Oregon's State Innovation Model Project
End of Year Report
Demonstration Period One
October 1, 2013–September 31, 2014

Table of Contents

Overview

The first demonstration testing year of Oregon's State Innovation Model (SIM) was one of rapid and exciting health system transformation change across the state, driven by the triple aim goal of better health, better care and lower costs for all Oregonians. Since January 2014, the implementation of the Affordable Care Act and Oregon Medicaid expansion have resulted in 357,500 additional Oregonians enrolled in coordinated care organizations (CCOs), bringing overall enrollment in Medicaid close to a one million or 1 in 4 Oregonians. With almost 80% of Oregon providers seeing Medicaid members and another 93,698 Oregonians covered through the exchange, a recent report issued by Oregon Health Sciences University suggests that 95% of Oregonians now have health insurance. The uninsured rate dropped dramatically from 14% in 2013 to 5.1% in 2014, largely as a result of Oregon's robust Medicaid expansion. SIM support has been vital to Oregon's efforts to implement and spread the coordinated care model, as transforming the health system is critical to ensure these newly enrolled have access to quality and affordable care to improve their health.

On top of this unprecedented increase in coverage, Oregon was successful in spreading the coordinated care model to state agencies and the university system populations. Oregon's Public Employee Benefits Board plan selection process for the upcoming 2015 benefit year resulted in several new carriers, including 2 CCOs as well as two other insurers closely involved with CCOs. All 2015 PEBB contracts align with the Coordinated Care Model (CCM) to: hold health plans accountable for the way they provide care; offer more ways for members to improve their health; seek new ways for members and providers to work together to achieve better health outcomes at lower costs; and support primary care homes that can enhance care coordination for members. The result of coverage expansion and PEBB purchasing changes is that many more Oregonians will receive care in alignment with the Coordinated Care Model, which is a key objective for Oregon under the SIM grant.

Evidence from the Medicaid system, where the Coordinated Care Model has been in place since late 2012, suggests that the model is resulting in improvements. In aggregate, the 2013 data showed significant improvements in these areas:

- Decreased emergency department visits (down 17% from 2011 baseline) and emergency department spending (down 19%)
- Increased primary care utilization and spending (11% and 20% increases from 2011 baseline, respectively), as well as increased enrollment of CCO members in patient-centered primary care homes (a 52% increase since 2012)
- Increased rates of developmental screenings during the first 36 months of life (from 21% in 2011 to 33% in 2013)
- Decreased hospitalizations for chronic conditions (hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%)
- Increased adoption of electronic health records (from 28% in 2011 to 59% in 2013).

The State Innovation Model support has forged new advances in Oregon's health system transformation efforts. We produced some notable accomplishments in this period and have built a foundation for exciting work going forward.

Oregon SIM Accomplishments, Demonstration Period One

Accomplishments from the first SIM demonstration year, by driver, that were possible thanks to this funding include:

Driver 1: Improving care coordination at all points in the system, with an emphasis on patient-centered primary care

Patient Centered Primary Care

Oregon has achieved its Patient-Centered Primary Care Home milestone a full year ahead of the anticipated milestone. Over 500 clinics in Oregon have achieved Patient-Centered Primary Care Home certification (based on 2011 and 2014 criteria). The PCPCH model can function as a critical starting point for further delivery system and payment reform, so increasing adoption of the PCPCH standards around the state supports spread of the coordinated care model.

- Oregon's Patient-Centered Primary Care Institute (PCPCI), housed under our multi-stakeholder partner, the Oregon Health Care Quality Corporation, conducted well-attended and valued technical assistance offerings throughout the period. For example, the program began new learning collaborative for clinics in the summer of 2014 and last through May 2015. These include:
    - *Improving Patient Experience of Care (two collaboratives):* includes the implementation of a patient experience of care survey, patient engagement methods and design of quality improvement projects in a way that addresses multiple PCPCH standards. This collaborative includes the practice-level fielding of the clinician and group Consumer Assessment of Healthcare Providers and Systems survey.
    - *Improving Access through PCPCH*: includes understanding practice supply and demand and how to move to an Open Access scheduling model. The collaborative will be tailored to support particular access needs related to absorbing many new patients, creating more same day capacity, reducing backlog and utilizing all team members in non-face-to-face visits. Please note this collaborative provides a practice coach-in-training component – this is ideal for multi-site practices who want to spread learning from this collaborative to other clinics.
    - *The Patient-Centered Communication Skills, Behaviors and Attitudes Collaborative*: includes embedding the spirit of patient-centered communication in organizational culture, identifying ways to measure patient-centeredness, mastery of basic patient-centered office skills, cultural agility, health literacy and self-management support
- Patient Centered Primary Care Home (PCPCH) program evaluation suggests that, after the first year of implementation, there was a significant net increase in preventive procedures (5%) and significant net reductions in specialty visits (6.9%) and expenditures (6.6%) for PCPCH sites vs. non-PCPCH sites.

Health Information Technology and Exchange

HIT and HIE tools are critical supports for coordinated care. Oregon achieved several significant milestones in this period, supported by SIM resources, including:

- OHA published Oregon's Business Plan Framework for Health Information Technology and Health Information Exchange. This is a significant milestone in the State's approach for a transformed health system that achieves better care, better health and lower costs for Oregonians.
- To enhance care coordination, OHA launched a Flat File Directory (FFD) service in July. This service is supported by the CareAccord Program and expands the discovery of health care professionals' addresses for direct secure messaging.
- The Emergency Department Information Exchange (EDIE), a partnership with the Oregon Health Leadership Council and the OHA, that support of SIM funds provided initial support, continues to progress. By October of 2014, all Oregon hospitals had completed legal agreements to begin the information technology integration progress and 42 (71%) had live feeds. The EDIE Governance and Operations Committee met regularly and presented a proposal to the Oregon Health Leadership Council and CCOs to support ongoing costs through a shared utility model.
- Supported by SIM funding, OHA and the Oregon Health Sciences University's Office of Rural Health launched a request for proposals to support tele-health initiatives in Oregon. The project received 76 letters of intent and 13 applicants were invited to submit full proposals. Proposals are due in early December, and projects will be launched in early 2015.

Driver 2: Paying for value and improved outcomes

Oregon has experienced progress in developing alternative payment models over the course of this demonstration period.

- In June, CCOs received their first payments from a 2% global budget withhold for improving performance or achieving performance benchmarks on measures of quality, access and patient experience of care. To earn their full payment, CCOs had to show improvement toward the goals on 17 measures. All CCOs showed improvements and 11 out of 15 CCOs met 100 percent of their improvement targets. 3% will be withheld for 2015 incentive payments. Over time an increasing portion of CCO reimbursement will be based on performance.
- The new PEBB contracts executed in June for the 2015 and 2016 state employees benefit plan years include clear provisions for quality reporting and performance bonuses or penalties. In addition, PEBB is legislatively required to keep its spending within a fixed rate of growth similar to the rate Oregon has committed to achieving in Medicaid and will echo this requirement in contracts.
- A multi-payer consensus was finalized in late 2013 among almost all of Oregon's major public and private payers. They signed an agreement to support alternative payment strategies for patient-centered primary care homes across the state. The Oregon Health Policy Board is currently considering additional strategies to support a robust primary care infrastructure, including formalizing the workgroup that developed the 2013 agreement and directing them to develop a statewide pilot project with a limited number of FFS-alternatives payment approaches and clear evaluation criteria.

Additional information is viewable at: http://www.oregon.gov/oha/OHPB/2013MeetingMaterials/December%2012,%202014%20Materials.pdf

- The Oregon Health Policy Board's Coordinated Care Model (CCM) Alignment Workgroup was launched in this demonstration year and charged with developing tools and strategies to support voluntary adoption of the CCM in new markets. The workgroup includes representatives from public and private purchasers, including self-insured and fully insured employers and large and small businesses, as well as a broker and Oregon's Insurance Commissioner. The initial deliverable of the workgroup is to create a framework for CCM purchasing that other health purchasers could use to be active purchasers of the coordinated care model. SIM is supporting the use of Michael Bailit as an expert consultant to this project. Additional information on the workgroup is available at: http://www.oregon.gov/oha/Pages/CCMA.aspx
- The Oregon Health Policy Board's Sustainable Healthcare Expenditures Workgroup, which includes representation from Oregon's major health plans, systems, and payers, was charted to develop a methodology for monitoring health care costs. The model will be finalized and presented to the OHPB at the end of 2014, after which the Board will take up the issue of setting a benchmark for a sustainable expenditure trend and identifying mechanisms to hold entities accountable to that benchmark. More information is viewable at: http://www.oregon.gov/oha/Pages/srg.aspx. As described in past reports, OHA has contracted with the Center for Evidence-based Policy at Oregon Health & Sciences University to engage with payers and providers on how to increase use of alternative payment methodologies (APMs) in Oregon. OHA Has received a preliminary draft report from the Center, and the Center facilitated a session on APM at the December CCM Summit. The report will be finalized for release following the Summit.

Driver 3: Integrating care across silos and with community health improvement

Behavioral Health Integration

A major component of the coordinated care model is integrating physical and behavioral health systems. In May and June 2014, Dr. Pamela Martin, director of the Addictions and Mental Health Division, and Leslie Clement, chief of health policy and programs, hosted six town hall meetings across the state to discuss the state's behavioral health system. The goal was to develop a comprehensive strategic plan that would create an integrated, coordinated and culturally competent behavioral health system that provides better health, better care and lower costs for all Oregonians. The feedback from the meetings was used to develop a two to five-year strategic plan, which will then be presented to stakeholders for additional input. The governor has included investments in behavioral health into his budget he delivered to the Legislature recently, and the strategic plan will help to guide the discussions during the upcoming 2015 Legislative session.

The SIM-funded Transformation Center has contracted with Oregon Health & Science University to conduct a scan of behavioral health integration in the state of Oregon. This work began in June and will continue through February of 2015. This work includes: discussions with stakeholders and OHA leadership about state-supported projects; listening at the town hall

meetings throughout the state that led to the development of a statewide behavioral health strategic plan, and interviews with key stakeholders. This work will focus on CCOs but also involve health systems, practices and community mental health services associated with CCOs and who serve across populations beyond just Medicaid. In addition, the Transformation Center engaged the services of Dan Reece, MSW, LCSW, to support the development of the behavioral health strategic plan and to provide technical assistance to CCOs.

SIM funding continues to support Oregon's Patient-Centered Primary Care Institute, which was established in partnership with the Northwest Health Foundation. The institute is housed at the Oregon Health Care Quality Corporation. The institute provides practice-level technical assistance to further the patient-centered primary care home model adoption including hands-on learning collaboratives as well as web-based resources. The institute will be focusing on developing sustainability plans to include resources from payers outside OHA as well as other stakeholders. Broadening the pool of supporting resources will allow the institute to reach additional providers, allow further spread of best practices and transformation, and also ensure sustainability of these activities beyond the SIM grant demonstration periods.

As described in our Year Two SIM operational plan update, OHA received an Adult Medicaid Quality Grant in December 2012 that is supporting: collection and analysis of data on the CMS Adult Core Measures (17 to date and more by January 2015); two quality improvement projects; and staff training for data analysis and reporting. Both of the performance improvement projects focus on integrating primary care and behavioral health, a key component of the coordinated care model. The first is a statewide collaborative among all CCOs on "Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder." The second is a project to increase access to patient-centered medical homes in two ways: 1) nine primary care practices are receiving practice-level facilitation and technical assistance. The focus has been to field the CAHPS Clinician and Group Survey with the Patient-Centered Medical Home Item Set to inform individual rapid-cycle improvement projects intended to advance each clinic's own transformation goals; 2) eleven mental health and chemical dependency treatment programs from across the state are receiving assistance with "reverse" integration, bringing primary care into behavioral health settings. Participating agencies have now started their improvement projects with the assistance of practice coaches who will provide intensive technical assistance for the duration of the grant period. This will inform OHA on what is needed to assist and further primary care integration into behavioral health focused clinical sites, which have the strongest bond with those with severely persistent mental illness and significant substance abuse needs.

Population Health

In the area of population health improvement, OHA leadership and staff are working with CMMI SIM staff and CDC officials on Oregon's SIM Population Health Roadmap and discussing any needed technical assistance to achieve the project goals. From May to September 2014, staff from OHA's Public Health Division facilitated community engagement sessions across Oregon to identify leading health priorities to include in an update to the state health improvement plan (SHIP). OHA will be using the SHIP update process to meet the requirements of the Roadmap by identifying health system change interventions that can be implemented in coordination with state transformation efforts. The Roadmap will build on Oregon's ongoing population health

strategic approaches and align with the state's accreditation effort. In addition, the SHIP and Roadmap will build upon population health strategies included in CCO community health improvement plans where possible. In July 2014, OHA reviewed and analyzed the CCO community health improvement plans. The analysis forms the basis for designing and implementing technical assistance to CCOs and their Community Advisory Councils (CACs). The CCO community health improvement plans are posted on the OHA website at http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/cco-chip.aspx. Additional SIM-supported population health achievements this period include:

- Collaborative partnerships between CCOs and local public health authorities were launched to tackle population health and clinical care challenges. Four grants have been made that integrate public health and clinical system approaches in the areas of: maternal and child health; tobacco prevention; and alternative opiate management strategies. The SIM community prevention grantees have established a variety of mechanisms (e.g. steering committees and platforms for online information sharing) to improve collaboration between CCOs and local public health agencies and have identified core measures to evaluate their progress towards achieving health outcomes over the term of the grant.
- An analysis of 31 public health indicators by race/ethnicity and by CCO region have been published and made available to CCOs. Multiple health indicators are included.[1] This information goes beyond what is available for CCOs in their claims data and can assist CCOs with identifying areas for further population-level quality improvement, particularly around the prevention of disease and disability. This will also be useful for evaluation and monitoring of transformation efforts across the state.

Regional Health Equity Coalitions

Due to SIM support, three additional Regional Health Equity Coalitions have been established. These coalitions expand a successful model instituted in other parts of the state to build regional cross-jurisdictional capacity to advance health equity practices for communities experiencing health inequities. The three new coalitions will serve Hood River, Jackson, and Klamath counties, where, according to ACS 5-year estimates (2008– 2012), people of color make up approximately 18.3 percent of the total population, but are disproportionately represented in the Medicaid population at 25 percent.

Health Equity Leadership Training

This period saw the graduation of the first SIM-funded Developing Equity Leadership through Training and Coordination (DELTA) cohort. The twenty graduates will act as drivers of equity and inclusion within Oregon's health promoting systems, facilitating the development and institutionalization of health equity and inclusion strategies in a variety of settings in their communities.

[1] Indicators to be included: leading causes of death, years of potential life lost, suicide deaths, opioid-related overdose deaths, motor vehicle crash deaths, health status, poor physical or mental health limiting daily activities, positive youth development, lung cancer incidence, heart attack hospitalizations, diabetes, hypertension, breast cancer by stage, pertussis, salmonella, chlamydia, HIV diagnosis, fall hospitalizations, overweight/obesity prevalence in adults and eighth-graders, alcohol-related deaths, binge drinking in teens and adults, cigarette smoking in adults and eighth-graders, low birth weight births, prenatal care in first trimester, teen pregnancy, teen births, and adequate immunization

Traditional Health Workers
The Transformation Center developed a survey in coordination with the Office of Equity and Inclusion and the Traditional Health Worker Commission and distributed it to CCOs, other health and community organizations, and traditional health workers. Survey results will inform efforts to foster engagement and support partnerships between traditional health workers, community-based organizations and CCOs.

Long Term Supports and Services
SIM- and state-funded long-term supports and services innovator agents have been on the ground developing relationships with stakeholders and working collaboratively with the Transformation Center Innovator Agents. Achievements during the first demonstration period include:

- LTSS Innovator Agents helped to establish memoranda of understanding (MOUs) between all CCOs and local long-term care agencies, describing how the parties will address care coordination and share accountability. These innovators were able to reduce the number of individual MOUs from 27, to 17 by encouraging and facilitating regional agreements. This represents a significant reduction of bureaucratic barriers.
- The 'housing with services' pilot project providing medical and long-term services and supports to adults in low-income housing units began to provide direct services this period, including medication management and health navigator assistance.
- CMS asked Oregon to outline strategies for long term care system coordination and integration. The group completed its work and submitted a report to CMS. The report includes an Oregon model framework with outcome statements that will support better coordination between long-term services and health systems. This model framework represents Oregon's definition of integration. The final report is viewable on line at: www.oregon.gov/dhs/cms/Meeting%20files/LTC_CCO%20Study%20Group%20Report%2012_20_13%20FINAL%20to%20CMS.pdf.

Medicaid/Medicare Dually Eligible
The OHA is working steadily forward on our efforts to improve the experience of care for Medicare-Medicaid dually eligible Oregonians. The program lead vacant position was filled in July of 2014. The new staff person has started working closely with the federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office) with initial focus on member communications and developing guidelines and templates for communications that meet CMS requirements. We do have over 50% of our dual population enrolled voluntarily in our CCOs, but this work will be used to provide more information about coordinated care options for dual eligibles not currently enrolled in CCOs. Data on the duals population has been shared with the CCOs to help them identify these members enrolled and help their efforts to serve this population. Streamlining administrative aspects facing the duals population is also on the work plan going forward.

Coordination with Early Learning Efforts
Oregon's Early Learning System transformation efforts continue to move forward concurrently with health system transformation. Under leadership from the state's Governor-appointed Early Learning Council, regional Early Learning Hubs [Hubs] have been implemented across the state with the responsibility to coordinate resources and ensure outcomes for children 0-6 and their

families. Eleven Hubs are now in operation, with five additional Hubs expected to come under contract by July 2015.

Early Learning Hubs are required to collaborate with their local CCOs as part of their contractual obligations in order to achieve mutual goals and performance measures. A variety of collaborative approaches have been seen between CCOs and Hubs in these early stages of development, including but not limited to: shared staffing, cross-governance, blending of resources, workforce training, joint participation in community needs assessment, and beyond. With support from the Transformation Center, the OHA's Child Health Director and staff are working towards implementation of one or more Hub/CCO learning collaboratives once all Hubs are operational.

The Oregon Health Policy Board and Early Learning Council has convened a Child and Family Well-being Measures workgroup to identify potential cross-sector accountability and system monitoring measures that can further drive Hub and CCO collaboration. Representation from Hubs and CCOs participate on this workgroup along other cross-sector representatives with focus on child and family well-being. The Child Health Director and team provide staff support for this workgroup, in addition to contractor Michael Bailit, with Bailit Consulting, LLC, who is supporting the development of the Child and Family Well-being measures library. Recommendations for the final measures library are expected from this workgroup by fall, 2015.

Driver 4: Standards for safe and effective care

Health Evidence Review Commission (HERC)
A key component of Oregon's transformation is translating evidence to ensure the right care is being delivered at the right time in order to achieve the triple aim. In the first demonstration year, SIM funding supported work by OHSU's Center for Evidence-based Policy (CEbP) to improve the Health Evidence Review Commission's clinical evidence synthesis and translation work to aid the spread of the coordinated care model. CEbP interviewed HERC staff and members of both the HERC and its three subcommittees and fielded a broader survey to over 400 stakeholders to identify the key areas of process improvement and needs of the delivery system for the HERC's work. The report includes twelve recommendations:

- Translate and disseminate HERC evidence products and customize to specific audiences;
- Ensure optimal coordination with the Transformation Center for development and dissemination of HERC products;
- Conduct periodic stakeholder needs assessment and evaluation of derivative products to increase relevance and improve translation and uptake activities;
- Define and share opportunities for stakeholder engagement;
- Clearly define and communicate the HERCs decision-making process;
- Streamline opportunities for stakeholder and public input in topic identification, review of product drafts and product disseminations;
- Create a strategic communications and dissemination plan that includes active outreach and engagement of HERC information;
- Optimize the HERC website to increase access and utilization;

- Review current meeting process to optimize time and create new, explicitly defined meeting processes;
- Develop clear documentation of roles, responsibilities, expectations, process, organizational structure and workflow;
- Align capacity of the HERC's resources with expectations for the HERC's workload;
- Lastly, establish continuous improvement processes including rapid improvement, training and benchmarking.

The findings from the report were shared with the HERC and its subcommittee members at their October retreat, with much discussion on how best to prioritize and address the findings, and support the transformational changes. HERC staff have already started implementing some of the changes needed for process improvement, and the HERC will continue improvement activities in 2015, with close interaction with stakeholders such as the CCO medical directors and other stakeholders as they progress.

Aligning standards and metrics across payers

Three accomplishments from this period signal Oregon plans' and payers' commitment to performance measurement and to adopting an increasingly consistent set of metrics that aligns with the triple aim:

- The HB 2118 work group, charged with identifying appropriate health outcomes and quality measures for Oregonians enrolled in qualified health plans available through Cover Oregon and contracted health plans through the Oregon Educators' Benefit Board and the Public Employees' Benefit Board, delivered its final report to the Legislature in May (available here: https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf). The report identified 13 measures that can be used immediately and 15 more that could be reported when data systems mature and measure specifications are further developed. The vast majority of those measures overlap with metrics being tracked in Medicaid as either CCO incentive measures or state performance measures. The work group recommended participating entities should incorporate the initial 13 quality measures into their contracts "at the next available opportunity." For PEBB plans, this will be for the 2015 plan year contracts.
- As a first step towards incorporating quality information into rate review, Oregon's Insurance Division asked carriers to report their performance on five metrics when submitting their 2015 rates for approval. The measures align closely with the CCO incentive measures and measures recommended by the HB 2118 Health Plan Quality Metrics Work Group (above). At this stage, the metrics will be used for informational purposes only to promote market-wide transparency and alignment (see: www.oregonhealthrates.org).
- PEBB, as signaled in its RFP completed in this period, will be using the metrics currently applied to the Medicaid CCOs, in alignment with the HB 2118 workgroup to hold the 2015 contracted plans and CCOs accountable for improvement.

Driver 5: Testing and accelerating the spread of the model

Transformation Center

In this first demonstration period, the Transformation Center launched several well-received and valued learning communities to test, share and accelerate innovation:

- The Council of Clinical Innovators is a group of 14 clinicians from diverse disciplines who will work on health improvement projects and act as champions for clinical change locally. Participants in this learning collaborative will receive mentoring from established improvement practitioners and provide expertise and leadership on health improvement.
- A statewide learning collaborative to support innovation in the care of complex patients was created at the request of CCO medical directors and other clinician partners, the Transformation Center launched. This collaborative meets approximately quarterly via webinars or in person one-day meetings.
- The CCO medical directors and quality improvement managers learning collaborative meets monthly and has focused on in depth discussions related to the seventeen incentive metrics.
- Another collaborative seeks to build the organizational capacity of the CCO Community Advisory Councils (CACs). Initial focus has been on assistance to develop the community needs assessments and community health improvement plans required by statute. The CAC learning collaborative also featured a summit in May to identify successes, plan for future learning and provide in depth networking opportunities.
- An Innovator Agents learning collaborative has focused on developing and sharing expertise in quality improvement science and techniques, and the managing and supporting the people side of change.
- In partnership with the Institute for Healthcare Improvement, a practice community for the CCOs was launched. The focus is on introducing and applying the principles and tools of science of improvement for CCOs. The in person training was offered in May 2014, with periodic convenings via conference call and webinar to support the ongoing work.

Other Transformation Center accomplishments during the first demonstration year include these:

- The Transformation Center is helping good ideas travel faster via the new "Good Ideas Bank" launched in July. Its purpose is to collect and share best and promising practices. The bank is an online, searchable database viewable at: http://transformationcenter.org/good-ideas-bank/
- With SIM support, the Technical Assistance Bank also launched this period. This resource matches CCOs' identified areas of interest with consultants and experts to support innovation or quality improvement projects. Six CCOs are currently receiving these services.
- OHA's Transformation Center and the Northwest Health Foundation sponsored a one-day summit December 5, 2013, bringing together all of the CCOs and representatives from the CCOs' Community Advisory Councils to share accomplishments, innovations and lessons learned from the first year of the model. There were more than 600 participants. The summit was a ringing success, with stakeholders clamoring for more

opportunities to learn from each other and share best practices. The summit information is viewable at http://transformationcenter.org/#cco-summit.

Analytical Tools and Resources

SIM resources support Oregon's efforts to create a powerful analytical toolbox to drive performance and enable data-driven decision-making. A key component of the coordinated care model is a commitment to transparency. Initial implementation of the model in Medicaid has featured published performance metrics data to guide CCO operations and inform the public and stakeholders about success and opportunities for ongoing improvement. As performance data become available for other public and private lines of business, this will help spread the coordinated care model across Oregon.

To provide status updates on the state's progress toward Medicaid goals, OHA now publishes regular reports showing quality and access data, financial data, and progress toward reaching benchmarks.

- In June, the first report to show a full year (2013) of performance data was published, and the results triggered the first incentive payment – payments for improvements in care, not just the quantity or types of services – to CCOs. All CCOs showed improvements on some measures and 11 out of 15 met 100 percent of their improvement targets. In aggregate, the 2013 data showed significant improvements in these areas:
    - Decreased emergency department visits and emergency department spending
    - Increased primary care utilization and spending, as well as increased enrollment of CCO members in patient-centered primary care homes
    - Increased rates of developmental screenings during the first 36 months of life
    - Decreased hospitalizations for chronic conditions
    - Increased adoption of electronic health records
- In addition, CCOs continue to hold down costs. Oregon is staying within the capped rate of growth for Medicaid spending to meet its commitment to Centers for Medicare and Medicaid Services. Reports are viewable at: http://www.oregon.gov/oha/Metrics/Pages/index.aspx
- SIM resources support a robust analytical capacity that improves our ability to provide timely, accurate, actionable data to CCOs. For example, Oregon has acquired and implemented the Milliman Grouper software to provide additional in-depth analysis of data sets. In addition, OHA and CMMI worked together with CMS to acquire Oregon's Medicare data set to be included in our All Payers, All Claims database so we can have a full picture of the health care delivery system in Oregon and assist our evaluation of the coordinated care model and its impacts.
- The OHA has executed a contract to share data, analytic and scientific capabilities to build an Accountable Care Data System (ACDS). The ACDS will be an interactive data and dashboard system that tracks cost and quality measures over time, compares CCO performance and allows for dynamic exploration of outcomes by key subgroups. OHA has contracted with a data layout consultant to help with presentation of dashboards for external audiences including the general public.
- OHA developed and presented two initial versions of a multi-payer dashboard providing data on health care cost and utilization, health insurance coverage and quality of and

access to care in demonstration year 1. The dashboards are viewable at: http://www.oregon.gov/oha/OHPR/RSCH/Pages/dashboards.aspx. Data came from Oregon's All-Payer All-Claims Database, among other data sources. OHA's intent is to provide a clear view of Oregon's health system from available data sources, including commercial insurance carriers, Medicare and Medicaid. Further iterations of the dashboard will be developed with input from the Oregon Health Policy Board.

- A contract with AUS Marketing Research Systems Inc., d.b.a. Social Science Research Solutions, has been executed to support data collection and analysis for the Oregon Health Insurance Survey. This survey will allow Oregon to monitor ACA implementation with the 2014 Medicaid expansion and the new health insurance exchange.

Spread of the model to other payers and populations

As the purchaser of health care benefits for more than 130,000 Oregonians, the Public Employees' Benefit Board (PEBB) uses its buying power to get the best health care available from health plans that serve its members. PEBB designed the 2015 benefit year RFP and the resulting contracts to align with the coordinated care model. The contracted health plans are being held accountable for not just the way they provide care, but also to offer more ways for members to improve their health, seek new ways for members and providers to work together to achieve better health outcomes at lower costs, and to support primary care homes that can enhance care coordination for members.

The new plans include two CCOs as well as two other insurers closely involved with CCOs. Plans will report baseline data on a standard set of quality measures (developed by the HB 2118 metrics alignment work group described elsewhere in this report) in 2015 and penalties/bonuses will be attached to performance in 2016. More than 95% of PEBB members will have a choice of two or more plans. Following negotiation and execution of new contracts for health plans available beginning in 2015; PEBB recently concluded the open enrollment process for beneficiaries.

Implementation Challenges Experienced in SIM Demonstration Period 1

With a few exceptions, Oregon has experienced minimal challenges to implementing the SIM project activities. Challenges experienced are described below.

Administrative and operational burden

Oregon continues to remain concerned about growing administrative requirements as we head into the second test year and need to focus on implementation of our activities. We hope that the demonstration year 1 requests for a risk mitigation plan, further delineation of our self-evaluation strategy and reporting on new metrics, the new-to-start population health planning activity; and participation in the SIM learning collaboratives will wrap up any new asks of us. Being unanticipated and often presented to us at the last minute, some of these requests have consumed a large amount of staff time and have reduced focused time for actual spread activities.

Networking among SIM test states
We understand there will be some events bringing the SIM test states together to share their work, which can be very useful, but we do recommend some significant alignment with other events and gatherings that many of these states already attend. Many of our staff participate in other learning collaboratives or large national meetings, so linking the SIM test states to a specific portion of those meetings or special event tagged onto those would require less travel and be more cost effective. Similarly, webinars are of limited usefulness unless topics are confirmed and details planned well in advanced so the most appropriate staff can attend, or unless the webinars are made available later for reference.

Oregon is currently participating in all three SIMergy collaboratives: population health, health information technology, and measurement. Our hope is that these collaboratives will not generate additional state assignments, as we are focused on the work required to meet our milestones and collecting information for CMMI reporting and have limited capacity beyond that. It appears that the newly launched learning system is responding to similar feedback from across the test states and we are happy to participate in further refinement of the shared learning efforts.

Need for technical assistance, resources and emerging issues
Oregon's greatest need is for resources targeted at the staffs and provider networks of our clinical delivery systems, health plans and CCOs. Most frequently, partners are requesting concrete examples of quality improvement and best practices, as well as access to technical experts with on-the ground implementation experience in delivery systems. We are investing in what we can afford to do, but it would be very beneficial to have CMMI share ongoing information and evaluation results from other federal initiatives such as the ACO and Shared Savings partners and to link Oregon's system leaders to others for peer-to-peer advice and pitfalls in implementation.

At the state agency level, we would benefit from information, good ideas, and peer-to-peer links with other business best practice leaders to support internal transformation efforts underway at the Oregon Health Authority. Technical assistance on transforming day-to-day agency operations from a regulatory slant to more of a partnership approach with our contracted health plans and CCOs would help our agency managers and likely those in other states. Making government work better, rather than just harder, would be of great value and would enhance our relationships with our delivery systems.

One topic that is emerging, and may benefit from collaborative efforts across states, federal programs and other health care purchasers, is the threat that certain health care costs pose for our health plans and CCOs to stay under a contracted cost trend cap. The new, extremely expensive Hepatitis C drugs (at $1,000/pill or $84,000 for one course of treatment) are a topic of much consternation for both commercial plans and Medicaid CCOs and represent just the beginning of a potential series of high-cost pharmaceutical products. Elements of Oregon's coordinated care model can help to control utilization costs but extremely high prices hamper our efforts to achieve the triple aim.

Medicaid Expansion, CoverOregon and Technology Transition Project
With over 400,000 Oregonians now covered either through the Medicaid program or a Qualified Health Plan on the exchange, OHA and its sister agencies, the Department of Human Services, the Oregon Insurance Division, and Cover Oregon, are working hard to ensure those enrolled are getting access to coverage. In addition, Oregon's decision to use federal technology for QHP eligibility and enrollment in 2015, and transitioning Medicaid eligibility and enrollment back to full state operations instead of our initial "single door" approach has meant that a significant amount of staff time is being dedicated to the technology transition project. OHA also faces a substantial workload in Medicaid eligibility redeterminations for those enrolled through the "fast-track" process. So while implementation and spread of the coordinated care model remain the state's focus for SIM, leadership and staff are stretched as we enter into the fourth quarter of the first Demonstration Period.

Health Care Interpreter Project
Oregon's proposed Health Care Interpreter Project has experienced delays in launch due to the initial disallowance of costs, and then a significant delay in negotiating an alternative approach, gaining federal approval and then implementing the changed strategy. This project was described in our application and initial operational plan, and steps towards implementation had begun when we were notified the funding had been disallowed. This work is underway with the request for proposals to deliver training and testing scheduled to be posted in early 2015. It will be challenging to achieve the initial goal of 150 qualified or certified interpreters in the remaining testing periods, but will be making every effort towards that goal.

42 CFR Part 2
Oregon's plans and providers continue to struggle with legal, regulatory, and technical barriers to information sharing in support of care coordination. In particular, 42 CFR Part 2 creates substantial confusion and poses constraints for integrated, whole-person care. OHA has recently convened an agency-wide group to coordinate work in this area and to offer the delivery system clarification, guidance and technical assistance where possible. The issue was the focus of discussion of the October 2014 CCO Medical Directors meeting, and will continue to look for any assistance on the federal level to ensure that whole-person care coordination can proceed amidst the existing barriers of this provision.

Self-Evaluation Findings from SIM Demonstration Period 1

Progress to date has been outlined throughout this report. In terms of the self-evaluation, some key activities and findings are:

Finalizing Self-Evaluation Measures
Over the course of the year OHA worked with staff from CMMI and their evaluation contractors and subcontractors to identify and report upon a set of core and state-specific measures. Work in this area is ongoing. The measures reported in the most recent quarterly report are below:

Set	Measure Title	Target	Q3 2014
Core	Percentage of beneficiaries impacted (by type)	26% (will need to amend - this is the target for total state population, but CMMI doesn't want that)	79.6% - PCPCH enrollment among those in CCOs. Rate is for Q1 2014 and excludes FFS. This is not a raw rate, but is weighted by PCPCH tier (per the CCO measure specifications). 86.1% - Proportion of Medicaid/CHIP population enrolled in a CCO (data for 15 September 2014)
Core	Percentage of participating providers (by type)	TBD	Continuing to explore the possibility of using Oregon's All-Payer, All-Claims data system to count number of providers who bill to Medicaid, PEBB, or (in the future) OEBB, and divide that count by total number of providers represented in APAC for the given time period.
Core	Percentage of participating provider organizations (by type)	TBD	Continuing to explore how to capture this measure, with particular attention to establishing the denominator. The numerator ('participating') will be based on payment: Those organizations that serve and receive payments for Medicaid, PEBB, or (in the future) OEBB beneficiaries.
Core	Percentage of provider organizations enabled for health information exchange	TBD	Oregon's Office of Health Information Technology (OHIT) will be able to track and report on this in the future. However, the OHIT is currently developing its own metrics and may have a more meaningful alternative metric to propose in the future.
Core	Payer Participation (number of payer types participating in the model)	3	3 - Medicaid + commercial and Medicare (via PCPCH only at this time)
Core	Cost of Care per Beneficiary per Month	TBD	$325 Commercial (note that this number includes both self-insured and state employees). Data are for Q2 2013 $264 Medicaid/CHIP. Data are for Q2 2013

Set	Measure Title	Target	Q3 2014
Core	Ambulatory Care: Emergency Department Visits (HEDIS)	TBD	Approx. 143.26 per 1,000 member months (Q2 2014; preliminary due to claims lag)
Core	Plan All-Cause Readmissions	TBD	Medicaid-specific results available here: http://www.oregon.gov/oha/Metrics/Pages/measure-plan.aspx Hospital-wide readmissions available here: http://www.orhospitalquality.org/index.php
Core	HCAHPS Percentage of survey respondents reporting a 9 or 10 (10 being best)	TBD	70% (October 2012 - Sep. 2013)
Core	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention: Four Level Smoking Status	TBD	Oregon does not currently track this measure. We are exploring administrative and survey data sources as options for this measure.
Core	Optimal Diabetes Care	n/a	Oregon is unable to report this measure for the statewide population during the SIM grant period because the specifications require medical record data. (This is true for both the composite and the individual components.) Note also that CMS has expressed reservations about this measure in the past due to concerns about the appropriateness of the HbA1C cut-off for older individuals. Oregon will instead report specific screening rates for diabetics (e.g. HbA1C, blood pressure). OHA will work with CMMI to ensure reporting tool is set up to accept these data in future reports.

Set	Measure Title	Target	Q3 2014
Core	Health Related Quality of Life— physically and mentally unhealthy days In the past month.	TBD	54.4% - proportion with no days. CMMI clarified it should be mean number of days, rather than the proportion. We are calculating the average days, but in the interim CMMI said to report the proportion.
Core	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	N/A	Oregon is unable to report this measure for the statewide population during the SIM grant period because the specifications require medical record data. Oregon will instead report statewide data on obesity rate using BRFSS as a data source. CMMI has agreed to these alternative measures. 61.5% = rate from 2012 BRFSS
State	Proportion – CCO non-FFS	TBD	59.4% (April - June 2014)
State	Proportion – PEBB non-FFS	TBD	As in the last quarter, the data collection vehicle is in development for the 2015 plan year; we will report progress beginning in 2015.
State	PCPCH recognition	2015: 500; July 2016: 600 Interim targets: end Q1 2015 – 517 End Q2 2015 – 534 End Q3 2015 – 551 End Q4 2015 – 568 End Q1 2016 - 585	514 recognized clinics as of September 2014
State	Average PCPCH individuals	N/A	6974 -Approximately 400 PCPCHs have provided data so far, so it's not yet possible to provide a total number (this is an increase from 300 clinics reporting in the previous quarter). Among the 400 clinics reporting, the average number of patients is 6,974 but the variation is large (50 min to 100,078 max).
State	Health care interpreter	Target: by July 2016,	0 - Planning is underway for the

Set	Measure Title	Target	Q3 2014
	training	150. Interim: 30 by June 2015; 35 in December 2015 (total 75); 75 in July 2016 (total 150 trained thus far); 75 in fall 2015	Health Care Interpreter Learning Collaborative, including interviewing stakeholders (training and testing centers). This will help OHA prepare for the collaborative. An RFP is also in development.
State	EDIE	100%	82%
State	EHR incentive payment	N/A	Eligible Professionals: 5,909 (note Salesforce does not have a place to report hospitals)
State	LTSS accountability tasks	N/A	64/83, 77.1%
State	CCO-LPHA collaboration	75% CCOs; 75% LPHAs	No new funding, same as previous quarter: 11 CCOs (69%) currently collaborating with 25 (74%) LPHAs
State	CCO OPHAT registration	N/A	12.5% (both Pacific Source CCOs are registered with OPHAT)
State	Number Learning Collaboratives	9	Transformation Center: 5 external (plus 1 internal for Innovator Agents)
State	CCO dual-eligibles	65%	55.2% of duals in CCOs as of September 15, 2014

Assessing the Success of the CCM in Medicaid

This year the first full calendar year of CCO metrics were collected and analyzed, with the initial set of incentive payments distributed in June. All CCOs saw improvement on at least some measures, and 11 of 15 CCOs met 100% of their improvement targets. In the aggregate, 2013 data showed:

- Decreased emergency department visits (down 17% from 2011 baseline) and emergency department spending (down 19%)
- Increased primary care utilization and spending (11% and 20% increases from 2011 baseline, respectively), as well as increased enrollment of CCO members in patient-centered primary care homes (a 52% increase since 2012)
- Increased rates of developmental screenings during the first 36 months of life (from 21% in 2011 to 33% in 2013)
- Decreased hospitalizations for chronic conditions (hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%)
- Increased adoption of electronic health records (from 28% in 2011 to 59% in 2013).

The contract and a large portion of the work on the independent evaluation of the CCM in Medicaid were finalized in this demonstration year. The contract was awarded to Mathematica Policy Research, which began data collection activities in December 2013. During the

demonstration year Mathematica completed key informant interviews; completed and administered the CCO Transformation Assessment Tool, which was used to assess the degree to which individual CCOs have transformed on key CCM elements; completed site visits at three CCOs; and, processed and began analysis of enrollment and claims data to assess outcomes. The final report from Mathematica is due at the end of December 2014.

Assessing Spread of the CCM and Determining the Relative Impact of individual Elements of the CCM

OHA contracted with Oregon Health & Sciences University for an independent, formative evaluation of Transformation Center. The evaluators have observed a range of Transformation Center meetings and events, and will interview CAC leaders and participants. The team is analyzing the data in real-time and debriefing with the Transformation Center routinely to share emerging findings and to refine the direction of the evaluation.

A contract for an independent evaluation of the degree and pace of spread of the CCM across markets in Oregon was finalized in this year. In addition to tracking the spread of the CCM, this evaluation will assess the impact of the CCM on spending, utilization, and quality in different market segments. The work spans the period of July 2014 to September 2016 and includes:

1. Development of a typology of health system transformation that is applicable across different market segments and that can be used to track changes over time. A draft of the typology was shared with OHA in October 2014. OHA provided comments, and it is being finalized over November and December 2014.
2. Three periodic reports of CCM spread in different markets, based on the typology described above; and
3. A quantitative assessment of spread (or "spillover") using data from Oregon's all-payer, all-claims data system.

Initial evaluation findings for spread of the patient-centered primary care model in Oregon

Although not directly funded using SIM resources, the PCPCH program conducted an evaluation to identify modifications to improve the PCPCH model, assess the OHA's implementation efforts, and provide evidence for continued support of the program.

Key findings from surveys and site visits to date include:

- Eighty-two percent of PCPCHs feel that implementation of the PCPCH model is helping them achieve the aim of improving the individual experience of care and improve population health management.
- Seventy-eight percent of PCPCHs feel that model implementation is helping practices increase the quality of care for patients and 75 percent feel that it is increasing access to services.
- The two most important factors influencing the decision of a practice to become recognized as a PCPCH are the opportunity to improve patient care, and the eligibility for enhanced payment.
- The most important barriers to PCPCH implementation are cost and lack of resources; staffing and training; time; and the administrative burden and reporting.