Budget Narrative, OHA plans to leverage its existing agency structure to carry out the activities in the model. In 2009, Oregon re-organized its agency structures to include most health care purchasing (Medicaid/CHIP, addictions and mental health, PEBB) and public health under the Oregon Health Authority, and all human services (LTSS, child welfare, developmental disabilities services, etc.) under the Department of Human Services, with key services (Information Services, Contracts and Procurement) shared between them. (See Innovation Plan, Appendix G for bios).

B. Expected Transformation of Health Care & Provider Entities

Oregon's vision for delivery system transformation is to deliver the right care, at the right time and right place. To achieve this vision, provider entities and community partners will need to work together to provide care that is centered on the person. Providers with the same patient must take a team-based approach by sharing information and coordinating efforts to make sure treatment plans are complementary. They must provide clear, trustworthy information to one

another to reduce miscommunication and avoid mistakes. This team of providers and community health partners will help manage care on the front end, avoiding unnecessary admissions and duplication of services. Individuals will also receive education and assistance to facilitate better decision making, helping them manage their own health. In a transformed delivery system, Oregon expects providers and plans to be able to:

- Coordinate and integrate care, including intensive case management for high needs members, and better integration of physical and behavioral health care;
- Focus on prevention to keep individuals healthier longer;
- Address needs in lower levels of care before problems become acute;
- Improve care planning and transitions;
- Invest in cost effective interventions and infrastructure;
- Reduce unwarranted or duplicative care; and
- Reduce medical errors.

Oregon's provider entities, plans, local LTSS systems, community health systems and other stakeholders are fully committed to this vision and are already taking steps to make it a reality.

The strong response to the state's RFP for CCOs to serve Medicaid clients is compelling evidence of changes in progress. By responding to the RFP and contracting with the state, CCOs have committed to making concrete changes in care delivery. In an example of commitment to proactive population health management, one CCO is funding positions at the local county health department in tobacco and obesity prevention and immunization promotion; support for community health assessment and planning work; and a senior analyst/epidemiologist to help the CCO identify opportunities to meet the Triple Aim.

In addition, CCOs must submit transformation plans by January 2013 that detail their strategies and milestones for advancing transformation further, particularly around PCPCH spread, integration of behavioral health, health equity and linkages to community/population health. These plans will provide a roadmap for continued transformation.

Over 280 clinics in Oregon have been recognized as PCPCHs, as noted earlier, and the program is on target to reach its goal of 300 by the end of 2012. Beyond the CCOs, commercial payers are initiating payment incentives, particularly in the 70 clinics under CPCI. Our largest PEBB partner plan is undertaking payment incentives across the PEBB population in the upcoming 2013 contract year.

Oregon's plans and providers are well-versed in using performance measurement for quality improvement. The Oregon Health Care Quality Corporation (QCorp) counts eight of the state's largest commercial plans, along with some Medicaid managed care and Medicare Advantage plans, among its data suppliers and QCorp produces a wide range of quality and utilization reports for providers, plans, and consumers. In 2009, Oregon passed legislation to create an All-Payer All-Claims reporting system; data from that system will be a key resource for performance measurement, continuous improvement, and evaluation of the success of the Coordinated Care Model and its key elements (see Section VII).

Similarly, many of the provider groups now involved in CCOs have experience with a variety of delivery system and payment innovations: fifteen federally qualified and rural health centers participated in a medical home pilot projected in 2009-2011 which has led to the development of a SPA for FQHC Medicaid alternative payment methodology that is currently under consideration at CMS; the major Medicaid plan in the Portland metro area has been using outreach workers to help high-needs clients manage their care, improve their health, and reduce

unnecessary hospitalizations and ED visits; and providers contracted with another one of our major commercial payers, PacificSource and Cascade Health Alliance (behavioral health) have been participating in risk-sharing arrangements across a shared population.

Oregon's Coordinated Care Model has been built upon strong stakeholder engagement over many years. Representatives from major provider associations in Oregon, including but not limited to the Oregon Medical Association, the Oregon Nurses Association, the Oregon Association of Hospitals and Health Systems, and the Oregon Health Care Association (a long-term care trade association) participated in the workgroups that help developed Oregon's Coordinated Care Model (See Innovation Plan, Appendix C). Many testified in favor of the two bills that launched CCOs in the state and several have provided letters of support for this application (See Section E). Providers will be directly involved in CCO governance, as the enabling legislation requires each CCO board to include an active primary care practitioner (physician or nurse) and active behavioral health professional.

Similarly, Oregon's PCPCH Standards and their implementation were developed through open public discussions that involved multiple providers and representation from health systems across the state, with focused outreach to providers for education and assistance already underway that this SIM opportunity can strengthen to ensure optimal spread across the state, particularly less well-supported rural and frontier primary care practices.

OHA is responsible for purchasing health care for approximately one-third of the non-Medicare insured population in Oregon, giving the agency direct leverage to spread the Coordinated Care Model to those populations. At the county level, Oregon's publicly-funded addictions and mental health service system is undergoing a system change separate from, but aligned with, the Coordinated Care Model. That system change includes global budgeting and

outcomes-based accountability. Oregon Health and Sciences University, the state's only academic medical and research center and only school awarding MD degrees, is a partner in the largest CCO (HealthShare, in the Portland metro area) and has provided a letter of support for this application.

C. Role of other Payers and Stakeholders

Oregon is committed to spreading the key elements of its model (described in Section A.3) to non-Medicaid payers, including Medicare and state employees (through PEBB), and ultimately to commercially covered populations. PCPCHs are at the heart of Oregon's health system transformation efforts and will be an initial focus for efforts to spread the Coordinated Care Model. Expanding the availability of PCPCHs through PEBB and other mechanisms will provide better access to care now and strengthen primary care networks as Oregon's transformation efforts mature. Oregon's health plans and provider stakeholders have been at the table from the beginning as the Coordinated Care Model has been developed, and those relationships are the foundation that SIM investment will strengthen to accelerate and spread the model while testing it and its key elements.

Medicare beneficiaries receiving care from providers participating in Oregon's model, such as recognized PCPCH clinics, will benefit from better integrated and coordinated care. For the dually eligible, Oregon aims to improve quality and experience of care by (1) aligning Medicare and Medicaid, physical/behavioral health care, and unifying care/health plan experience from the member's perspective as much as possible, (2) extending the key elements of the model to both sides (Medicare/Medicaid) for dually eligible individuals, and (3) maximizing enrollment of dually eligible individuals in the most integrated/coordinated care possible.

To accomplish these aims, Oregon has applied for Medicare/Medicaid Alignment demonstration (financial alignment demonstration). This demonstration will allow CCOs to apply to serve as integrated Medicare and Medicaid plans for dually eligible individuals, and will allow the passive enrollment with opt out of dually eligible individuals into demonstration plans. This passive enrollment will help to maximize enrollment of dually eligible individuals in integrated care and improve the quality and coordination of care delivered to this population.

If the demonstration does not move forward, Oregon intends to integrate care for dually eligible individuals as much as possible, leveraging the Coordinated Care Model. Oregon will explore encouraging CCOs to roll out key elements of the Coordinated Care Model in their affiliated Medicare Advantage plan, with a particular focus on use of PCPCHs. For Dual Eligible Special Needs Plans (DSNPs), OHA would consider leveraging the contracts to require that they have key CCO elements in their plans. OHA would also work to maximize enrollment of dually eligible individuals into the Medicare Advantage plan affiliated with their Medicaid CCO to the greatest extent possible.

Public Employees: Extending the model to Oregon state employees whose benefits are provided via Oregon's Public Employees' Benefit Board (PEBB) offers the opportunity to test the model with a commercially insured population. PEBB resides within OHA and is a self-insured entity with approximately 134,000 covered lives served currently through three plans: a PPO that serves almost 85% of beneficiaries, and two HMO-like plan designs. PEBB plan performance is generally strong: plans meet or exceed the 75th percentile nationally for commercial plans on most HEDIS measures. PEBB has a long history of innovation with evidence-based plan design and working on incentivizing delivery system change to achieve the Triple Aim.

The PEBB Board will emulate the model in its current and future contracting and plan design elements. Creating incentives through payment is a key element to aid practices in their transformation, and one of our contracted vendors, Providence Health Plan, has recently begun to pay an extra per-member reimbursement in the Statewide PPO plan primary care groups that attain more advanced levels of recognition from Oregon's PCPCH program. In 2013, PPO plan members who seek care from a recognized PCPCH will see a decrease in their cost sharing from 15% to 10%.

Work is underway for the PEBB RFP for the 2014 plan year, due for release this fall. The PEBB Board is currently aligning the requirements in its RFP with those of the Coordinated Care Model. A key example is that any successful bid will need to demonstrate incentives to spread the PCPCH model, including alternative payment for PCPCHs, using the same common set of standards for their provider networks that is also expected of the CCOs in Medicaid. PEBB will also be looking at other key quality metrics being used in CCO contracts to align expectations in the new RFP as well. Investing in the Transformation Center will accelerate spread of the PCPCH model and other delivery system changes by partnering with plans and providers that serve PEBB, including sharing of best practices through participation in the learning collaborative and technical assistance.

Discussions are also proceeding to ask bidders to offer alternative payment mechanisms that would mitigate the PEBB cost trend. CCOs, which are currently Medicaid-only plans, could potentially respond to the PEBB RFP and if successful, be an option for PEBB beneficiaries. The ultimate goal is to achieve the same results expected under Medicaid – a reduction in health care cost growth over the next 3 to 5 years, while at least maintaining, if not improving, access and quality, whether under a traditional commercial plan or a new CCO.

Other Payers and Stakeholders: The primary payers participating in the test, as outlined earlier, are Medicaid, Medicare, and PEBB as a commercial payer. Their role will be to advance the model and its key elements through their purchasing power – they will or have already changed provider and plan contracts to include expectations for integration of physical and behavioral services, care coordination, proactive population health management, and outcomes-based accountability, among other reforms. In addition, participating payers will actively assess the performance of the model in their systems to identify best practices, shortcomings, and opportunities to mature the model. Payers will also be key participants in the peer learning and collaboration opportunities created by the Transformation Center as well as serve on the Transformation Center Steering Council.

In addition, there are other payers participating in testing Oregon's PCPCH model, all of whom have aligned themselves around an enhanced care management fee as an initial alternative payment methodology.

The proposed Transformation Center and related supports will also connect a wide range of other payers and stakeholders to the Coordinated Care Model. By inviting other payers and stakeholders to serve on the Steering Council, to join the Center's learning collaboratives, to adopt the alternative payment methodologies being tested through the Center, or participate in collaborations with the Early Learning Council to increase rates of developmental screening and improve kindergarten readiness, Oregon will engage the entire state health system in transformation and all Oregonians will benefit.

D. Linkage of the model to Oregon's Health Care Innovation Plan

Designed to be a comprehensive approach to achieving the Triple Aim, Oregon's Coordinated Care Model reflects all elements of the state Innovation Plan. Long-term services

and support and community-level prevention are explicitly part of the model and the SIM testing strategy, as described in Section A. In its implementation, the Coordinated Care Model will benefit from its connection to other health reform initiatives in the state, including:

- *The Oregon Health Insurance Exchange*: Oregon's Exchange was established as a public corporation in 2011 and is currently preparing for federal readiness review in January 2013. Exchange and Health Authority staffs communicate regularly, as do the governing Boards of both bodies (the OHA Director sits on the Exchange Board by statute), to ensure as much alignment as possible between the key elements of the Coordinated Care Model and the criteria for Qualified Health Plans on the Exchange.
- *Public Health*: In addition to the targeted collaboration projects described in Section A, CCOs and state and local health authorities will partner on an ongoing basis around three of the four strategies outlined in the National Prevention Strategy: expanding quality preventive services in clinical and community settings; empowering people to make healthy choices; and eliminating disparities.
- *Workforce development*: In addition to efforts described earlier to prepare a new workforce of non-traditional health care workers (e.g., community health workers and interpreters), the state has committed through its 1115 waiver to allocate $2 million annually in loan repayment for primary care providers who commit to serving Medicaid and serving in rural or underserved areas, beginning July 2013. The Oregon Health Policy Board's Health Care Workforce Committee is currently developing a statewide strategic plan for primary care provider recruitment that will help ensure that CCOs and other entities will have the skilled workforce they need to meet the demand for care.

- *Education*: As described in A.16, improving kindergarten readiness will be the first new area of focused collaboration between CCOs and the education system; Oregon's strong school-based health center (SBHC) network is already engaged and is encouraging SBHCs to become certified PCPCHs.

E. Multi-Stakeholder Commitment

Consistent with Oregon's reputation as a leader in the public process for health policy development, Oregon committed itself to obtaining a wide range of input and feedback throughout the process of planning for health systems transformation, CCO implementation, and this proposal. These efforts have included: (1) Oregon Health Policy Board (OHPB) meetings, workgroups, and public comment; (2) the OHPB's targeted expert and stakeholder workgroups (more than 130 participants); (3) OHA's Health System Transformation Community Meetings (more than 1,000 participants, 8 cities); (4) tribal consultations with the nine federally-recognized tribes in Oregon; (5) PCPCH development stakeholder groups; and (6) individual staff engagement with advisory councils, committees and other stakeholders to gain input and feedback throughout the process. There were more than 76 public meetings in total leading up to the development of the overall CCO implementation proposal and almost 350 key stakeholders and experts gave hours of their time to help build and refine the Coordinated Care Model. See Appendix C in the Innovation Plan for more details.

Ongoing support from key stakeholders is evident in the number and range of letters of support accompanying this proposal. They include letters from key policy-making and advisory groups to the OHA such as the Oregon Health Policy Board (OHPB), Medicaid Advisory Commission (MAC), and Oregon's Public Employees' Benefit Board (PEBB); CCOs including HealthShare in the Portland metro area and Trillium in Lane County; key delivery system

partners and academic medical center partners such as Oregon Health & Sciences University, the Oregon Association of Hospitals and Health Systems, Oregon Health Care Association, Oregon Association of Area Agencies on Aging, and the Office of Rural Health; commercial payers represented by Providence Health Systems and the Oregon Business Council, philanthropic organizations such as the Northwest Health Foundation, and consumer advocacy organizations such as AARP.

As CCOs and elements of the Coordinated Care Model take root and begin to spread in Oregon, many of the same policy-making and stakeholder bodies that contributed to the model development will continue to provide oversight and feedback. The Oregon Legislature has explicitly requested quarterly reports on the implementation of health systems transformation through 2017. The OHPB, PEBB, the MAC, and other existing bodies will track implementation and provide input. Targeted stakeholder and expert workgroups, such as the Metrics & Scoring Committee, the CCO contractors, and the "Medi-Medi" advisory group consisting of CCOs and their affiliated Medicare Advantage plans, will provide input on policies to further model implementation.

OHA will continue its strong record of outreach and inviting input through various methods, including stakeholder presentations and webinars, annual regional listening sessions, a robust open public process of public meetings, transparent and public reporting of CCO performance and of progress toward health systems transformation goals, and ongoing direct work with key stakeholder groups.

Section VI: Project Plan for Performance Reporting, Continuous Improvement, and Evaluation Support

CCOs represent a transformation of the delivery system for almost 850,000 residents of Oregon in Medicaid as the first steps towards the Coordinated Care Model statewide. This will include a sweeping redirection of the system toward prevention, integration of disparate silos of care, the establishment of proactive and evidence-based management of chronic illness care, and increasing patient and community engagement. Payment reforms implemented in each CCO will support this redesign and result in improved outcomes. The changes are complex and necessitate a robust plan for quality monitoring and improvement, as well as an evaluation strategy that can illuminate unique and combined effects of different innovations. Oregon's goals for performance reporting, continuous improvement and evaluation support are to:

- Provide continuous feedback on performance for multiple audiences, to allow timely assessment, corrections, and dissemination of best practices;
- Generate data necessary for testing the Coordinated Care Model, its key elements, and spread; and
- Build evidence toward a broader evaluation of the Coordinated Care Model and health systems transformation.

Performance Reporting: Quality data and timely performance reporting are essential to improve the targeting and delivery of services and to drive change across the health care system. Oregon has already committed to a robust measurement agenda that includes 16 Triple-Aim focused performance measures (e.g., ambulatory care sensitive hospital admissions, tobacco use and obesity rates, potentially avoidable ED visits; see Appendix E of the State Innovation Plan) to be collected and reported on a quarterly basis both by CCO and statewide, as well as measures of access (e.g., % beneficiaries with a preventive visit in last year). Collection and reporting of

these 16 measures will establish a strong foundation for monitoring implementation of the Coordinated Care Model, assessing the impact of the model's key payment, delivery system, and support elements, and for enabling continuous improvement.

With legislative direction, the state has also established a Metrics and Scoring Committee to oversee performance measurement for Medicaid CCOs. One of this group's first tasks is to make recommendations for a robust CCO performance incentive system, to drive the outcomes-based payments that will make up an increasing proportion of CCO revenue (see Project Narrative Section 3). The proposed incentive design will be submitted to CMS in November 2012. Beyond incentive design, the Committee is responsible for recommending future performance measures and for establishing performance benchmarks for certified CCOs. The state intends to gain alignment with these core metrics between PEBB as it develops RFP expectations and with the Health Insurance Exchange as it establishes requirements for qualified health plans.

Oregon has a range of existing data sources that will be leveraged for ongoing monitoring of trends, problem identification and characterization, and for testing and evaluation. These include: claims and utilization data from Oregon's All-Payer All-Claims database; state-assembled population health status data; enrollee surveys and experience of care data (e.g. CAHPS); and key operational data such as enrollee grievance and appeal logs, external quality review organization reviews, and provider capacity reports. To supplement these sources, OHA is planning direct patient health and risk assessments at enrollment and re-determination for Medicaid clients as well as other more qualitative data collection (e.g. interviews, focus groups, observation with OHA/ CCO staff and providers to assess how model elements are being implemented).

The Oregon Transformation Center will act as the nerve center for performance reporting on the Coordinated Care Model. Using the data sources described above, the Transformation Center will produce a variety of specific reports targeted to different audiences and uses, including:

- Monthly monitoring reports on the Medicaid CCO performance, trends, and emerging issues for OHA staff, Innovator Agents and CCOs themselves;
- Predictive modeling reports to help the Medicaid CCOs and providers determine what risks clients present for future utilization and costs as well as what gaps in care could be filled to reduce those risks;
- Quarterly dashboards on the 16 core Medicaid CCO performance measures (described above) with comparisons to peers and benchmarks. When established, these dashboards will be publicly reported as well as provided to CCOs and CMS; and
- Periodic reports from enrollee experience surveys or other surveys, or from qualitative data collection from with OHA and CCO staff and providers.

Continuous Improvement: Oregon has chosen the strategy of fostering the Medicaid CCOs and their member providers to become "Rapid Learning Health Systems," whereby a system assesses and applies evidence in real time and facilitates bi-directional learning between evidence and practice.[1] This model has been tested in large and complex health systems and has demonstrated success in rapid implementation of new models of care, improved population outcomes, high patient satisfaction, and enhanced morale of health care teams.[2] The elements of the Learning Health System include: data and information collection, design of the intervention or change, implementation, evaluation with feedback from all parties, adjustments and

[1] Etheredge L, A rapid-learning health system. Health Aff 2007: 26: 107-18.
[2] Greene, Sarah M. MPH; Reid, Robert J., MD, PhD; and Eric Larson, MD, MPH, "Implementing the Learning Health System: From Concept to Action," *Annals of Internal Medicine*, 2012; 157:207-210.

refinements in the intervention as well as dissemination of findings to reinforce the learning culture.

The Transformation Center will be the main vehicle for rapid cycle learning in Oregon. Building on the performance reporting mechanisms described above, the Center will support continuous improvement through multiple methods including learning collaboratives, technical assistance and coaching, as well as Innovator Agents to disseminate reforms and innovations. The Transformation Center will involve clinicians, CCO and other health systems staff, and others to understand what new processes and new innovations are being implemented. Practices that have been successful in one setting will be collected and shared by the Transformation Center with other CCOs, as well as with external health systems and payers. Other stakeholders will be included to ensure broad community engagement. In addition, the Center will provide data and research on external innovations by recruiting expertise and input from around Oregon, regionally and nationally on the best evidence-based practices and innovations in quality and payment that will facilitate improvement on problems that have been identified.

While some innovations and potential improvements will emerge from the field, seven initial focus areas for quality improvement have already been identified as part of Oregon's Medicaid waiver and will guide the Transformation Center's work. These focus areas were selected because of their significant potential for improving the patient experience of care, improving population health, and reducing the per capita expenditure trend within and beyond Medicaid. The areas are: 1) Reducing preventable rehospitalizations; 2) Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area; 3) Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by high risk patients; 4) Integrating primary care and behavioral health; 5) Ensuring

appropriate care is delivered in appropriate settings; 6) Improving perinatal and maternity care; 7) Improving primary care for all populations through increased adoption of PCPCHs.

Evaluation Support: The Transformation Center will use the expert research resource of contractors (such as Oregon Health Research & Evaluation Collaborative, or OHREC) to provide support for evaluation activities. The state and OHREC members have already received two grants for the Medicaid CCO evaluation: a 2-year grant from the Robert Wood Johnson Foundation to examine CCOs' differing structures and operations and assess their initial impact on a range of measures; and a 4-year NIH grant to study the economic consequences of CCO implementation, using Colorado as a control/comparison. As part of the SIM opportunity, Oregon proposes to conduct a more in-depth evaluation of the key elements of the Coordinated Care Model and their ability to advance the Triple Aim across the target and other populations. This study will make use of a longitudinal panel of CCO enrollees and a comparison group of non-enrollees and will assess two broad groups of outcomes: 1) utilization, costs, and quality via the state's All-Payer All-Claims data system; and 2) experience of care, health status, access to care and other measures available via the survey and health status assessment tools described earlier.

Section VII. Oregon SIM Project Plan and Timeline

Timeframe	Key Activities/Milestones	Responsible Parties
Payment Transformation		
	Shift CCO payment from volume to value	
By Dec. 2012	▪ OHA will have a plan for a CCO incentive pool rewarding CCO performance on quality, access and efficiency metrics with CMS approval	OHA, Metrics & Scoring Committee
July 2013	▪ CCO incentive pool implemented	OHA
July 2013 – June 2016	▪ Proportion of CCO budget based on performance grows over time	OHA
	▪ Performance metrics and incentive design updated as necessary and as new sources of outcomes data are available (e.g. clinical data from EHRs)	Metrics & Scoring Committee
	Shift provider payments from volume to value	
2013 - 2014	▪ CCOs begin testing APM starter set; every CCO tests at least one APM by 2015	CCOs
2013 - 2014	▪ Support of APM adoption and implementation with T.A., resources, and rapid cycle evaluation & feedback about most successful methods	Oregon Transformation Center (OTC)
2013 - 2014	▪ Increasing provider participation in APMs	CCOs
2015-16	▪ Successful APMs are spread to other payers	OTC
	Incent coordination & outcomes in Long Term Care	
2013	▪ Identification and collection of quality metrics for long-term services and supports	DHS, OHA
2013-14	▪ Stakeholder process to develop public reporting and financial accountability mechanisms	DHS, OHA, stakeholders
2014	▪ Launch and test Congregate Housing with Services model in at least one community	DHS, OHA with partners
2015	▪ Shared financial accountability mechanisms in place	DHS, OHA
2015-16	▪ Cost shifting between CCOs/health system and the LTC system reduced or eliminated	DHS, OHA
Delivery System Reforms		
	Advance development and use of PCPCHs	
Fall 2012	▪ CPCI Multi-payer Payments to 70 clinics begin ▪ Common data sharing platform to providers for quality, cost of care (CPCI)	OHA, other payers
Fall 2013	▪ PCPCH Technical Assistance Institute begins; will reside under Transformation Center in future	OHA

Timeframe	Key Activities/Milestones	Responsible Parties
2013	▪ PCPCH model spreads to PEBB, Medicare, and commercial carriers for non-OHA populations	OTC, other payers
2013-16	▪ Over 50% of PCPCH practices recognized annually are Tier 3	Providers, OTC
2015	▪ 75% of Oregonians have access to PCPCHs, 80% of Oregon's primary care clinics are recognized as PCPCHs	OHA, providers
	Address health care workforce gaps	
2013	▪ System for certifying non-traditional health workers established (NTHW) ▪ Training and certification incentives for health care interpreters in place	OTC with stakeholders
2013-15	▪ Outreach increases number of Oregonians who complete approved NTHW or interpreter training	OTC, training partners
By Dec. 2015	▪ 300 additional community health workers certified	OHA
2016	▪ 150 additional interpreters trained and qualified	
	▪ Continuing education options established for NTHWs, including pathways to other health care careers.	OTC, training partners
	Promote alignment between medical care and LTSS	
By Dec. 2013	▪ All CCOs have memoranda of understanding with local LTSS field office	CCOs
Starting July 2013	▪ LTSS Innovator Agents provide technical assistance and promote promising approaches for alignment	OTC, Agents
2014-16	▪ Better integrated care, improved outcomes for persons receiving medical and LTSS	DHS, OHA, CCOs and LTSS system
	Support evidence-based care & patient engagement	
By July 2013	▪ Contract for expanded volume of clinical review and guideline production in place	OHA
2013-2015	▪ 24 evidence-based decision tools produced annually	OHA
	▪ Widespread use of patient engagement tool in PCPCHs	PCPCHs
By 2016	▪ Tools result in a reduction of costs associated with the management of target conditions	Providers, Payers
Multipayer participation in model		
	Individuals eligible for Medicare and Medicaid	
Fall 2012	Oregon and CMS negotiation of Medicare-Medicaid financial alignment demonstration	Oregon, CMS
2013	*Demonstration not moving forward*: Explore options to have CCOs with affiliated MA plans adopt key elements of Coordinated Care Model, including PCPCH	OHA

Timeframe	Key Activities/Milestones	Responsible Parties
Jan. 2014	*Demonstration moving forward*: CCOs, at their option, participate in demonstration and begin to serve as integrated Medicare and Medicaid plans for dually eligible individuals; care coordination and outcomes for duals improved	CCOs
	Public Employees' Benefit Board members	
Fall 2012	▪ RFP for 2014 plan year released and open to CCOs; language will require bidders to incorporate elements of Coordinated Care Model beginning with PCPCH	OHA
	▪ Largest PEBB plan begins to provide extra per-member reimbursement to PCPCHs	Plan
2013	▪ PEBB PPO plan members seeking care from PCPCH have reduced cost-sharing responsibilities	Plan
Ongoing, starting 2013	▪ Increasing number of PEBB members enrolled in a PCPCH	OHA
2014	▪ CCO(s) successful with bid begin to serve PEBB members; members receive person-centered care	CCOs
Other Targeted Improvements		
2013	▪ Statewide implementation of Kindergarten Readiness Assessment tool	Early Learning Council
2013-16	▪ CCO–local community health partner collaborations to test community prevention practices (5/year)	CCOs, comm.-unities
2013-16	▪ Coordination of screening, services and data between CCOs and Early Learning Council hubs to achieve kindergarten readiness	CCOs, ELC hubs
Active Support and Tools for Innovation		
	Create Oregon Transformation Center	
Sept. 2012	▪ First Learning Collaborative (PCPCH Institute) launches	OTC, OHA
By Jan. 2013	▪ Each CCO has Innovator Agent assigned	
	▪ Core staffing and leadership in place to launch the Center; OTC Steering Council established	OHA
By Mar. 2013	▪ Innovator agents complete training	OTC
	▪ Other learning collaboratives launched	OTC
By July 2013	▪ Council of Clinicians selected and trained; LTSS Innovator Agents hired	OTC
By Dec. 2013	▪ Three new Regional Health Equity Coalitions established	OTC
2013-16	▪ Statewide conference (1/year), regional workshops (number TBD) held, technical assistance and other support provided to CCOs	OTC

Timeframe	Key Activities/Milestones	Responsible Parties
	Use data and analytic tools to drive improvement	
By Jan. 2013	▪ Statewide Medicare FFS data acquired	
	▪ Health status and risk assessment in place for OHP clients at enrollment and redetermination	OHA
Ongoing starting Jan. 2013	▪ Produce quarterly dashboards of CCO performance including core measures of quality and access	
Initial capacity July 2013, further development ongoing	▪ Predictive modeling tools acquired; staff trained ▪ Web-based tools or portals to access & analyze performance, enrollment & utilization data established ▪ Integration and alignment of datasets	OTC
	Support HIT and HIE functionality	
Current/ ongoing	▪ Identify promising HIT/HIE approaches	OHA
By Dec. 2012	▪ Submit HIE IAPD to CMS to fund technology needed to support more sophisticated HIT and HIE	OHA
2013	▪ Collect baseline data for both the adoption and meaningful use of certified EHR technology and participation in HIE	OHA
Ongoing starting Jan. 2013	▪ Provide information and technical assistance for providers and other stakeholders on using HIT and HIE effectively	OHA
By Mar 2013	▪ Develop pilot projects around the use of mobile devices and remote monitoring devices and telehealth	OTC OHA
By July 2013	▪ Projected implementation of real-time notifications (assuming funding through HIE IAPD)	OHA
By July 2013	▪ Launch first pilot project around use of mobile devices, remote monitoring devices or telehealth	OHA
By Dec 2013	▪ Projected implementation of shared patient care plans service (assuming funding through HIE IAPD)	OHA
By Dec 2013	▪ Launch second pilot project around use of mobile devices, remote monitoring devices or telehealth	OHA
2014-2015	▪ Test the effectiveness of notifications, shared care plans, pilots, and other HIT/HIE efforts. Develop technical assistance, guidance and other supports to providers and stakeholders to use these tools effectively	OHA