

# **Oregon Health Care Innovation Plan Oregon Health Authority**

**Submitted to Centers for Medicare &  
Medicaid Innovation  
September 21, 2012**



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## **I. Vision of Oregon’s Health Care Innovation Plan**

- Includes: #1 Vision statement for health system transformation;**  
**#13 State goals for improving care, population health, and reducing health care cost; and**  
**#18 Policy, regulatory and/or legislative changes necessary (and underway) to achieve the state’s vision for a transformed health care delivery system.**

### **Vision**

Oregon has a long history of choosing more innovative means of managing its Medicaid program – almost all of its Medicaid population is in managed care; most of its long term care program is in home and community based services; and, when faced with the need to curb costs, the state developed the Prioritized List of Health Care Services to ensure that there was a rational, open process for selecting services to be covered based on their impact on population health. Even with this history as background, Oregon has faced a number of challenges in recent years that will be familiar to many states: health care costs that are increasingly unaffordable for businesses, individuals, and for the state and federal government; cost growth that far outpaces the growth in state general fund revenue and personal income; and a system focused on volume, not value.

Instead of responding to trends over the last several years with one of the conventional approaches to reducing health care spending—reducing provider payments, the number of people covered, or covered benefits—Oregon has chosen a fourth pathway: change the delivery system for better efficiency, value and health outcomes. Oregon has developed a Coordinated Care Model for this transformation that is built on the Triple Aim (better health, better care, lower costs), and is initially being implemented in Medicaid through Coordinated Care Organizations (CCOs). This model will spread next to state employees and other payers through strategies that emphasize the model’s key elements (alternative payment models, patient-centered primary care,

robust quality measures for accountability, and others) and alignment with community health goals.

The Coordinated Care Model was the logical next step for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan (OHP). The Coordinated Care Model design grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs. Mental health, substance abuse, oral health, and long term care services are fragmented and are insufficiently tailored to meet the diverse needs of Oregon's population. There is a sense of urgency in the state to rein in these costs or they will continue to overwhelm state, business and personal budgets.

Meanwhile, for all of the dollars spent, the quality of care is uneven and the allocation of resources is illogical. Nationally, it is estimated that about 30% of care provided is either unnecessary or does not lead to patient health. For racial and ethnic minorities, access to care and health status are worse than for the general population. For example, 35% of minority women in Oregon have no regular care provider, compared to 18% for white women, and the life expectancy for African-Americans and American Indians/Alaska Natives in Oregon is two years less than for Caucasians. Addressing these disparities and waste will go a long way toward improving Oregon's health system.

The Coordinated Care Model will be implemented via Coordinated Care Organizations (CCOs). CCOs are community-based organizations governed by a partnership among those sharing in financial risk, providers of care, and community members. CCOs are and will be the single point of accountability for the health quality and outcomes for their members, and they have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the best possible outcomes for their membership. CCOs integrate and

coordinate physical, behavioral and oral health care, and operate 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.

Additionally, the Coordinated Care Model aims to link community health and services with the clinical delivery system. Population health efforts and alignment with schools and the education system are integral to improve the health of all Oregonians by going beyond the four walls of the clinics and hospitals of the health care system.

Oregon's vision is to create a health system in which:

- The health of all Oregonians is improved;
- Physical health, behavioral health and oral health are integrated and coordinated;
- Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;
- The system prioritizes prevention, wellness, and the community-based management of chronic conditions, keeping individuals healthy rather than only caring for them when they are sick;
- Individuals, providers, community leaders, and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable;
- Quality and consistency of care is improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;
- Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve overall population health;

- The state acts as a smart purchaser, an integrator of health care and community services, and a partner in developing and spreading community-based innovation;
- The health care workforce is strengthened and prepared for team-based, community-oriented coordinated care; and
- Electronic health information is available when and where it is needed to improve health and health care through a secure, private health information exchange.

In order to move this new care model beyond Medicaid alone, we need to evaluate how well the model achieves the goals of access and quality improvement as well as cost reduction targets, and then accelerate and spread promising and successful innovations across the delivery system. At its heart, the Coordinated Care Model is about changing both the care model and the business model for the health system. By leveraging the state's purchasing power in order to realign incentives and spread transformation moving forward, state employees, individuals and businesses purchasing qualified health plans on Oregon's Health Insurance Exchange, and dually eligible beneficiaries will all have high quality, low cost options that are sustainable over time.

## Goals and levers

To achieve this vision, Oregon's Health Care Innovation Plan is built on three pivotal goals – Oregon's Triple Aim.<sup>1</sup> These simply stated objectives are powerful because within them they encompass all that we would hope our state health system would include:

- Improve the lifelong health of all Oregonians,
- Increase the quality, reliability and availability of care for all Oregonians, and
- Lower or contain the cost of care so it is affordable for everyone.

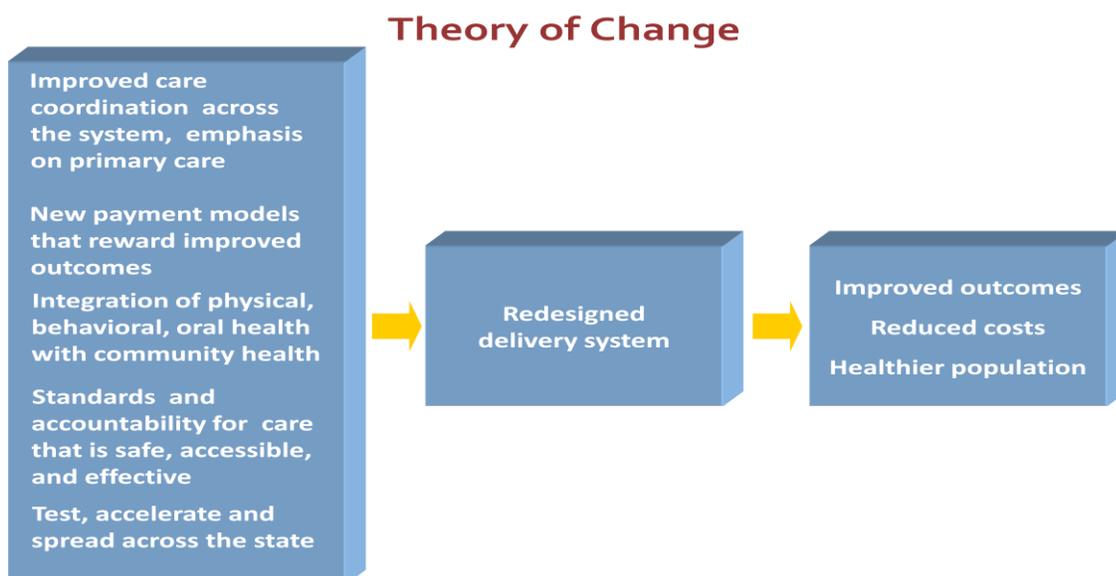
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<sup>1</sup> Adapted from Institute for Healthcare Improvement, The Triple Aim, <<http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm>>, accessed November 22, 2010.

To meet these goals, Oregon’s Coordinated Care Model relies on five key levers to generate savings and quality improvements and accelerate spread across the delivery system. Our theory of change is depicted in Figure 1 and these levers drive our transformation:

- Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH) ;
- Lever 2: Implementing alternative payment methodologies to focus on value and pay for improved outcomes;
- Lever 3: Integrating physical, behavioral, and oral health care with community health improvement;
- Lever 4: Implementing standards and accountability for safe, accessible and effective care;
- Lever 5: Testing, accelerating and spreading effective delivery system and payment innovations, both for the Medicaid population and for other payers and populations through a state-coordinated Transformation Center.

**Figure 1: Theory of Change for Oregon’s Coordinated Care Model**



## Policy and legislative background

Oregon's Health Care Innovation Plan is the synthesis of three documents, four major pieces of legislation, an approved 1115(a) waiver renewal and amendment, and amendments to the Medicaid State Plan (See Appendix A). Oregon's plans for Health System Transformation, as outlined in these documents, forms the Health Care Innovation Plan and meets the requirements as described by the Centers for Medicare and Medicaid Innovation's (CMMI) State Innovation Models (SIM) Initiative. These documents demonstrate Oregon's focused and evolutionary attention to health system transformation from 2007 through today:

### *Documents*

- Oregon Health Fund Board Report, "[Aim High: Building a Healthy Oregon](#)" November 2008
- Oregon Health Policy Board's "[Oregon's Action Plan for Health](#)" December 2010
- Oregon Health Policy Board's "[Coordinated Care Organizations Implementation Proposal](#)" January 2012

### *Enabling Legislation*

- [HB 2009 \(2009 legislative session\)](#): Created Oregon Health Authority (OHA, Patient-Centered Primary Care Home (PCPCH) program, Oregon Health Policy Board (OHPB), directed creation of a plan for an Oregon Health Insurance Exchange, created the Health Information Technology Oversight Council (HITOC), health care workforce initiatives and created an All-Payer, All-Claims database (APAC)
- [HB 3650 \(2011 legislative session\)](#): Directed OHPB to create an implementation plan for health system transformation using Coordinated Care Organizations as a

vehicle in Medicaid, to create a business plan for the Health Insurance Exchange, and to develop a plan for spreading model to Public Employees' Benefit Board (PEBB)

- [SB99 \(2012 legislative session\)](#): Legislative approval for the creation of a Health Insurance Exchange as a public corporation
- [SB1580 \(2012 legislative session\)](#): Legislative approval for the creation of CCOs.

*Waiver and State Plan Amendment Requirements*

- [Section 1115\(a\) Waiver Renewal and Amendment](#): Submitted March 1, 2012, approved July 5, 2012
- ACA Section 2703 State Plan Amendment: Approved effective Oct. 1, 2011
- Non-traditional health care worker State Plan Amendment: Submitted, pending

The following narrative discusses how the elements listed above combine to form Oregon's Health Care Innovation Plan, describes the key elements of Oregon's Health System Transformation, and responds to specific questions posed in the State Innovation Models Funding Opportunity. Much greater detail is available in the above referenced materials.

Oregon's commitment to the Coordinated Care Model as outlined in our Health Care Innovation Plan is demonstrated through an intentional multi-year planning and implementation process that included extensive public discussion across the state and active engagement by the Governor, the Legislature and the Oregon Health Authority. (See Oregon Health System Transformation Timeline, Appendix B.) Beginning in the spring of 2007, the Oregon Legislature created the citizen Oregon Health Fund Board (OHFB) to examine the state's health care challenges and develop an action plan for reform. Over 18 months, the OHFB, through an extensive public process, produced a comprehensive analysis of the major drivers of health care

cost in Oregon and a plan for reform in their “Aim High” report to the legislature. This plan provided the foundation for Oregon’s current efforts. A key building block of the OHFB’s plan was a recommendation that the Legislature create the Oregon Health Authority (OHA) to consolidate most state health care purchasing, as well as integrate and oversee all aspects of health reform to ensure components of the Triple Aim are reached in balance. The Legislature incorporated the recommendations from the “Aim High” report in Oregon’s health reform bill, HB 2009, in July 2009, including the creation of the OHA. In a single agency, this brought together purchasing for more than 850,000 lives through Medicaid and CHIP, state employees and Oregon educators, the high risk pool, and the premium subsidy program, as well as public health, addictions and mental health programs. Reorganizing OHA’s purchasing power in this way gives OHA the ability to align across a significant portion of the health care market and to drive delivery system change. HB 2009 also replaced OHFB with the citizen Oregon Health Policy Board (OHPB) to serve in an oversight and advisory capacity to OHA, and initiated work on development of Oregon’s Health Insurance Exchange.

Furthering the vision of the “Aim High” report, the OHPB developed a comprehensive strategic plan, titled “Oregon’s Action Plan for Health” in 2010, which laid out specific strategies and next steps for Oregon to achieve the Triple Aim. The OHPB and OHA were advised by a broad stakeholder group of over 300 people who served on 20 committees, subcommittees, workgroups, taskforces, and commissions to examine all aspects of the health and health care system. More than 850 people attended six community meetings across the state to provide feedback to the OHPB. Likewise, many organizations and groups, such as the Oregon Health Leadership Council (which includes the major health systems and commercial insurance carriers in the state), and small businesses and community groups provided extensive input. (See

Appendix C, Oregon’s Health System Transformation Stakeholder Involvement). A majority of the action items identified by the OHPB based on this stakeholder process have either been implemented or are in the process of being implemented, including the requisite legislation. Notable among these are the development of the Coordinated Care Model, and the establishment of Oregon’s Health Insurance Exchange. (See Appendix D, Oregon’s *Action Plan for Health: Status of Action Items* (May 2012)).

In June 2011, as the first step to implement the Coordinated Care Model, House Bill 3650 passed with broad bipartisan support (Senate 22-7, House 59-1), creating the legislative authority for the development of CCOs as the Medicaid delivery system, in support of the model and health system transformation. Essential elements of the transformation outlined in the bill are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care; and
- A global Medicaid budget tied to a sustainable rate of growth.

Prior to final approval to implement, HB 3650 directed the OHPB to bring back a CCO Implementation Proposal by January 2012. The “CCO Implementation Proposal” resulted in the enactment of SB 1580, which launched CCOs and directed the state to examine how to spread the Coordinated Care Model to state employees. SB 1580 also garnered broad bipartisan support, passing in the Senate 18-2 and in the House 53-7 in February 2012.

Adoption of the Coordinated Care Model for the Medicaid population is underway with legislative authorization in place and federal waiver authorities approved, and the procurement process will be completed as of November 1, 2012. Oregon is confident that this model will achieve cost savings and has committed to the federal government to reduce the growth trend in

per capita Medicaid expenditures by 2 percentage points through implementation of its health care innovation plan.

Oregon is now well-poised to spread the Coordinated Care Model to other populations and payers. As stated earlier, OHA purchases health care for approximately 640,000 people in Medicaid and CHIP, and also helps pay for the health care of some 200,000 others, including state employees and public school teachers and Oregonians who would otherwise be uninsured, essentially touching one in four insured Oregonians. The timing is right for incorporating the major elements of the Coordinated Care Model for individuals who are dually eligible for Medicaid and Medicare and in the contracting procedures for state employees' health benefits. Our intent is ultimately to further leverage this purchasing power by asking qualified health plans in the new Health Insurance Exchange to align with this new care model as a high quality, low cost option for all Oregonians. Many of the commercial health plans are already business partners with the state—offering coverage options for the Medicaid population or state employees. We envision that there will be a “tipping point” for transformation of Oregon's health care system when the Coordinated Care Model's delivery system and payment innovations spread beyond Medicaid beneficiaries and state employees to more of the Medicare and commercial populations to create a truly transformed system. This spread of transformation will help to ensure that Oregon's delivery system and health care workforce is ready for the new expansions of Medicaid and the Exchange, and will help ensure costs remain sustainable over time. The proposed Transformation Center, outlined below, is instrumental in building on our existing multi-payer efforts and in creating learning systems to accelerate innovation and the spread of the model across all payers. Advancing the date of that tipping point will ensure real

and sustainable improvements in health status, enhanced patient experience and lower per capita cost trends.

## II. Payment Models

**Includes: #6 Delivery system payment methods both “current as is” and future “to be” payment methods; and #15 Describe proposed payment models (also addressed in section III).**

### Current situation: in transition

Payment for health care in Oregon is currently in a state of transition. Traditionally, fee-for-service and capitation have been the dominant methods. In the last few years, however, examples of payment innovation have multiplied in several markets. Examples include:

- Providence Health Systems and Health Plan, which serves the majority of public employees and is also part of the large Portland-based CCO, is implementing the PACES (Prometheus) software as an approach to paying for episodes of care based on diagnosis, procedure, and co-morbidities in its network, as well as a capitation approach for oral surgery;
- Numerous payers are testing enhanced payments for primary care medical homes: The Oregon Health Plan (Medicaid FFS), Medicare, and five private payers through CMMI’s Comprehensive Primary Care Initiative, and the state and its managed care plans through the ACA Section 2703 state plan amendment for enhanced payment for chronic, high risk Medicaid population;
- The state-directed alignment of payment across payers with the passage of legislation in 2011 standardizing DRG payment for hospitals and ambulatory surgical centers according to Medicare methodology (SB 204) and prohibiting reimbursement for hospital acquired infections (part of HB 3650); and
- Establishment of global budgets and payments that shift some payment away from capitation and toward payment for outcomes for Coordinated Care Organizations in Medicaid.

## Impetus for change

The momentum for reform in Oregon comes from widespread recognition that past practices for health care payment are not sustainable. Per capita health spending has risen faster than consumer prices and personal income for decades, and total health spending consumes an ever-growing percentage of our nation's gross domestic product. Health care is too often of poor quality—not safe, timely, effective, efficient, patient-centered, and equitably provided, and it is estimated that about 30% of services provided to patients are unnecessary or inappropriate.<sup>2</sup>

But we have the system we created. The fee-for-service (FFS) payment system fails to link payment to achievement of desired outcomes. It pays for units of service and procedures, and not for improving health or delivering superior quality and efficiency. It rewards hospital admissions and expensive procedures; it does not reimburse for care coordination, discharge planning, and other activities that are critical to keeping people healthy. This is true across all populations and payers; 84% of Oregon providers serve Medicaid and CHIP populations, so the same clinics, hospitals and clinicians which serve this population are also serving state employees and Medicare beneficiaries, and privately-insured populations.

The delivery system is in urgent need of change, and any solution requires a multi-payer approach. Without fundamental reform, quality and access will continue to deteriorate because we cannot afford to maintain the system as it is. Key change strategies will include measuring quality and efficiency and deploying payment strategies that hold all participants in the system accountable for improvement.

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<sup>2</sup> IOM, National Academy of Engineering, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington, DC: National Academies Press; 2005.

## Future state

Oregon's goals for payment reform are aligned with the Triple Aim and encourage transparency in methods and measurement of outcomes. These goals are also guided by the principles outlined by the OHPB's Incentives and Outcomes Committee in 2010, as part of their work summarized in "Oregon's Action Plan for Health":

- Equity - Payment for health care should provide incentives for delivering evidence-based care (or emerging best practices) to all people.
- Accountability - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.
- Simplicity - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.
- Transparency - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.
- Affordability (cost containment) - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

The state believes that for most providers, the path from fee-for-service payment to comprehensive payments will traverse some intermediate ground wherein providers are paid in a mix of ways as they transition to greater accountability for outcomes. Some providers may have

the capacity to move more quickly along the transition path than others. During the intermediate phases, we expect payers to use the following types of alternative payment methodologies:

- “Pay-for-performance” incentive payments are built on a FFS base to reward structure, process, or health outcome achievements. Incentive payments are often calculated as a percentage of the underlying FFS payment. They may result in increased total provider payments. However, a payer’s total cost may be kept neutral by reducing base FFS payments and using the difference to create a pool from which incentive payments can be made to top performers. Relevant Medicare approaches include Hospital Value-Based Purchasing (where 1% of payments are dependent on performance on quality metrics), the Physician Value-Based Payment Modifier (with payments based on measures of quality of care), and other value-based purchasing models under development by CMS.
- “Shared savings” payments are also built on a FFS base. If a provider or group of providers keeps costs of care below a target while maintaining or improving quality standards, an insurer or other payer may allow the provider to keep a portion of the savings—thereby encouraging coordination of care and efficiency.
- “Bundled” or “episode” payments are a single payment for all services connected to an episode of care such as a hospital admission for a surgery and post-acute care or a year’s care for a diabetic patient. The payment covers services performed by multiple providers in multiple settings, thereby encouraging coordination of care and avoidance of unnecessary readmissions. Oregon had success in partnership with its partial-risk Physician Care Organizations in the 1980s and early ‘90s. Two CCOs, PacificSource and Cascade Comprehensive Health, are using risk-sharing arrangements with providers to create incentives to control costs and utilization.

- “Primary care base payments” support primary care practices’ infrastructure development, care coordination, patient engagement, and other activities that the current FFS system does not reimburse. The base payment can also include reimbursement for provision of a bundle of primary care services. This is the method used both in Oregon’s ACA Section 2703 health home demonstration and in the multi-payer Comprehensive Primary Care Initiative. CareOregon, one of Oregon’s largest Medicaid managed care organization now aligned with several CCOs in the state, is an Oregon pioneer in the implementation of Patient-Centered Primary Care Homes (PCPCHs) and payment for primary care services and care management through sub-capitation.

In addition, Accountable Care Organization (ACO) models are aligned with Oregon’s Coordinated Care Model, as both share the goal of achieving the Triple Aim. Currently, Oregon’s ACO experience is thin with only one participating ACO in Oregon (North Bend Medical Center in Southwest Oregon). However, it is worth noting that the new Medicaid CCOs are essentially a hybrid of managed care and ACOs, with the CCO allowing providers to share savings (and potentially risk) via APMs when they better coordinate care, improve outcomes and reduce costs. North Bend’s experience with the shared savings program is one example that can be examined and shared across the state, with particular attention to its suitability for the remaining Medicaid fee-for-service populations. CCOs and other payers in Oregon may be interested in working with providers to develop ACO or ACO-like payment methodologies as a comprehensive approach to share savings.

There is significant evidence supporting these alternative payment approaches:

- Bundled payments - perhaps the strongest evidence of potential savings from bundled payments pertains to the PACES (formerly Prometheus) episodic payment methodology.

A Robert Wood Johnson study found that potentially avoidable costs constitute roughly 40% of the dollars spent on a set of chronic conditions including CHF, CAD, Diabetes, Hypertension, COPD, and Asthma.<sup>3</sup> In addition, an evaluation of the first year's experience with Geisinger's ProvenCare coronary bypass program applying the methodology showed a 10% reduction in readmissions, shorter average length of stay, reduced hospital charges, and a 44% decrease in hospital admissions over an 18 month period.<sup>4</sup>

- Risk and gain sharing arrangements between health plans and their providers - Ketchum and Furukawa (2008) found that compared to other hospitals, 13 hospitals in gain sharing arrangements for coronary stent patients reduced costs by 7.4% per patient, and found that based on available measures of access and quality it appeared that neither was reduced.<sup>5</sup> In 2005, the Medicare Payment Advisory Committee endorsed gain-sharing agreements.<sup>6</sup> In the Medicare Physician Group Practice Demonstration, an ACO-like model where physician groups received bonuses for lowering costs and meeting quality targets, significant savings averaging \$532 per year were achieved for dually eligible individuals in addition to improvements in quality.<sup>7</sup>
- Service agreements aligning incentives for specialty and primary care physicians - the Center for Health Care Strategies studied several physician incentive programs and summarized the results from several of these programs. The overarching Robert Wood

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<sup>3</sup> Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care, Francois de Brantes et al, Robert Wood Johnson Foundation.

<sup>4</sup> MEDPAC, cited by Mechanic, Robert E. and Stuart H. Altman. "Payment Reform Options: Episode payment is a Good Place to Start: Health Affairs.

<sup>5</sup> Ketcham, Jonathan D. and Michael F. Furukawa. Hospital-Physician Gainsharing in Cardiology, *Health Affairs*. 803: 12. (May/June 2008).

<sup>6</sup> "Issues in Physician Payment Policy", Report to the Congress: Medicare Payment Policy, March 2005.

<sup>7</sup> Collam, Carrie H, Wennberg, David E, Meara, Ellen, et al. Spending Differences Associated With the Medicare Physician Group Practice Demonstration., *JAMA* 308:1015-1023 (2012).

Johnson Foundation-funded effort was the Rewarding Results Demonstration projects, which increased the number of patients receiving annual screenings and motivated physicians to monitor patient care more aggressively, particularly for chronically ill patients. In the Bridges to Excellence demonstration, physicians were rewarded on a per person, per year basis for excellence in diabetes and/or cardiac care; findings indicate that physicians who are recognized for providing high-quality and more efficient care deliver it at 15 to 20 percent lower cost than physicians not participating in the program. The Local Initiative Rewarding Results demonstration focused on Medicaid patients and showed that a combination of financial and non-financial incentives led to increases from 4 to 35% in the rate of well-baby visits, and from 7 to 14% in visits to the doctor by teens.<sup>8</sup>

Although there are few formal evaluations of the effectiveness of incentives for health plans, there are studies showing positive results:

- New York: Since 2002, NY's Medicaid program has offered quality-based bonuses and auto-assignment incentives to health plans. Over the first four years of the program, NY paid approximately \$71.5 million in bonuses. The state has seen an increase in enrollment in plans that the state identifies as "high quality." A Commonwealth Fund study after the incentives were implemented reported that appropriate postpartum care rose from 49% to 68%.<sup>9</sup>
- General Motors: GM implemented a program that linked the size of the employee contribution to premiums to health plan quality. The observed health plans improved

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<sup>8</sup> 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.

<sup>9</sup> Commonwealth Fund, States in Action Newsletter. States in Action Archive: Medicaid Pay-for-Performance: Ongoing Challenges, New Opportunities. January/February 2007.

quality over time in response to the incentives. Experience showed that better performing plans improve faster while low performing plans sometimes did improve but “break-through” improvements often required internal health plan changes (leadership, cultural, etc.).<sup>10</sup>

- BCBS of Massachusetts: In 2009, BCBS of MA implemented a global payment model called the Alternative Quality Contract (AQC). It includes specific quality benchmarks for providers that they must meet to achieve rewards and places provider groups at financial risk for failure to meet budget targets. After two years, AQC provider groups showed lower spending and improved quality compared to a control group. Participating providers improved quality and saved more money in year 2 than year 1. Participation in the contract led to overall savings of 2.8% over the two years (1.9% in year one and 3.3% in year two). Reductions in outpatient facility spending on procedures, imaging, and testing accounted for most of the savings.<sup>11</sup>

Payment reform cannot drive system change in isolation; Figure 2 below from the California Public Health Institute is a fairly good representation of how Oregon envisions the evolution of payment models alongside reforms in health care delivery and governance. The multiple elements that progress over time demonstrate the vision and goals of Oregon’s Coordinated Care Model. Accelerating and spreading the elements across the preponderance of the state’s population are critical for rapidly achieving the Triple Aim.

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<sup>10</sup> Bailit Health Purchasing, LLC. Ensuring Quality Health Plans: A Purchaser’s Toolkit for Using Incentives. National Health Care Purchasing Institute. May 2002. [www.bailit-health.com/articles/NHCPI-healthplanstoolkit.pdf](http://www.bailit-health.com/articles/NHCPI-healthplanstoolkit.pdf)

<sup>11</sup> 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

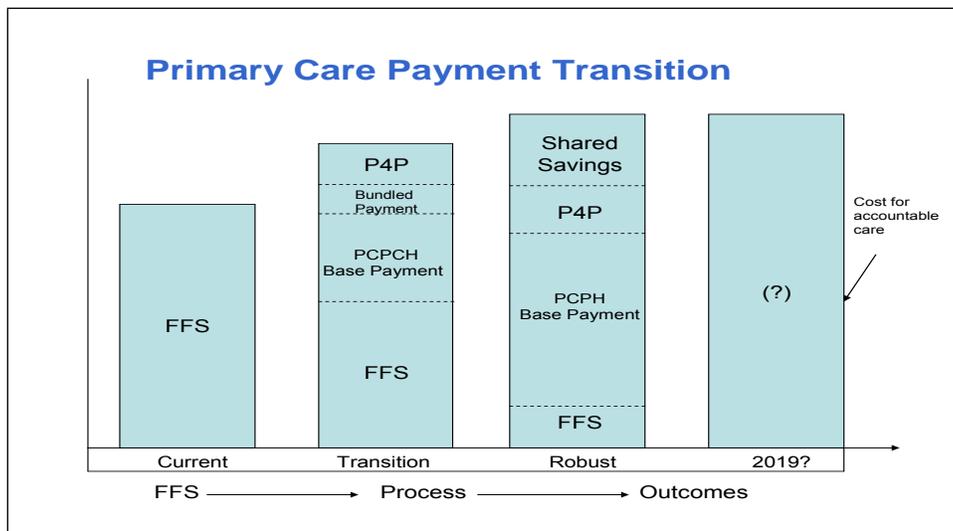
**Figure 2: Oregon’s Key Steps towards Transformation**

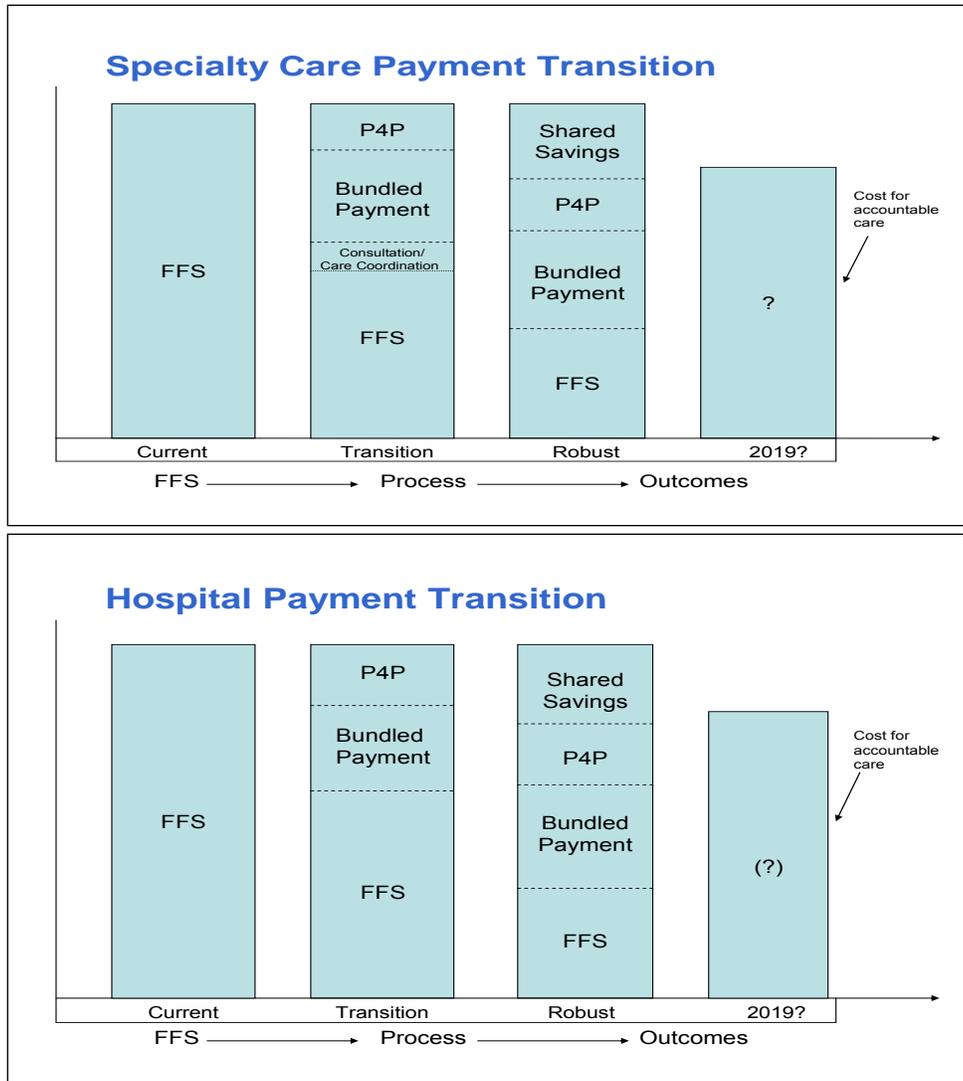
<b>Today</b>			<b>Tomorrow</b>
<b>PAYMENT MODELS</b>			
Fee for service	Episode-based reimbursement	Partial/full risk capitation	Global budgeting
<b>INCENTIVES</b>			
Conduct Procedures	Evidence-based medicine Clinical PFP	Expanded care management Risk-adjusted PFP	Reduce obstacles to behavior change Address root causes
<b>METRICS</b>			
Net revenue improvement	Improved clinical outcomes Reduced readmits	Reduced/preventable hospitalizations/ED Reduced disparities	Aggregate in health status & QOL Reduced HC costs
<b>GOVERNANCE</b>			
Informal relationships & referrals	Joint partnerships between organizations e.g. mental health & behavioral health		New community-based accountability linking all

*Information from Public Health Institute*

Oregon’s specific vision for the transition from FFS to more comprehensive, outcomes-oriented payment is shown for different provider types below (Figure 3). In each illustration, FFS payments decline over time as a share of all payments, while other payment methods grow.

**Figure 3: Payment Transitions**





### Key steps toward the future state

We see Oregon’s health system payments moving away from FFS and increasingly more toward global budgeting and payment for outcomes, beginning with Medicaid and CHIP. In alignment with the vision of improving quality and consistency of care, emphasizing outcomes and value rather than volume, and containing costs through new payment systems (see Section I), the first steps of payment transformation will be:

*Changes in how the state pays for Medicaid through CCOs*

1. Employ “global budgets” to compensate CCOs (the Medicaid vehicle for Oregon’s Coordinated Care Model). A global budget, which integrates previously siloed funding streams, represents the total cost of care for all services for which the CCO is responsible and held accountable for managing, either through a capitated per member per month payment or through payment for outcomes. Maximizing services and populations included in the global budget over time will promote financial accountability and help align incentives for cost-effectiveness as well as discourage cost shifting. Along with the state’s 1115 waiver, the SIM initiative provides an opportunity to test effectiveness of the global budget as a tool for containing costs and effectively integrating care.
2. Design and implement a CCO quality pool as a bridge strategy to move CCO payments from volume to value. Over time, the proportion of a CCO’s global budget based on capitation is expected to decrease as the proportion based on incentives tied to improvements in outcomes and efficiency will increase. The state and CMS are currently working with national experts to create the appropriate metrics and incentives, and are required to submit a plan by early November 2012 for CMS approval. Beginning July 2013, incentives will be tied to each CCO’s performance on quality, cost and access measures as well as EHR adoption. In addition, CCOs will be required to align provider incentives with the incentive program established between the state and CCOs in order to maximize the potential for achieving quality goals.

*Changes in how Medicaid CCOs and other health plans pay providers*

3. Transition to a payment system that rewards health outcomes improvement and not volume of services by working with CCOs and other interested plans to test a “starter set”

of alternative payment methodologies (APMs), which will include the approaches described in more detail above. CCOs must use APMs alone or in combination with delivery system changes to promote the Triple Aim; however CCOs have the flexibility to choose which APM(s) they implement. In addition to alternative methods for payments between CCOs and their contracted providers, Oregon plans to test financial incentives and/or penalties for CCOs and Long Term Supports and Services (LTSS) to coordinate care and achieve desired outcomes for individuals they serve in common.

In addition, the state will use the purchasing power of the OHA to incent and encourage adoption of APMs in contracting for state employees, while accelerating the spread of the effort to other local government and private purchasers of health care, in partnership with commercial plans, health systems and providers. Discussions are underway to expand these efforts through qualified health plans when the new Oregon Health Insurance Exchange becomes operational, as well as through the Oregon Insurance Division's rate regulation authority to align the individual and small markets with the Coordinated Care Model.

In Oregon's current vision, the Oregon Transformation Center is the state's hub, or integrator, for innovation and improvement, and is key to its strategy for implementing the Coordinated Care Model successfully and rapidly statewide. The Center will support Medicaid CCOs' and other payers' implementation of APMs by offering technical assistance and tools related to the "starter set" of promising APM models described above. The Center will bring together the best national and local expertise in payment reform to work with OHA, as well as Oregon's plans, health systems and providers. The Center will also provide technical assistance to align with and leverage the work that CMS has already done with specific Medicare APM

models, including any future Medicare value-based purchasing efforts, and will provide other payment incentive options as appropriate.

SIM funds would support the Transformation Center's testing of these APMs in a variety of different CCO and non-CCO environments. Testing activities may include expert consultation, technical supports such episode grouper software or assistance with risk mitigation, and—most importantly—assembling evidence about the effectiveness of APMs in different settings and disseminating best practices. APMs will be evaluated for their success in the alignment of incentives so that the primary care team (with the patient at the center), specialty providers, hospitals, and palliative care providers, including hospices, are all working to reflect the patient's preferences in a plan of care that is clinically sound, accountable for resources used, and contributes to both individual and community health. Analytic capacity built into the functions of the Transformation Center will allow for rapid cycle improvement at all levels to swiftly correct policies and design decisions and keep the transformation moving forward.

### III. Delivery Models

- Includes:**
- #4 Health system models “current as is” and “future to be” states, including the level of integration of behavioral health, substance abuse, developmental disabilities, elder care, community health, and home and community-based supportive services;**
  - #15 Describe proposed services delivery models;**
  - #5 Opportunities or challenges to adoption of Health Information Exchanges (HIE) and meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT; and**
  - #14 Describe delivery system models and approaches including how public health care entities, such as publicly supported university hospitals and faculty practices will transition to value-based business and clinical models.**

#### Current state of the delivery system

Oregon’s current health care delivery system is fragmented, often with discrete entities providing physical health, mental health, and substance abuse care. Others provide oral health care, elder care, community health care, long term care, or intellectual and developmental disabilities services and supports, among other types of care. Each manages its distinct element of a person’s health and is paid separately across payer types. This structure limits the system’s ability to maximize efficiency and value by effectively integrating and coordinating person-centered care through new delivery models. The current payment system—primarily fee-for-service and carved-out managed care entities—provides little incentive for optimal prevention or disease management actions that can lower costs or sustain new and innovative approaches to coordinated care that don’t fit with ‘widget-based’ payment system. Facing myriad requirements and expectations from private health plans, as well as publicly-funded plans like Medicaid and state employees, it is difficult for providers to focus on a common set of metrics and performance outcomes that improve the quality of care and care coordination.

### *Current state for Medicaid & CHIP in the Oregon Health Plan (OHP)*

Until August 1 2012, when CCOs were established as part of health system transformation, the Oregon Health Plan (which includes both Medicaid and CHIP) was fragmented, resulting in diluted accountability for patient care and duplication of infrastructure and services. Care was delivered through a system that included three kinds of health plans (16 physical health organizations, 10 mental health organizations (MHO) and eight dental care organizations(DCO)), while some individuals continued to receive care on a fee-for-service basis. Specifically:<sup>12</sup>

- Approximately 78 percent of OHP clients were enrolled in physical health managed care.
- Nearly 90 percent of OHP clients eligible for dental services were enrolled in managed dental care. (Adults in OHP-Standard, Oregon’s Medicaid expansion population do not have dental coverage).
- Approximately 148,000 clients not enrolled in managed care received services on a fee-for-service (FFS) arrangement — providers billed the state directly for their services based on a set fee schedule. Some providers receiving FFS also got a case management fee (in areas where there are no managed care plans).
- About 88 percent of OHP enrollees were enrolled in capitated mental health organizations (MHOs). In many cases, through capitated MHO payments to the counties, the counties function as the MHO, bearing full risk for the services and contracting with panels of providers for direct services to enrollees. Addiction services for Medicaid clients are covered in fully capitated physical health plans, not through MHOs or counties.

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<sup>12</sup> Oregon Health Authority. Oregon Health Policy Board meeting slides, Jan. 18, 2011

- 84% of Oregon’s providers see Medicaid and CHIP enrollees yet are often closed to new patients due to low reimbursement and the challenges of managing individuals with complex conditions in a traditional clinical practice setting.

Further, Oregon’s long term care supports and services (LTSS)<sup>13</sup> and intellectual/developmental disabilities (I/DD) are provided on a FFS basis (LTSS are legislatively excluded from managed care), and coordination between Medicaid health plans and LTSS and I/DD local case workers and providers is inconsistent. See the section: *Current state for individuals eligible for Medicare and Medicaid* for more information about LTSS and I/DD services.

#### *Current state for state employees*

The Public Employees’ Benefit Board (PEBB) oversees the purchase and management of benefits for approximately 134,000 covered lives through three options: a self-insured PPO that serves almost 85% of beneficiaries, and two HMO-like plan designs. It purchases on behalf of state employees and Oregon’s university system. PEBB has a long history of innovation over the past decade with evidence-based plan design and efforts to improve the delivery of care. The PEBB vision states that it “seeks optimal health for its members through a system of care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible, and affordable. The system emphasizes the relationship between patients, providers, and their community; is focused on primary care; and takes an integrated approach to health by treating the whole person.”

However, PEBB has been frustrated by the limited impact it can have as a single purchaser with limited market share. Care remains fragmented across delivery systems and costs are

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<sup>13</sup> Note: in this plan, the term “LTSS” is used to refer to both Nursing Facility care and Home and Community Based Services (HCBS) for individuals who are aged or physically disabled and require services and supports for their activities of daily living. Services for individuals who are intellectually or developmentally disabled (I/DD) or who require long term care/residential treatment related to mental health or chemical dependency are specifically identified as such, and are not referred to as LTSS in this plan.

continuing to escalate beyond the growth of either the state budget or individual income, threatening the sustainability of the health care benefit and salaries for state employees.

The PEBB board has challenges improving the health of the population for which it is responsible in the context of other populations and health plans across the state. While it has been innovative in initiating wellness and obesity benefits, these are isolated activities and generally not connected with activities of other purchasers, including Medicaid, or with community and population health efforts. The PEBB board has made cuts to health benefits yearly in order to mitigate the rising cost of health care resulting from medical inflation and the increasing burden of chronic disease in the state employee population, as demonstrated in the Oregon BRFSS (Behavioral Risk Factor Surveillance System) results in the PEBB population, as described in section VI below. In the past year, costs were passed on to state employees for the first time, with employees now sharing in premium cost, along with additional surcharges for tobacco use. On the incentive side, beneficiaries who enroll in a Health Engagement Model (HEM) program, featuring an initial health assessment and participation in at least two online health lessons and follow-up, receive a small taxable incentive (\$17 in 2013) as part of their monthly pay.

#### *Current state for individuals eligible for Medicare and Medicaid*

Oregon's Medicaid and Medicare Advantage health plans are largely local or regional, and a significant portion of individuals who are dually eligible for both programs are enrolled in plans that take steps to coordinate Medicare and Medicaid benefits, such as Medicare Advantage Special Needs Plans. In Oregon, 61% of dually eligible individuals are enrolled in a Medicaid managed care plan for their physical health care, while nationwide only 12% were enrolled in comprehensive managed care. Similarly, 47% of dually eligible individuals in Oregon are

enrolled in a Medicare Advantage program—primarily Special Needs Plans (31%), which coordinate individuals' Medicare and Medicaid benefit to some extent. Nationally, only 15% of individuals who are dually eligible are enrolled in Medicare Advantage plans, including Special Needs Plans.

Although Oregon's Medicaid managed care organizations, mental health organizations and dental care organizations, and Oregon's Medicare Advantage plans have achieved some successes in better managing care and reducing costs for individuals who are dually eligible, the current structure limits their ability to maximize efficiency and value through effective integration, coordination, and person-centered care. Each entity is paid separately by the state and/or CMS and focuses on a single aspect of an individual's overall health. As with individuals eligible for Medicaid only, the current payment system does not provide strong incentives for the prevention or disease management services that can improve health and stabilize chronic conditions, and thus also lower costs. Further, navigating several different plans to receive services can be confusing and difficult for the individuals served and thus work against patient engagement and improved health. Furthermore, for the significant proportion of dually eligible individuals not enrolled in managed care, even more substantial opportunities exist to better coordinate care and integrate services, particularly for those individuals with high needs.

Oregon has excelled in providing eligible individuals the ability to choose the most appropriate long term care supports and services (LTSS) setting and provider to meet their needs. A broad selection of LTSS systems are available in Oregon, including a well-developed delivery system for home and community based services (HCBS), which many individuals strongly prefer. Receiving care in an HCBS setting helps to maintain an individual's independence and relationships, both of which can contribute to their overall health. Overall, 37% of dually eligible

individuals received LTSS in 2010. In Oregon, dually eligible individuals receiving LTSS were nearly twice as likely to do so in an HCBS setting as they are nationwide: more than 80% of the 21,550 dually eligible individuals in Oregon who received LTSS did so in an HCBS setting, whereas nationally the figure is only 44%.

Oregon's Department of Human Services (DHS) serves approximately 17,000 Medicaid-eligible individuals with intellectual or other developmental disabilities (I/DD) throughout their life span, approximately 45% of whom are dually eligible. All individuals who request supports are provided with case management through the county systems. Adults (18 and older) who live at home or in their own home and qualify for Medicaid can be provided case management and in-home and community supports through Adult Support Service Brokerages. Oregon's model of support is based on the values that individuals with developmental disabilities need to be fully engaged in their communities. To that end, Oregon does not operate any institution, private or public, for people with I/DD; all services are provided in the community. For those individuals who cannot continue to live with families or live on their own with some supports, there is a network of group homes and foster care. However, the majority of people, even people with some of the most significant disabilities, live at home.

### **Future vision for the delivery system**

Oregon's Coordinated Care Model is expressly intended to change how health care services are delivered with a strong focus on primary and preventive care and more effective care management, especially across transitions of care, and on integration of physical and behavioral health services, as well as better coordination with non-CCO services such as LTSS and I/DD services. Patient-centered primary care homes; proactive, collaborative care planning; ongoing community health needs assessments; evidence-based practices; health information technology;

and broader use of non-traditional health care workers (e.g., community health workers, peer wellness specialists) are key strategies that Oregon's model are expected to use to improve health and reduce health disparities.

As noted in the SIM application, Oregon proposes to test its innovative model's ability to reduce cost growth and improve quality and access in three ways: (1) assessing the success of the overall model in OHP with the new CCOs, as outlined in the state's landmark 1115 waiver, as well as (2) pulling apart the key delivery system elements of the model to assess the extent to which these elements contribute to the overall model's success, and (3) testing the spread of these key elements of the model to other payers, including public employees and Medicare.

#### *The Patient-Centered Primary Care Home (PCPCH) model*

At the core of Oregon's Coordinate Care Model is a model of primary care that has received attention in Oregon and across the country for its potential to advance the Triple Aim goals of health reform: a healthy population, extraordinary patient care, and reasonable costs. PCPCHs achieve these goals through a 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.

In 2009 and 2010, Oregon developed its comprehensive standards for PCPCHs. The initial public stakeholder group reviewed the various approaches to a medical home including the National Council of Quality Assurance (NCQA) standards that were becoming widely adopted, but felt the NCQA standards did not go far enough to encourage improved health outcomes. Designed from the perspective of the patient and family, the following six key attributes of a PCPCH are at the core of the Oregon standards and are key to the expected outcomes:

- Access to Care: "Health care team, be there when we need you."

- Accountability: “Take responsibility for making sure we receive the best possible health care.”
- Comprehensive, Whole-Person Care: “Provide or help us get the health care, information, and services we need.”
- Continuity: “Be our partner over time in caring for us.”
- Coordination and Integration: “Help us navigate the health care system to get the care we need in a safe and timely way.”
- Person and Family-Centered Care: “Recognize that we are the most important part of the care team—and that we are ultimately responsible for our overall health and wellness.”

In its “Action Plan for Health”, the Oregon Health Policy Board charged OHA with providing access to patient-centered primary care for all of its covered lives including Medicaid/CHIP, state employees, and Oregon educators. Supported by HRSA State Health Access Planning (SHAP) grant funding, the OHA initiated a PCPCH program for practice recognition, technical support, and performance improvement that just started, with more than 280 primary care practices recognized to date – more than 60% as Tier 3, the highest level of attainment in Oregon’s system.

As delivery system transformation is supported by the evolution of payment methods from fee-for-service models, a crucial component will be the innovation and supports necessary for a primary care practice to transform to a team-based, patient-focused model of care that works closely with its community. Implementing a strong primary care system through a network of recognized PCPCH providers will be a requirement of CCOs, to the extent practicable in Medicaid, and the Public Employees’ Benefit Board (PEBB) will be adding similar requirements in its contract for the January 2014 benefit year as Oregon spreads its model.

Oregon's goals for furthering development and adoption of PCPCHs are:

- 75% of Oregonians have access to a recognized PCPCH by the end of 2016 and most of these PCPCHs are Tier 3.
- Increasing the spread of the PCPCH model to PEBB, Medicare, and commercial carriers for non-OHA populations by end of 2013.

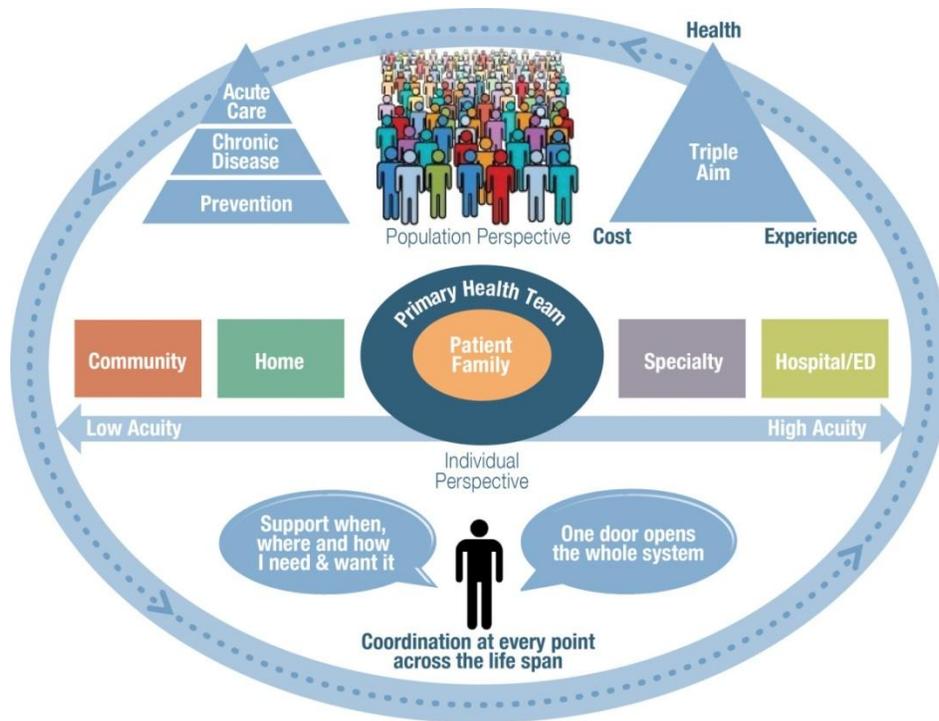
Support from CMMI under the SIM is integral to accelerate and spread Oregon's PCPCH program. We anticipate that the PCPCH program will be sustainable by 2016, but it requires additional up front investment to accelerate primary care transformation.

*Oregon's Coordinated Care Model drives new delivery system models of care*

Figure 4 illustrates how Oregon's Coordinated Care Model will be achieved with PCPCH at the core across all populations. Under Oregon's Coordinated Care Model, patients and families are at the center, and physical, behavioral and other types of care and services are integrated and provided in a community setting to the greatest extent possible. The system emphasizes prevention, chronic disease management, health outcomes and health equity. The benefits expected from these care improvements are many. For example:

- The integration of physical, behavioral and other types of care will result in improved care coordination, reducing unwarranted or duplicative care and reducing medical errors;
- This will also result in administrative alignment, which will reduce administrative costs;
- Better prevention, care in community settings, and stronger coordination and case management will begin to reduce hospitalization and emergency room use and achieve improved outcomes; and
- Increased financial flexibility will enable communities to prioritize their own needs and encourage the use of the most cost effective care.

**Figure 4: Primary Care Home at the Core of Oregon’s Coordinated Care Model**



*The Coordinated Care Model shapes the delivery system in Medicaid*

The Oregon Health Plan’s CCOs under the recently renewed Section 1115(a) Medicaid waiver are the vehicle for initiating the Coordinated Care Model in Oregon and are directly in line with the objectives of the CMMI State Innovation Models (SIM) initiative. Medicaid CCOs are community-based, risk-bearing organizations governed by a partnership among providers of care, community members and those taking financial risk. The CCOs operate within a global budget and are responsible for the integration and coordination of physical, mental, behavioral and dental health care, and coordination with outside services such as LTSS and I/DD services. They are the single point of accountability for health care quality and outcomes for the populations they serve and have the flexibility, within model parameters, to institute their own payment and delivery reforms that achieve the greatest possible outcomes for their membership.

Currently, 13 CCOs are certified and operational in 33 counties, covering 500,000 of the Oregon Health Plan members (See Map of CCO Service Area, Appendix H). By November 2012, CCOs will be certified in all of Oregon's 36 counties, serving an estimated 90% of the Medicaid population.

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 active Community Advisory Councils. CCOs must collaborate with local hospitals, public health agencies, social services organizations and others to conduct a community health needs assessment and develop a community health 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.

Simply put, CCOs are a vehicle for delivering patient-centered care that is focused on improving health and lowering costs at every point in the health care system. The CCOs are replacing the previously fragmented and siloed delivery system. Each CCO is required to partner with or implement a network of PCPCHs and, over time, the state expects every OHP member to have access to a PCPCH. CCOs are required to outline what their efforts will be to achieve PCPCH access and how they will use alternative payment methods to incent and sustain the PCPCH model in their Transformation Plans due in January 2013. Transformation relies on ensuring that CCO members have access to high-quality care beyond just PCPCHs to other clinical and health professionals, including the specialists and hospital providers and also non-traditional health care workers who can bring care outside the clinic setting and into the community. This will be accomplished by the CCO through a provider network capable of

meeting health systems' transformation objectives and ensuring that members experience enhanced care coordination between the members of the network to meet their needs.

While the state is committed to assist CCOs in achieving this aim, the SIM investments will allow for optimal testing of Oregon's model in Medicaid, and it will ensure that rapid cycle improvements can be implemented and allow for acceleration and spread of the delivery system changes needed to successfully achieve the Triple Aim.

In addition, CCOs will be integral to ensuring access and sustainability of coordinated care as over 200,000 Oregonians become eligible for Medicaid in 2014. Through SIM investment, acceleration, testing, and rapid cycle improvements will help evolve the global payment and incentive program as well as the key elements of the Coordinated Care Model and its underlying PCPCH delivery model, so that CCOs are effectively paying providers for outcomes.

#### *The Coordinated Care Model for state employees*

Care delivered in the right place and time leading to improved health status and health equity also describes the future for state employees. The Public Employees' Benefit Board (PEBB) represents an early opportunity to translate the Coordinated Care Model to the commercial market. The PEBB Board is adopting the Coordinated Care Model in its current and future contracting and plan design elements, focusing on the value gained through creating incentives and accountability for improved health outcomes with its partner plans. PEBB will be releasing an RFP this fall for the 2014 plan year. Metrics for accountability will be aligned with those required for CCOs, and the RFP offers opportunities for financial arrangements and other key elements to align the Coordinated Care Model.

Spread to the state employee population and the commercial market will be enhanced because many of the same delivery systems in Oregon are part of the new CCO networks, and

several CCOs have commercial health plan partners as part of their governance. Additionally, PEBB and its health plan partners were involved as key stakeholders in the development of the coordinated care model. 84% of Oregon's providers see Medicaid patients, most of whom also serve state employees, so alignment of contracting expectations will support delivery system transformation so the new CCOs will be contracting with many of the same provider networks as the commercial plans, and share similar metrics for performance.

Finally, the PEBB Board has encouraged patient-centered primary care for many years as part of its contracts, but with the overall statewide acceleration there will be increased incentive to move to the new team-based model. PEBB members will have increased PCPCH options starting in 2013, as the largest PEBB PPO plan members who seek care from a recognized PCPCH will see a decrease in their cost sharing from 15% to 10% and the providers will receive incentive payments if they fulfill the standards for a higher level PCPCH.

Moving to the future, any successful bid for the upcoming 2014 RFP will be required to demonstrate incentives to further spread the PCPCH model, including alternative payment methodologies. By aligning standards and payment incentives between Medicaid and PEBB, primary care providers and payers will have a common set of expectations across provider networks serving 25% of the Oregon insured population. CCOs can also bid on the 2014 PEBB RFP and, if successful, be offered as a plan choice for PEBB members. Additionally, the investment in the Transformation Center will provide the needed resources to bring national and local expertise in payment methodologies, analytics and evidence-based practices and tools across both public and private plans to accelerate the spread of the model into the commercial market. Oregon's commercial plans and the health systems and providers that work with them have been at the table in designing the model, but investment in moving the model to fit the

different purchasing worlds and learning from each others' success is vital for the transformation of Oregon's overall health care delivery system.

*The Coordinated Care Model for individuals eligible for both Medicare and Medicaid*

Oregon has applied for Medicare/Medicaid Alignment demonstration (financial alignment demonstration). If this demonstration moves forward, it will allow CCOs to apply to serve as integrated Medicare and Medicaid plans for dually eligible individuals, allowing CCOs to better integrate and coordinate care for this population, with a combined benefit package and better aligned processes. The blended payments for Medicare and Medicaid services will allow CCOs to focus on the care that will best serve an individual, rather than which coverage should pay for it. Participation in the demonstration will be voluntary for CCOs, but all CCOs will be required to be able to provide Medicare services to dually eligible enrollees by January 2014, either through participation in the demonstration, or through an owned, affiliated, or contracted Medicare plan, as some plans do now. The demonstration proposal requests passive enrollment with opt out of dually eligible individuals into demonstration plans, which 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 still intends to integrate care for dually eligible individuals as much as possible, leveraging the CCO.

By coordinating physical, behavioral, and oral care by integrating Medicare and Medicaid programs for individuals who are dually eligible, CCOs will work to better meet these individuals' myriad needs. Integration and coordination are particularly relevant for the significant proportion of dually eligible individuals with both chronic conditions and behavioral health needs, who often face barriers to care that meets their interrelated needs. PCPCHs and

other intensive needs care coordinators will actively coordinate care and help to ensure that individuals access the supports needed to better manage their own health.

Additionally, integration of health care silos, including Medicare and Medicaid, will address administrative inefficiencies and poorly aligned financial incentives. Administrative and organizational alignment will help to create an integrated and seamless system for individuals, with a single set of materials, processes, and benefits. Integrating these programs also resets incentives to invest in more person-centered care. For example, investing in coordination under the Medicaid program would typically result in savings to the Medicare program, but, with integration of Medicare and Medicaid, savings are achieved within the same health plan.

While individuals with I/DD will continue to receive their I/DD services in the same way that they do now, those that are enrolled in CCOs will receive their physical and behavioral health services through the CCO. Each CCO will be expected to establish and maintain relationships with the developmental disabilities service system in their area, and to work with that system to effectively coordinate services and supports to meet the complex needs of this population. DHS will support CCO coordination with I/DD services for their members with I/DD, including potentially sharing additional client-specific data related to the CCO's members with I/DD. OHA will reflect the disabled population, including the I/DD population in the quality metrics for CCOs to track and monitor outcomes and ensure that CCOs are addressing the needs of this population, and work to reduce disparities.

Given that Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the state, Oregon sought extensive input from stakeholders in developing its key strategies for coordination between CCOs and the Medicaid-funded LTC system. In order to ensure shared responsibility for delivering high quality, person-

centered care and to reduce costs, CCOs and the local LTSS system will be required to coordinate care and share accountability, including financial accountability. Investment through the SIM will ensure success at achieving that alignment, particularly the LTSS innovator agents that are not part of our Medicaid waiver requirements. These LTSS IAs will partner with the Medicaid CCO IAs and with OHA's sister agency, the Department of Human Services, to ensure services for individuals receiving LTSS will be aligned and coordinated.

Support from SIM will allow us to test shared accountability and coordination between CCOs and LTSS, as we consider how best to further spread these types of accountability and coordination strategies to types of non-health services, with potential to ensure person-centered care and the ability to leverage other social services providers and community partners in best engaging individuals in their care, addressing social determinants of health, and ensuring the delivery system is responsive to their needs.

One very promising approach to building effective, person-centered care for individuals served by social services, LTSS, and health care, is the Congregate Housing with Services model. As implemented in other states, including Vermont's Medicare Multi-Payer Advanced Primary Care Practice Demonstration, the "Support and Services at Home (SASH) program," this approach targets a low-income population living in subsidized housing apartments or other highly concentrated, naturally occurring communities with a greatly coordinated and efficient model of support. These communities often include higher proportions of non-English speaking populations, providing the opportunity to better address health disparities including those related to race/ethnicity/language. As envisioned, Oregon Congregate Housing with Services pilots will target social determinants of health, include prevention and wellness programs, and seek to prevent unneeded emergency and acute health care. CCOs would be key participants in a multi-

agency consortium of experienced providers to deliver social, support, and health services. Pilot sites would be required to partner and coordinate with CCOs for behavioral supports, substance abuse treatment, acute and primary care, and other models such as onsite nurse practitioners and wellness programs. Support from CMMI would provide start-up and evaluation support for one to three pilot sites, and would be critical to accelerating, testing and evaluating this model of pairing housing with services for its potential to improve health outcomes, lead to better quality of life and lower costs.

### **Other delivery models and tools to aid the Coordinated Care Model's success**

In addition to the centrality of PCPCH, other tools are needed to fully adopt, accelerate and spread the Coordinated Care Model. The state has worked closely with CMS in negotiation of its Medicaid waiver in developing the concept of Innovator Agents (IAs) who will not only help CCOs break down the bureaucratic barriers between the CCO and the state, but also serve as a conduit for data, sharing of best practices and bringing technical assistance to assist CCOs in adopting and adapting the model. Oregon seeks support for spreading the IA concept to long-term care, as mentioned above. However, the delivery system of the future in Oregon will require some other key elements for the success of the transformation.

#### *Workforce development to achieve the Coordinated Care Model: Non-traditional health care workers and health care interpreters*

Non-Traditional Health Care Workers (NTHW) include Community Health Workers, Peer Wellness Specialists, Patient Navigators, Doulas and Health Care Interpreters and are an integral part of effectively implementing the Coordinated Care Model and reducing health disparities. This takes care beyond the four walls of clinics and hospitals, out into homes and the community, supporting the Coordinated Care Model in a variety of ways. By focusing on

culturally sensitive and linguistically appropriate approaches, they support adherence to treatment and care plans, coordinate care and support system navigation and transitions, promote chronic disease self-management, and foster community-based prevention.

In Medicaid, CCOs are required to incorporate NTHWs and health care interpreters (HCIs) in their service delivery model. As the model of coordinated care accelerates and spreads, Oregon expects an increased demand and utilization of NTHWs and HCIs which will necessitate a consistent and integrated workforce development system to ensure a steady pipeline of this group of workers. Standards for the NTHWs have been developed and a Medicaid state plan amendment has been submitted to CMS. The goals to build this workforce for the future to sustain Oregon's model are as follows:

- Establish systems for certifying NTHWs, and certify 300 new community health workers by December 2015;
- Establish infrastructure to accelerate the certification of health care interpreters, and certify 100 interpreters by June 2016.

These workers will also be invaluable as Oregon's model spreads to the Public Employees' Benefit Board (PEBB) and Medicare, and other commercial payers. As greater accountability for improved outcomes and reduced costs, investing in these workers now will allow Oregon to be ready for the increasing need CCOs and other health plans, even the emerging ACOs will have as the model accelerates and spreads. Testing their impact is critical now to continuously improve the expectations and requirements of the workers as the new relationships needed with PCPCHs, specialists, hospitals and other health systems and providers start building.

### *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. 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 Clinical Preventive Services. OHA plans to facilitate CCOs' partnerships with local public health authorities and other local organizations to reduce the leading causes of disease, injury, and death while also driving down the leading drivers of health care costs in their communities. These collaborations 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*

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 and processes. 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 model expansion to link more closely with Oregon's education system.

### **Adopting standards for safe and effective care statewide**

Oregon has had a long history of applying evidence to health care policy and purchasing. The state's Health Evidence Review Commission (HERC) has initiated the development of evidence-based decision-making tools that are founded in extensive research and expertise on treatment effectiveness in achieving meaningful clinical outcomes. The new Commission combines the almost 20 years of work by the Health Services Commission who initially developed Oregon's Prioritized List and the Health Resources Commission that pioneered evidence drug and medical technology reviews. Working closely with the new HERC, the drug reviews have now been consolidated with the OHA's drug utilization review for the Oregon Health Plan to increase efficiencies across the OHA and provide alignment with evidence-based drug class education for providers and patients with pharmaceutical purchasing. Since the earliest days of health reform in Oregon, the state's evidence review process includes extensive discussion with stakeholders in an open and transparent public forum to achieve consensus.

The HERC's clinical and coverage decision-making tools provide critical information for both public and private stakeholders to purchase and deliver health care that is both clinically effective and cost-effective. The HERC has looked at national efforts in this area, with designated reliable resources for the work such as AHRQ and Cochrane. Extensive evidence reviews and existing guidelines have been pulled together in partnership the Oregon Health and Science University's Center for Evidence-based Policy, as part of the Medicaid Evidence Based Decisions (MED) project with 11 other states. A small number of evidence-based guidelines,

health technology assessments and coverage guidance have already been developed through this program with a public process for vetting the findings through the HERC.

This work benefits CCOs and their Clinical Advisory Panels, as well as provides resources to other health plans, providers and health systems on the best available evidence. Topics address areas involving high practice variation or the provision of services with uncertain benefit, where evidence can inform the best use of resources. The Public Employees' Benefit Board (PEBB) has begun to use this work in development of its benefit package in order to align cost sharing and coverage with evidence-based benefits. Continued expansion of this effort on a broader scale will require expertise that can provide identification and interpretation of comparative effectiveness research necessary to continue production of these tools. Similarly, while originally developed in Medicaid with efforts around the Prioritized List and the MED project, the additional evidence-based clinical guidelines, expanded workforce capacity and other results of SIM investment in delivery system transformation will benefit all providers, health systems and plans across Oregon and could be used by other states. A key part of targeting the tools, Oregon seeks investment in the complex detail to accelerate the tool development, and enhancements in the information systems, particularly the All-Payer All-Claims database to be able to apply utilization data in determining the focused clinical areas and procedures that are driving cost and quality.

Additionally, there is a need to better educate consumers about the importance of evidence-based care. Individuals and their families are at the center of Oregon's Coordinated Care Model and helping them self-manage, understand and prevent illness is a crucial tool to improving and maintaining their health. Identifying best practices for communicating the importance of evidence-based care to CCO members, PEBB and other public plans is an area of need upon which the Transformation Center will focus. Providers, health plans and employers all need to

also have a common message to dispel the concept of a “take away” and instead focus on the provision effective care. Patients can also benefit from discussions prior to proceeding with extensive surgeries or other treatments, so enhanced evidence-based tools can be shared to ensure the use of the most effective care and to defray costs where appropriate. Oregon will also support payers and providers with evidence-based approaches and tools to support patient activation and informed decision-making.

An additional aspect of Oregon’s intent to focus on evidence-based care includes disseminating and incentivizing best practices on overall patient engagement. Several models have been tested, including one developed by Dr. Judith Hibbard at the University of Oregon, that provide tools for providers and health systems to assess the level of engagement of a patient in order to plan for the resources needed to assist that patient in their own care.

### **Role of HIT and HIE in delivery system reform**

Oregon’s Coordinated Care Model hinges on access to essential tools that can improve care coordination and the quality, while reducing the cost of care. Currently, there is redundant testing and gaps in information as patients move within the fragmented health care system. Optimal coordination of care is hindered by inadequate sharing of clinical and other types of information that the original paper-based system and fax machines cannot keep pace with. Structures are not in place to systematically ensure that patient information remains safe but is available at the right time and the right place to reduce medical errors, improve the quality of care and reduce costs.

OHA was directed in HB 2009 to accelerate the adoption and use of electronic health records and directed the creation of a new Health Information Technology Oversight Council (HITOC) as a citizen body tasked with setting goals and developing a strategic health information technology plan for the state, as well as monitoring progress in achieving those goals and

providing oversight, with the goal of developing and implementing a strategic plan for creating a statewide system of health information exchange.

HITOC's efforts have enabled Oregon to meet federal requirements so that providers are eligible for federal health information technology stimulus dollars. HITOC has worked closely with OHA on outreach to providers and health systems to spur adoption and meaningful use of EHRs. As of September 2012, 976 eligible professionals and 36 eligible hospitals have received Medicaid EHR incentive payments in Oregon, with approximately 200 more applications in process of approval. Sixty-eight percent of those providers are practicing in urban settings and 30% are located in rural Oregon. The majority of those payments have been made to physicians (including pediatricians) and nurse practitioners, but notably, 69 dentists have also received payments, with the remainder of payments being made to certified nurse midwives and physician assistants. Outreach efforts are being coordinated with the Oregon Regional Extension Center (O-HITEC), with CareAccord™ engagement staff, with provider associations and IPAs across the state and with organizations such as Oregon Health Network and the Health Information Management Systems Society (HIMSS) to inform and educate all eligible professionals about the Medicare and Medicaid EHR Incentive payment programs and the value of HIE within Oregon's Health System Transformation.

Although Oregon is among the leading states in EHR adoption, large gaps in adoption remain, particularly among providers in rural areas, those in small practices, those working in settings such as behavioral health and long-term care, and public health, particularly home visiting case management. Providers in Oregon use a diverse array of EHR products, and the HIT infrastructure must be able to support care coordination among providers using different EHRs or not yet using any EHR at all. Several strategies are underway to increase the adoption

and meaningful use of EHRs, increase the electronic exchange of both clinical and administrative information and to lower barriers providers face in moving their practices into the digital age.

OHA and its Office of Health IT and HITOC are working with stakeholders to address the challenges of limited connectivity between disparate electronic health record systems across Oregon and its border states' delivery systems. OHA has launched CareAccord™ as Oregon's statewide Health Information Exchange, offering Direct Secure Messaging as the first HIE service. A few regional efforts to stand up community-based HIE services also are under discussion, although most of those efforts have not emerged as quickly as anticipated in Oregon's 2010 Strategic Plan for HIE as part of a Cooperative Agreement with Office of the National Coordinator for Health IT. To fully realize the potential of HIE to support care coordination, additional HIE services are needed across the state, and connectivity challenges in rural areas need to be addressed.

Rigorous planning is currently underway for the second phase of HIE services, which will include electronic notifications sent to a primary care provider's EHR or to a direct email address for a provider without an EHR during a care transition or emergency room visit. Other services being contemplated are a record locator service and an electronic registry for shared care plans, with additional tools for data collection of clinical quality metrics, aggregation and analytics planned within the Medicaid HIE IAPD request, currently under development.

In the Oregon Strategic Plan for Health IT, adopted in September 2012 by HITOC, strategies and action steps are outlined for increasing adoption of certified EHRs and the achievement of Meaningful Use of EHRs, including a proposal to supplement federal incentives for EHRs for high-priority care settings such as long-term care and behavioral health providers. The Plan details other actions to educate and engage providers and health care consumers on the use of

HIT to better manage and coordinate care, including a public recognition campaign for providers achieving Meaningful Use and actively participating in electronic HIE. Additional strategies contained in the Plan address interoperability, enterprise architecture, a statewide data strategy, technical assistance needs and public health needs, as well as telehealth and mobile health devices as transformative elements of a new health care environment where HIT and HIE are part of the foundational infrastructure.

To address the gaps for behavioral health providers, OHA's Addictions and Mental Health Division (AMH) is in the process of implementing a certified EHR, the Oregon Web Infrastructure for Treatment Services (OWITS), which is currently available to publicly funded behavioral health providers at no cost. Although some providers have already begun using OWITS and more have expressed interest in doing so, a more robust provider engagement and education strategy is envisioned to support the providers with implementation and training of that system. In other provider categories, particularly long term care and home health workers, there are significant gaps in incentives, in technical assistance and technical readiness for a digital health delivery system. Moving those provider sectors into a connected network of health information will require a myriad of strategies, including the provision of web-based tools that are affordable and easy to use. Oregon will be leveraging Direct Secure Messaging as an onboarding strategy for better care coordination in these provider sectors, with the vision of supplementing incentives for EHR adoption and technical assistance as referenced earlier.

As a requirement of their contracts with OHA, the approved CCOs in Medicaid must lay out a plan to improve the use of HIT and increase the adoption and meaningful use of EHRs, and to measure their progress in doing so. Contracts stipulate that CCOs will ensure that every provider in its network is either:

- Registered with statewide or local Direct-enabled Health Information Services;
- Provider (registration will ensure the proper identification of participants and secure routing of health care messages and appropriate access to the information); or
- A member of an existing Health Information Organization (HIO) with the ability for providers any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

CCOs are also required to submit transformation plans to OHA by January 15, 2013, where they will outline, among other things, how they will leverage HIT tools to transform from a volume-based to a value-based delivery system. Current capacity and improvement plans in the areas of health analytics, quality reporting, patient engagement through HIT and plans for use of telehealth and/or mobile devices are required to be part of those transformation plans.

### **Role of publicly-supported university hospitals and faculty practices**

The state's only academic health and research university, Oregon Health & Science University (OHSU) brings together patient care, research, education of the next generation of health care providers and scientists and community service to improve the health and well-being of all Oregonians. As an academic health center, OHSU has always played a significant role in caring for the underserved. In 2011 alone, OHSU provided \$29.8 million in charity care and \$25 million in Medicaid care. In total, OHSU provided \$106 million for health services to the underinsured and uninsured. These efforts combined with dozens of other OHSU programs provided \$307 million in community service last year. Along with a rich diversity of activities happening across our campuses in and around Portland, OHSU also serves as a critical resource outside of Portland to rural and frontier patients, providers and health care delivery systems.

OHSU supports this pivotal moment in the evolution of our health care system. Moving towards providing integrated, outcomes-based care that CCOs will pioneer requires a paradigm shift that emphasizes to coordination and collaboration. This shift is not only about the patient-centered primary care home, it encompasses the multiple parties working together to prevent readmissions, the integration of mental health with physical health and about using evidence-based medicine to allocate how we spend our dollars and decide which treatments are effective and which ones aren't. Coordinated care means doing things differently. The president of OHSU has been actively engaged in the development of Oregon's vision, serving as a member of the Oregon Health Policy Board, and believes that transformation of the health care delivery system is absolutely critical if we hope to ever achieve the Triple Aim.

Oregon's SIM proposal tests the Coordinated Care Model currently being implemented in the state, focusing on the presumed value gained through the flexibility created for local communities to institute payment and delivery system reform to meet the health care needs of their populations more effectively and at less cost. Identification and dissemination of best practices in delivery system and payment reforms in Medicaid and a significant portion of the Medicare and commercial populations will create a "tipping point" for transformation of Oregon's delivery system. This transformation would ensure real and sustainable improvements in health status, enhanced patient experience and lower costs. OHSU is already integral to the new model in Oregon. They are a partner in the new CCO, Health Share of Oregon, the landmark collaboration between multiple health systems and plans in Portland's large tri-county metropolitan area, with the president of OHSU as a founding board member for Health Share.

OHSU will also act as a key partner in accelerating and spreading the Coordinated Care Model, bringing their expertise to the state and the forthcoming Transformation Center to test

delivery system and payment innovations for as well as to disseminate effective strategies via learning collaboratives, technical assistance, and innovator agents. They have been acting as an expert resource to the state for many years through the Center for Evidence-based Policy, Evidence-based Practice Center, and the Center for Health System Effectiveness. Other OHSU staff and clinical units, such as the Pediatric and Family Medicine Departments, have had ongoing consultative relationships and partnerships with the OHA that will be enhanced through this proposal. Many of the faculty clinical practices in internal medicine, family medicine and pediatrics have been credentialed to serve as Patient-centered Primary Care Homes.

In addition to sharing expertise in evidence review, health services research and best clinical practices, OHSU is supporting transformation by educating future physicians, nurses, and other health care practitioners about new models of care and preparing them to work collaboratively and efficiently to improve health. Together with the state, OHSU is aimed to innovate rapidly, disseminate successful practices across the state to achieve the Triple Aim, and to effectively communicate the results of this model to inform Oregon and national policymakers.

## **IV. Support and Assistance from a New Oregon Transformation Center**

**Includes: #18 Related to how data and evidence will be collected and used to support state goals and strategies.**

### **The Oregon Transformation Center**

In 2008 the Oregon Health Fund Board recognized the need for an infrastructure to stimulate system innovation and improvement. The Oregon Health Policy Board directed OHA in creating “Oregon’s Action Plan for Health” to provide necessary supports for success of the model of coordinated care. Oregon proposes, following published expert advice,<sup>14</sup> to include the formation of a Transformation Center to support the rapid learning and improvement necessary to implement the Coordinated Care Model and to make any required mid-course corrections quickly. In Oregon’s current vision, the Oregon Transformation Center is the state’s hub, or integrator, for innovation and improvement and its strategy for implementing the Coordinated Care Model successfully and rapidly throughout the state.

The Transformation Center will work with payers, providers, community stakeholders and consumers to promote the successful implementation and spread of the key elements of reform and integration. The activities of the Center will be aimed at creating the optimal conditions for the rapid spread of the key elements of the Coordinated Care Model. Research on the diffusion of innovation suggests that there are eight critical components in the successful spread of innovation. These characteristics are based on Everett Roger’s Diffusion of Innovation theory research and have been used successfully in IHI’s breakthrough collaborative work. Using this theory, the Transformation Center will conduct activities aimed at identifying or achieving:

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<sup>14</sup> Fisher E, Shortell S, *Accountable Care Organizations: Accountable for What, to Whom, and How*, JAMA. 2010;304(15):1715-1716

1. Change leaders: respected individuals who can serve as key messengers for the innovations;
2. Active learning networks: peer-to-peer networks, collaboratives and other communication channels that enable stakeholders (CCOs and other payers, their providers, communities and consumers) to engage in learning and sharing information about the innovations;
3. Relative advantage: stakeholders believe that the innovations are an improvement over current practice and their benefits outweigh the risks.
4. Compatibility: stakeholders understand how the innovations fit in with their current system and community needs.
5. Simplicity: innovations are as easy as possible to implement.
6. Trialability: stakeholders are able to try out an innovation with minimal investment before moving to full implementation.
7. Observability: stakeholders see demonstrated evidence that an innovation works
8. Reinvention: stakeholders can appropriately adapt innovations to serve local community needs.

By achieving the above characteristics and mechanisms, the Transformation Center will create the optimal environment for the rapid and successful spread of the Coordinated Care Model to additional population and payers, including the commercial market (such as those covering public employees and those participating in the Oregon Health Insurance Exchange) and Medicare (either through the proposed Medicare/Medicaid Alignment demonstration, or through other alignment or participation of Medicare Advantage plans).

The specific tools and support mechanisms to be provided by the Transformation Center include access to data and analytic tools to improve care coordination and management, technical support for a variety of alternative payment strategies, and focused learning and collaboration opportunities on a variety of topics including advancing health equity. The tools and supports are described in detail in the application narrative. The SIM investment will provide key start-up funding for the Transformation Center and the specific tools it will offer to support implementation and testing of payment and delivery system reforms within Oregon's Coordinated Care Model. Over time, the Transformation Center may transition to a public-private collaborative supported in part by fees from participating health sector entities.

Timely data and targeted analytic tools are among the most important supports that the Transformation Center will provide. In order to make sustainable progress towards integrating and coordinating care, CCOs and other health system partners will need better tools and stronger incentives to improve performance. In cooperation with OHA's Office of Health Analytics, the Transformation Center will provide:

- Timely, reliable information and analysis to improve the targeting and delivery of services;
- Data to drive accountability mechanisms, such as alternative payment methodologies aligned with performance measures and health outcomes; and
- Clear communication of analyses on performance, progress, and opportunities for improvement to help develop consensus around priorities and improve decision making.

The Center will have the capacity for sophisticated analysis, the ability to produce timely, accurate and reliable information and improved mechanisms for data transfer. Oregon plans to leverage technology investments currently underway related to program modernization and the

Health Insurance Exchange, and will use SIM investment to expand and accelerate technology and state capacity to collect, validate, integrate, and share information to support evaluation and testing of the Coordinated Care Model, as well as enable rapid cycle feedback to correct practices mid-stream. It will work closely with the commercial health plans in the Public Employees' Benefit Board (PEBB) to understand the spread of PCPCH across state employees, and how other key elements of the Oregon model is currently impacting or could be included to achieve the Triple Aim in the commercial market. Testing the model will be critical for other purchasers to join PEBB in furthering the model's elements. Additionally, the state will be working closely with CMS on data and analytics impacting Medicare beneficiaries, to better understand the learnings of the model for their populations.

## V. Roadmap for Transformation

**Includes: #16 Provide a timeline for transformation;  
#17 Review milestones and opportunities; and  
#19 Describe any waiver or state plan amendment requirements and their timing to enable key strategies for transformation, including changes or additions required to position the Medicaid and CHIP programs to take advantage of broad health care delivery system transformation.**

Oregon's timeline for health systems transformation is exhibited in Appendix B. The timeline demonstrates how the vision for Oregon's Coordinated Care Model developed over time with substantial stakeholder input to reach its current stage. Moving into the future with SIM investment, the Oregon Transformation Center will accelerate the pace of transformation as noted by the milestones shown for different areas of reform. For more information about specific SIM project milestones, please see Section VII of the application, Project Plan and Timeline. For more information about the SIM Initiative key leadership in Oregon, please see Appendix G.

2014 is an important date for health systems transformation in all states. The increased participation in health care made possible by the individual mandate, availability of subsidies and coverage through the Oregon Health Insurance Exchange, and the potential Medicaid expansion creates a tremendous opportunity—and a key deadline—for Oregon to advance its transformation agenda. We estimate that more than 200,000 Oregonians will gain coverage in 2014 and each of those individuals stands to benefit from the system improvements that have been accomplished by that time, and to participate in the new care model. Conversely, the success of coverage expansion will be greatly limited if the health care delivery and payment systems are not ready to meet the demand for care in a way that advances the Triple Aim.

In addition to the ACA-related changes, Oregon will meet some of its own transformation milestones in 2014:

- 2014 is the last year that the Medicaid program may issue new contracts to stand-alone physical managed care organizations; thereafter, all new contracts will be with CCOs;
- 2014 is also the year in which Oregon must decrease Medicaid per capita expenditure trend by 2 percentage points;
- In the 2014 benefit year, PEBB beneficiaries will start to benefit from key elements of the Coordinated Care Model, particularly PCPCHs;
- By January 2014, all CCOs will be required to be able to provide Medicare services to dually eligible enrollees, either through an owned, affiliated, or contracted Medicare plan, or through participation in the Medicare-Medicaid financial alignment demonstration (if Oregon's demonstration goes forward); and
- The Oregon Transformation Center will be operating at full capacity, testing and disseminating the payment and delivery system reforms that have been described earlier in this document.

The SIM initiative will provide critical support to help Oregon meet these transformation milestones, particularly those related to accelerating delivery system and payment reforms and spreading the Coordinated Care Model out from Medicaid to other payers. Beyond investment, Oregon is well-positioned to be able to move rapidly toward better health, better care, and reduced costs. With the recently renewed 1115 waiver and three state plan amendments recently approved or pending, Oregon does not anticipate the need for additional federal waivers or Medicaid state plan amendments to continue with health systems transformation. Please see Appendix F for descriptions of other federal initiatives currently operating in Oregon.

## VI. Performance and Trends

- Includes: #7 Health care delivery system performance “current as is” and future “to be” performance measures;**
- #8 Describe the current health care cost performance trends and factors affecting cost trends (including commercial insurance premiums, Medicaid and CHIP information, Medicare information, etc.);**
- #9 Current quality performance by key indicators (for each payer type) and factors affecting quality performance; and**
- #12 Delivery system cost, quality, and population health performance targets that will be the focus of delivery system transformation.**

Oregon’s goal for health system transformation is to achieve the Triple Aim, or to:

- Improve the lifelong health of all Oregonians,
- Increase the quality, reliability and availability of care for all Oregonians, and
- Lower or contain the cost of care so it is affordable for everyone.

In this section, we provide data about Oregon’s current performance on each of these domains, discuss the factors driving performance, outline the state’s goals for improvement, and explain how the SIM initiative will help Oregon meet those goals. A wealth of additional data about population health and health systems performance in Oregon is available from some of the links provided in Appendix A.

### Improve the lifelong health of all Oregonians

#### *Current performance and key performance issues*

Statewide trends: According to the United Health Foundation, Oregon was the 14<sup>th</sup> healthiest state in the nation in 2011. Contributing to this top-third ranking were the state’s low prevalence of smoking overall, low rate of preventable hospitalizations, and low levels of air pollution.

Factors preventing a better score included a higher-than-average rate of uninsurance (although a new Census Bureau publication cites Oregon as the only state to have significantly reduced its

uninsurance rate between 2009 and 2011<sup>15</sup>, likely due to recent expansions in children's coverage in the Oregon Health Plan), lower per capita public health funding, and a high percentage of children in poverty.<sup>16</sup>

Among Oregon adults, almost half have at least one chronic disease.<sup>17</sup> Obesity, tobacco, and alcohol abuse are the key drivers and together are responsible for 50 percent of the chronic disease deaths in Oregon each year.<sup>18</sup> Despite the potential for better chronic disease management, Oregon adults who live with chronic conditions report poorer general health than those without chronic conditions. Among those with a chronic disease, 51% perceive their health to be excellent or very good; 80% of adults who do not have a chronic disease report the same.<sup>17</sup>

Health status of Medicaid populations: Tobacco use is disproportionately high among the Medicaid population and is a driver of high costs and poor health. 38% of Medicaid recipients in Oregon self-report as current smokers, compared to only 19% of the general Oregon population. Rates of chronic disease among the Medicaid population are higher than in the general population; statistically, the prevalence of arthritis, asthma, heart attack, heart disease, stroke, diabetes, high blood pressure, and high blood cholesterol are significantly higher among the Medicaid population in Oregon. Medicaid recipients in Oregon are also less likely than the general population in Oregon to eat the recommended daily servings of fruit/vegetables per day (22% vs. 26%, respectively) or meet the current CDC recommendations for daily physical activity (42% vs. 57%), and are more likely to be obese (34% vs. 24%). Additionally, female

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<sup>15</sup> U.S. Census Bureau. Income, Poverty, and Healthy Insurance Coverage in the United States: 2011 report. Released September 12, 2012, see: <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2011/index.html>

<sup>16</sup> United Health Foundation, see: <http://www.americashealthrankings.org/OR>

<sup>17</sup> 2009 Oregon Behavioral Risk Factor Surveillance System.

<sup>18</sup> Oregon Department of Human Services analysis of 2003 Death Certificate data.

Medicaid recipients are less likely to receive the recommended cancer screening (PAP test and mammogram) at the recommended interval.<sup>19</sup>

Health status of Public Employees' Benefit Board (PEBB) enrollees: Surveys conducted of PEBB enrollees in 2009 and 2010<sup>20</sup> found that a quarter of the population reported having excellent health status, compared to 19% in Oregon's general population. Depression is a significant concern in PEBB and is more than twice as common in women as men (19.0% vs. 8.4%). Survey results also reveal that PEBB members are slightly more likely to be obese than Oregon adults in general (28% vs. 24%) and that two in five PEBB respondents did not meet recommended levels of physical activity. A large percentage of the PEBB members reported having ever been diagnosed with high cholesterol and high blood pressure, 31.4% and 23.7%, respectively.<sup>20</sup>

However, the survey also found positive outcomes among the PEBB population. Only one in 11 PEBB members smoke and almost two-thirds of those who do smoke reported that they stopped smoking for at least one day in the past year in an attempt to quit. Other protective factors include a relatively high colorectal cancer screening rate of 60.3% and over 90% of PEBB members reporting that they are trying to lose or maintain weight.

Health status of individuals eligible for Medicare and Medicaid: Individuals that are dually eligible for Medicare and Medicaid often suffer from chronic physical and behavioral health conditions and multiple co-morbidities that create substantial needs for medical and long-term services among this population. Two-thirds of dually-eligible individuals in Oregon have at least one chronic condition. The prevalence of diabetes is 264 per 1,000; congestive heart failure is

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<sup>19</sup> Oregon DHS "Keeping Oregonians Healthy" July 2007 Report.

<sup>20</sup> 2009-2010 Behavioral Risk Factor Surveillance System (BRFSS) Survey of State and School Employees REPORT. Oregon Health Authority. February 2011 and Oregon Public Health Department analysis of 2010 BRFSS, unpublished (September 2012).

105 per 1,000; dementia is 101 per 1,000; and schizophrenia is 85 per 1,000.<sup>21</sup> Co-morbidity among dually-eligible individuals is common and more likely for older dually-eligible individuals, which make service use high and care coordination across Medicare and Medicaid particularly challenging. Nationally, Medicare and Medicaid per capita spending is substantially higher for dually-eligible individuals with multiple chronic conditions, particularly when mental/cognitive conditions are present.<sup>22</sup> Expanding the Coordinated Care Model to the dually-eligible population should improve care coordination and improve individuals' experience, as well as reduce costs.

#### *Future targets*

Because chronic disease is the overwhelming driver of premature mortality, reduced quality of life, and health care spending, Oregon's primary focus for health improvement is to reduce chronic diseases and the risk factors that contribute to them. The key measures that Oregon will track include rates of tobacco use, obesity, and physical inactivity, as well as the prevalence of chronic diseases and self-reported health and functional status.

Several of these indicators are among the core measures that will be reported quarterly for CCOs, with breakouts for individuals eligible for both Medicare and Medicaid (see Appendix E). After the first year of operation, CCOs will be accountable for meeting standards on each of the core measures; those performance benchmarks will be established by the state's Metrics & Scoring Committee, which oversees performance measurement for CCOs. PEBB also tracks a variety of health status measures for its population using a PEBB-specific fielding of the Behavioral Risk Factor Surveillance Survey. Similar robust measurement and performance

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<sup>21</sup> Fact Sheet on Medicare and Medicaid Services for Individuals who are Dually Eligible, Oregon Medicare-Medicaid Integration Workgroup.

<sup>22</sup> By Judy Kasper, Molly O'Malley Watts and Barbara Lyons. Kaiser Family Foundation. Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. July 2010.

requirements, in alignment with those expected of the Medicaid CCOs, will be expected of PEBB plans and providers in the future.

SIM investment would accelerate Oregon’s progress toward the goal of improving the lifelong health of all Oregonians in three primary ways: 1) by advancing the spread of the Coordinated Care Model, with its emphasis on prevention and proactive population health management; by providing targeted support for a handful of local “flood the zone” collaborations aimed creating lasting changes in practice and/or policy around leading causes of death and disease; and 3) by enabling increased population health performance measurement through updates to the Public Health Analysis Tool and expanded samples for the Behavioral Risk Factor Surveillance Survey to allow CCO- and race and ethnicity-specific estimates.

## **Increase the quality, reliability and availability of care for all Oregonians**

### *Current system performance and key issues*

Fragmentation and lack of coordination are some of the most significant barriers to improving health system performance. The rationale for Oregon’s coordinated care model, as articulated earlier, is that poorer health and higher costs are in large part due to lack of integration between the physical, mental, substance abuse, oral health, and long-term care services that people need. Person-centered care and care planning are difficult when coverage and delivery system entities operate in silos.

Measurement of care coordination and integration is still in its infancy (see Future System Performance Targets). However, the data on patient experience, potentially avoidable care, and health system quality measures included below describe the outputs of the health system as it currently operates.

Medicaid trends: Key indicators of system performance for Oregon’s Medicaid program are shown in the two tables below.

**Table 1: Key Indicators of System Performance in Medicaid**

Measure	Oregon Medicaid	National Average Medicaid
Getting needed care*	45%	51%
Getting care quickly*	51%	56%
How well doctor communicates*	66%	70%
Health plan information and customer service*	53%	53%
Adult access to primary care** (determined by one or more ambulatory visits)	Age 20-44: 84.2% Age 45-64: 90.1%	Age 20-44: 77.1% Age 45-64: 82.8%

\*Adult member-ratings from 2011 CAHPS survey; Both Oregon and national statistics are for MCO members only.

\*\* NCQA HEDIS 2011 data; Oregon statistics include overall OHP members (not just MCO); national statistics are for MCO members only.

In Oregon, scores for patient experience of care measures for individuals enrolled in MCOs are slightly lower than the national Medicaid average for adult members reporting getting needed care and positive communication with doctor, but slightly higher for getting care quickly. Access to primary care, determined by one or more ambulatory visits per year, was above the national Medicaid average at over 80% for all age groups.

**Table 2: Potentially Avoidable ED Visits and Admissions Across Payers in Oregon**

Measure	Oregon Medicaid Population	Oregon Commercial Insurance Population	Oregon General Population
Potentially avoidable ED visits, adult (age 18+) (PA ED visits/total visits)	12.7%	10.0%	11.0%
Potentially avoidable ED visits, child (age 1-17) (PA ED visits/total visits)	19.4%	9.5%	16.8%
Potentially avoidable hospital admissions, adult (18+) (per 100,000 patients)	3,795	407	1,769

Source: OR Quality Corp, 2012 Report “Keeping Oregonians Healthy”

Potentially avoidable ED visits for both adults and children are notably higher in the Medicaid population than among the commercially insured or general population in Oregon; in particular, the rate for children in Medicaid is approximately twice as high as the rate for commercially insured children. The Medicaid rate of potentially avoidable hospitalizations for adults is nine times the rate for commercially insured groups, and twice as high as the rate for the general population.

Public Employees' Benefit Board (PEBB) Trends: Selected HEDIS indicators demonstrate plan performance across multiple PEBB plans for 2011, as shown in the tables below.

**Table 3: PEBB Plans' 2011 Performance on Selected HEDIS Indicators**

Category	Measure	PEBB Statewide 2011	Providence Choice 2011	Providence Commercial Book 2011	Kaiser PEBB 2011	Kaiser Commercial Book 2011
Cancer Screening	Breast cancer screening	71%	69%	72%	84%	81%
	Cervical cancer screening	73%	78%	77%	89%	87%
	Colorectal cancer screening	N/A - did not meet measure criteria	66%	65%	73%	70%
	Chlamydia screening	31%	35%	32%	75%	74%
Diabetes	% of members with diabetes who had A1c tested	95%	95%	94%	95%	94%
	% of members with diabetes who had A1c poorly controlled	16%	15%	17%	22%	22%
Cardiovascular conditions	% of members with cardiovascular conditions who had LDL-C tested	N/A - did not meet measure criteria	96% (denominator is <30)	89%	91%	94%
	% of members with cardiovascular conditions who had LDL-C controlled	N/A - did not meet measure criteria	96% (denominator is less than 30)	67%	67%	71%

Category	Measure	PEBB Statewide 2011	Providence Choice 2011	Providence Commercial Book 2011	Kaiser PEBB 2011	Kaiser Commercial Book 2011
Depression	Antidepressant medication management - effective continuation phase treatment	52%	63%	50%	66%	56%
Asthma	Use of appropriate medications for people with asthma	100% (denominator is <30)	92%	89%	93%	95%
Imaging	Use of imaging studies to treat low-back pain	83%	91%	82%	88%	85%

On a number of measures, PEBB plans are meeting or exceeding the 90th percentile in terms of performance, including the percentage of members with diabetes who have had A1c levels tested, the percentage of members with diabetes who have had LDL-C tested, and the appropriate use of medications for people with asthma. Using overall commercial plan data as a proxy for PEBB, rates of potentially avoidable ED visits and hospitalizations are low (see below).

	Commercial	Medicaid	Medicare
Potentially avoidable ED visits (PA ED visits/total visits)	10.0%	12.7%	8.4%
Potentially avoidable hospital admissions rate (per 100,000 patients)	407	3,795	6,442

Source: Oregon Healthcare Quality Corporation, 2012 statewide report

Trends for individuals eligible for Medicare and Medicaid: Because Oregon’s dually-eligible individuals are covered through a variety of fee-for-service and managed care mechanisms (see Section VII), it is challenging to report on system performance exclusively for this population. Some of the Medicaid performance data described earlier reflects the experience of individuals eligible for both programs. More than a third of dually eligible individuals receive long-term

services and supports (LTSS) and Oregon’s system is a national leader in delivery of LTSS. In recent rankings,<sup>23</sup> Oregon was rated third in the nation for delivery of LTSS services – in part due to Oregon’s successes in providing LTSS services to individuals in less restrictive, lower-cost home and community based settings as opposed to nursing facilities (roughly 80% and 20%, respectively).

#### *Future system performance targets*

Transparency and accountability are key features of Oregon’s Coordinated Care Model. Robust performance measurement and public reporting will help ensure that health systems transformation leads to better care for all Oregonians. Feedback loops and mechanisms for holding plans and providers accountable for quality and outcomes will help to ensure that the system is changing in alignment with Oregon’s vision for health systems transformation.

As part of the state’s recent waiver renewal, Oregon has committed to improving access to and quality of care for Medicaid beneficiaries over the 5 years of the renewal, compared to a baseline level of performance. A core set of 16 quality metrics has been set for the first two years (see Appendix E) and includes:

- Member/patient experience of care (CAHPS tool or similar);
- Health and functional status among CCO enrollees;
- Rate of tobacco use and obesity among CCO enrollees;
- Potentially avoidable emergency department visits;
- Ambulatory care-sensitive hospital admissions
- Medication reconciliation post discharge; and

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<sup>23</sup> Houser, Ari, Kassner, Enid, Mollica, Robert, Reinhard, Susan “Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.” September 2011.

- All-cause readmissions.

While measuring care coordination or integration directly is challenging, several of those measures were selected because of their ability to reflect coordination (e.g. readmissions, medication reconciliation, and patient experience of care). Oregon has also committed to reporting the key measures separately for two groups that experience greater than normal challenges with care coordination: individuals with severe and persistent mental illness and individuals eligible for both Medicare and Medicaid.

These same metrics are important in other populations in Oregon, and are reflective of quality of care and impact cost trends. As the Coordinated Care Model is spread to the state employees, it is anticipated the PEBB's 2014 contracts will align performance reporting with the requirements set for the Medicaid CCOs.

Specific performance targets for the core measures have not yet been set but will be established by the state's Metrics & Scoring Committee, which oversees performance measurement for CCOs. The Metrics & Scoring Committee is also responsible for designing a robust CCO performance incentive system to drive the outcomes-based payments that will make up an increasing proportion of CCO revenue. The incentive design proposal will be submitted to CMS in November 2012 and may include financial incentives tied to some of the performance measures above.

As described in more detail earlier and in the project narrative, SIM investment will fuel and support many delivery system and payment innovations that Oregon believes will result in improved system performance across all payers. Better care management, increased provider and community accountability, administrative efficiencies, increased use of evidence-based clinical guidelines, patient engagement tools, and health IT, and development of a community-based

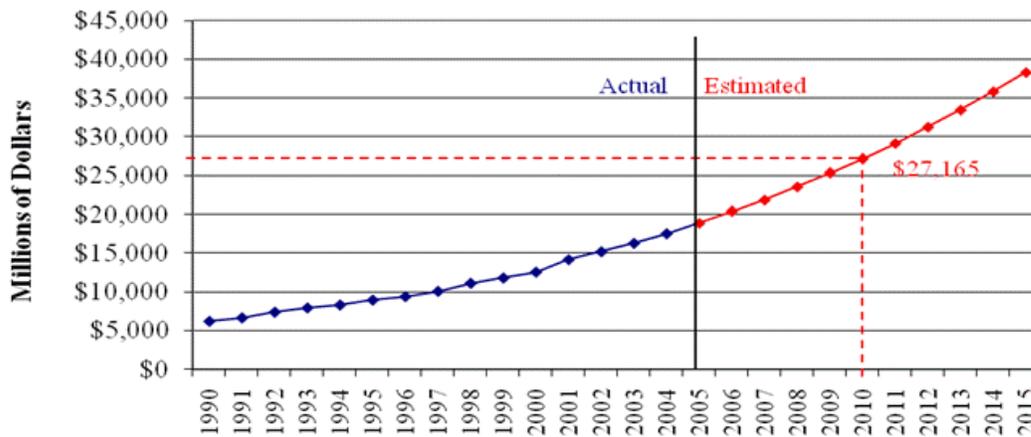
health care workforce will all help to improve the quality, reliability, and accessibility of care. In addition, SIM funding will provide direct support for robust measurement, sophisticated analysis, and timely, tailored reporting on system performance to drive improvement.

## Lower or contain the cost of care so it is affordable for everyone

### *Current performance and key drivers*

General trends in Oregon: In the past two decades, Oregon’s health care expenditures have been increasing exponentially (see Figure 5). It is one of the sectors of Oregon’s economy with the highest growth rate, averaging 7.6 percent annually. In 1990, the total health care expenditures in Oregon were \$6.2 billion, and in 2010, they are estimated to be at \$27 billion; more than quadruple in 20 years. If no changes are made to the current spending patterns, health care expenditures in Oregon would reach \$38 billion by 2015.

**Figure 5: Health Care Expenditures in Oregon, 1990-2015 Estimated**



Source: 1990-2004 National Health Expenditure (NHE) Data, Center for Medicare & Medicaid Services (CMS).

Medicare and Medicaid represented 32% of Oregon health care expenditures in 2010, or \$8.8 billion in 2010 (Table 4). Nationally, the share of Medicare and Medicaid health care

expenditures is estimated to be about 36 percent. Oregon’s annual per capita health care expenditures are estimated at about \$7,041, slightly lower than the national figure of \$8,280.<sup>9</sup>

**Table 4: Oregon Health Care Expenditures by Payer Type, 2010 Estimates**

<b>Payer Type</b>	<b>Total expenditures</b>	<b>Percent of total</b>	<b>Oregon population</b>	<b>Per capita expenditures</b>
<b>Medicare</b>	5.5 billion	20%	587,800	\$9,312
<b>Medicaid</b>	3.3 billion	12%	539,700	\$6,049
<b>Private &amp; Other</b>	18.8 billion	68%	2,730,500	\$6,749
<b>Total</b>	<b>27.2 billion</b>	<b>100%</b>	<b>3,858,000</b>	<b>\$7,041</b>

Sources: Population counts: Portland State University; 2010 expenditures by payer type from 1990-2004 National Health Expenditure (NHE) Data, Center for Medicare & Medicaid Services (CMS)

Trends for SIM target populations: Health care accounts for an estimated 16 percent of Oregon’s state General Fund budget.<sup>24</sup> Medicaid and the Public Employee Benefit Board (PEBB) represented most of these expenditures. In PEBB, total expenditures grew at a rate of 7 percent, between 1999 and 2011, from \$231 million to \$429 million, respectively. In the last decade, Oregon’s total Medicaid spending has doubled from \$3.2 billion in 2001-03 to \$7.0 billion in 2011-2013.

Projected growth in Medicaid costs are in the 7% range, a rate that outstrips the projected annual rate of growth for state general fund collection of 5.5% on average over the next five years. Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as \$12 billion in the FY 2017-2019 biennium with more than 900,000 individuals enrolled in the program. This figure includes approximately over 200,000 newly eligible under federal health reform expansion provisions that take effect in 2014. For clients considered fully dually eligible for Medicare and Medicaid, the total Medicaid medical expenditures for 2010 were \$168,280,719. This represents an average PMPM

<sup>24</sup> Oregon Health Policy Board’s “Action Plan for Health,” December 2010.

expenditure of \$235. Expenditures for long-term care and post-acute nursing facility care for dually-eligible individuals in 2010 totaled \$620,682,827.

#### *Future targets*

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, without harming access or quality.

For state employees (PEBB) and dually eligible populations the ultimate goal is the same: a reduction in per capita trend while at least maintaining, if not improving, access and quality. Since the first step of expanding Oregon's Coordinated Care Model to PEBB and dually eligible individuals is focused on increased access to patient-centered primary care homes, Oregon expects to see cost containment via reductions in ambulatory-care sensitive hospital admissions and potentially avoidable ED visits for these populations. Overall, Oregon's goal is to reduce cost trend by 2 percentage points for these populations as well through increased use of primary care homes and the use of other key elements of the Coordinated Care Model.

SIM funding will accelerate and amplify Oregon's efforts to contain health care costs. Testing a variety of alternative payment mechanisms within Medicaid CCOs and other health plans such as those serving state employees will provide evidence about the most effective ways to reduce costs while maintaining standards of quality. On the delivery system side, SIM-supported collaborations on community-level prevention and expansion of patient-centered primary care will reduce the use of more intensive and costly services. Finally, support for the Oregon Transformation Center will provide a mechanism for implementing the Coordinated Care Model successfully and rapidly throughout the state and across all payers.

## VII. Population Demographics

- Includes: #2 Population demographics (including Medicaid and CHIP populations);**  
**#3 Describe population health status and issues or barriers that need to be addressed;**  
**#10 Describe population health status measures, social/economic determinants impacting health status, high risk communities, and current health status outcomes and the other factors impacting population health; and**  
**#11 Describe specific special needs populations (for each payer type) and factors impacting care, health, and cost.**

### General population demographics and trends

Oregon's population is increasing and changing; as described below, the state is growing older and becoming more diverse. These trends are part of the powerful rationale for health systems transformation in the state. If Oregon cannot reform the system to achieve the vision articulated in this Innovation Plan, the state's providers, health plans, and budget will be overwhelmed by the demand for care in the future.

Oregon's population in 2011 was approaching 3.9 million<sup>25</sup>—a 2.5-fold increase since 1950—and is expected to reach 4.3 million by the year 2020. However, Oregon's population growth rate in the last decade has seen a decline compared to previous decades, due in large measure to the impact of the recent recession. Currently, Oregon's growth rate is below the national growth rate, but is expected to outpace the U.S. growth in the long run.<sup>26</sup>

Over the last twenty years, Oregon's racial and ethnic minority population has grown, adding to the state's diversity. This trend is expected to continue. In 2010, 21.5 percent of Oregonians belonged to a minority race or ethnic group, compared to 36.3 percent in the United States.<sup>27</sup> The growth of Hispanic or Latino Oregonians over the past twenty years is dramatic, and this trend is

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<sup>25</sup> <http://quickfacts.census.gov/qfd/states/41000.html>

<sup>26</sup> Oregon's Demographic Trends. Office of Economic Analysis, Department of Administrative Services, State of Oregon. November 2011.

<sup>27</sup> U.S. Bureau of Census; and Oregon Office of Economic Analysis.

expected to continue, from 4.0 percent in 1990, to 12 percent in 2011, constituting over 464,000 Oregonians. The need to eliminate racial and ethnic health disparities is imperative given the rapid increase in diversity in Oregon over the last twenty years. The distribution of Oregon’s population by race and ethnicity is shown in the table below.

<b>Race/Ethnicity</b>	<b>% of Oregon Population, 2011</b>
Native Hawaiian and Pacific Islander	0.4%
American Indian and Alaska Native	1.8%
Black	2.0%
Two or more races	3.4%
Asian	3.9%
Hispanic/Latino	12.0%
White, non-Hispanic	78.1%

Source: U.S. Bureau of Census Quick Facts

### **Demographics of target populations**

Medicaid and CHIP (Oregon Health Plan): Current Medicaid and CHIP enrollment is approximately 640,000. A modest annual enrollment growth of 3% is projected through state fiscal year 2014, followed by a rapid increase between 2014 and 2015 when the Affordable Care Act Medicaid expansion will go into effect (see Figure 6 below). While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population’s 2 percent. This trend is critical, as the disabled and dually eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.

**Figure 6: Projected Enrollment by Sub-group**

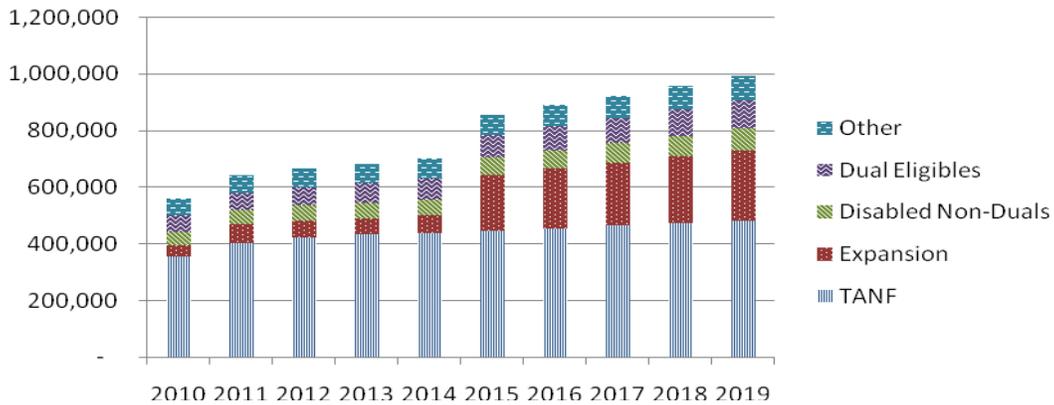


Table 5 shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup and the age profile of the population has remained generally stable and unchanged over the last three years. However, there has been a slight shift from the 0–18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. While the gender distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

**Table 5: Oregon Medicaid Demographics (2011)**

Demographic	%
<b>Race/Ethnicity</b>	
White	61%
African American	4%
Hispanic or Latino	22%
Asian, Native Hawaiian or Other Pacific Islander	3%
American Indian or Alaska Native	2%
Other/Unknown	8%
<b>Age (in years)</b>	
0-18	56%
19-64	37%
65+	7%
<b>Gender</b>	
Male	44%
Female	56%

Table 1: Data were extracted from the demographic reports published by the Oregon Health Plan, July 2011.

By November 2012, about 90% of the OHP population is expected to be enrolled in a Coordinated Care Organization (CCO). The enabling legislation specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

PEBB demographics and trends: As of March of 2012, state of Oregon employees, their spouses and dependents receiving health care coverage through the Public Employees benefit Board (PEBB) comprised nearly 134,000 members. The majority (70%) of the PEBB population is from 20 to 64 years of age and is mostly female (55%); 28% of the population is 0 to 19 years of age, and 3% is over 65 years of age. PEBB saw a slight increase in its enrollment compared to others years after the Affordable Care Act raised the age limit for dependents to remain on their parents insurance up to age 26, but otherwise has not reported any noticeable changes in their population demographics over time. No major changes in enrollment or population demographics are expected during the SIM project period.

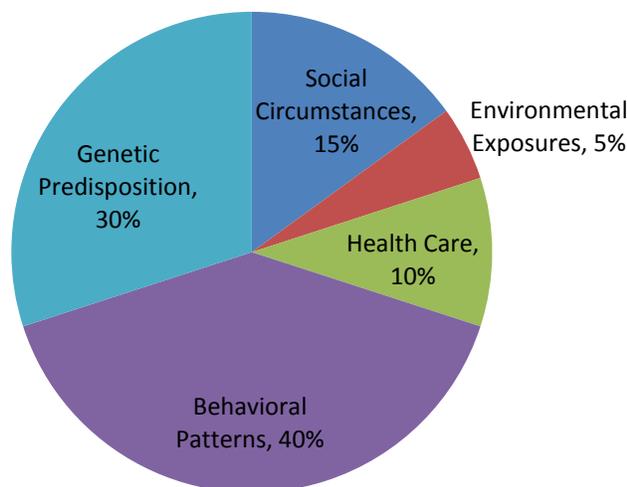
Medicare-Medicaid dually eligible population: There are approximately 60,000 fully dually eligible individuals in Oregon (i.e. those eligible for Medicare and a full Medicaid benefit); by January 2014, this figure is expected to be 68,000. This does not include individuals enrolled in Medicare who receive only a partial Medicaid benefit such as premium or cost-sharing assistance (“partially dually eligible”). In Oregon, 82% of the dually-eligible individuals are white, and 62% are female; 59% are between the ages of 19 and 69 years, and the rest are over 70 years of age. Special needs groups among the dually eligible include those with a serious and persistent mental illness (SPMI) diagnosis - about 20% of dually eligible individuals have a diagnosis of SPMI and 28% of individuals with an SPMI diagnosis receive LTSS. In addition, 12% or 7,000 dually eligible individuals have an intellectual or developmental disability.

Overall, approximately 37% of the dually eligible population in Oregon receives LTSS. Oregon has excelled in providing eligible individuals the ability to choose the most appropriate LTSS setting and provider to meet their needs and 80% do so in a home or community-based setting, compared to only 44% nationwide.

### Health status and health care disparities

Most major diseases are determined by a network of interacting social, economic, and physical forces that may increase or decrease the risk for disease (Figure 7)<sup>28</sup>. Individuals who live in high opportunity neighborhoods have better health outcomes because they have better access to living wage jobs, high quality education, vibrant built environments that promote physical activity and access to healthy food, and social networks. In these communities it is easier for individuals to make healthy choices.<sup>29,30</sup>

**Figure 7: Proportional Contributions to Premature Death**



<sup>28</sup> Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Affairs* 2002;21:78-93.

<sup>29</sup> Thomas R. Frieden, MD, MPH. A Framework for Public Health Action: The Health Impact Pyramid, *American Journal of Public Health*, April 2010, Vol 100, No. 4.

<sup>30</sup> Diez Roux, Phd, MD. Investigating Neighborhood and Area Effects on Health. *American Journal of Public Health*, Vol 91, No. 11, November 2001.

Racial and ethnic minorities experience significant health disparities in Oregon. As illustrated below, the prevalence of chronic conditions and health behaviors that contribute to those conditions is greater among non-white populations.

**Table 6: Prevalence of Select Chronic Conditions among Adult Oregonians by Race and Ethnicity (years vary as noted)<sup>31</sup>**

	Non-Latino				Latino
	African American	American Indian/Alaska Native	Asian /Pacific Islander	White	
Chronic Conditions (2004-2005) <sup>32</sup>					
Asthma	16.5%	15.3%	6.4%	10.1%	4.9%
Diabetes	13.4%	12.2%	7.2%	6.2%	9.6%
Hypertension	41.4%	29.5%	18.9%	25.3%	19.2%
Risk Factors for Chronic Conditions (2004-2005) <sup>33</sup>					
Smoking	30%	38%	10%	20%	14%
Obesity	29%	30%	15%	24%	31%
Years of Potential Life Lost per 100,000 (age-adjusted) (2009) <sup>34</sup>					
Before Age 75	7,708	8,660	3,342	6,047	3,988

Within the Medicaid population, the utilization rate of preventative services for children from birth to 10 years of age is substantially lower among American Indians and Alaska Natives (3.01 per person year) than among whites or Asians (4.21 and 4.93 per person year, respectively). African American and Native American populations have a higher rate of potentially avoidable hospitalizations compared to the benchmark of non-Hispanic Whites (3,172 and 3,463 per 100,000 person years, respectively, compared to 2,789 per 100,000 per person years).<sup>35</sup>

Similarly, Oregonians with low socioeconomic status (lower income, lower education, or both) suffer disproportionately from chronic diseases and have higher rates of chronic disease

<sup>31</sup> Oregon Behavioral Risk Factor Surveillance System, race oversample 2004-2005; Data Note: All estimates age adjusted to the U.S. standard population, 2000.

<sup>32</sup> Oregon Vital Statistics and National Center for Health Statistics, 2009

<sup>33</sup> Ibid.

<sup>34</sup> <https://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/healththequity.pdf>

<sup>35</sup> Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

risk factors. For example, smoking is much more common among low SES groups compared to those that are not disadvantaged (34% vs. 14%). Oregonians who are economically disadvantaged are also more likely to be uninsured. Roughly three-fifths of uninsured adults in Oregon have incomes below 200% of the Federal Poverty Level.<sup>36</sup> The uninsured are less likely to report a usual source of care, less likely to have had a routine check-up in the last year, and more likely to have delayed routine care and dental care due or not filled a prescription due to cost.

Finally, Oregon's varied geography and population distribution—30.5% of the population is in rural or frontier areas, on nearly 99 percent of the land<sup>37</sup>—are also associated with health status disparities. The prevalence of obesity ranges from 20-36% among Oregon's 36 counties (26% overall) and tobacco use among adults ranges from 10 – 27% (18% overall).<sup>38</sup>

Particularly in the Medicaid population, the Coordinated Care Model is key to addressing the high risk and vulnerable populations. Each CCO is expected by contract and accountability metrics to prioritize working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services. Many of these high needs CCO members are dually eligible, and OHA is focusing strategies to maximize the proportion of dually eligible individuals in a CCO for Medicaid and that CCO's affiliated or integrated Medicare plan, allowing CCOs to prioritize their care and integrate their approach. A similar focus would be expected from plans who respond to the 2014 PEBB RFP, as similar needs in our state employee and their families exist.

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<sup>36</sup> OHPR May 2011 Legislative Report. *Trends in Oregon's Health Care*

<sup>37</sup> Crandall, Mindy and Bruce Weber. November 2005. *Defining Rural Oregon: An Exploration*. Rural Studies Working Paper Series, No. 05-03.

<http://ir.library.oregonstate.edu/xmlui/bitstream/handle/1957/21047/em8937.pdf>

<sup>38</sup> RWJF /University of Wisconsin County Health Rankings, 2011. See: <http://www.countyhealthrankings.org/#app/>

## Oregon Health Care Innovation Plan - Key Resources

### Key Documents/Reports/Proposals:

- Oregon Health Policy Board, Coordinated Care Organizations Implementation Proposal to the Legislature, (January 2012):  
<http://www.oregon.gov/oha/OHPB/meetings/2012/2012-0124-cco.pdf>
- Oregon Health Policy Board's "Action Plan for Health" (December 2010):  
<http://cms.oregon.gov/oha/actionplan/rpt-2010.pdf>
- Oregon Health Fund Board, "Aim High: Building a Healthy Oregon" (December 2008):  
[http://cms.oregon.gov/OHA/OHPR/HFB/docs/final\\_report\\_12\\_2008.pdf](http://cms.oregon.gov/OHA/OHPR/HFB/docs/final_report_12_2008.pdf)
- Medicare/Medicaid Alignment Demonstration Proposal (May 2012)
- <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ORProposal.pdf>
- CCO year 1 accountability metrics (March 2012):  
<http://www.oregon.gov/oha/OHPB/healthreform/docs/cco-rfa-attachment-8-table-c1.pdf>

### Enabling Legislation

- Senate Bill 1580, 2012 session: Legislative approval for the creation of Coordinated Care Organizations [www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.intro.pdf](http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.intro.pdf)
- SB99, 2012 legislative session: Legislative approval for the creation of a Health Insurance Exchange as a public corporation  
<http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.en.pdf>
- House Bill 3650, 2011 session: Directed OHPB to create an implementation plan for health system transformation using Coordinated Care Organizations as a vehicle in Medicaid, to create a business plan for the Health Insurance Exchange, and to develop a plan for spreading model to Public Employees' Benefit Board (PEBB).  
<http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.intro.pdf>
- HB 2009 (2009 legislative session): Created Oregon Health Authority, patient-centered primary care home program, Oregon Health Policy Board, directed creation of a plan for an Oregon Health Insurance Exchange, created the Health Information Technology Oversight Council (HITOC), health care workforce initiatives and created an All-Payer, All-Claims database (APAC).  
<http://www.leg.state.or.us/09reg/measpdf/hb2000.dir/hb2009.en.pdf>

### Waiver and State Plan Amendment Requirements

- Oregon's 1115 waiver (July 2012): <http://cms.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf>
- ACA Section 2703 State Plan Amendment: Approved effective Oct. 1, 2011 (not currently available online)
- Oregon's Patient-Centered Primary Care Home standards:  
<http://www.oregon.gov/oha/OHPR/pages/healthreform/pcpch/standards.aspx>
- Non-traditional health care worker State Plan Amendment: Submitted, pending. (Not currently available online.)

### Coordinated Care Organizations:

III. State Health Care Innovation Plan – Oregon CMMI SIM Model Testing Application, Sept. 2012

- Oregon’s Request for Applications (RFA):  
<https://cco.health.oregon.gov/RFA/Pages/Overview.aspx>
- Oregon’s certified CCOs: <http://cms.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>

#### **Websites:**

- Oregon’s Health System Transformation and Oregon Health Policy Board (OHPB)  
<http://www.oregon.gov/oha/Pages/index.aspx>  
<http://www.oregon.gov/oha/OHPB/Pages/index.aspx>
- Health Information Technology Oversight Council (HITOC)  
<http://cms.oregon.gov/OHA/OHPR/HITOC/Pages/index.aspx>
- Medicaid Advisory Committee (MAC)  
<http://cms.oregon.gov/oha/OHPR/pages/mac/macwelcomepage.aspx>
- Metrics and Scoring Committee, <http://cms.oregon.gov/oha/Pages/metrix.aspx>
- HB3650 groups <http://cms.oregon.gov/oha/OHPB/pages/health-reform/workgroups/index.aspx>
- Health Evidence Review Committee (HERC)  
<http://cms.oregon.gov/oha/OHPR/pages/herc/index.aspx>
- All Payers All Claims (APAC)  
[http://cms.oregon.gov/oha/OHPR/RSCH/pages/all\\_payer\\_all\\_claims.aspx](http://cms.oregon.gov/oha/OHPR/RSCH/pages/all_payer_all_claims.aspx)
- Public Employees Health Purchasing Committee  
<http://cms.oregon.gov/oha/OHPB/pages/committees/pub-hlt-bn-prch.aspx>

#### **Input from beneficiaries and community members:**

- OHA Community Meetings Summary, September - October 2011:  
<http://www.oregon.gov/OHA/OHPB/meetings/2011/2011-1108-com-mtgs.pdf>
- Oregon Dually Eligible Beneficiary Listening Session Final Report, February 2012:  
<http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-oregon-listening.pdf>
- Oregon Dually Eligible Beneficiary Focus Groups Report (CMS/Thomson Reuters) Summer 2011:  
<http://www.oregon.gov/oha/OHPB/healthreform/docs/2011-1019-focus-grp.pdf>

# OREGON HEALTH SYSTEM TRANSFORMATION (HST) TIMELINE

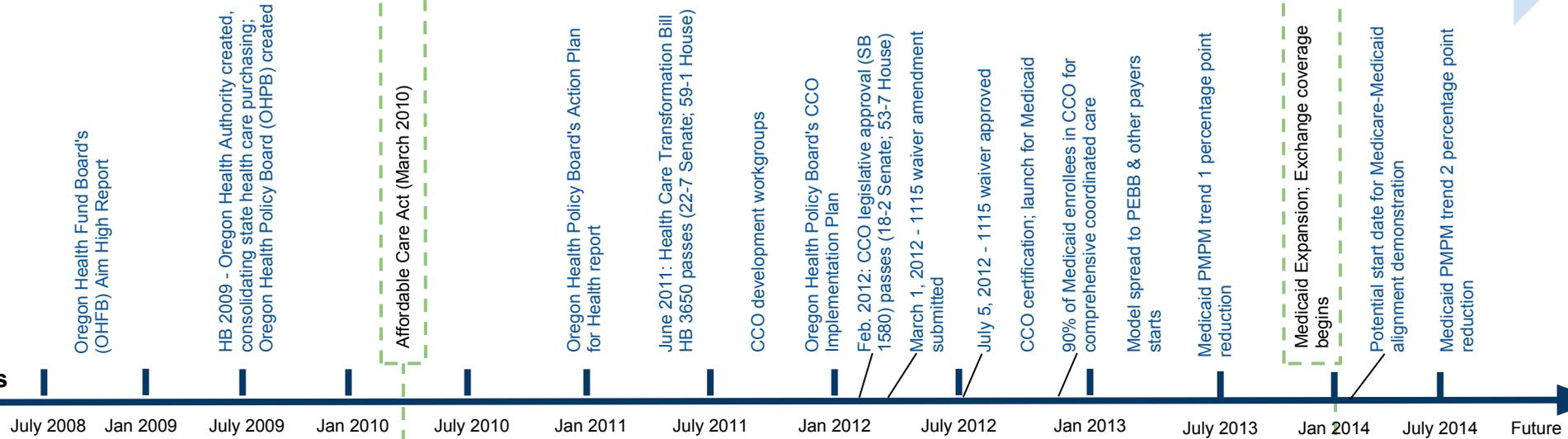
## System Characteristics

- Fragmented delivery of care
- Isolated innovations
- Cost growth without quality or health improvements

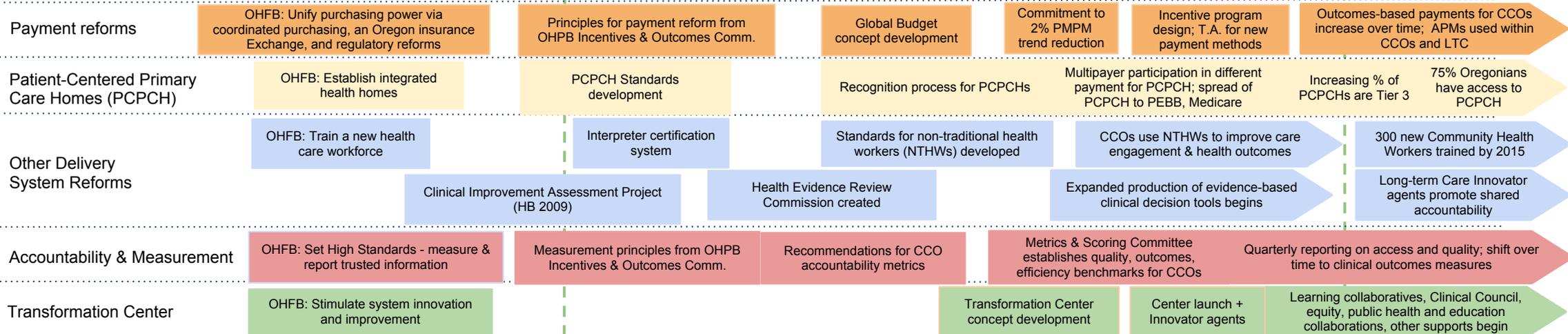
- Integration & coordination of health services
- Accountability for costs & quality
- Focus on prevention, health improvement, equity

- Integration of health care & community services
- Population health improvement

## HST Major Milestones



## Key Element Milestones



**Oregon's Health System Transformation Stakeholder Involvement (2009-present)**

Stakeholder Group Name	Dates		Status
Senate Bill 204 Stakeholder Workgroup	Nov-11	Dec-11	Completed
Health System Transformation Team	Feb-11	Mar-11	Completed
Health System Transformation Implementation - CCO Criteria	Aug-11	Nov-11	Completed
Health System Transformation Implementation - Global Budget	Aug-11	Nov-11	Completed
Health System Transformation Implementation - Medicaid/Medicaid Alignment	Aug-11	Nov-11	Completed
Health System Transformation Implementation - Metrics	Aug-11	Nov-11	Completed
Health Care Workforce Committee	Feb-12	present	Ongoing
House Bill 2009 Public Employers Health Purchasing Committee	Dec-09	present	Ongoing
Health Equity Policy Review Committee	Sep-10	Feb-11	Completed
House Bill 2009 Health Information Technology Oversight Council	Dec-09	to present	Ongoing
Health Information Technology Oversight Council - Finance Workgroup	Sep-10	Dec-11	Completed
Health Information Technology Oversight Council - Legal & Policy Workgroup	Sep-10	Oct-11	Completed
Health Information Technology Oversight Council - Technology Workgroup	Sep-10	Jun-11	Completed
Medicaid Advisory Council	Mar-04	present	Ongoing
Health Incentives and Outcomes Committee	Apr-10	Oct-10	Completed
Patient-Centered Primary Care Home Standards Committee	Oct-09	present	Ongoing
Senate Bill 1580 Metrics and Scoring Committee	Aug-12	present	Ongoing

### Oregon's Health System Transformation 2011-2012 Public Engagement Process

Date	Meeting
Jan. 18, 2011, 9am - 4 pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 2, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Feb. 8, 2011, 1pm - 3:30pm	Oregon Health Policy Board meeting; public comment accepted
Feb. 9, 2011, 6pm -9pm	Public meeting: Weekly Health System Transformation Team
Feb. 11, 2011, 9:30am - 2:30pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 16, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Feb. 23, 2011, 6pm - 9pm	Tribal Health Services: SB 770 Meeting
Feb. 23, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Mar. 2, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Mar. 8, 2011, 8:30am - 12pm	Oregon Health Policy Board meeting; public comment accepted
Mar. 9, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Mar. 16, 2011, 6pm - 9pm	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 6pm -9 pm	Public meeting: Weekly Health System Transformation Team
Mar. 23, 2011, 9am - 12pm	Medicaid Advisory Committee
Mar. 30, 2011, 10am – 11am	Oregon Healthcare Workforce Committee (web meeting)
April 12, 2011, 12:30pm - 4:30pm	Oregon Health Policy Board meeting; public comment accepted
May 5, 2011, 1:30pm - 4:00pm	FQHC/RHC/IHS & Tribal 638 meeting
May 10, 2011, 8:30am - 12pm	Oregon Health Policy Board meeting; public comment accepted
April 27, 2011, 9am - 12pm	Medicaid Advisory Committee
April 29, 2011, 9am - 10am	Tribal Consultation
May 16, 2011 9am - 10am	Tribal Consultation
May 25, 2011, 9:30am - 2:30pm	Tribal Health Services: SB 770 Meeting
June 2, 2011, 9am -10am	Tribal Consultation
June 2, 2011, 1:30pm - 4:00pm	FQHC/RHC/IHS & Tribal 638 meeting
June 8, 2011, 10am – 11am	Oregon Healthcare Workforce Committee (web meeting)
June 23, 2011, 10am -11am	Oregon Health Policy Board meeting; public comment accepted
June 29, 2011	Senate passes House Bill 3650 by a vote of 22-7
June 30, 2011	House passes House Bill 3650 by a vote of 59-1
July 1, 2011	Governor Kitzhaber signs House Bill 3650, providing a framework for Coordinated Care Organizations and launching four workgroups and next round of public comments
July 12, 2011, 8am -1pm	Oregon Health Policy Board meeting; public comment accepted
July 18, 1211	CMS/Thomson Reuters Focus Groups with Dually Eligible Oregonians – The Dalles
July 19, 2011, 2pm - 3pm	Tribal Consultation
July 19, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Portland (2 groups)

Date	Meeting
July 20, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Portland
July 21, 2011	CMS/Thomson Reuters Consumer Focus Groups with Dually Eligible Oregonians – Roseburg (2 groups)
July 27, 2011, 9am - 12pm	Medicaid Advisory Committee
July 27, 2011, 1pm – 4pm	Oregon Healthcare Workforce Committee meeting
Aug.4, 2011, 1:30pm - 4:00pm	FQHC/RHC/IHS & Tribal 638 meeting
Aug. 9, 2011, 1pm - 4:30pm	Oregon Health Policy Board meeting; public comment accepted
Aug. 16, 2011, 6pm - 9pm	Public Work Group Meeting: Medicare-Medicaid Integration
Aug. 17, 2011, 6pm - 9pm	Public Work Group Meeting: Global Budget
Aug. 18, 2011, 6pm - 9pm	Public Work Group Meeting: CCO Criteria
Aug. 22, 2011, 9am - 12pm	Public Work Group Meeting: Metrics
Aug. 24, 2011, 9:30am - 2:30pm	Tribal Health Services: SB 770 Meeting
Sep. 1, 2011, 1:30pm - 4:00pm	FQHC/RHC/IHS & Tribal 638 meeting
Sep. 13, 2011, 8am -12:30pm	Oregon Health Policy Board meeting; public comment accepted
Sep. 20, 2011, 6pm - 9pm	Public Work Group Meeting: Global Budget
Sep. 21, 2011, 6pm - 9pm	Public Work Group Meeting: CCO Criteria
Sep. 22, 2011, 6pm - 9pm	Public Work Group Meeting: Medicare-Medicaid Integration
Sept. 22, 2011, 8am -11am	Legislature: Interim Joint Health Care Committee hearing
Sep. 26, 2011, 9am - 12pm	Public Work Group: Metrics
Sep. 26, 2011, 6pm - 8pm	Community meeting: Roseburg
Sep. 27, 2011, 6pm - 8pm	Community meeting: Medford
Sep. 28, 2011, 9am - 12pm	Medicaid Advisory Committee
Oct. 3, 2011, 6pm - 8pm	Community meeting: Pendleton
Oct. 5, 2011, 6pm - 8pm	Community meeting: Florence
Oct. 6, 2011, 6pm - 8pm	Community meeting: Bend
Oct. 10, 2011, 6pm - 8pm	Community meeting: Portland
Oct. 11, 2011, 1pm - 5pm	Oregon Health Policy Board meeting; public comment accepted
Oct. 12, 2011, 6pm - 8pm	Community meeting: Eugene
Oct. 13, 2011, 6pm - 8pm	Community meeting: Astoria
Oct. 17, 2011, 6pm - 9pm	Public Work Group Meeting: Global Budget
Oct. 17, 2011, 9am - 12pm	Public Work Group Meeting: Metrics
Oct. 18, 2011, 6pm - 9pm	Public Work Group Meeting: CCO Criteria
Oct. 19, 2011, 6pm - 9pm	Public Work Group Meeting: Medicare-Medicaid Integration
Oct. 26, 2011, 9am - 12pm	Medicaid Advisory Committee
Oct. 27, 2011, 1:30pm – 4:30pm	Oregon Healthcare Workforce Committee meeting
Nov. 1, 2011, 1pm - 4pm	Medicare-Medicaid / Long Term Care Integration Sub-Group HB5030
Nov.3, 2011, 1:30pm - 4pm	FQHC/RHC/IHS & Tribal 638 meeting
Nov. 8, 2011, 8:30am - 12pm	Oregon Health Policy Board meeting; public comment accepted
Nov. 9, 2011 3:30pm - 4:30pm	Tribal Consultation

Date	Meeting
Nov. 14, 2011 1pm - 5pm	Tribal Health Services: SB 770 Meeting
Nov. 14, 2011, 6pm - 9pm	Public Work Group Meeting: Global Budget
Nov. 14, 2011, 9am - 12pm	Public Work Group Meeting: Metrics
Nov. 15, 2011, 6pm - 9pm	Public Work Group Meeting: CCO Criteria
Nov. 16, 2011, 8am - 11am	Legislature: Interim Joint Health Care Committee hearing
Nov. 17, 2011, 6pm - 9pm	Public Work Group Meeting: Medicare-Medicaid Integration
Nov. 30, 2011, 10:30am - 11:30am	Tribal Consultation
Nov. 30, 2011, 1pm - 4pm	Medicare-Medicaid / Long Term Care Integration Sub-Group HB5030
Dec. 1, 2011, 1:30pm - 4pm	FQHC/RHC/IHS & Tribal 638 meeting
Dec. 7, 2011, 1pm - 4pm	Medicare-Medicaid / Long Term Care Integration Sub-Group HB5030
Dec. 12, 2011, 2pm - 4pm	Medicare-Medicaid Beneficiary Listening Group - Portland
Dec. 13, 2011, 1pm - 6pm	Oregon Health Policy Board meeting; public comment accepted
Dec. 14, 2011, 1pm - 3pm	Medicare-Medicaid Beneficiary Listening Group - Eugene
Dec. 15, 2011, 10am - 12pm	Medicare-Medicaid Beneficiary Listening Group - Bend
Dec. 15, 2011, 9am - 11am	Medicare-Medicaid Beneficiary Listening Group - Roseburg
Dec. 15, 2011, 3pm - 5pm	Medicare-Medicaid Beneficiary Listening Group – Coos Bay
Dec. 19, 2011, 1pm - 4pm	Medicare-Medicaid / Long Term Care Integration Sub-Group HB5030
Dec. 20, 2011, all day	Legislature: Interim Joint Health Care Committee hearing
Dec. 20, 2011 9am - 12pm	Tribal Consultation
Jan. 10, 2012, 10am - 12 pm	Tribal Consultation
Jan. 10, 2012, 8:30am - 3pm	Oregon Health Policy Board meeting; public comment accepted
Jan. 18, 2012, 8am - 11am	Legislature: House Health Care Committee hearing
Jan. 20, 2012, 1pm - 3pm	Legislature: Senate Health Care and Human Services Committee hearing
Jan. 24, 2012, 8am - 12pm	Oregon Health Policy Board meeting; public comment accepted
Jan. 25, 2012, 10am - 12pm	Tribal Consultation
Jan. 25, 2012, 9am - 11am	Medicaid Advisory Committee
Jan. 25, 2012, 9am – 12pm	Oregon Healthcare Workforce Committee
Feb. 2, 2012, 1:30pm - 4pm	FQHC/RHC/IHS & Tribal 638 meeting
Feb. 12, 2012, 9:30am - 2:30pm	SB 770 Quarterly Health Services Cluster (Tribal)
Feb. 14, 2012, 1pm - 4pm	Oregon Health Policy Board meeting, public comment accepted
Feb. 14, 2012	Senate passes Senate Bill 1580 by a vote of 18-12
Feb. 16, 2012, 2pm - 3pm	Tribal Consultation
Feb. 23, 2012	House passes Senate Bill 1580 by a vote of 53-7
Mar. 13, 2012, 8:30am - 12pm	Oregon Health Policy Board meeting, public comment accepted
Mar. 20, 2012	Medicare-Medicaid Alignment and Shared Accountability Webinar
Mar. 28, 2012, 9am - 12pm	Medicaid Advisory Committee

Date	Meeting
Apr. 4, 2012, 1pm – 4pm	Oregon Healthcare Workforce Committee
Apr. 10, 2012, 1pm - 2:30pm	Oregon Health Policy Board meeting, public comment accepted
Apr. 24, 2012	CCO Informational Webinar
Apr. 27, 2012	CCO Informational Webinar
May 23, 2012, 9am - 12pm	Medicaid Advisory Committee
May 24, 2012, 9am - 3pm	Oregon Health Policy Board meeting, public comment accepted
June 6, 2012, 1pm – 4pm	Oregon Healthcare Workforce Committee
Jun. 12, 2012, 1pm - 4pm	Oregon Health Policy Board meeting, public comment accepted
July 10, 2012, 8:30am - 12pm	Oregon Health Policy Board meeting, public comment accepted
July 13, 2012	CCO Medicaid Providers Webinar
July 25, 2012, 9am - 12pm	Medicaid Advisory Committee
July 26, 2012, 11:30am - 5pm	CCO Summit
Aug. 3, 2012, 1pm - 5pm	PCPCH Standards Advisory Committee
Aug. 8, 2012, 9am – 12pm	Oregon Healthcare Workforce Committee
Aug. 14, 2012, 12pm - 3pm	Oregon Health Policy Board meeting, public comment accepted
Aug. 14, 2012, 1pm - 5pm	PCPCH Standards Advisory Committee
Aug. 22, 2012, 9am - 12pm	Medicaid Advisory Committee
Aug. 22, 2012, 8:30am - 11:30am	Metrics and Scoring Committee
Sep. 11, 2012, 8:30am - 12pm	Oregon Health Policy Board meeting, public comment accepted
Sep. 11, 2012, 9am - 12pm	Metrics and Scoring Committee

**Oregon stakeholders participating in Health System Transformation Boards, Committees, Workgroups (2009-2012) by Organization Type**

**Business**

Director of Healthcare Ecosystem & Strategy	Intel
Co-owner	New Seasons Market
Executive Director	OEA Choice Welfare Benefit Trust
Executive Secretary	OR State Bldg. & Construction Trades Council
Consultant	Oregon Business Council
Manager - Benefits and Compensation	Oregon Steel Mills
President/CFO	Ornelas Enterprises Inc.
	StanCorp Financial Group, Inc. and Standard Insurance Company
Board Chair	

**Consumer/Advocates**

Director of Government Relations	AARP Oregon
Consumer	Archimedes
	Asian Pacific American Network of Oregon (APANO)
Coordinator	Center for Intercultural Organizing
Executive Director	Center for Intercultural Organizing
Executive Operations Manager	City Center Parking
Cashier	Community Advocate
Community Advocate	Consumer
Retired	Disability Rights Oregon
Attorney, Executive Director	Governor's Commission on Senior Services
Member	Medicaid Advisory Council
Consumer	Mid-Valley Health Care Advocates
Chairwoman	National Alliance on Mental Illness
Executive Director	Oregon Action
Executive Director	Oregon Alliance of Senior and Health Services
Executive Director	Oregon Council on Developmental Disabilities
Representative	Oregon Disability Commission
Board Member	Oregon Health Action Campaign
Executive Director	Oregon Latino Health Coalition
Attorney	Oregon Law Center
Public Interest Advocate	OSPRIG
Attorney	Private practice
Physical Therapist	Retired
Director and Political Educator	The Tree Institute
Health Equity Organizer	Urban League of Portland
Organizing and Advocacy Director	Urban League of Portland
President, Chief Executive Officer	Urban League of Portland
Director of Employee Benefits	Vigilant

**Education**

Vice President, Instruction	Blue Mountain Community College
Policy Advisor	Dept. of Community Colleges & Workforce Dev.
Dentist	Dept. of Community Colleges & Workforce Dev.
Superintendent	Gladstone Public Schools
Dean	Linn-Benton Community College
Administrator	Mt. Hood Community College
Dean of Clinical Operations	National College of Natural Medicine
Physician	Oregon Area Health Education Center
Public Affairs Consultant	Oregon Education Association
Dean, School of Medicine	Oregon Health Sciences University
Chief Financial Officer	Oregon Health Sciences University
Associate Professor	Oregon Health Sciences University
Emergency Medicine	Oregon Health Sciences University
Professor	Oregon Health Sciences University
Professor - Public Policy	Oregon Health Sciences University
Associate Vice President	Oregon Institute of Technology
Researcher	Oregon State University
Faculty Research Assistant	Oregon State University - Dept. of Public Health
Director - OUS Human Resources	
Division	Oregon University System Chancellor's Office
Executive Dean	Pacific University
Assistant Professor	Pacific University
Healthcare Interpreter Training Manager	Portland Community College
Dev. Dean - Health & Allied Health	Portland Community College
	Portland State University, Center for Public Service
Researcher, Senior Fellow	
Assistant Director University Studies	Portland State University, School of Community Health
Community Health - Urban & Public Affairs	
President	Rogue Community College
	School of Community Health, Portland State University
Professor/Director	University of Oregon
Professor	University of Oregon
Assistant Professor	Western Oregon University

**Foundations**

President	Northwest Health Foundation
Vice President of Planning and Operations	Northwest Health Foundation
Program Director Health Workforce	Northwest Health Foundation
Program Officer	Northwest Health Foundation

**Health Information Technology****Partner**

Liaison	Bay Area Community Informatics Agency
Vice President - Business Services	OR Community Health Information Network

Clinical Coordinator - Behavioral Health	OR Community Health Information Network
Integrity Officer Vice President - Quality and Practice Transformation	OR Community Health Information Network Oregon Community Health Information Networks, Inc.
<b>Industry Consultants</b>	
Consultant	Barney and Worth, Inc.
Attorney	Stoel Rives, LLP
<b>Local Government</b>	
Administrator	Benton County
Benefits Supervisor	City of Portland
Commissioner	Deschutes County
Benefits Coordinator	Deschutes County
County Judge	Grant County Court
Human Resources Manager	Marion County
Benefits Manager	Mulnomah County
Consultant	Multnomah County
Chief Operations Officer	Multnomah County
Commissioner	Multnomah County Board of Commissioners
Finance Manager	Port of Hood River
<b>Local Mental Health</b>	
Director	Coos County Mental Health Dept.
Division Manager for Mental Health and Addictions	Jackson County Mental Health Division
<b>Local Long Term Care/Area Agencies on Aging</b>	
Retired, Chair	Clackamas County Area Agency for Aging Advisory Council
Director	Lane Council of Governments Senior and Disability Services
Director - Senior and Disability Services	Oregon Cascade West Council of Governments
Director	Rogue Valley Council of Governments
<b>Payers (Medicaid, Medicare, Commercial)</b>	
President / Chief Executive Officer	Advantage Dental
Director - Information Technology	Advantage Dental
Benefits Manager	Blount International
OHP Services Director	Capitol Dental Care, Inc.
Director of Business Integration and Medicare	CareOregon
Senior Manager - Public Policy	CareOregon
Chief Medical Officer	CareOregon

Chief Financial Officer	CareOregon
Medical Director	CareOregon
Medical Director	Cascade Comprehensive Care
Director Behavioral Health and Wellness	Cascade Health Solutions
Executive Director	City County Insurance Services (CIS)
Chief Executive Officer	Doctors of the Oregon South Coast
Chief Executive Officer	Douglas County Independent Practice Assoc.
Physician, Chief Medical Officer	Douglas County Independent Practice Assoc.
Vice President, Chief Financial Officer	Douglas County Independent Practice Assoc.
Director - Health Services	FamilyCare Health Plans
Medicare Director	FamilyCare Health Plans
Chief Executive Office	Greater Oregon Behavioral Health, Inc.
Clinical Quality Representative	Kaiser Permanente
Vice President - Strategic Planning & Health Plan Svcs	Kaiser Permanente
Assoc. Director - Provider Contracting	Kaiser Permanente
Planning Coordinator	Kaiser Permanente
Director - Health Information Collaboration	Kaiser Permanente
Chief Executive Officer	Klamath Health Partnership, Inc.
Healthcare Executive, Chief Executive Officer	Lane Individual Practice Association
Chief Financial Officer	Lane Individual Practice Association
Director	LaneCare
Chief Medical Officer, Vice President	Legacy Health
Assistant General Counsel	Legacy Health
Senior Medical Director	Legacy Health
Senior Vice President of Medicaid and Medicare Services	LIPA and Trillium Comm. Health Plan
Contracts Manager	Mid-Rogue Independent Physicians Assoc.
Chief Executive Officer	Mid-Rogue Independent Physicians Assoc.
Health Plan Administrator, RN	Mid-Rogue Independent Physicians Assoc.
Chief Financial Officer	Mid-Valley Independent Physicians Assoc.
Nurse Case Manager	MVP Health Authority
Executive Director	Northeast Oregon Network (NEON)
Director of Actuarial and Analytical Services	ODS Companies
Director - EDI, Privacy and Information Security	ODS Companies
Medical Director for Quality and Health Policy	ODS Companies
Director - Web Strategy	ODS Companies
Senior Vice President	ODS Companies
Executive Director	Oregon Coalition of Health Care Purchasers
Chief Operations Officer	PacificSource Health Plan
Director of Medicaid	PacificSource Health Plan
President, Chief Executive Officer	PacificSource Health Plan

Chief Info. Officer, Vice President of Operations	PacificSource Health Plan
Senior Vice President - Government Programs	PacificSource Health Plan
Chief Medical Information Officer	Providence Health & Services
Research Scientist	Providence Health and Services
Chief Financial Officer	Providence Health and Services
Chief Operations Officer	Providence Health Plans
Senior Vice President, Chief Executive Manager	Providence Health System
Director - Health Information Collaboration	Public Employees Retirement System (PERS)
President - Provider Services	Regence BlueCross BlueShield of Oregon
Manager - Provider Contracting	Regence BlueCross BlueShield of Oregon
Vice President - Provider Services	Regence BlueCross BlueShield of Oregon
Medical Director	Regence BlueCross BlueShield of Oregon
Chief Executive Officer	Samaritan Health Services
Director, Chief Operations Officer	Samaritan Health Services
Director of Accounting and Reimbursement	Tuality Health Alliance
President, Chief Executive Officer	Tuality Healthcare
Chief Financial Officer	Tuality Healthcare
Vice President - Strategy and Development	Willamette Dental
Medical Director of IS and Informatics	Willamette Dental
	WVP Health Authority
<b>Providers</b>	
Executive Director	Accountable Behavioral Health Alliance
Senior Vice President	Albertina Kerr Centers
Chief Information Officer	Asante Health System
Information Security Officer	Asante Health System
	Avel Gordly Center for Healing - OR Health Science University
Clinical Director	Cascade AIDS Project
Executive Director	Cascade AIDS Project
Public Policy Coordinator	Cascadia Behavioral Health
Sr. Director, Peer and Wellness Services	Cascadia Behavioral Health Care
Director of Community and Family Involvement	Cascadia Behavioral Health Care
Chief Medical and Operating Officer	Cascadia Behavioral Health Care
Chief Medical / Operating Officer	
Chief Executive Officer, Physician Assistant	Center for Women and the Family
Medical Director	Central City Concern
Director - Community Partnerships & Strategic Dev.	Central City Concern
Executive Director	Children's Community Clinic
Family Practitioner	Christine M. Seals, MD., PC

Executive Director	CODA, Inc
Registered Nurse	Columbia Memorial Hospital
RHIA	Columbia Memorial Hospital
Pres. and CEO of Willamette Dental	Consultant
Physician	Dunes Family Health Care
Physician	Gateway Women's Clinic
Medical Director	GreenField Health
Senior Pastor	Highland Christian Center
Chief Executive Officer	Hope Orthopedics
Director of Quality Improvement	InterHospital Physicians Assoc. dba Portland IPA
Controller/CPA	InterHospital Physicians Assoc. dba Portland IPA
Clinical Services Manager	Kaiser Permanente
Research Scientist	Kaiser Permanente Center for Health
Chief Executive Officer	Kartini Clinic of Disordered Eating
Executive Director	Klamath Child and Family Treatment Center
President, CEO	LifeWorks NW
Culturally Specific Addictions Services Director	LifeWorks NW
President, Chief Operations Officer	Mercy Medical Hospital
Health IT Evangelist	Mid-Columbia Medical Center
Executive Director	Mid-Valley Behavioral Care Network (MVBCN)
Chief Executive Officer	Mosaic Medical Clinic (FQHC)
Chief Executive Officer	North Bend Medical Center
Pediatrician	North Bend Medical Center
Administrator	Northwest Ambulatory Surgery Center
Executive Director	OnTrack, Inc.
	Oregon Center for Children/Youth w/ Special Health Needs Child Development and Rehabilitation Center - OHSU
Director	Oregon Center for Nursing
Executive Director	Oregon Center for Nursing
Executive Director	Oregon Health Resources
Chief Executive Officer	Oregon Health Sciences University
Chief Health Information Officer	Oregon Health Sciences University
Chair - Dept. of Family Medicine	Oregon Health Sciences University
Director - Healthcare Applications	Oregon Health Sciences University
President	Oregon Health Sciences University
Physician	Oregon Health Sciences University
Pediatric Oncologist	Oregon Health Sciences University
Vice President, Chief Information Officer	Oregon Health Sciences University
Physician	Oregon Health Sciences University
Physician	Oregon Health Sciences University
Deputy Executive Director	Oregon Medical Association
Vice President	Oregon Treatment Network
Geriatric Nurse Practitioner	Peace Health Medical Group
Vice President, Chief Quality Officer	PeaceHealth Medical Group
Director of Quality Improvement	PeaceHealth Medical Group

President, Chief Executive Officer	Planned Parenthood - Columbia Willamette
Chief Information Officer	Portland InterHospital Physicians Assoc.
Physician	Private practice
Optometrist	Private practice
Physician	Private practice
Executive Director	Providence ElderPlace
Chief Health Care Intelligence and Informatics Officer	Providence Health & Services
Chief Financial Officer	Providence Health & Services - OR Region Hospitals
Chief Medical Officer / President	Providence Health and Services/ Oregon Academy of Family Physicians
Chief Human Resource Officer	Providence Health System
President - Regence Blue Cross Blue Shield	Regence Blue Cross Blue Shield of OR, Health Leadership Taskforce
Chiropractic Physician	Saboe Chiropractic Clinic
Chief Executive Officer	Saint Alphonsus Medical Center
Vice President - Network and Business Development	Salem Health
Chief Medical Officer	Salem Health
Chief Financial Officer	Salem Hospital
Regional Operations Manager	Salud Medical Center - Yakima Valley Farm Workers Clinic
Hospital Administrator	Samaritan Health
Pharmacist	Samaritan Health Services Pharmacy
Neuropsychologist	Southern OR Neuropsychological Clinic
Executive Director	Southern Oregon Adolescent Study and Treatment Center
Director - Quality Management	St. Charles Health System
Director of Payer Relations & Contracting	St. Charles Health System
Executive Director	St. Charles Medical Center - Cascades East AHEC
Physician	Veteran's Administration
Associate National Director - eHealth, Patient Care Services	Veterans Health Administration
Chief Operations Officer	Virginia Garcia Memorial Health Center
Chief Executive Officer	Youth Villages (formerly ChristieCare)
Physician, Researcher	OR Health Sciences Uni. / Veterans Adm.
<b>Provider Associations</b>	
Peer Support Specialist	Assoc. Oregon Community Mental Health Programs
Executive Director	Association of Oregon Community Mental Health Programs (AOCMHP)
Director	Good Shepherd Health System
President, Chief Executive Officer	OR Assoc. Hospitals & Health Systems

President	Oregon Health Care Association
Internal Medicine Physician / President Elect	Oregon Medical Association
General Counsel	Oregon Medical Association
Executive Director	Oregon Nurses Association
Representative	Oregon Nurses Association
Registered Nurse	Oregon Nurses Association
Physician, Medical Director	Oregon Pediatric Improvement Partnership
Human Resources and Recruitment Executive Director	Oregon Primary Care Association
Executive Director	Oregon Primary Care Association
Executive Director	Oregon Healthcare Workforce Institute
<b>Public Health</b>	
Health Director	Benton County Health Dept.
Clinical Information Systems Analyst	Deschutes County Health Services
Director	Hood River County Health Dept.
Public Health Informatics Manager	Multnomah County Health Department
Director	Multnomah County Health Department
Director of Integrated Clinical Services	Multnomah County Health Dept.
Public Health Officer	Tri County Public Health
<b>Quality Partners</b>	
Director	Center for Evidenced Based Policy - OHSU
Medical Director	OR Health Care Quality Corp., OR Medical Assoc.
Executive Director	Oregon Health Care Quality Corporation
Executive Director	Oregon Health Care Quality Corporation
<b>Researcher</b>	
Policy Analyst	RAND
<b>State Legislature</b>	
Representative - Eugene	State of Oregon Legislature
Representative - Portland	State of Oregon Legislature
Representative - Roseburg	State of Oregon Legislature
Representative - Portland	State of Oregon Legislature
Senator - Gresham	State of Oregon Legislature
Representative - Dallas	State of Oregon Legislature
Senator - Roseburg	State of Oregon Legislature
Senator - Albany	State of Oregon Legislature
Senator - Portland	State of Oregon Legislature
Representative - Oregon City	State of Oregon Legislature
Senator - Medford	State of Oregon Legislature
<b>Native American/Alaskan Native Tribes</b>	
Executive Director	Confederated Tribes of Grand Ronde

Clinic Director	Cow Creek Band of Umpqua Tribe of Indians
Coordinator - Indigenous Community Engagement	Native American Youth & Family Center
Executive Director	Northwest Portland Area Indian Health Board

**Union**

Staff Representative / Board Member	AFSCME / Public Employees Benefit Board
	Service Employees International Union (SEIU)
Assistant Executive Director	Local 503
Political Organizer	SEIU Local 503
Researcher	SEIU Local 503
Executive Director	SEIU Local 503
Home Care Council Coordinator	SEIU Local 503
Political Director	SEIU Local 49
President	UFCW Local 555

## Oregon's Action Plan for Health, 2010: Status of Action Items

### Action Items

Action	Status
Set a target for health care spending in Oregon	Through Health System Transformation (SB1580), Coordinated Care Organizations (CCOs) will operate on a global budget that will increase at a fixed rate not tied to increases in medical costs.
Align purchasing: <ul style="list-style-type: none"> <li>• Standardize certain provider payments to Medicare methodology to set stage for future payment reform.</li> <li>• Focus on quality and cost improvement efforts to achieve critical momentum.</li> <li>• Introduce innovative payment methods that reward efficiency and outcomes.</li> </ul>	<p>Senate Bill 204 required the state to develop and implement standardized alternative payment methodologies for hospital services for all state purchased insurance (PEBB, OEBC, Medicaid). A work group met three times in late 2011 and made recommendations on standardized payments. The methodology has been implemented in most parts of the state.</p> <p>CCOs will have the flexibility to offer innovative payment methods that will reward providers for health outcomes, both on a patient level and/or a population level. CCOs will also partner with local Patient-Centered Primary Care Homes (PCPCH). PCPCHs will receive payment incentives for keeping patients healthy. The PCPCH Program is working toward a system that provides additional supports to recognized primary care homes for their commitment to patient-centered care, allowing them to focus on prevention and better management of chronic conditions. Recognized primary care homes can apply to receive additional Medicaid funding to support the comprehensive, coordinated and patient-centered care they offer Medicaid patients with chronic conditions such as diabetes and asthma.</p>
Reduce administrative costs in health care	OHA is working with CCOs and with representatives from the Centers for Medicare and Medicaid Services to find ways to reduce administrative red tape and burdens that weigh down the system by creating inefficiencies.

Action	Status
	<p>The legislature passed SB 94 in 2011 which expanded some of the recommendations from the Administrative Simplification work group and allows DCBS to create uniform standards for administrative aspects of health insurance and care. OHA, through a partnership with the Health Leadership Council (HLC), has been working to implement these recommendations and has now completed companion guides on uniform standards for Eligibility Transactions (270/271) and Claims and Encounter Transactions (837); both mandated to be effective this year. A centralized portal for common credentialing is also being considered by the HLC at this time.</p> <p>OHA is also working to implement reductions to administrative burdens identified through Health Systems Transformation work. Specific work related to these burdens that are also part of SB 94 and SB 238 (2011), which required the Addictions and Mental Health Division to revise rules related to administrative burdens on providers, are being incorporated into streamlining work and efficiencies.</p>
Decrease obesity and tobacco use	<p>Obesity and tobacco are identified as priorities in the recently released Public Health strategic plan. Public health and partners are meeting May 14-23, 2012 to identify targets and strategies to move all of the public health priority areas forward, including obesity and tobacco. Like tobacco, the most effective strategies to reduce obesity involve changing the social and physical environment.</p> <p>OHA is continuing to make significant progress around tobacco, including toward tobacco-free state properties, reducing tobacco use among state employees through the health engagement model and cessation services, supporting tribal casinos in going smoke-free, and engaging in a social marketing campaign to warn</p>

Action	Status
	<p>the public about the risks of tobacco use.</p> <p>Obesity and overweight continues to be a significant challenge for the State. Although there is currently no funding for an obesity prevention program, positive steps are being taken. On May 15, OHA released a report on the significance of the obesity epidemic in Oregon. Evidence-based approaches to changing the social and physical environment, such as ensuring healthy food options and altering the information environment, continue to be the best way to prevent and reduce overweight and obesity.</p> <p>Public Health Division plans to work with the CCOs to encourage the adoption of evidence-based approaches to prevention and health promotion, and will provide technical assistance around CCO metrics related to tobacco use and obesity/overweight.</p> <p>The Public Health Division will continue to monitor tobacco use and obesity/overweight among all Oregonians to evaluate the effectiveness of our efforts.</p>
<p>Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange</p>	<p>SB 99 established the Oregon Health Insurance Exchange Corporation in 2011. Created as a public corporation and governed by a 9-member Board of Directors who are appointed by the Governor and confirmed by the Senate, the Exchange's mission is many-fold: advance the Triple Aim in Oregon; administer the exchange in the public interest that is accountable to the public; empower Oregonians by providing information and tools to make smart health insurance choices; improve health care quality and mitigate health disparities; and encourage innovative health insurance products. In February 2012, the Legislature approved the Corporation's Business Plan as required in SB 99.</p>

Action	Status
	<p>The Corporation has hired an Executive Director and several other key staff; developed its own infrastructure; applied for and received federal grants that fund the planning, implementation and operational activities of the Exchange; and has established the policy and functional framework for all aspects of Exchange operations, including working with the OHA to develop the IT systems and Exchange web portal.</p>
<p>Promote local and regional accountability for health and health care</p>	<p>CCOs will operate on a local and regional level and will be accountable for the health of the entire population they serve. Each CCO will be responsible for performing a community health assessment and for finding ways to help improve the overall population health of the region they serve.</p> <p>At the same time, CCOs will utilize innovator agents that will help them collaborate statewide on best practices and innovations.</p>
<p>Build the health care workforce</p> <ul style="list-style-type: none"> <li>• Use loan repayment to attract and retain primary care providers in rural and underserved areas</li> <li>• Standardize prerequisites for clinical training via a student “passport”</li> <li>• Extend requirement to participate in Oregon’s health care workforce database to all health professional licensing boards.</li> </ul>	<p>The Workforce Committee heard presentations on loan repayment and their estimated impact on recruitment and retention. Primary Care Office (PCO) staff is working to maximize the number of awards that can be made to Oregon clinicians and scholars. Additionally, PCO is administering a federal grant to retain National Health Service Corps (NHSC) clinicians in underserved areas who are currently taking advantage of Loan Repayment.</p> <p>As part of the state’s agreement with the Centers for Medicare and Medicaid Services (CMS) for significant federal investment through matching Designated State Health Programs (DSHP), the state will reinvest in a loan repayment program and train more Community Health Workers.</p> <p>April concluded the third meeting of a stakeholder work group convened through SB 879 (2011). The work group made draft recommendations on how to create a more efficient system by standardizing administrative requirements for student</p>

Action	Status
	<p>clinical placements. The recommendations included:</p> <ol style="list-style-type: none"> <li>1. Standards that address immunization, training, drug screening, background checks, and other (liability, health insurance, etc.).</li> <li>2. Articulating the standards in administrative rule by OHA. The effective date of the rules should be far enough in the future that training programs and clinical sites have time to amend contracts as needed.</li> <li>3. Some type of student “passport” that will allow for easy tracking of students’ standings.</li> </ol> <p>Next step is to vet recommendations around widely, in particular get buy-in from leadership of organizations that will be affected. A report was delivered to the legislature May 21, 22 during interim legislative committee hearings. A final report to the legislature will be sent by the end of June.</p> <p>In the fall of 2011, OHPR met with three new licensing boards in preparation for including their data in the Oregon Healthcare Workforce Database: the Board of Licensed Professional Social Workers; the Board of Professional Counselors and Therapists; and the Board of Psychologist Examiners. HB 3650 directed OHA to expand the database but does not compel new boards to make participation a requirement for licensure; OHPR will assess the response rate with voluntary participation. As of January 2012, the Board of Licensed Clinical Social Workers and Board of Professional Counselors and Therapists will begin participating in the healthcare workforce database this spring (on a voluntary basis). The Board of Psychologists Examiners is interested but cannot commit at this time due to staffing shortages. More and more of the 7 original boards are choosing to use a centralized online questionnaire developed by OHPR, rather than embedding the required workforce items into their own systems, which should increase the comparability and timeliness of the data.</p>

Action	Status
<p>Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, state employees, educators) and then statewide</p>	<p>As of May 2012, over 150 practices statewide have been recognized by the OHA as Patient-Centered Primary Care Homes (PCPCH).</p> <p>The Division of Medical Assistance Programs received approval from CMS in March 2012 to provide enhanced payments to recognized PCPCH practices for Medicaid clients meeting certain criteria. Payments are anticipated to begin flowing to clinics in June 2012. Once payment begins, an update on number of covered lives receiving care through a PCPCH will be available.</p> <p>Similar payment structures for PEBB and OEBC lives are under discussion. Contract language requiring PEBB and OEBC insurance carriers to provide enhanced payments to recognized PCPCH practices for PEBB and OEBC covered lives is anticipated to be in place October 2012.</p> <p>OHA, in partnership with the Northwest Health Foundation, is creating the Center for PCPCH Technical Assistance. The Center will provide resources through a variety of strategies to assist clinics with practice transformation and achieving the PCPCH standards. A request for proposals for an entity to lead this work recently closed. The successful proposal will be announced by June 2012.</p>
<p>Introduce a value-based benefit design that removes barriers to preventive care.</p>	<p>There have been 20 value-based services representing preventive care and chronic disease management identified by the Health Services Commission. The set has highest evidence of clinical and cost-effectiveness for which little or no cost-sharing should be required. Please see attached document for a full list of the highlighted value-based services.</p> <p>A value-based benefit design prototype is available, using the Prioritized List of Health Services and the 20 sets of value-based services available with model pricing. It uses four tiers of cost-sharing which increase for services prioritized</p>

Action	Status
	lower on the list. Some elements of the fourth tier are used in PEBB's current (2012) benefit design.
Expand the use of health information technology (HIT) and exchange (HIE)	<p>Oregon's Health IT Extension Center (O-HITEC) measures progress in achieving electronic health record (EHR) adoption and meaningful use by Oregon providers in terms of three progressive Milestones for the federally-set target of 2,674 Priority Primary Care Providers (PPCPs)::</p> <ul style="list-style-type: none"> <li>• Milestone 1 (PPCP membership)- currently have 3,016 members, 113% of target</li> <li>• Milestone 2 (Go Live) – currently 1,962 PPCPs have achieved this milestone (73%), above the projected figure for June 2012 of 60%</li> <li>• Milestone 3 (Meaningful Use) – pending meaningful attestations bring the figure to 28% of target PPCPs, near the projected figure for June 2012 of 30%</li> </ul> <p>Incentives for the adoption and meaningful use of EHRs are being paid through federally run Incentive Programs for Medicare, and by states for Medicaid. Oregon's Medicaid EHR Incentive Program launched in September 2011. As of May 3<sup>rd</sup>, 2012 that program has delivered the following incentive payments (federal dollars) to Oregon providers:</p> <ul style="list-style-type: none"> <li>• 609 Eligible Professionals have received a total of \$12,679,179</li> <li>• 35 Eligible Hospitals have received a total of \$25,065,341</li> </ul> <p>CareAccord statewide health information exchange (HIE) services launched in April, 2012, offering web-based secure Direct Messaging Services to any provider regardless of whether they have an EHR system or not. Phase One services are available at no cost, Phase Two services will include additional functionality as per market demand. Regional Health Information Organizations continue to develop services that their local markets will support.</p>

Action	Status
	Oregon's Health Information Technology Oversight Council (HITOC) is developing Oregon's Strategic Plan for Health IT that will offer policy recommendations for continued steps to expand the use of HIT and HIE.
Develop guidelines for clinical best practices	<p>Health Evidence Review Commission (HERC) created in January 2012, assuming the Prioritized List work of the Health Services Commission and the health technology review work of the Health Resources Commission. HERC will provide evidence-based guidance to public and private purchasers on coverage of health care services with high cost, high utilization and/or high variation in provider practice.</p> <p>Two guidelines approved by HSC/HERC so far:</p> <ul style="list-style-type: none"> <li>• Evaluation and management of low back pain (includes pharmacologic and non-pharmacologic, non-invasive treatments)</li> <li>• Advanced imaging for low back pain</li> </ul> <p>One guideline completed and awaiting HERC consideration on 6/14/12:</p> <ul style="list-style-type: none"> <li>• Percutaneous interventions for low back pain</li> </ul> <p>20 "coverage guidances" to be complete by end of 2012 (8 awaiting HERC consideration on 6/14/12).</p>
<p>Strengthen medical liability system</p> <ul style="list-style-type: none"> <li>• Remove barriers to full disclosure of adverse events by providers and facilities</li> <li>• Clarify that statements of regret or apology may not be used to prove negligence</li> </ul>	<p>Senate Bill 1580 established the work group on Patient Safety and Defensive Medicine that will recommend legislation to be introduced during the 2013 regular session.</p> <p>The work group will focus on legislation that</p> <ul style="list-style-type: none"> <li>• Improves patient safety</li> <li>• More effectively compensates individuals who are injured as a result of</li> </ul>

Action	Status
	<p>medical errors, and</p> <ul style="list-style-type: none"> <li>• Reduces collateral costs associated with the medical liability system.</li> </ul>
Performance measurement	<p>Based on the initial work of the Board's Incentives and Outcomes committee, there has been further development of metrics through the health system transformation workgroup process and included in the implementation plan for CCOs. The CCOs will be accountable based on metrics, and SB 1580 set up an ongoing Metrics and Scoring Committee to continue this work. A transitional Metrics and Scoring Committee was established by OHA Director Bruce Goldberg and held its first meeting on March 15, 2012. The transition committee endorsed a set of core metrics to be included in CCO contracts for the first contract year.</p> <p>CMS will include terms and conditions for accountability, including metrics and transparency requirements, as part of the 1115 waiver request.</p> <p>Performance measurement will be a critical aspect of CCOs, as payment methodology evolves to reward providers for health outcomes rather than discrete services.</p>

**“The Future”**

Vision	Status
<p>A coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian.</p>	<p>Health System Transformation (HB 1580) established a system for delivering Medicaid that will help coordinate care for patients at a local level. CCOs will be paid through a global budget that will create incentives for providers to keep their patients healthy and out of the hospital, creating better and more affordable health care.</p> <p>CCOs will operate on a local/regional level, where they can cater services to a specific population with specific needs. Each CCO will have a governing board that includes financial stakeholders, physicians, and community members. CCOs also must have Community Advisory Councils (CACs) to help ensure that the health care needs to the consumers and the community are being met.</p>
<p>A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and health lifestyles.</p>	<p>CCOs will have incentives and be accountable for providing health to patients in a holistic manner. They will be responsible for a patient’s physical, mental, and oral health care (starting in 2014). Prevention will be key in keeping patients healthy and out of the emergency room. Many CCOs might take an approach that includes community health workers, who will be charged with building relationships with high use patients and ensuring that those patients are receiving patient centered, holistic, preventative care, as well as taking medications on time and routinely visiting their primary care doctor.</p> <p>CCOs must also conduct regular Community Health Assessments (overseen by the CAC) to determine where the greatest needs for services are, what measures and programs can be implemented to provide better overall health, and where general improvements in the community’s health and health systems could be made.</p>

Vision	Status
A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick	CCOs will offer patients a team-based approach to health that will include providers of different types. Behavioral therapists, community health workers, nurse practitioners, chiropractors, primary care doctors, and more can all be involved in a patient's health care. That will ensure that patients are receiving the right care, at the right time, in the right place.
Providers get paid for keeping people healthy.	CCOs will be paid a global budget and will be responsible for maintaining the health of the entire population they serve. The goal is to eventually have all Medicaid members receive care through a CCO that is responsible for keeping the person healthy. Performance measurement will include measures of population health as well as health care and efficiency metrics.
Private, secure electronic medical records help providers see their patients' complete health picture and know what tests have already been done.	<p>Currently, Oregon is exceeding its goals for adoption of Electronic Health Records (see above section on expanding the use of HIS for more details). Incentives for the adoption and meaningful use of EHRs are being paid through federally run incentive programs for Medicare and by states for Medicaid. Oregon's Medicaid EHR Incentive Program launched in September 2011.</p> <p>We are currently addressing the issue of offering providers a "complete health picture" (a provider having access to all of a patient's health-related data, such as claims, clinical, demographic, etc.) in Oregon's Strategic Plan for HIT.</p>
A highly efficient health care system	<p>OHA is working with CCOs and with representatives from the Centers for Medicare and Medicaid Services to find ways to reduce administrative red tape and burdens that weigh down the system by creating inefficiencies.</p> <p>The legislature passed SB 94 in 2011 which expanded some of the recommendations from the Administrative Simplification work group and allows DCBS to create uniform standards for administrative aspects of health insurance and care. OHA, through a partnership with the Health Leadership Council (HLC), has been working to implement these recommendations and has now</p>

Vision	Status
	<p>completed companion guides on uniform standards for Eligibility Transactions (270/271) and Claims and Encounter Transactions (837); both mandated to be effective this year. A centralized portal for common credentialing is also being considered by the HLC at this time.</p> <p>OHA is also working to implement reductions to administrative burdens identified through Health Systems Transformation work. Specific work related to these burdens that are also part of SB 94 and SB 238 (2011), which required the Addictions and Mental Health Division to revise rules related to administrative burdens on providers, are being incorporated into streamlining work and efficiencies.</p>
<p>Together, clinical and public health providers will be accountable for the health of the whole community.</p>	<p>OHA is implementing CCOs which will be held accountable for outcomes. One requirement for CCOs will be to collaborate with the community to develop a community health assessment that considers the health of the entire community.</p> <p>The Public Health Division of OHA has announced plans to pursue national accreditation, and has developed a strategic plan, statewide community health assessment, and a statewide community health improvement plan focused on health outcomes.</p> <p>Local public health authorities are being supported by Public Health Division, as a part of a public health system transformation initiative, in their pursuit of accreditation, When performing Community Health Assessments, CCOs will partner with local health care systems and local public health to determine where the greatest needs for services are, what measures and programs can be implemented to provide better overall health, and where general improvements in the community's health and health systems could be made.</p>

Vision	Status
<p>As more people get health insurance coverage, public health systems will devote more time and resources to maintaining healthy populations.</p>	<p>OHA's Public Health Division has announced a reorganization and strategic plan to refocus its work on the community-based health improvement opportunities, and will continue to support clinical health services where those are essential to the health of the population.</p> <p>Public Health Division and other parts of OHA are working together with federal partners to identify opportunities to integrate community prevention activities into healthcare transformation efforts within CCOs.</p> <p>Public Health Division has developed and is starting to implement an initiative to support local public health authorities in their transition to help prepare for the shift in the focus of activities, when all people are covered. Regular Community Health Assessments, performed in collaboration with local public health, will allow innovations and improvements to occur often. These assessments will allow CCOs to track where progress is being made, both on an individual and community level. Where programs are working on a population scale, more resources can be diverted to those programs to help improve the overall health of the population.</p>

**Year 1 CCO Accountability and Transparency Metrics  
Excerpt from Oregon Health Authority (OHA) Final Request for Proposals, March 2012**

<p>Note: CCOs’ accountability in Year 1 is for reporting only - reporting encounter data or reporting on measures under the second heading below. Because accountability is for reporting only, measures are not categorized into “core” or “transformational.” The OHA Metrics &amp; Scoring Committee (established by SB 1580) will advise the Authority on development of benchmarks, accountability structure, and incentive design for future years.</p>	<p align="center"><b>Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.</b></p>
<p><u>Measures to be collected by OHA and CCOs</u></p> <p><b>1. Reduction of disparities - report all other metrics by race and ethnicity</b>  <i>Data collection responsibility:</i> OHA collection of race and ethnicity at enrollment; responsibility for reporting by race and ethnicity depends on specific measure  <i>Measure also collected or required by:</i> n/a</p> <p><u>Measures to be reported by OHA or contractor, validated with CCOs</u></p> <p><b>1. Member/patient Experience of care (CAHPS tool or similar)<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA  <i>Measure also collected or required by:</i> Medicaid (Adult Core and CHIPRA Core); Medicare Advantage and ACOs; OR PCPCH; others</p> <p><b>2. Health and Functional Status among CCO enrollees<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA, at enrollment and reauthorization or via member survey  <i>Measure also collected or required by:</i> n/a</p> <p><b>3. Rate of tobacco use among CCO enrollees<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA, at enrollment and reauthorization or via member survey  <i>Measure also collected or required by:</i> n/a</p> <p><b>4. Obesity rate among CCO enrollees<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA collection of height, weight via member survey  <i>Measure also collected or required by:</i> n/a</p> <p><b>5. Outpatient and ED utilization<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA or contractor via encounter data  <i>Measure also collected or required by:</i> Medicaid (CHIPRA Core)</p> <p><b>6. Potentially avoidable ED visits<sup>^*</sup></b>  <i>Data collection responsibility:</i> OHA or contractor via encounter data  <i>Measure also collected or required by:</i> QCorp</p> <p><b>7. Ambulatory care sensitive hospital admissions (PQIs)<sup>^*</sup></b></p>	<p>CMS Medicaid Adult Core Measures including:          Flu shots for adults 50-64          Breast &amp; cervical cancer screening          Chlamydia screening          Elective delivery &amp; antenatal steroids, prenatal and post-partum care          Annual HIV visits Controlling high BP, comprehensive diabetes care          Antidepressant and antipsychotic medication management or adherence          Annual monitoring and for patients on persistent medications          Transition of care record</p> <p>CMS CHIPRA Core Measures including:          Childhood &amp; adolescent immunizations          Well child visits Appropriate treatment for children with pharyngitis and otitis media          Annual HbA1C testing          Utilization of dental, ED care (including ED visits for asthma)          Pediatric CLABSI Follow up for children prescribed ADHD medications</p> <p>SAMSHA National Outcome Measures including:          Improvement in housing (adults)          Improvement in employment (adults)          Improvement in school</p>

<p><i>Data collection responsibility: OHA or contractor via encounter data Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs; Q-Corp</i></p> <p><b>8. Medication reconciliation post discharge<sup>^*</sup></b>  <i>Data collection responsibility: OHA or contractor via encounter data (use measure administrative specifications)</i>  <i>Measure also collected or required by: Medicaid (CHIPRA Core)</i></p> <p><b>9. All-cause readmissions<sup>^*</sup></b>  <i>Data collection responsibility: OHA or contractor via encounter data</i>  <i>Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs; Q-Corp</i></p> <p><b>10. Alcohol misuse – screening, brief intervention, and referral for treatment<sup>^</sup></b>  <i>Data collection responsibility: OHA or contractor via encounter data Measure also collected or required by: Medicaid (Adult Core); Meaningful Use, OR PCPCH</i></p> <p><b>11. Initiation &amp; engagement in alcohol and drug treatment<sup>^</sup></b>  <i>Data collection responsibility: OHA or contractor via encounter data Measure also collected or required by: Medicaid (Adult Core); Meaningful Use, OR PCPCH</i></p> <p><b>12. Mental health assessment for children in DHS custody</b>  <i>Data collection responsibility: OHA via encounter and administrative data</i>  <i>Measure also collected or required by: Current MHO performance measure/ DHS wraparound initiative</i></p> <p><b>13. Follow-up after hospitalization for mental illness<sup>^</sup></b>  <i>Data collection responsibility: OHA or contractor via encounter data</i>  <i>Measure also collected or required by: Medicaid (Adult Core)</i></p> <p><b>14. Effective contraceptive use among women who do not desire pregnancy<sup>*</sup></b>  <i>Data collection responsibility: OHA via member survey</i>  <i>Measure also collected or required by: Medicaid (Adult Core)</i></p> <p><b>15. Low birth weight</b>  <i>Data collection responsibility: OHA or contractor via encounter or vital statistics data</i>  <i>Measure also collected or required by: Medicaid (CHIPRA Core)</i></p> <p><b>16. Developmental Screening by 36 months</b>  <i>Data collection responsibility: OHA or contractor via encounter data, (use measure administrative specifications)</i>  <i>Measure also collected or required by: Medicaid (CHIPRA Core)</i></p> <p>Measures to be collected by CCOs or EQRO</p>	<p>attendance (youth) Decrease in criminal justice involvement (youth)  Others TBD, for example:  Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc.  Initiation and engagement of mental health treatment</p>
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<p><b>1. Planning for end of life care (documentation of wishes for members 65+)</b>  <i>Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based</i>  <i>Measure also collected or required by: n/a</i></p> <p><b>2. Screening for clinical depression and follow-up<sup>^</sup></b>  <i>Data collection responsibility: CCOs or via EQRO; could be sample rather than population-based</i>  <i>Measure also collected or required by: Medicaid (Adult Core); Medicare ACOs</i></p> <p><b>3. Timely transmission of transition record<sup>^</sup></b>  <i>Data collection responsibility: CCOs or via EQRO; could be sample-rather than population-based</i>  <i>Measure also collected or required by: Medicaid (Adult Core, Health Homes Core); AMA-PCPI</i></p> <p><b>4. Care plan for members with Medicaid-funded long term care benefits</b>  <i>Data collection responsibility: CCOs or via EQRO; could be sample- rather than population-based</i>  <i>Measure also collected or required by: n/a – to promote coordination with long term care services</i></p> <p>*Report separately for members with severe and persistent mental illness  <sup>^</sup> Report separately for individuals with Medicaid-funded Long Term Care (LTC)  – These measures may be used to promote shared accountability between CCO and LTC systems.</p>	
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## Federal Initiatives Operating in Oregon that Align/Coordinate with the CMMI Project

### 1) Initiatives through the Innovation Center & the Affordable Care Act

- The Comprehensive Primary Care Initiative: *to test the ability of public and private collaboration to significantly strengthen primary care.*

In August 2012, Oregon became one of the seven markets in the Comprehensive Primary Care Initiative. Oregon will be participating state-wide, which encompasses 70 primary care practices, 517 providers, and 5 Oregon payers with Medicare, who serve an estimated 49,000 beneficiaries. The Oregon plans participating include CareOregon, the Oregon Health Authority- Medicaid FFS, Providence Health Plans, Regence BlueCross BlueShield, Tuality Health Alliance as well as Teamsters Multi-Employer Taft Hartley Funds. Many of the payers are involved in the new Medicaid CCOs or also serve PEBB employees, as well as have Medicare Advantage plans.

- Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees: *in collaboration with the Medicare and Medicaid Coordination Office, to test the ability of states to deliver more integrated care for dually eligible Medicare and Medicaid beneficiaries through two financial models, a capitated model and a managed fee-for-service model.*

In 2011, Oregon was competitively selected to receive planning funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals*. As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. In May 2012, Oregon submitted a proposal to participate in a capitated financial alignment demonstration through its CCOs. The proposal is currently being reviewed by CMS. Further details are included in Oregon's Health Care Innovation Plan.

- Health Care Innovation Awards: *to test local innovation in communities across the nation to achieve better care, better health and lower costs through continuous improvement.* Oregon health systems and providers are part of five of the Health Care Innovation awards announced in May of 2012. All of these projects are important investments in particular programs that will assist portions of Oregon's delivery system towards accelerating the coordinated care model. The Providence Portland award is integral to the development of the HealthShare CCO which has undertaken considerable challenges by aligning multiple health systems and commercial and Medicaid plans into one CCO to serve Medicaid enrollees in the large Portland metro area. The Oregon Awardees are summarized below:

*Project Title: "Redesigning service delivery through the Tri-County Health Commons"*

*Summary: The Providence Portland Medical Center, in partnership with CareOregon, Providence Health & Services, Kaiser Permanente, Legacy Health, Oregon Health and Science University, the Coalition of Community Health Centers, Multnomah County, Clackamas County, and Washington County, is receiving an award to develop a Medicaid*

Coordinated Care Organization (CCO). This CCO will integrate care delivery for Medicaid and Medicare/Medicaid dual-eligible beneficiaries through an unprecedented level of cooperation among traditional competitors. The program will include a Care Coordination Registry with real-time alerts to enable care coordination across all service sites, standardized discharge and transition processes from hospitals to primary care (with care transition teams to coordinate at-risk discharges), emergency room navigation services to divert non-urgent cases to primary care, and intensive patient support services through community-based and cross-disciplinary care teams. The result should be reduced use of emergency rooms, fewer avoidable hospital readmissions, and better access to a more appropriate and cost-effective level of health care services. Over a three-year period, Providence Portland Medical Center’s program will train an estimated 54 workers. It will create an estimated 62 jobs. These new workers will include community outreach.

*Project Title: “Tele-critical care and emergency services”*

*Summary:* St. Luke’s Regional Medical Center is receiving an award for remote intensive care unit (ICU) monitoring and care management in rural southwestern and central Idaho and eastern Oregon. Critical care for patients in ICUs will be provided by physician intensivists working in teams with care providers and coordinators working on site and in a central monitoring unit. Through early identification of patients in need of specialized care, improved care coordination, and standardized clinical quality practices, the program will reduce ICU days, increase access to specialty care, and provide more appropriate and timely care for patients. Over a three-year period, St. Luke’s Regional Medical Center, Ltd’s program will train an 110 workers, while creating an estimated 24.5 jobs for critical care nurses, health care assistants, information technology (IT) support and IT analysts, clinical educators, accountants, billing specialists, financial analysts, an IT project manager, a business analyst, a medical director, and an operations director.

*Project Title: “Engaging patients through shared decision making: using patient and family activators to meet the triple aim”*

*Geographic Reach:* California, Colorado, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, Washington

*Summary:* The Trustees of Dartmouth College is receiving an award to collaborate with 15 large health care systems around the country to hire Patient and Family Activators (PFAs). The PFAs will be trained to engage in shared decision making with patients and their families, focusing on preferences and supplying sensitive care choices. PFAs may work with patients at a single decision point or over multiple visits for those with chronic conditions. It is anticipated that this intervention will lead to a reduction in utilization and costs and provide invaluable data on patient engagement processes and effective decision making—leading to new outcomes measures for patient and family engagement in shared decision making. Over a three-year period, the Trustees of Dartmouth College-sponsored program will train 5,775 health care workers and create 48 positions for patient and family activators.

*Project Title: "Brookdale Senior Living (BSL) Transitions of Care Program"*

*Geographic Reach:* Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin

*Summary:* The University of North Texas Health Science Center (UNTHSC), in partnership with Brookdale Senior Living (BSL), is receiving an award to expand and test the BSL Transitions of Care Program which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living and dementia specific facilities in Texas and Florida. In addition, community dwelling older adults who receive BSL home health services will be included in the Transitions of Care Program. Over the course of the award the program will expand to other states where BSL communities are located. The program will employ clinical nurse leaders (CNLs) to act as program managers. CNLs will train care transition nurses and other staff on the use of INTERACT and health information technology resources to help them identify, assess, and manage residents' clinical conditions to reduce preventable hospital admissions and readmissions. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults. Over a three-year period, the University of North Texas Health Science Center's program will train an estimated 10,926 workers and create an estimated 97 jobs for clinical nurse leaders and other health care team members.

- The Partnership for Patients (PfP): *a public-private initiative to test different models for improving patient care and patient engagement to reduce hospital acquired conditions and to improve care transitions in hospitals nationwide.*  
In Oregon, 77 groups have signed the Partnership Pledge, including hospitals, health systems, health centers, health plans, pharmacies, universities, physicians, consumer/patient organizations, government organizations, union organizations, and employers. In association with the Health Research and Education Trust of the American Hospital Association, the Oregon Association of Hospitals and Health Systems (OAHHS) is providing support and resources state-wide to physicians and other healthcare providers in order to improve patient safety, reduce healthcare costs, and provide higher quality care. This aligns with Oregon's overall transformation efforts and our coordinated care model. One example of how Oregon is actively working towards the goals of this initiative is through state-wide meetings for targeted participants. Oregon's Partnership for Patients initiative will be having an in-person statewide meeting for hospital participants on September 28, 2012, and will be addressing adverse drug events, safe surgery/SSI, and how to engage physicians and leadership.
- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: *to assess the impact that additional support has on FQHCs transforming their practice and becoming formally recognized as patient-centered medical homes.*  
In Oregon, nine FQHCs are participating in the demonstration project and have agreed to pursue Level 3 patient-centered medical home recognition from the National Committee

for Quality Assurance, by November 1, 2014. Participating Oregon FQHCs are all working to coordinate care for patients and assist patients in managing their chronic conditions. The clinics involved are also certified by the Oregon's patient-centered primary care home (PCPCH) program, and aligns with Oregon's coordinated care model and its emphasis on PCPCH.

## 2) Affordable Care Act and CMS initiatives to test other models for care transformation

- Medicaid State Option to Provide Health Homes for Enrollees with Chronic Conditions (Section 2703)**: *enhanced Federal Medicaid matching funds for states that opt to provide a health home to support and enhance medical care for persons with at least one chronic condition and a risk of another, or with a serious and persistent behavioral health conditions, including mental health or substance abuse disorders.*

Oregon received a Section 2703 State Plan Amendment (SPA) in 2011, in order to provide health homes for Medicaid beneficiaries with chronic conditions. The work under the SPA is aligned with the overall statewide efforts to spread PCPCH as discussed in both the Narrative of the application and in Oregon's State Health Care Innovation Plan. Starting in October 2011, this has provided enhanced payments, aligned with Oregon's proposed tiered payment structure using the PCPCH Standards. Clinics get credit for NCQA certification, but are required to provide further evidence of improving outcomes to fulfill Oregon's Standards.
- Independence at Home (Section 3024)**: *to test a new model of utilizing primary care teams to deliver certain services to Medicare beneficiaries in their homes.*

Portland, Oregon-based Housecall Providers, Inc. is one of 15 individual practices that will be testing new models of home healthcare through this demonstration project which will provide learnings for the new CCOs and Oregon's commercial plans as the coordinated care model spreads. Independence at Home is particularly important for the large number of dually eligible Oregonians who receive long term care services and supports in their home rather than in an institutional setting.

## 3) Other CMS and HHS care transformation initiatives in Oregon

- 5 Star Quality Bonus Demonstration**: *to test whether providing incentives to Medicare Advantage Plans such as scaled bonuses and fewer enrollment restrictions for high scoring plans will increase quality performance.*

In 2011, Oregon's Medicare Advantage plans received an average star quality rating of 3.82 out of 5, above the national average of 3.49 stars. On average, due to its high benchmarks for quality and its double bonus status, Oregon is projected to receive a bonus of approximately \$400 per Medicare Advantage enrollee in 2012. Oregon has one of the highest penetration rates of dual eligible individuals enrolled in Medicare Advantage at 47 percent, most of whom are served by Dual Special Needs or other Medicare Advantage plans that are closely affiliated with a Medicaid plan. Nearly all of these plans have a star rating of 3.5 or higher, and are important partners in spreading the coordinated care model to their dually eligible members.

- Aging and Disability Resource Center Grants (ACA Section 2405): *The Administration for Community Living (ACL) seeks to ensure that older adults, individuals with disabilities and family caregivers have clear and ready access to integrated systems of health and human services. The Aging and Disability Resource Center (ADRC) Program model supports this objective by facilitating their access to long-term services and support, through a uniform, statewide system.*

Oregon is one of eight states chosen to serve as a high-performing national model on how to provide high quality long-term care services and supports counseling to older adults, individuals with disabilities, and their families, through the Enhanced ADRC Options Counseling Program grant. This is a good starting point for Oregon to enhance its success at spreading the coordinated care model.

#### 4) Other Affordable Care Act Funding initiatives in Oregon

- Maternal, Infant and Early Childhood Home Visiting Program: *a HRSA grant to support collaboration and partnership among all levels of government to improve health outcomes for at-risk children through evidence-based home visiting programs.*  
Oregon was awarded two of these grants, totaling \$4.34 million annually, to establish and expand three evidence-based home visiting models across eight counties. In addition to serving more than 400 families, these funds will resource the development of a statewide home visiting system that for the first time aligns services of nine home visiting programs, establishes common outcome measures and monitors progress through a common data system and evaluation process. This complements our efforts in Health Information Technology through the Office of the National Coordinator and our efforts to align Medicare and Medicaid in adopting the coordinated care model.
- Emerging Infections Program, Enhancing Epidemiology and Laboratory Capacity: *a grant to support the enhancement of existing state and local health departments' surveillance infrastructure through increased epidemiological and laboratory capacity.*  
Epidemiology and Laboratory Capacity (ELC) ACA funds have been used by the Oregon State Public Health Laboratory (OSPHL) to develop the capacity to develop faster methods of serotyping Salmonella, which in turn leads to faster detection of outbreaks. OSPHL has also developed the capacity to test for additional viruses and bacteria that cause respiratory illness, enabling them to test isolates from outbreaks of respiratory illness and hospitalized patients with negative tests for influenza. Stable funding has also been secured for an electronic surveillance manager, who oversees Oregon's electronic laboratory reporting system and has led the implementation of Orpheus, a secure internet-based reporting system used by counties to report cases of communicable diseases, including HIV, tuberculosis, and STDs. This will be a useful resource for the new CCOs as they look across their community to meet their needs under our state innovation plan.
- Strengthening Public Health Infrastructure for Improved Health Outcomes: *a grant to strengthen the capacity and performance of public health departments in order to effectively and efficiently meet public health goals.*  
The Oregon Public Health Division (PHD) is using ACA funding to build structures to measure program performance, drive progress reporting and document successes and

opportunities for improvement. Specifically, PHD and 15 local health departments have used ACA funding to develop strategic plans, community health assessments and community health improvement plans that form the prerequisites for applying for national accreditation. Additionally, the ACA funds have allowed for investment in Quality Improvement staff and resources that are helping state and local public health become more efficient and effective by removing waste from processes. This has built expertise and knowledge in Oregon's local and state health departments to enhance work on improving population health, an important component of our innovation model.

- Behavioral Risk Factor Surveillance System (BRFSS) Supplemental Funding: a CDC grant to support State Health Departments with additional resources in order to sustain and expand the utility of BRFSS and other state-based public health surveillance infrastructure.

The Oregon Public Health Division received one-time supplemental funding to conduct surveillance and to assess the prevalence of Influenza-Like Illness (ILI) to support pandemic influenza response and preparedness activities. These funds also enabled Oregon to conduct multi-mode surveillance to enhance and expand the utility of Oregon's BRFSS and maintain Oregon's public health surveillance infrastructure. This complements and aids the ability to use the BRFSS which has been valuable at assessing the health behaviors of our population overall, and has been used to focus on our target populations of the Oregon Health Authority including state employees.

- Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance: a grant to support Section 317 grantees in their ACA transitions.

The Immunization program has received an ACA grant for the VTrckS Enhancement Project which is helping the Oregon Immunization Program to build upon the current ALERT Immunization Information System (IIS) activities to support vaccine ordering, inventory and other interface with CDC's VTrcks System (CDC Vaccine Ordering System). This interface will support vaccine management, distribution and accountability for all Oregon providers that use State-supplied vaccine. It also will support security and planning for contingencies if the data system becomes unavailable. We are currently working with our vendor to make the needed changes in the ALERT IIS. Oregon's go live date to roll out the new functionality with our Immunization providers is January 2013.

In addition, the State's Immunization program was recently notified that it has been selected to receive two other ACA grants for Adult Immunizations, and for Immunization Billables. This is a compliment to efforts focused on health information technology and streamlining of administration of healthcare activities.

## **5. Other federal initiatives: The HITECH Act provisions of ARRA**

Oregon has gained support via the ONC HIE Cooperative Agreement and the Medicaid EHR Incentive Program, to build health IT infrastructure needed to support the triple aim. Both of these are invaluable to provide incentives and tools to providers that will allow Oregon's coordinated care model to succeed. Specifically:

- State HIE Cooperative Agreement with the Office of the National Coordinator for Health IT (ONC): supporting development of strategic planning for health information exchange. Under the Cooperative Agreement, OHA has launched CareAccord™, Oregon’s statewide HIE. The first service available through CareAccord™ is Direct Secure Messaging, an “on-ramp” that will lower the cost of point-to-point HIE in a secure and trusted fashion. Further work is underway to expand on this first step to enhance information exchange amidst the Medicaid CCOs, as well as across the multiple health systems and the full variety of providers in order to aid health system transformation.
- Medicaid EHR Incentive Program: encouraging the adoption and meaningful use of certified EHR technology. Oregon's Medicaid EHR Incentive Program launched in September 2011 and, as of August 2012, 976 eligible professionals and 36 hospitals in Oregon had received payments through that program, in addition to the eligible providers and hospitals that received Medicare incentive payments. The adoption of certified EHRs is a key strategy behind Oregon's drive for better health, better care and lower costs.

## Biographical Sketches of Oregon SIM Initiative Key Leadership

**Tina Edlund, Chief of Policy, Oregon Health Authority**, has worked for the last 25 years in health services research and health policy with the Oregon Division of Medical Assistance Programs, Providence Health System, the Oregon Health Policy Institute, and with the Office for Oregon Health Policy and Research (OHPR). She became the Deputy Director for Planning and Policy Implementation at the newly created Oregon Health Authority (OHA) in July 2009 and currently serves as the Chief of Policy. The OHA brings most of Oregon's health and health care services into a single entity, and is responsible for purchasing health care services for over 850,000 Oregonians. Ms. Edlund was part of the management team for the Oregon Health Policy Board, established by the Oregon Legislative Assembly in 2009, responsible for developing the legislative concept that become Oregon's health system transformation enabling legislation. Most recently, Tina was the lead for OHA in negotiating the terms and conditions for Oregon's recent 1115(a) waiver amendment and renewal process, which paved the way for transforming the Medicaid health care delivery system in Oregon. Ms. Edlund is a graduate of the University of Oregon and has a Masters degree in Urban Affairs from Portland State University.

**Jeanene Smith, MD, MPH, is the Administrator of the Office for Oregon Health Policy and Research (OHPR)** and has been with the Office since 2000. OHPR provides oversight and coordination for all elements of the Oregon Health Plan and state health trends, providing technical and policy support to the legislative and executive branch decision-making on health policy. This includes the work of Oregon's Health Policy Board which is focused on implementing a state health reform plan, the Health Evidence Review Commission, Medicaid Advisory Council Pain Management Commission, Patient Centered Primary Care Home Program, and the Primary Care Office. She graduated from Oregon Health Sciences University (OHSU) School of Medicine, completed a residency in Family Medicine at Jefferson University Hospital in Philadelphia, Pennsylvania. She graduated with a Masters in Public Health from Portland State University in 2001. She has practiced family medicine in both private practice and community clinics for over 15 years, and continues to see patients on a limited basis at an Oregon federally-qualified health center.

**Judy Mohr Peterson**, has been the Director for Medical Assistance Programs of the Oregon Health Authority since September 2009. In 2010, she was one of six Medicaid Leadership Institute Fellows. She began her career with Medicaid in 1997, and worked eight years as the manager of the analysis, evaluation and quality improvement units. She then spent five years managing caseload forecasting, actuarial services and the DHS budget. Before DHS, Judy was evaluated and reported on children's mental health in Texas. She received her doctoral degree in cultural anthropology from the University of Texas at Austin.

### **Gretchen Morley, MPA, Director, Office of Health Analytics**

Ms. Morley provides leadership, balanced information and analysis for the new Health Analytics Office within the Oregon Health Authority. Ms. Morley has 18 years of health research, policy, and budget experience at the national and state level, including positions as the lead Medicaid analyst at the Office of Management and Budget and the Administrator of the Office of Federal

Financial Policy at Oregon's Department of Human Services. Most recently, she held the position of Director of Health Policy Development at the Office of Oregon Health Policy Research and has been directly involved in the policy development and public vetting of Oregon's health care reform and transformation initiatives. Ms. Morley reviewed and verified the financial analysis required as part of the SIM application.

**Joan M. Kapowich, Administrator of the Public Employees' and Oregon Educators Benefit Boards.** The boards design and administer benefits for over 277,000 members and dependents. Their value based insurance designs were featured in the November 2010 issue of Health Affairs. The boards are among the first in the nation to feature low and high co-payments to encourage preventive care and discourage care based on the value of the services to health outcomes. She previously managed the Program and Policy Section of the Oregon Health Plan. She is a member of National Academy of State Health Policy (NASHP). Ms. Kapowich has a sociology degree from UC Santa Barbara and a nursing degree from Lane Community College.

**Cathy Kaufmann, M.S.W., is the Administrator for Oregon's Office of Healthy Kids and Office of Client and Community Services.** Since Ms. Kaufmann took the lead for the then-new Office of Healthy Kids in 2009, the program has seen 113,000 Oregon children added to coverage, reducing Oregon's child uninsurance rate from 11.3 to 5.6. Before joining the Oregon Health Authority, Ms. Kaufmann served as the Policy and Communications Director for Children First for Oregon, a statewide child advocacy organization. Ms. Kaufmann also served as the Co-Chair for the Human Services Coalition of Oregon, a coalition of over 100 organizations working to improve public policy and support for human services. Ms. Kaufmann will be directing the development of the Transformation Center and Innovator Agents until a Transformation Center Director is hired.

**Nicole Merrithew, MPH, Director, Patient-Centered Primary Care Home Program**  
Nicole is currently responsible for oversight of the Oregon Health Authority's (OHA) Patient-Centered Primary Home Program housed within the Office for Oregon Health Policy and Research (OHPR). The goals of the program are to develop strategies to identify and measure Patient-Centered Primary Care Homes, promote their development, and encourage all Oregonians, particularly those populations covered by the OHA, to receive care in this new model. Prior to her current position, Ms. Merrithew was the Director of the Oregon Medicaid Advisory Committee, a federally-mandated body charged with advising the legislature and the OHA on the operation of Oregon's Medicaid program. Prior to her position with OHPR, Ms. Merrithew worked as a program development analyst for the Oregon Public Employees' Benefits Board and as a Research Assistant with Oregon Health and Science University. She holds a Bachelor's Degree in Biochemistry and Molecular Biology and a Master's Degree in Public Health.

**Susan Otter** is *Project Director for the Medicare/Medicaid Alignment Project* at the Oregon Health Authority. Susan led a stakeholder process to design alignments between Oregon's new Medicaid Coordinated Care Organizations and Medicare to benefit individuals eligible for both programs, and worked with stakeholders and Department of Human Services staff to develop strategies to coordinate care and share accountability between CCOs and long term care system to improve outcomes for individuals served by both systems. Previously, she directed the

Medicaid Health Information Technology (HIT) Project and was responsible for development of the State Medicaid HIT Plan and the implementation of Oregon's Medicaid EHR Incentive Program. As a Policy Analyst for the Office for Oregon Health Policy and Research, she conducted health policy analysis and planning around health information technology (HIT) planning efforts in Oregon, including development of the State Medicaid HIT Plan and the Statewide Health Information Exchange Strategic and Operational Plan. She wrote and coordinated the initial grant applications for these two projects, which will brought in more than \$12 million in federal funding for Oregon.

**Latricia Tillman, MPH, Administrator, Office of Equity and Inclusion**

Under Ms. Tillman's leadership, the Office of Equity and Inclusion has elevated the mandate for health equity in Oregon's health care reform efforts, increased funding for culturally specific community organizations to promote health and well being, created opportunities for diverse health professionals to serve in policy leadership roles, and advanced the creation and implementation of policies that promote equity in health and human services. She continues to work with OHA leadership to ensure that health equity and culturally and linguistically appropriate service standards are a strong part of Oregon's Health Systems Transformation and to advance the integration of community health workers, doulas and other "non-traditional health workers" in the integrated health team. Previously, Ms. Tillman served as a program manager at the Multnomah County Health Department. She initiated and managed the county's Health Equity Initiative and the African American Sexual Health Equity Program. Her work helped create a mandate for policy makers and elected officials to support policies and programs that reduce avoidable and unfair health inequities experienced by communities of color, immigrants and refugees.

**Mel Kohn, M.D., M.P.H., Director for Public Health - State Public Health Officer of Portland**, is the Director for the State Public Health Division and State Health Officer at the Oregon Health Authority. Previously he served as State Epidemiologist and administrator of the Department of Human Services (DHS) Office of Disease Prevention and Epidemiology. He has worked in the public health sector since 1993, including two years as an Epidemic Intelligence Service Officer for the Centers for Disease Control and Prevention. Before joining DHS in 1999 Kohn was Medical Director for a Section of the Louisiana Office of Public Health in New Orleans where he was also an assistant professor of Pediatrics at Tulane University School of Medicine. Dr. Kohn received a B.A. in Russian and East European Studies from Yale (1981), took pre-med courses at Columbia University, received his M.D. from Harvard (1990), and received his Masters in Public Health (MPH) from Tulane School of Public Health and Tropical Medicine (1997). He completed his internship and residency in pediatrics at the Children's Hospital in Boston, completed a preventive medicine residency at Oregon Health and Sciences University, and is board-certified in pediatrics and preventive medicine.

**Carolyn Lawson, Chief Information Officer, Oregon Department of Human Services and the Oregon Health Authority**

Carolyn Lawson is the Chief Information Officer for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). Her role as CIO is to bring innovation and vision to continually improve the health and human service needs of Oregonians. The DHS/OHA technology services division delivers and supports technology for 11,000 agency staff and

20,000 partner staff at 350 locations around Oregon. Recently she has been appointed by the Governor to the Health IT Oversight Council. Lawson came to Oregon in July from the state of California where she most recently served as director of the California eServices office and deputy director of the Technology Services and Government Division. She was previously CIO for the California Public Utilities Commission and held leadership positions with the California State and Consumer Services Agency and the Department of Alcohol and Drug Programs.

Lawson's background is in using technology to support open government and creating innovative partnerships that leverage technology to increase public access at lower costs. She's considered a national thought leader and innovator with several awards to her credit, including being named one of the Top Innovators in Government by Information Week in 2009 and 2010, and one of the Top 100+ Women in Government Technology by GovFresh in 2010. She holds several national leadership positions, including service on the advisory boards of Information Week and Code for America.

***Carol Robinson, Administrator, Office of Health IT and State Coordinator of Health IT.***

Prior to her current position, Ms. Robinson served Governor Kulongoski as the Interim Executive Director of the Oregon Health Fund Board during the 2009 legislative session. Her experience in public policy spans many subject areas including education, tax policy, clean energy and health care. She has represented Oregon on several national committees focused on health information exchange and is currently co-leading the Western States Consortium, working to demonstrate secure electronic interstate exchange of health information. Robinson currently serves on the Oregon Health Leadership Council Executive Committee for Administrative Simplification, the O-HITEC Advisory Committee (Oregon's Regional Extension Center) and serves as Director of the Oregon Health Information Technology Oversight Council.

***Michael McCormick, Deputy Director, Aging & People with Disabilities***

With 16 years of state service, 13 of those being with DHS, Michael has extensive knowledge of the agency's program structure, client needs and policy guidelines. Michael McCormick became the Deputy Director for Aging and Disability Programs on January 2, 2012. Prior to this new role, Michael led the Department's Office of Rates, Contracting and Research. During his tenure, Michael provided leadership on financial management, effective use of data in administering programs and establishing fair, competitive rates for long term care providers. During his leadership role for the Provider Audit Section, Michael adopted a data analytics approach towards assessing risk of errors, fraud and abuse in the Oregon Health Plan's medical programs. Millions of tax dollars were recovered under Michael's leadership, which were ultimately used to fund needed services for Oregonians. Originally from Baltimore, Mike graduated from University of Oregon with a BS in Business Administration.

# Waves 1 to 3 Coordinated Care Organization Service Area Density

