Oregon Health Plan

Section 1115 Annual Report

Demonstration Year: 12

7/1/2013 – 6/30/2014

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I. Introduction

A. Letter from the State Medicaid Director

I am pleased to let you know about the Oregon Health Authority (OHA)'s progress in meeting the goals of the Oregon Health Plan (OHP) demonstration for the past demonstration year.

Lever 1 - Improving care coordination

The number of recognized Patient-Centered Primary Care Homes (PCPCHs) increased to 507 in June 2014. This exceeds the program's goal of 500 recognized clinics by the end of 2014. In addition:

- As of March 2014, 79.6% of coordinated care organization (CCO) members were enrolled in a PCPCH, an increase of 52% from the baseline (51.8%).
- 14 of 15 CCOs showed an increase in members enrolled in a PCPCH.

Lever 2 – Implementing alternate payment methodologies

OHA made their first CCO Quality Pool payments in June 2014. 11 of the 15 CCOs earned 100 percent of their quality pool. In June 2014, OHA received approval to set up a hospital quality pool to provide similar incentives to hospitals. To learn more, visit the Hospital Metrics Advisory Committee website.

Lever 3 – Integrating physical, behavioral and oral health care

This year, OHA completed its integration of dental services into CCO delivery systems. As of June 30, 2014, over 680,000 OHP members receive dental services through their CCO. Substance use disorder residential and detoxification services are also integrated into the CCO model, and four CCOs have integrated non-emergent medical transportation.

Lever 4 – Increased efficiency in providing care

The first full year of CCO performance data was published in June 2014. Statewide, there was improvement on 14 of the 17 CCO incentive measures. Notable efficiencies demonstrated by the statewide quality and access test measures include:

- Decreased emergency department (ED) visits (-17%) and ED spending (-19%)
- Decreased hospitalizations for chronic conditions: Congestive heart failure (-27%), chronic obstructive pulmonary disease (-32%), and adult asthma (-18%)

Lever 5 – Implementation of health-related flexible services

The first CCO financial reports to include flexible services reporting were published in June 2014. OHA is analyzing the data to understand how, and in what degree, CCOs are providing flexible services.

Lever 6 – Innovation through the Transformation Center:

Innovator Agents built relationships among CCOs and within OHA to better spread best practices in support of innovation. By the fourth quarter, IAs helped local Community Advisory Councils (CACs) complete their Community Health Improvement Plans, and led Tiger Teams to address OHA's internal transformation needs to better support CCOs.

Judy Mohr Peterson, PhD, State Medicaid Director

B. Demonstration description

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

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

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

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

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

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

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

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

- **Workforce:** To support the new model of care within CCOs, Oregon will establish a loan repayment program for primary care providers who agree to work in rural or underserved communities in Oregon, and training for 300 community health workers by 2015.

The primary goals of the Oregon demonstration are:

- **Improving health for all Oregonians**: The State is committed to fostering innovative approaches to improving population health through a focus on linking community health and services with the clinical delivery system. Population health efforts and alignment with schools and the education system are integral to improving the health of all Oregonians by going beyond the walls of the clinics and hospitals.

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- **Improving health care:** The State is working to coordinate physical, behavioral and oral health care and increase the focus on prevention and improved care. Individuals can get the care and services they need, coordinated regionally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language.

- **Reducing the growth in Medicaid spending:** The state has agreed to reduce per capita medical trend, the growth in per capita spending, by 2 percentage points by the end of the second year of the demonstration period from an assumed trend rate of 5.4 percent as calculated by federal Office of Management and Budget.

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

In June 2014, the Hospital Transformation Performance Program (HTPP) was approved for implementation in July 2014. The program will temporarily offer incentive payments to support hospitals' quality improvement efforts.

B. State contacts

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II. Title

Oregon Health Plan Section 1115 Annual Report
4/1/2014 – 6/30/2014
Demonstration Year (DY): 12 (7/1/2013 – 6/30/2014)

III. Overview

A. Accomplishments

The Transformation Center has provided assistance to CCOs through Innovator Agent (IA) leadership and learning collaboratives throughout the year. Highlights include:

Innovator Agent leadership

Innovator Agent scope of work

Innovator Agents serve as region-specific experts, with knowledge of their CCO's strengths and weaknesses and a comprehensive understanding of the health needs of their region. With this expertise, they are tasked with being a key liaison between their CCO and OHA. In addition to serving as an expert and liaison, the IAs have also increased stakeholder engagement, and provided guidance to Community Advisory Councils' (CAC)s work to create Community Health Assessments (CHAs) and craft Community Health Improvement Plans (CHIPs). IAs participate in the collaborative development and sharing of learning resources across the state, and assist in transformation through supporting implementation of the CCOs' Transformation Plans and adapting learning resources to their region. Assuring positive communication among CCO partners involves attendance at a myriad of stakeholder events to provide OHA updates, listen to concerns, and recommend next steps when requested.

Four-quarter summary of Innovator Agent accomplishments

The first quarter, IAs focused on relationship building and information dissemination. Types of support included research and education on transformation along with learning about the individual needs of their CCOs. The second quarter gave IAs the opportunity to provide detailed guidance to CCOs in implementing transformative health system change by sharing best practices and interpreting OHA regulations and data. The third quarter saw IAs convene OHA leadership to facilitate enrollment and gain clarity on contract deliverables. This fourth quarter highlighted IAs role providing community leadership through assisting CACs with completing Community Health Improvement Plans and elevating the need for internal transformation to state leadership through the use of Tiger Teams.

Innovator Agent relationship with stakeholders

One key to success for IAs lies in their ability to work with and coordinate efforts across stakeholders. IAs have strong relationships with the following parties involved in transformation: CCO executive team, staff, and board; state Medicaid personal; state mental health personnel; OHA account representatives; Community Advisory Councils; regional Human Service staff; regional provider task forces; community health assessment committees, early learning services; and local health councils. Because the IA's role is to serve as an expert and liaison, they navigate these relationships in order to represent community and CCO needs to OHA for planning purposes and to disseminate and collect information on behalf of OHA.

Innovator Agent subject area expertise

The following topics of transformation are areas in which IAs are working in collaboration with their CCOs: Transformation Plan implementation; Transformation Fund implementation; non-emergency medical transportation; behavioral health integration; community health assessments and community health improvement plans; early learning services; traditional and non-traditional community health workers; CCO financing; prenatal care and early learning services; substance abuse, readmissions, and high utilizers; provider prescribing patters; patient centered primary care homes; health information technology and meaningful use; cultural competency; and enrollment. These subjects indicate that transformation and IA activity encompasses a broad range of issues that involve different partners, skillsets, and outcomes.

Transformation Center support of Innovator Agent Work

Participation in Transformation Center Learning Collaboratives

The Transformation Center launched five learning collaboratives this year that complement the Innovator Agents' work of spreading innovation.

1. The monthly Statewide CCO Learning Collaborative is geared towards medical and behavioral health directors and focuses on spreading best practices for Oregon's 17 incentive metrics.

   The Transformation Center ran a learning collaborative specific to the eight Innovator Agents to assist them in their work. Assistance included providing lessons learned from consultant to assist IAs with the human side of change and providing a forum for in-state experts on trauma informed care, alternative payment methods, Choosing Wisely Campaign, 'One key question' information, and Bridges out Of Poverty training.

2. The monthly Community Advisory Council Learning Collaborative provides support to Community Advisory Council members and steering committee members, providing resources on leadership, board roles, and planning in conjunction with IA support to facilitate the completion of CHAs and implementation of CHIPs.

3. The Complex Care Collaborative is a forum for providers and health care professionals to share ideas and learn innovative care models, with over 100 attendees that met twice this year.

4. The Institute for Healthcare Improvement's Improvement Science in Action learning collaborative began as a 3 day intensive training, supplemented by 4 webinars, geared specifically to over 100 CCO Transformation Fund Portfolio Managers, QI Managers and their project teams to facilitate the implementation of quality improvement concepts, tools, techniques and methods. Follow up continues through site visits and through online social networking.

5. The Oregon Council of Clinical Innovators is a statewide, multidisciplinary cadre of 14 innovation leaders, consultants and mentors who meet quarterly and work with project teams to implement health system transformation projects in their local communities.

Innovator Agents have helped in the development, and ensuring CCO attendance at, these learning collaboratives. In this way, they have helped good ideas spread faster to a broad audience of key players spread throughout the state.

Other Transformation Center support

Innovator Agent work was intense and fast passed, and required various supports from the Transformation Center.

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1. Innovator Agents are leading OHA internal transformation through **Tiger Teams**, which are teams of transformation formed to address key internal areas within the agency. The Director of OHA is the Executive Sponsor, the Executive Director of the Transformation Center is the Project Director, and OHA Sub-Cabinet approves completion of all chartered deliverables. Of particular note is that Innovator Agents are the lead staff for teams working towards adult mental health residential integration into the global budget, rate setting, rules promulgation, and contracts. In addition to learning collaboratives, the Transformation Center took leadership in health system transformation more generally as follows:

2. The first CCO Summit, "Transformation in Action," was attended by over 600 people. With Governor Kitzhaber paving the way, the Transformation Center led panel discussions on progress across the state, behavioral health integration, patient centered care, alternative payment, and health learning systems.

   The CAC Summit brought 150 participants (including over 100 CAC members) from across the state to provide opportunities for members to connect with and learn from other members and learn leadership skills.

3. **CCO Issue Tracker** data: Innovator Agents, Transformation Analysts, and other OHA staff discussed the accuracy of language codes that CCOs report. Because of the Issue Tracker, the Transformation Center was able to identify the issue as reoccurring and chronic.

4. The **Good Ideas Bank** is in prototype stage, and will highlight best practices for health system transformation happening across the state, including hospital to home transition teams, screenings for foster care, a mental health literacy campaign, and an example of online population health data sharing.

B. Project status

Significant CCO/MCO network changes - Approval and contracting with new plans

Effective date(s)	Specific change	Effect on		Number affected	
		Delivery system	Members	CCOs	CCO members
7/1/2013 – 6/30/2014	Continued dental integration into CCOs	Strengthens transformation and integration	Provides positive access and coordination of benefits	10	682,619 individuals have dental benefits through a CCO as of 6/30/2014
9/1/2013	Cascade Health Alliance CCO began coverage in southern Klamath County	CCO has contracted with a sufficient number of local mental health providers to serve their members.	Members continue to transition from managed care and fee for service into the CCO.	1	10,723 individuals enrolled
1/1/2014	Pacific Source divided into two separately contracted organizations, one of them a new CCO (Pacific Source	Wasco and Hood River Counties are now covered by the new CCO.	Members in Wasco and Hood River Counties moved to the new CCO.	2	9,261 members moved to the new CCO.

Effective date(s)	Specific change	Effect on		Number affected	
		Delivery system	Members	CCOs	CCO members
	Columbia Gorge).				

C. Quantitative and case study findings

Innovator Agents – Summary of promising practices statewide

Task	Summary of activities	Promising practices	Number of participants	
			CCOs	Innovator Agents
Innovator agent training	Please see summary of Learning Collaborative work	-	-	-
Learning Collaborative activities	Please see summary of Learning Collaborative work	Topics that were best received were those chosen by CCOs and Innovator Agents as timely and pressing needs. Hence it is important for the Transformation Center to be quick and responsive to issues as they are raised.	16	8
Assisting and supporting CCOs with Transformation Plans	Please see summary of IA work above.	Because each CCO is in a different stage of development, IAs have learned to shift roles as needed, from serving as a trusted source of counsel, to becoming more of an advocate for integration depending on the CCOs needs.	16	8
Assist CCOs with target areas of local focus for improvement	Please see IA subject matter expertise	Created new dental care coordination mechanism for members. Coordinated community advisory councils for 3 overlapping CCOs. IAs also facilitated internal health equity learning series for staff so that they can help CCO with same issue in future.		
Communications with OHA	Please see IA relationship with stakeholders	Tiger Teams are helpful to focus internal energy on transformation. With the help of consultants, Innovator Agents identify and act upon specific strategies to improve state communication to CCOs	16	8
Communications with other Innovator Agents	As they work together on internal transformation, they share promising practices to promote through	Examples include facilitating communication between dental advocates, oral health association, Volunteers in Medicine, LTSS Innovator Agents, BH staff, local Research	16	8

Task	Summary of activities	Promising practices	Number of participants	
			CCOs	Innovator Agents
	regular in-person and electronic communication.	Collaborative by serving as a 3rd party convener.		
Community Advisory Committee activities	Please see IA Four quarter summary of accomplishments	Balancing the needs of the CACs with CCO priorities requires careful acumen and respect.		
Rapid-cycle Stakeholder feedback	Please see IA Scope of Work	Communication with all stakeholders is critical to success		
Data base implementation – Tracking of CCO questions, issues and resolutions in order to identify systemic issues	Please see Issue Tracker summary above		16	8
Information sharing with public	Innovator Agents continue to present to a large variety of stakeholders and share information with their Community Advisory Councils and community partners.	Communicating with Community Advisory Councils is a good way of reaching community members.	16	8

Innovator Agents – Measures of effectiveness

Measure	Data published
Surveys rating IA performance	N/A: Plans for qualitative interviews with stakeholders are forthcoming.
Data elements (questions, meetings, events) tracked	Innovator Agents submit quarterly reports that track activities to support transformation within their CCO, in partnership with OHA, and other activities focused in the community.
Innovations adopted	A prototype of the Good Ideas Bank has been successfully launched online and will be publicly available after being reviewed to ensure that Innovator Agent input on how to communicate best practices is taken into account. Ideas that will be highlighted include changes beyond CCO activity, including hospital to home transition teams, screenings for foster care, a mental health literacy campaign, and an example of online population health data sharing.
Progress in adopting innovations[1]	Progress in innovations surrounding behavioral health integration in primary care settings continues to be a top priority. Additional work finding innovative ways to expand non-emergency medical transportation is also underway.

[1] These items will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

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Measure	Data published
Progress in making improvement based on innovations *	CCOs are making solid progress based on Progress Reports and Milestone reports submitted that report on 8 areas of transformation, including: oral and behavioral health integration; primary care home; alternative payment; health information; and community empowerment.
CCO transformation plan implementation	Transformation Plans are on track, as evidenced by milestone reports recently submitted. The Transformation Center is developing a Technical Assistance Bank for CCOs, to be launched by October 2014. The Transformation Center will create a menu of technical assistance topics that CCOs may access upon request. The Transformation Center will pay for a set number of hours of TA for each CCO. Each CCO will decide how to best utilize the TA resources by selecting the topics of most interest and need. Priority topics include: Community Health Improvement Plan (CHIP) implementation and evaluation; Community Advisory Council (CAC) development; health equity; oral health integration; and public health integration.
Learning Collaborative effectiveness	Learning collaborative have been very well received, with the majority of the hundreds of participants indicating that their participation will result in the sharing and spreading of innovative ideas.
Performance on Metrics and Scoring Committee metrics	All Innovator Agents assist their CCOs in internal planning to align internal work with improvements on performance metrics. Their consultation and guidance include contract review and in some cases, clinical recommendations related to behavioral health integration.

Policy and administrative difficulties and solutions in the operation of the demonstration

Outside of ongoing technical problems with automated systems during second half of Demonstration Year , none reported.

D. Comments and issues raised by the public at public forums

List the sources of the comments, i.e. the names of the meetings for which we submitted comments during the year and refer to the links

Forum	Comments and issues raised
Oregon Health Policy Board	For more detail, please refer to the Board's 2013 and 2014 meeting archives. ■ Rate review should be actuarially based and account for quality. ■ Support for complimentary and traditional medicine is critical to transforming and improving our health care system. ■ It is disappointing that funding for homeless shelters is not part of health system transformation. ■ Consider declining access for Medicaid/Medicare recipients. ■ Call for greater accountability for health insurance companies to contain costs, improve care and increase transparency in Oregon's commercial health insurance market. ■ Small employers should not be required to change how they provide health insurance coverage to their employees. ■ CCO metrics and standards should be incorporated into the rate review process. ■ Provide more notice to consumers about, and encourage consumer involvement in, the rate review process. ■ Consider that any increase in regulations risks increased costs to small

Forum	Comments and issues raised
	employers. ■ Consider postponing ACA implementation to relieve stress on insurance carriers (related to implementing new requirements). ■ All Payer All Claims database may be missing certain types of data. ■ Put "teeth" in the all payer agreement as there is no mechanism for starting or requiring the process. Engaging all payers in supporting alternate payment methodologies is important to the success of Patient-Centered Primary Care Homes.
Future of Public Health Services Task Force	For more detail, please refer to the Task Force website. ■ Consider adding metrics and data to track the work of the task force. ■ Consider the broad scope of public health that is rooted in community and working collaboratively. ■ Map the local perspective for all counties (funding of individual services, populations, and policies related to those investments) to understand the entire landscape of public health funding, not just one part of the system. The local reality is very different from the state perspective. ■ Please take the message back to universities that our public health system needs more public health nurses. Recruitment is extremely difficult. ■ Keep in mind the role of accreditation and what we need to do about it.
Metrics and Scoring Committee	For more detail, please refer to the Committee website. ■ Dental metrics should address each part of the triple aim (reducing cost, improving health outcomes and quality of patient experience with care). ■ The sealant metric should incentivize everyone in the community (*e.g.,* non-dental settings such as Head Start, WIC, School-Based Health Centers), not just dental providers. Prevention work in non-dental settings has been proven very successful. ■ Frequency of dental exams should be measured for children, adults and especially seniors. ■ Incorporation of dental exam results in the primary care medical record could also be a metric, leading to PCPs encouraging patients to see their dentists and support care coordination. ■ Include a metric to measure patient wait time for appointments.
Medicaid Advisory Committee	For more detail, please refer to the Committee's meeting archive. ■ Consider approaching CMS for a waiver if the state were to opt for the Basic Health Program. ■ The Oregon Primary Care Association would like to work with OHA on the options the committee is considering to mitigate OHP enrollment churn as the time for eligibility redetermination draws near, as well as policies that involve OHP eligibility determination. ■ Please come up with a solution for people on transplant lists who lose their Medicaid eligibility. When this happens, they fall off the transplant list even if they are still waiting for a determination.

IV. Workforce provider capacity

A. Health professional graduates participating in Medicaid

In DY12, OHA finalized a data use agreement with Oregon Health and Sciences University (OHSU) to allow OHSU to send periodic information on physician assistant, nurse practitioner, and dentistry program graduates to OHA. These data are matched against Medicaid provider enrollment data to ascertain whether graduates are serving Medicaid clients.

The primary limitation of this method is that a "no match" result could mean one of several things:

- The graduate has left Oregon; or
- The graduate is still in Oregon but is not currently working as a direct care provider (e.g. working in policy or academia) or is not working at all (perhaps pursuing further education, or raising a family, or seeking a job but not yet employed); or
- The graduate is working in direct care and seeing Medicaid patients under the auspices of an enrolled clinic or CCO, and so is not enrolled individually as a Medicaid provider; or
- The graduate is working in direct care but not seeing Medicaid patients.

The advantage of this method—as discussed with school officials—is that it is likely to produce better results over time than a survey of graduates, because survey response rates would likely be low and the school's ability to provide accurate contact information for graduates would deteriorate quickly over time.

OHA performed an initial match for spring/summer 2013 graduates during DY 12. A file with information on fall 2013 and spring/summer 2014 graduates will be obtained in fall 2014 and a second match performed at that time.

Results from the initial match, as described in our October-December 2013 quarterly report, were as follows:

- Among 70 spring 2013 graduates of the dental school, %) are enrolled as Oregon Medicaid providers.
- Among 38 masters of nursing/nurse practitioner graduates in 2013 and 38 physician assistant graduates in summer/fall 2012 (the latest data available from that program). PAs and NPs providing Medicaid services may be more likely than physicians not to enroll as individual Medicaid providers.
- Medical school graduates do not go directly into practice but instead continue their training in a residency program. Residencies are based at academic or private medical centers. Of the 31 spring 2013 medical school graduates doing residencies in Oregon, 100% are at facilities enrolled as Medicaid provider facilities.

V. Utilization data

See interim evaluation findings (Lever 4) for discussion of access to health care services.

VI. Enrollment reporting

A. Ever enrolled report

		Population	Total Number of Clients	Member Months
Expansion	**Title 19; OHP Standard**	OHP Parents	25,939	127,634
		OHP Childless Adults	46,164	245,471
	Title 19; OHP Plus	PLM Children FPL > 170%	3,002	21,892
		Pregnant Women FPL > 170%	1,589	10,746
	Title 21; Plus	SCHIP FPL > 170	40,518	327,660
Optional	**Title 19; Plus**	PLM Women FPL 133-170%	21,684	149,303
	Title 21; Plus	SCHIP FPL < 170%	88,121	635,755
Mandatory	**Title 19; Plus**	Other OHP Plus	563,747	5,771,106
	Title 19; Plus	MAGI Adults/Children	425,477	2,382,082
	Title 19; Plus	MAGI Pregnant Women	5,513	29,024
		TOTALS	1,221,754	

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

B. OHP eligibles and managed care enrollment

	OHP Eligibles*	FCHP	CCOA[1]	CCOB[2]	PCM	DCO	MHO	CCOE	CCOG
July	626,177	15,012	26,123	506,260	536	579,439	12,115	28,916	0
August	626,841	14,711	26,821	503,214	523	575,584	11,780	28,146	1,234
September	627,574	3,920	27,363	510,665	520	573,461	11,535	28,389	1,256
October	623,209	3,759	153,305	388,196	0	445,333	11,294	24,035	5,882
November	624,424	3,686	154,739	386,799	0	444,098	11,146	24,646	5,808
December	614,183	3,521	151,450	377,139	0	432,690	10,814	24,235	5,843
January	821,221	3,484	467,130	207,650	0	258,736	4,300	13,294	24,574
February	854,288	3,442	497,979	216,147	0	270,472	4,278	13,525	24,898
March	901,108	3,409	517,455	221,568	0	275,365	4,326	13,634	25,072
April	935,026	3,351	611,949	179,510	0	228,529	4,500	9,042	33,049
May	963,651	3,299	634,308	184,373	0	235,072	4,478	9,085	36,790
June	971,104	3,233	642,560	185,379	0	237,753	4,467	9,003	38,421
Total	**765,734**	**5,402 0.71%**	**325,932 42.56%**	**322,242 42.08%**	**132 0.02%**	**379,711 49.59%**	**7,919 1.03%**	**18,829 2.46%**	**16,902 2.21%**

*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, CX Families, Adults & Couples, OAA, ABAD, CHIP, FC and SAC. Due to retroactive eligibility changes, the numbers should be considered preliminary.

[1] =CCOA Physical, Dental and Mental Health
[2]= CCOB Physical and Mental Health
[3] = CCOE Mental Health only
[4]= CCOG Mental and Dental

VII. Interim evaluation findings

In December 2013, OHA awarded a contract for a midpoint evaluation of the waiver to Mathematica Policy Research. Following guidance in Attachment H, the waiver Accountability Plan, the midpoint evaluation assesses the association between transformation activities and changes in access and quality that occurred over the first two years of the five year demonstration.

The evaluation is in three parts:

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

Mathematica hosted an informational webinar for stakeholders (including OHA and CCO leadership and staff); the webinar and slides can be accessed at OHA's Medicaid Demonstration page.

All data collection for the midpoint evaluation was completed during the demonstration year. This included document reviews, interviews with key informants (both from OHA, the CCOs, and community partners), and completion of the CCO Transformation Assessment Tool (which assesses the degree to which CCOs have transformed along elements of the coordinated care model). Mathematica also began processing enrollment and claims data to assess outcomes. The final report on the midpoint evaluation of the waiver will be available early in 2015.

Preliminary findings related to the impact of Oregon's waiver activities were also published in this demonstration year:

- The first report to include data on CCO performance for an entire calendar year was published and the first CCO incentive measure payments were made (see the CCO Quality and Accountability website and Section XII); and,
- Some initial findings from a Robert Wood Johnson funded State Health Access Reform Evaluation (SHARE) project were presented (SHARE assesses the impact of the CCOs on health care access, quality, outcomes, and costs). These findings are outlined below.

A. Evaluation activities and interim findings

In this section, relevant OHA and CCO activities for the demonstration year are reported by the "levers" for transformation identified in our waiver agreement and Accountability Plan.

Lever 1: Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through patient-centered primary care homes (PCPCH)

Evaluation activities:

OHA contracted for a broad evaluation of PCPCH implementation and early outcomes from a clinic, patient, and organizational/agency perspective. This included a survey of recognized clinics, qualitative findings on implementation of the PCPCH model, site visits, and a comparison of service utilization and

expenditures for individuals in selected PCPCH practice sites one year prior and following PCPCH recognition with those in non-PCPCH settings.

In this year the PCPCH program launched a new online application system based on updated 2014 recognition standards. The application now includes many of the questions from a survey used for the formal evaluation of the program. Completion of these questions is optional, but the program hopes to use them for evaluation purposes.

Interim findings:

The number of clinics gaining PCPCH recognition grew significantly over the demonstration year, increasing from 425 in September 2013 to 507 in June 2014. This exceeds the program goal of 500 recognized clinics by the end of 2014.

PCPCH enrollment is an incentive measure for the CCOs. The benchmark is that each CCO will enroll 100% of members in a PCPCH. The statewide baseline for this measure is 51.8%. The most recent data for a full calendar year (2013) show improvement in this area:

- As of March 2014, 79.6% of CCO members were enrolled in a PCPCH, an increase of 52% from the baseline.
- Fourteen of fifteen CCOs showed an increase in members enrolled in a PCPCH, with performance ranging from 54.4% - 96.7% across the CCOs.

Evaluation findings from the survey of recognized clinics, qualitative findings on implementation, and findings from the initial site visits were finalized this demonstration year. Key findings from the survey showed:

- 85% of practices reported that PCPCH implementation is helping them achieve the aim of improving the individual experience of care.
- 82% of clinics reported progress towards improving population health management.
- Less than half reported that implementation of the model helped them decrease costs.
- In terms of what influenced their decisions to become PCPCHs, half said eligibility for enhanced payment, but half said the opportunity to improve care.
- Over 80% of practices added at least one service during implementation of the PCPCH model (e.g., sending reminders for preventive services or a process for tracking patients admitted/discharged from hospitals).

The on-site verification visits found:

- About 25% of clinics visited received improvement plans because they had attested to things which couldn't be verified.
- Though Tier 3 PCPCH structure was found to be good measure of *overall* PCPCH model of practice, there was significant variability in performance capability for individual standards within a single tier level.
- Lack of resources under current payment/reimbursement models were unanimously identified as a primary barrier to continued transformation and sustainability.

Improvement activities:

In this year a broad coalition of Oregon's major public and commercial payers, professional associations and providers reached a pioneering agreement to coordinate their efforts to support primary care homes in Oregon. The sunset of Section 2703 Medicaid payment incentives was a partial impetus for this work. The coalition (the Multi-Payer Primary Care Payment Strategy Workgroup) agreed to:

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- Use a common definition of primary care homes and levels of coordination, based on the state's PCPCH program.
- Based on that definition, payers have agreed to provide payment models to practices in their network that are based on PCPCH participation and increasing levels of patient centered, coordinated care.
- Utilize a common set of core metrics to measure progress toward achieving outcomes.
- Find additional opportunities for meaningful collaboration that will support the long term sustainability of primary care homes.

New standards for PCPCHs aimed at making the model more robust went into effect January 1, 2014. OHA also published a quick reference guide which outlines the changes to the criteria.

In this year Oregon's Patient-Centered Primary Care Institute (PCPCI) continued to provide technical support and resources for transformation to practices statewide.

- Support is offered in various avenues and modes, from ongoing learning collaboratives to as-needed discrete training sessions, from webinars to intensive in-person sessions.
- A wide range of topics have been covered, ranging from behavioral health integration to building resiliency in the primary care home team.
- Assistance is also provided to clinics as they work through the recognition process (*e.g.*, online learning modules for the 2014 PCPCH recognition standards). The online learning modules and slides and audio recordings of webinars are on PCPCI's Resources page.

In addition, the PCPCH program worked to expand and improve their verification site visit process and provide additional technical assistance to clinics during the demonstration year.

- The program is conducting an innovative pilot project to include a community-based clinical consultant at all site visits to provide an overall assessment of the clinic's transformation efforts, and offer recommendations for improving patient care.
- The program has contracted with five community-based clinical consultants who participate in the site visit day, and who work with the clinic for up to 6 months after the visit on established quality improvement goals.

In this year eight CCOs chose to use their Transformation Fund[2] monies to further PCPCH, including supporting practices in achieving PCPCH status, increasing PCPCH tier, and providing PCPCH technical assistance and learning collaboratives. Furthermore, four CCOs chose to use their Transformation Funds to implement alternative payment methods focused on payment for outcomes, two of which are focused specifically on PCPCHs.

[2] In this year the Transformation Center issued a call for CCO proposals for awards from the Health System Transformation Fund, which is part of OHA's legislatively-approved budget for 2013-15 and is intended to provide strategic investment in CCO projects to support better health, better health care and lower costs in their communities. All 16 CCOs applied for and were awarded grants. Transformation Fund projects are throughout this table as they relate to the waiver levers for transformation. More detail on each of the projects can be found on the Transformation Center's website, here: http://transformationcenter.org/transformation-center-news/transformation-fund-grant-awards/.

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

Evaluation activities:

Work continued to support implementation of CCO incentive measures associated with the bonus pool, including meetings of the CCO Metrics Technical Advisory Group, the CCO Metrics and Scoring Committee, and the Dental Quality Metrics Workgroup. OHA provided additional guidance documents on the incentive measures, and published a revised quality pool methodology document (see Section XII for more detail).

In this year the first report to include a full calendar year of data on CCO performance against the CCO incentive and state performance measures was published, and OHA made the first quality pool payments to CCOs (see the CCO Quality and Accountability website and Section XII for more detail).

Oregon established the Hospital Metrics Advisory Committee as part of its waiver amendment to establish a Hospital Transformation Performance Program. The Committee finalized the list of measures to submit to CMS as part of a proposed hospital incentive quality pool under the waiver. The Committee recommended twelve measures across seven domains. The amendment request was submitted to CMS and OHA received approval to set up the hospital quality pool in June. Final discussions with CMS are expected to conclude early in the next demonstration year. Information on the Committee, including presentations and meeting minutes, is available on the Committee's website.

OHA consulted with CCO and contractor representatives on updates to the CCO financial reporting template, designed to provide more detail about alternative payment methodologies used by CCOs to pay providers and contractors. The new reporting format took effect January 1, 2014.

Interim findings:

OHA made the first quality pool payments to CCOs in June 2014. Eleven of the 15 CCOs earned 100 percent of their quality pool, three earned 80 percent, and one earned 70 percent (see Section XII for details).

To further the use of APMs, Oregon established the Rural Health Reform Initiative Advisory Group. This group is tasked with developing recommendations on which rural (type A/B) hospitals should transition from cost-based reimbursements to rates negotiated with local CCOs.

- In March the workgroup agreed on final recommendations for submission to OHA's Director's Office.
- After applying the workgroup's recommended decision criteria in April, it was decided that 18 hospitals would transition away from cost-based reimbursement (meaning they will need to negotiate with their CCOs), and 14 will continue to use a cost-based reimbursement method. This will be re-evaluated every two years.

The report is available on the Advisory Group's Web page.

The quarter one 2014 CCO financial reports showed that over half of all plan payments (52.5%) were non-fee-for-service (2.0% salary; 26.3% capitation and alternative costs to affiliated providers; and 24.2% other payment arrangements). OHA is validating these data and working with CCOs to refine reporting mechanisms.

Work continued to expand the number of programs included in CCOs' global budgets:

- Dental services and Alcohol and Drug Residential and Detox services are now fully integrated
- By the end of the demonstration year four of the CCOs had already integrated Non-Emergency Medical Transportation, with the others following later in 2014.

Improvement activities:

With support of the SIM grant, the Center for Evidence-based Policy (CEbP) at Oregon Health & Sciences University convened and facilitated the Multi-Payer Primary Care Payment Strategy Workgroup. The consensus agreed by this group (described under Lever 1) is a significant accomplishment for primary care payment reform in Oregon. Almost 30 organizations, representing nearly all commercial and public payers in Oregon, agreed to offer structured payments to support patient-centered primary care homes. Payers will establish the amount and type of payment with the providers in their networks.

OHA has worked to support the CCOs in implementing payment reform. OHA has a separate contract with CEbP to work on payment reform overall (not just focusing on primary care). CEbP will identify options and consult stakeholders around shared-risk multi-payer payment models. They will also identify or develop tools to help CCOs put those models into practice. The final report, expected by the end of calendar year 2014, will include findings, models, tools and strategies for use in payment reform.

All CCO Transformation Plans include a domain focused on furthering the use of alternative payment methodologies. Examples of work that individual CCOs are taking on include: transitioning outpatient mental health services from fee-for-service to case rates; piloting an incentive payment model at a pilot PCMP OB clinic; and realigning contracts with hospitals to include capitation payments with incentives.

Four CCOs are using their Transformation Fund grant awards to implement alternative payment methods focused on payment for outcomes, two of which focus specifically on PCPCHs, and one of which is adopting a tiered payment model based on quality measures. Detailed plans for the fourth are in development.

One of the projects from the Transformation Center's Council of Clinical Innovators is focused on spreading an incentive payment model of primary care which shifts from a fee-for-services model to one that rewards outcomes and incentivizes clinics to focus on five metrics and using data from their own electronic health records to monitor progress and make adjustments to improve performance as needed.

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

Evaluation activities:

Five of the 33 state performance and CCO incentive measures relate specifically to behavioral health integration, and four have established benchmarks. Interim reports showed CCO performance on these measures throughout 2013, and full 2013 data were published in June (see Section XII for details). For some measures (e.g. follow up after hospitalization from mental illness), the number of cases included is too small to comment on whether movement on the metrics represent a meaningful change from baseline.

Interim findings:

Detailed data for calendar year 2013 are in the available in the CCO performance report, and are discussed in Section XII. Of the four behavioral health integration measures with established benchmarks:

- Statewide, there was progress on all four from the 2011 baseline to 2013, though this varied across the CCOs.

- SBIRT increased from 0.0% to 2.0%, below the 13.0% benchmark. Performance across CCOs ranged from 0.0% to 8.7%.
- Follow-up after hospitalization for mental illness increased from 65.2% to 67.6%, just short of the 68.0% benchmark. Across CCOs, performance ranged from 55.3% to 81.0%. Performance exceeded the benchmark among Asian Americans and Whites, but was just under the benchmark for Hispanic/Latinos and well below the benchmark for African Americans.
- Follow-up care for children initially prescribed ADHD medications exceeded the benchmark (53.3% versus a 51.0% benchmark), though this varied by CCO (from 43.5% to 70.8%). Follow-up for children on ADHD medication for over 210 days showed improvement, but did not reach the benchmark (improving from 61.0% to 61.6%, compared to a 63.0% benchmark). This metric is not available at the CCO level.
- Mental and physical health assessments for children in DHS custody improved from 53.6% to 63.5%, but was below the benchmark (90.0%). Rates across CCOs varied significantly, from 23.1% to 100.0% (though some of the wide variation is due to the fact that this measure is based on small denominators).
- Proof of concept data on the depression screening measure was submitted by all 16 CCOs, but one CCO did not meet the 10% member threshold for this measure. The CCOs meeting the threshold were paid the remaining amount from their quality pools for this and three other measures (see Section XII). Based on these data, a benchmark will be established by the Metrics and Scoring Committee in Q3 2014.

Improvement activities:

OHA's Transformation Center launched a learning collaborative for CCO Medical Directors and Quality Improvement personnel in July 2013. The collaborative is focused on improving care in areas aligned with the CCO incentive metrics. The group held four sessions focused on integration measures over the demonstration year. In addition, the June 2014 learning collaborative for members of the Community Advisory Council (CAC) focused on oral health.

As CCOs begin their dental integration, the Transformation Center is speaking with leaders in the state to assess how best to promote best practices related to dental integration. In addition, OHA will be hiring a Dental Director to assist with this work.

In this year the Transformation Center began work on an environmental scan of behavioral health integration activities across the state. A consultant was retained, and activities will include collecting data from existing reporting mechanisms and interview with leaders involved in integration across the state. Once baseline data are compiled, the Transformation Center will develop in-house resources and provide technical assistance as needed.

OHA received an Adult Medicaid Quality Grant in December 2012 that is supporting two quality improvement projects which focus on integrating primary care and behavioral health. The first is a statewide learning collaborative among all CCOs on "Diabetes Monitoring for People with Diabetes and Schizophrenia or Bipolar Disorder." The second is a project to increase access to patient-centered medical homes in which 11 mental health and chemical dependency treatment programs will receive assistance with "reverse" integration, bringing primary care into behavioral health settings.

Twelve CCOs are using their Transformation Fund grants to fund integration, with efforts ranging from funding mental health and addiction counselors to co-locating physical and behavioral health services.

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

Evaluation activities:

In December 2013 Mathematica Policy Research was contracted to conduct a midpoint evaluation of the waiver. This will assess the association between transformation activities and changes in access and quality.

As described in more detail above, work on the midpoint evaluation has included:

- Finalizing the evaluation plan;
- Hosting an informational webinar about the evaluation;
- Working on document reviews;
- Conducting key informant interviews;
- Completing site visits at three CCOs;
- Processing of enrollment and claims data to assess outcomes; and,
- Completion of the CCO Transformation Assessment Tool used to assess the degree to which individual CCOs have transformed on key elements of the coordinated care model.

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The final report on the midpoint evaluation of the waiver will be available early in 2015.

Interim findings:

The first full year of CCO performance data were published in June 2014 and compared 2013 performance to baseline data from 2011. Statewide, there was inprovement on 14 of the 17 CCO incentive measures, and improvement on nine of the 17 state quality and access 'test' measures (see the CCO Quality and Accountability website and Section XII).

A number of the measures point to the success of the coordinated care model in Medicaid:

- Decreases in emergency department visits (17% decrease) and spending (19% decrease), and decreased hospitalizations for chronic conditions (congestive heart failure hospital admissions reduced by 27%, chronic obstructive pulmonary disease decreased by 32%, and adult asthma by 18%).
- Increases in primary care utilization (11% increase in visits) and spending (over 20% increase), PCPCH enrollment (52% increase), rates of developmental screenings (58% increase), and Electronic Health Record adoption (110% increase).

However, there were measures that indicate areas where performance could improve:

- Screening for risky drug or alcohol behavior (SBIRT) and access to care (CAHPS measure) increased only slightly and were below the benchmark in both instances. No CCO met the SBIRT benchmark and all racial and ethnic groups were below the benchmark. Only five CCOs met the access benchmark or improvement target.
- The proportion of women screened for cervical cancer decreased (from 56.1% to 53.3%, well below the benchmark of 74.0%); none of the CCOs approached the benchmark in this area, and performance diminished across all CCOs and among all race and ethnic groups.
- Chlamydia screening decreased (from 59.9% to 54.4%, below the 63.0% benchmark). The decrease was across all CCOs, though performance at Health Share remained above the benchmark despite decreasing from its baseline. Performance was mixed by race and ethnic group: Performance worsened for Whites, African Americans, and Asian Americans (though was still above the benchmark for African Americans), and improved for all other races.

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- OHA is exploring the possible reasons behind the decreases in cervical cancer and chlamydia screenings. It is possible that some of the decline to the cervical cancer screening rate is related to the 2012 change in guidelines around appropriate screening frequency from the U.S. Preventive Services Task Force (which changed the recommendation from annual screenings to screening every three years). This, in turn, may have affected the chlamydia screenings frequency as screening for both may occur at the same visit. There were also changes to grant funding for family planning services outside of Medicaid; this may have led to a drop in the number of such services which would appear in Medicaid claims. OHA is exploring this further.

A team of Oregon researchers released some initial survey data about the impact of the CCOs on health care access, quality, and outcomes from a Robert Wood Johnson-funded State Health Access Reform Evaluation (SHARE) grant. These preliminary findings show that, compared to fee-for-service Medicaid and lack of insurance, CCO membership was associated with better access to care, more frequent primary care use, better improvements in care quality ratings, and better assistance with the social determinants of health. CCO membership was not associated with greater reductions in emergency department visits, nor was CCO membership associated with better screenings than fee-for-service Medicaid. More complete data from this project should be available at the end of 2014.

Improvement activities:

Throughout the demonstration year OHA provided progress reports on the incentive measures to the CCOs. These assist the CCOs in monitoring their progress and in making interim process improvements as needed to improve performance.

In October 2013, an RFP was issued for new **regional health equity coalitions (RHECs)** (using State Innovation Model [SIM] funding). RHECs are designed to reduce disparities and address the social determinants of health. RHECS will help communities build their capacity to work with CCOs, and serve as a bridge to communities that have historically been underrepresented in health program and policy development.

In December, OHA awarded four communities grants from the SIM-funded **Community Prevention Program.** The grantees consist of joint partnerships between at least one CCO and at least one local public health authority; collectively, the four grantees represent six of Oregon's 16 CCOs and 20 of Oregon's 34 local public health authorities. Grantees are required to implement at least one evidence-based population health intervention in the community and one intervention in the health system setting. Grantees will be working through the term of the SIM grant on population health issues of importance to their local communities, and as a group have selected tobacco, maternal and child health and opioid prevention as their focus areas.

Thirteen CCOs are using Transformation Fund grants to bolster HIT, including expanding the meaningful use of EHR and implementing telemedicine and other innovative uses of HIT.

Oregon's "Phase 1.5" HIE/HIT development, which aims to support immediate coordination between providers while building a foundation for statewide interoperability, progressed during the demonstration year. As outlined in the HIT/HIE Development Strategy, Phase 1.5 includes six elements: state-level provider directory; incremental development of state-level patient index attributing patients to providers; statewide notification of emergency department and hospital visits; statewide direct secure messaging; statewide clinical quality data registry; and, technical assistance to providers.

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Oregon is establishing **Early Learning Hubs**, which are coordinating bodies pulling together resources for children and families in defined service areas.

- In the Hubs, all sectors that touch early childhood education, including health, have a common place to focus their efforts.
- Oregon's HB 2013 requires that services coordinated by the Hubs be aligned with those provided by CCOs and county public health departments.
- At the state level, there is a joint Early Learning Council/Health Policy Board subcommittee focused on integrating health care and early learning policies, sharing resources, and aligning goals.

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

Evaluation activities:

An advisory workgroup of CCO representatives formed in late 2013 to make suggestions for tracking and reporting flexible services at the member level. It held its first meeting in quarter 1 of 2014. The workgroup aims to have a reporting tool available by January 2015. Broader evaluation work related to the impact of flexible services on cost and quality will rely upon the data collected by this process.

Interim findings:

Will be available in future reports.

Improvement activities:

The first CCO financial reports to include provision of flexible services were available in June. OHA is analyzing these data to understand how (and the degree to which) CCOs are providing flexible services. These data, along with additional guidance for flexible service policies and tracking, will be discussed with the Flexible Services Workgroup in latter part of 2014.

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

Evaluation activities:

In this year the Transformation Center began to evaluate its connections with CCOs, learning collaboratives, and other convening opportunities in a variety of ways, including tracking participation and participant feedback.

- In the last quarter of the demonstration year the Transformation Center launched a process for rapidly evaluating the effectiveness of the learning collaboratives. This process consistently tracks attendance (including roles of attendees) and asks participants to respond to a standard set of questions after each event. This allows the Transformation Center to track satisfaction from session to session, and across learning collaboratives. The core questions ask attendees to rate the value of the sessions in supporting their work, and whether and how they will use what they have learned in the session further health system transformation. Results are included below.
- OHA has contracted for an independent, formative evaluation of the Transformation Center.
- The Transformation Center is monitoring the success of its online collaboration website, which was launched in October 2013.

Interim findings/ Improvement activities:

The Transformation Center is creating a Council of Clinical Innovators, which will be a statewide, multidisciplinary cadre of innovation leaders, consultants, and mentors who are actively working with project teams to implement health care transformation projects in their local communities.

- Fellows will work on a systems improvement project during the program (July 2014 – June 2015) and will participate in a year-long learning experience to develop and refine skills in leadership, quality improvement, implementation and dissemination science.
- The goal is to create a network of expertise supporting the coordinated care model. More detail can be found in Section G.

In addition to the Council of Clinical Innovators, The Transformation Center launched four external learning collaboratives in the demonstration year (an internal learning collaborative for CCO Innovator Agents also exists):

- Statewide CCO learning collaborative focused on incentive metrics;
- Learning collaborative for CCO Community Advisory Council members;
- Complex care collaborative; and,
- Institute for Healthcare Improvement for CCO Transformation Fund Portfolio Managers collaborative.

In the demonstration year a total of 23 sessions were held across the four external learning collaboratives. These sessions were a mix of webinars and in-person meetings, covering topics from trauma-informed care in primary care settings to public health and health system transformation. Results from the Transformation Center's internal evaluation of the effectiveness of the learning collaborative sessions (covering the last quarter in the demonstration year) were positive:

- 89.2% of respondents found the session valuable or very valuable to their work.
- 61.2% of respondents say they will attend future sessions.
- 60.4% of respondents say will take action to change processes at their organizations as a result of the session.
- 50.9% of respondents say they will reach out to colleagues, experts or OHA for more information or ideas as a result of today's session.

The Transformation Center held two summits in this demonstration year. One, the Transformation Summit in December 2013, pulled together state and CCO leadership and partners to discuss a range of topics from applying alternative payment models to coordination between health and early learning systems. The Community Advisory Council learning collaborative also held a summit over two days in May. This gathering included updates from OHA leaders, updates on CAC work, networking, breakout sessions, and a panel of foundation funders.

In addition to the learning collaboratives, the Transformation Center hosts online learning communities via its Groupsite Web portal.

- These learning communities are online tools that allow staff and representatives of CCOs, Community Advisory Councils (CACs), and OHA to collaborate, network and share best practices.
- The Groupsite Web portal now hosts seven online internal learning communities for OHA staff focused on transforming OHA activities to further health system transformation, and seven external online learning communities for representatives of CCOs, Community Advisory Councils, and OHA staff to collaborate and share best practices.
- From November to June membership in the CCO learning community increased by over 70% (from 65 to 111 members).

- The Complex Care learning community membership increased from 59 when it launched to 123 in June (a 108.5%) increase.

Through the Innovator Agents and learning collaborative activities, the Transformation Center has been identifying, collecting and compiling information on innovative or promising practices in what is being called a 'Good Ideas Bank'. The information will be housed within a searchable database on the Transformation Center website.

The Transformation Center is also developing a Technical Assistance Bank for CCOs, which will help CCOs move toward their Transformation Plan goals. The Transformation Center will create a menu of technical assistance topics for which CCOs may access a set number of hours of technical assistance. Each CCO will decide how to best utilize the TA resources by selecting the topics of most interest and need.

VIII. Two-percent test – reducing per capita expenditure trend growth

The state continues to report quarterly on its progress of reducing the per capita expenditure growth trend. For state fiscal year (SFY) 2014, the state must reduce the per-member-per-month (PMPM) growth from 5.4 percent to 4.4 percent. With the report for quarter ending June 30, 2014, Oregon submitted the final SFY 2014 update to CMS and demonstrated that the state's PMPM growth remained within the parameters of the test.

For SFY 2015, the state must reduce PMPM growth to 3.4 percent. Preliminary estimates indicate the state will continue to remain within the parameters, but with only a little extra room under the target PMPM because SFY 2015 includes $150 million in first-year payments for the CMS-approved Hospital Transformation Performance Program.

IX. 1% withhold and incentives

For all subject months analyzed during this demonstration year (July 2013 through June 2014), all CCOs met the Administrative Performance (AP) standard and no 1% withholds occurred.

For incentives discussion, please refer to the 2013 Quality Pool.

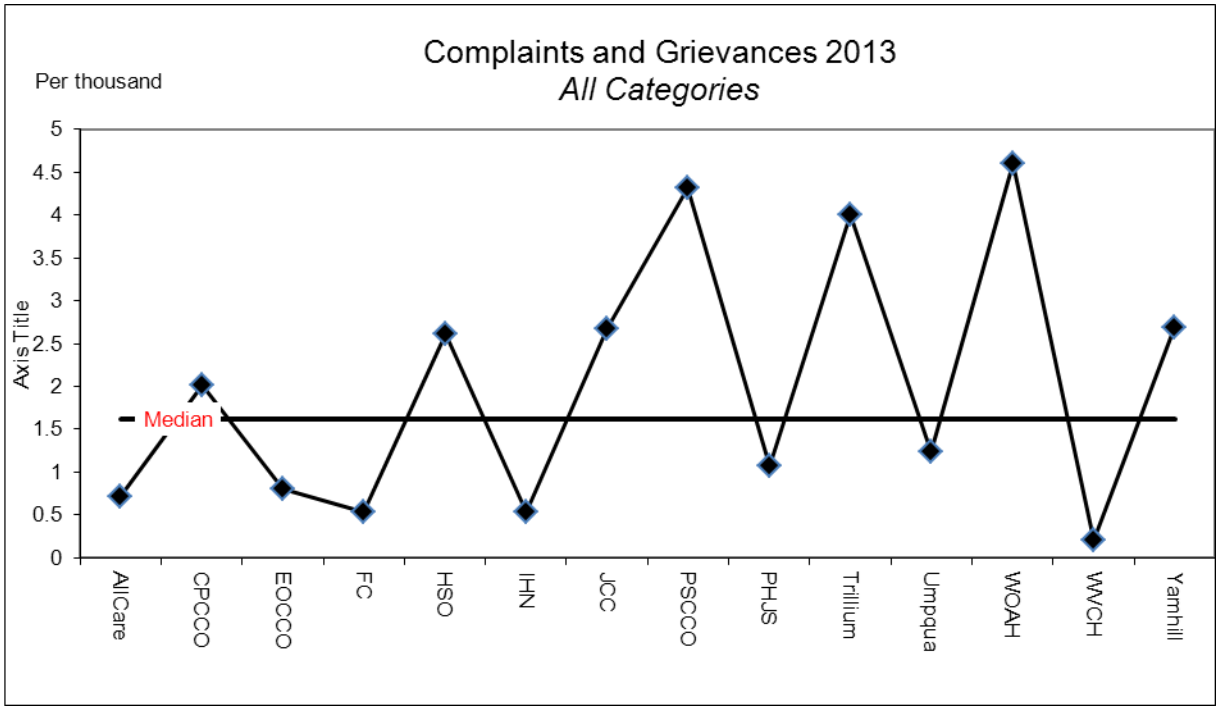
X. DSHP tracker

Attached separately.

XI. Complaints, grievances and hearings – Data and narrative

A. Complaints and grievances

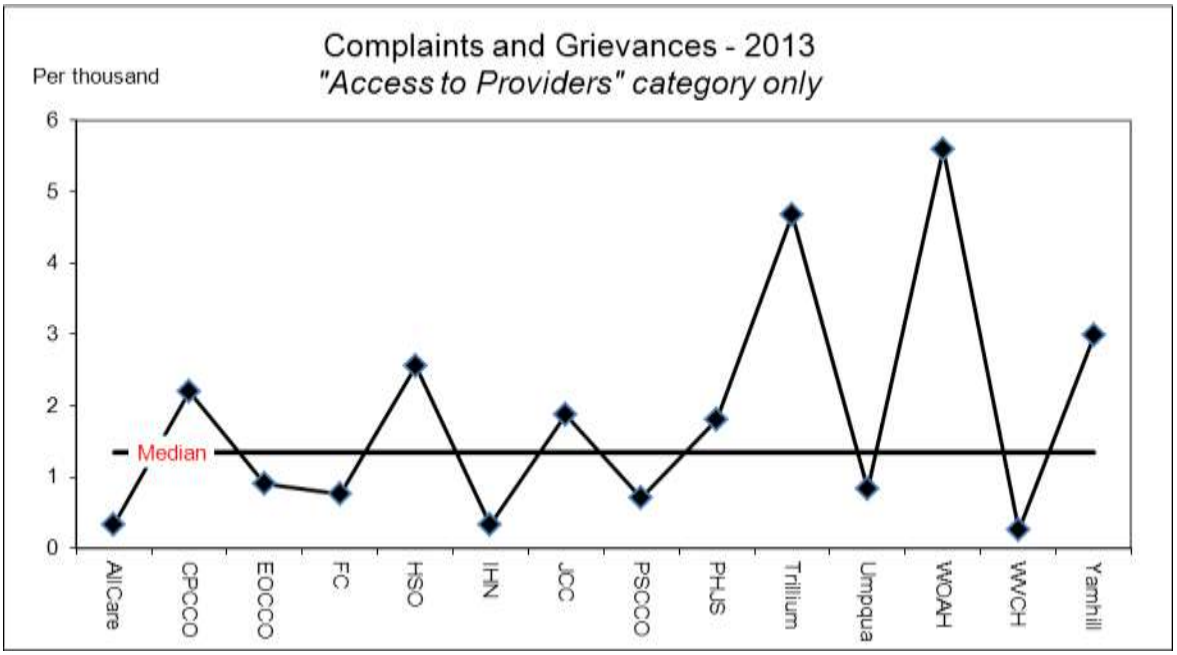
Throughout 2013, trend rates continued to have large fluctuations between plans, but averaged over the 4 quarters 0.5 to 5.4 complaints/grievances per 1000 members, an overall downward trend. Plans are working with OHA to identify reasons for the large variances.



The OHP Client Services Unit averaged 7,295 complaints and grievance calls. An average of a third are related to fee for service clients; the remaining calls are related to concerns from enrolled members. Highest categories over the year included enrollment/disenrollment requests, medical services access, and dental/pharmacy services access. CCO integration of dental and non-emergent transportation services during this time also generated additional calls and service coordination complaints.

Access to providers, provider office responsiveness, and scheduling/interactions with provider offices have remained our highest categories. Plans continue to screen for urgent or emergent needs and reach out to members to educate on the reasons for delay. Quality of care issues have not been recognized and have supported this continued triage component.

The reason identified for a large number of complaints in these categories was the assignment of newly-enrolled CCO members to primary care providers that may be different from the providers members had seen in the past. This is possible when CCOs do not have history about the new member's provider preferences available to assist with assignment. CCOs have been assisting members with this transition. The greatest access concerns during this transition are for pharmacy, specialists and pain management.



B. Appeals and hearings

During 2013 the rate of CCO appeals ranged from 0.64 to 4.90 per 1,000 members. The appeal overturn rates at the plan level remained consistent, in a range from 0.64 to 4.17 per 1,000 members.

Contested case hearings ranged from 0.32 to 2.1 per 1,000 members.

Billing, referral, pharmacy and surgical denials remain the highest categories. Appeals and hearings in billing categories have been decreasing. Two plans remain high in this category and are on focus reviews. OHA has continued engaging clients and providers in education related to Medicaid billing requirements.

Due to the continued high rate of appeals and hearings overturned by plans, OHA is conducting a focus review of utilization activities with each plan.

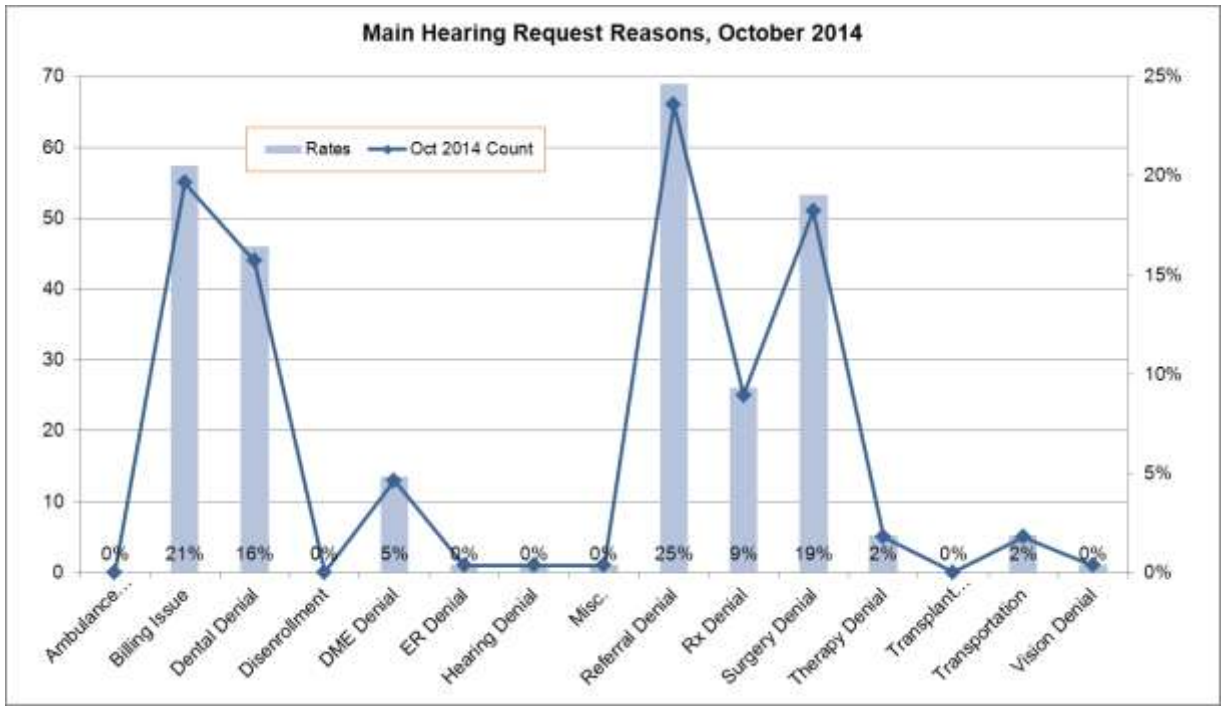
Hearing requests received - October 2014

Plan	Total Received	Plan Enrollment *	Per 1000 Members
CCO			
ALLCARE HEALTH PLAN, INC.	15	49,031	0.3059
CASCADE HEALTH ALLIANCE	7	12,836	0.5453
COLUMBIA PACIFIC CCO, LLC	2	26,142	0.0765
EASTERN OREGON CCO, LLC	16	46,763	0.3422
FAMILYCARE, CCO	21	112,437	0.1868
HEALTH SHARE OF OREGON	46	231,447	0.1987
INTERCOMMUNITY HEALTH NETWORK	15	54,400	0.2757
JACKSON CARE CONNECT	5	28,860	0.1733
KAISER PERMANENTE OR PLUS, LLC	2	2,107	0.9492
PACIFICSOURCE COMM. SOLUTIONS	33	52,220	0.6319
PACIFICSOURCE COMM. SOLUTIONS - GORGE		12,561	0.0000
PRIMARYHEALTH JOSEPHINE CO CCO	7	10,967	0.6383
TRILLIUM COMM. HEALTH PLAN	17	73,409	0.2316

Plan	Total Received	Plan Enrollment *	Per 1000 Members
UMPQUA HEALTH ALLIANCE, DCIPA	17	26,466	0.6423
WESTERN OREGON ADVANCED HEALTH	6	20,437	0.2936
WILLAMETTE VALLEY COMM. HEALTH	45	96,904	0.4644
YAMHILL CO CARE ORGANIZATION	4	21,380	0.1871
DCO			
ACCESS DENTAL PLAN, LLC		2,005	0.0000
ADVANTAGE DENTAL	3	29,678	0.1011
CAPITOL DENTAL CARE INC		15,709	0.0000
CARE OREGON DENTAL		2,129	0.0000
FAMILY DENTAL CARE		1,991	0.0000
MANAGED DENTAL CARE OF OR		2,177	0.0000
ODS COMMUNITY HEALTH INC	2	8,569	0.2334
WILLAMETTE DENTAL GROUP PC		14	0.0000
FFS	12	209,763	0.0572
Total	275	1,150,402	0.2390

Data Source: New_HearingLog.mdb & DSSURS
Data Extraction Date: 11/03/2014

Main hearing request reasons, October 2014



XII. Metrics progress

Throughout the demonstration year, OHA continued to enhance its measurement strategy, including measure specification development with stakeholders and the roll out of standardized reporting to coordinated care organizations and increased public transparency. During the second year of the transformation demonstration, OHA also distributed the first quality pool payments to CCOs. This report provides an overview of measurement activities occurring during the year.

A. Measure development and reporting

Throughout the demonstration year, OHA worked to finalize measure specifications for the 17 CCO incentive measures, the 33 quality and access "test" measures, and the core performance measures. OHA also produced all calendar year 2011 baseline data that had not previously been calculated, as well as final calendar year 2013 data at the state and CCO level.

Measure specification development

Throughout the demonstration year, OHA worked with stakeholders to develop or refine measure specifications, for example, reviewing codes selected for the alcohol and drug misuse (SBIRT) measure to identify workarounds to coding challenges identified by providers. OHA staff also explored options for reporting on core performance measures, including finalizing an approach to monitor effective contraceptive use among women at risk of unintended pregnancy using Behavioral Risk Factor Surveillance System data.

OHA has also published a number of guidance documents for CCOs. These documents provide additional information on the measures, including coding options, best practices for implementation, and resources such as toolkits for providers. All measure specifications and guidance documents are published online at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx.

Clinical measures (diabetes, hypertension, and depression)

Throughout the demonstration year, OHA worked to provide CCOs with guidance for developing a technology plan to extract clinical data from electronic health records. CCOs successfully submitted their year one proof of concept data to OHA in May 2014.

CCOs were asked to submit electronic data representing at least 10 percent of their member population, with the understanding that the population threshold would increase in 2014 and 2015, transitioning over time to pay for performance rather than pay for reporting on these three measures.

Progress reporting

OHA began producing preliminary 2013 data and providing CCOs with progress reports so they could track their progress. OHA provided regular reports to CCOs beginning in August 2013 and concluding on April 2014 with a report for final CCO review and validation prior to the distribution of the CY 2013 quality pool.

Throughout the demonstration year, OHA provided four reports on the CCO incentive and state performance measures to the Oregon Health Policy Board and the general public. The reports were published in August 2013, November 2013, February 2014, and the final CY 2013 performance report in June 2014. All reports are available online at http://www.oregon.gov/oha/Metrics/.

Final 2013 performance report

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

- Decreased emergency department visits. Emergency department visits by people served by CCOs have decreased 17% since 2011 baseline data. The corresponding cost of providing services in emergency departments decreased by 19% over the same time period.
- Decreased hospitalization for chronic conditions. Hospital admissions for congestive heart failure have been reduced by 27%, chronic obstructive pulmonary disease by 32%, and adult asthma by 18%.
- Developmental screening during the first 36 months of life. The percentage of children who were screened for the risk of developmental, behavioral, and social delays increased from a 2011 baseline of 21% to 33% in 2013, an increase of 58%.
- Increased primary care. Outpatient primary care visits for CCO members' increased by 11% and spending for primary care and preventive services are up over 20%. Enrollment in patient-centered primary care homes has also increased by 52% since 2012, the baseline year for that program.

Oregon saw statewide improvement on all 14 of the 17 CCO incentive measures included in the report (the three clinical measures were address separately – see below for details on the year one proof of concept data submission). All 15 CCOs improved on four incentive measures: emergency department utilization, developmental screening, early elective delivery, and electronic health record adoption[3].

Of the remaining 17 state quality and access "test" measures, Oregon saw statewide improvement on 9 measures. See the 2013 final report for additional details.

The report also shows areas where there has been progress but more gains need to be made, such as screening for risky drug or alcohol behavior and whether people have adequate access to health care providers. While there were gains in both areas, Oregon will put greater focus on them in the year to come. Access to care is particularly important with more than 340,000 new Oregon Health Plan members joining the system since January of 2014 that were not captured in the final 2013 metrics.

2013 Quality Pool

OHA made the first quality pool payments to CCOs in June 2014. Under the coordinated care model, OHA held back two percent of the monthly payments to CCOs, where were put in the common quality pool. To earn their full payment for CY 2013, CCOs had to meet the benchmark or improvement target on at least 12 of the 17 incentive measures (including EHR adoption), and have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

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

In summary: 11 of the 15 CCOs earned 100 percent of their quality pool. One CCO earned 70 percent and the remaining three earned 80 percent.

[3] For the purposes of the 2013 quality pool and final reporting, OHA is counting PacificSource as one CCO, for a total of 15 CCOs. PacificSource will be counted as two CCOs (Central Oregon Region and Gorge Region) for the 2014 quality pool and reporting, for a total of 16 CCOs.

Table E1: 2013 Quality Pool Distribution

Coordinated Care Organization	Number of measures met (of 17)	Percent of quality pool funds earned (without challenge pool)	Percent of quality pool funds + challenge pool funds earned	Total dollar amount earned
AllCare Health Plan	11.6	80%	84%	$2,239,160
Cascade Health Alliance[4]	13.7	100%	100%	$748,517
Columbia Pacific	13.8	100%	104%	$1,461,310
Eastern Oregon	11.6	100%	83%	$1,931,432
FamilyCare	13.7	80%	105%	$4,354,150
Health Share	12.8	100%	104%	$13,720,133
Intercommunity Health Network	11.9	80%	84%	$2,669,122
Jackson Care Connect	11.4	70%	74%	$1,286,078
PacificSource	12.9	100%	106%	$3,452,010
PrimaryHealth of Josephine County	13.0	100%	102%	$1,024,938
Trillium	12.9	100%	104%	$4,949,647
Umpqua Health Alliance	13.7	100%	105%	$1,716,647
Western Oregon Advanced Health	14.7	100%	104%	$1,282,648
Willamette Valley Community Health	14.9	100%	107%	$4,987,244
Yamhill CCO	14.8	100%	105%	$1,137,005

B. Committees and Workgroups

Throughout the demonstration year, OHA continued to engage stakeholders in the measurement strategy through public Committees and workgroups.

Metrics & Scoring Committee

This legislatively-appointed Committee met eight times during the demonstration year to refine measure selection, specifications, benchmarks, and overall methodology for the CCO pay for performance program. Committee decisions during this period primarily focused on clarifying the 2013 program and establishing the parameters for the 2014 program. All meeting materials are available online.

Dental Quality Metrics Workgroup

This workgroup was established in July 2013 and charged with recommending objective outcome and quality measures and benchmarks or oral health services provided by CCOs to the Metrics & Scoring Committee. The workgroup met eight times during the demonstration year and made three recommendations to the Metrics & Scoring Committee. All meeting materials and the workgroup recommendations are available online.

[4] Reflects prorated quality pool for partial year as a CCO.

CCO Metrics Technical Advisory Workgroup (CCO Metrics TAG)

This workgroup met monthly during the demonstration year to address details related to the incentive measures and overall analytic activities. More than 40 individuals representing the 16 CCOs participated. Meeting materials are available online.

CCO Metrics TAG – Data Analyst Subgroup

This workgroup was convened late in the demonstration year by request from CCO staff tasked with developing reports on the incentive measures and validating data provided by OHA. This subgroup provides a venue for data analysts to discuss technical challenges and the minutia of the metrics.

C. Quality and Access Test

During the demonstration year, OHA has been working with its contractor, the Oregon Health Care Quality Corporation (Q Corp) to conduct the quality and access test.

In late 2013, Q Corp conducted a review of the quality and access test methodology outlined in the demonstration waiver. Throughout the demonstration year, Q Corp has been independently producing the 33 quality and access "test" measures to verify OHA's reporting. OHA and Q Corp have been conducting a multi-directional validation process on the CCO incentive measures and quality and access "test" measures that includes code review and process checks on the 2011 baseline data, the dry run measurement period, and the calendar year 2013 reporting.

OHA and Q Corp have worked to reconcile differences found in the data to ensure the quality and accuracy of the dry run (July 2012 – June 2013) and the upcoming quality and access "test" (July 2013 – June 2014) calculations. Dry run results were initially reported to CMS in May 2014 and are included as Appendix A. The first quality and access "test" will be reported to CMS in February 2015.

XIII. OPHP (premium assistance programs) wrap-up reporting

A. Programs in transition due to ACA expansion

Family Health Insurance Assistance Program (FHIAP)

Opened in 1998, FHIAP helped families or individuals pay the monthly premium for insurance plans. FHIAP is not an insurance company, or an insurance plan. Adults and families used FHIAP subsidies to pay for insurance at work, or to help pay for a health plan if they cannot get insurance through an employer.

- FHIAP paid from 50 percent to 95 percent (100 percent for children up to age 19) of the premium.
- FHIAP members paid for deductibles, co-payments, and other costs not covered by health plans.
- Enrollment in FHIAP was managed by a reservation list that is now closed.

The program closed December 31, 2013. FHIAP members transitioned as follows:

- FHIAP adults (age 19 and above) under 138 percent FPL enrolled in an ESI, individual, COBRA, or portability plan enrolled in OHP. Certain eligible individuals remain enrolled in employer-sponsored insurance and obtain subsidies through OHA's Health Insurance Premium Program (HIPP) as more cost effective.
- All FHIAP children (ages 0-18) under 200 percent FPL enrolled in OHP.
- FHIAP adults (age 19 and above) under 138 percent FPL **and** enrolled in the Oregon Medical Insurance Pool (Oregon's high risk insurance plan) enrolled in OHP.

- All FHIAP adults (age 19 and above) over 138 percent FPL were invited to apply for other health coverage through Cover Oregon.

Oregon Medical Insurance Pool (OMIP)

Operating since 1987, the state's "high-risk pool," OMIP provided health insurance for adults and children who were unable to get health insurance due to certain pre-existing health conditions (*e.g.*, diabetes, cancer), or who did not have access to commercial portability insurance. OMIP contracted with Regence BlueCross BlueShield of Oregon to administer this program.

- Cost was based on age and the plan chosen.
- While OMIP was not low-cost health coverage, FHIAP was able to help pay monthly premiums for qualified OMIP members
- The OMIP program also administered the Children's Reinsurance Program (CRP), which started in August 2011. The CRP spread the cost of insuring high risk children among all companies licensed to sell health insurance in Oregon.

The program closed December 21, 2013. Members under 138 percent FPL transitioned to OHP. To transition OMIP members above 138 percent FPL to other health coverage:

- OHA sent notices explaining that OMIP coverage would end, and to apply for coverage through Cover Oregon.
- OHA created the Temporary Medical Insurance Plan (TMIP) to make sure members did not lose coverage when OMIP ended on December 31. TMIP was a short-term emergency plan that provided month-to-month coverage while members worked to complete their enrollment in OHP, a Qualified Health Plan through Cover Oregon, or bought a plan directly from an insurance carrier.
- OHA worked closely with TMIP members to help facilitate successful transition out of TMIP and into new coverage. Any members remaining in temporary coverage as of March 31, 2014 lost their coverage when the temporary program ended.

Healthy KidsConnect (HKC)

Healthy KidsConnect was for families that earn too much to qualify for the OHP, but could not afford private health insurance. HKC covered children up to age 19 in families with incomes 200-300 percent of the Federal Poverty Level (FPL). It was a private market insurance option that is comparable to OHP Plus coverage. HKC Families were supported with premium assistance depending on their family income.

The program stopped accepting new enrollees October 1, 2013. The program closed December 31, 2013. OHA transitioned HKC children to OHP.

B. Program members transitioned to OHP or Cover Oregon

Members in households with incomes at or below 138 percent FPL transitioned to OHP. OHA notified members in households with incomes above 138 percent FPL about the process to apply through Cover Oregon to transition to other health coverage.

Program	Total	<=138%FPL		> 138% FPL	
		Age <=18	Age >18	Age <=18	Age >18
FHIAP	4,493	*1,012*	*2,218*	*4,126*	*783*
FHIAP Reservation	40,640	-	-	-	-
OMIP	10,453	-	-	-	-
OMIP with FHIAP Subsidy	1,082	*23*	*873*	*4*	*182*
Healthy KidsConnect	8,307	-	-	-	-

XIV. EQRO or Quality Strategy Update

In progress for mid-term evaluation.

XV. Appendices

A. Quality and access test – Dry run results in composite methodology

Attached separately, using validated data as of April 29, 2014.

B. Oregon Measures Matrix

Attached separately.