

Oregon Health Plan

Section 1115 Annual Report



Demonstration Year: 13

July 1, 2014 – June 30, 2015



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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's progress in meeting the goals of the Oregon Health Plan (OHP) demonstration for the past demonstration year.

Lever 1 - Improving care coordination

As of June 2015, there were 565 recognized patient-centered primary care home (PCPCH) clinics in the state (surpassing Oregon's goal of 500 clinics by 2015). This represents over 50 percent of the estimated 1,000 primary care clinics in Oregon.

Lever 2 – Implementing alternate payment methodologies

OHA made progress on collecting and evaluating data about alternate payment methodologies (APMs) CCOs and federally qualified health centers (FQHCs) have begun using.

- OHA worked with CCOs to draft a revised CCO Financial Report (Exhibit L) for calendar year 2016 that will allow detailed, annual APM reporting.
- Quality metrics indicate quality of care continued or improved under the FQHC APM pilot.

Lever 3 – Integrating physical, behavioral and oral health care

Oregon Health & Science University and the Transformation Center closely examined behavioral health integration activities across the state. Findings include:

- While there has been extensive integration activity statewide, the penetration of integrated care is variable, with smaller and rural practices facing the most challenges.
- Greater clarity and guidance is needed on key integration issues, such as sharing behavioral health information, credentialing, coding, billing, practice standards and measures.

CCOs continue to improve their performance in integration-related incentive measures. OHA also completed transition of OHP members to dentally integrated CCOs. As of June 2015, more than 970,000 OHP members receive dental services through their CCOs.

Lever 4 – Increased efficiency in providing care

Key measures of efficient and effective care continued to improve. A variety of studies were completed during the demonstration year. One report found CCO enrollment was associated with improved member-reported access to medical care. The midpoint evaluation of the OHP demonstration found significant changes in improving primary care, but needed more time before making further conclusions.

Lever 5 – Implementation of health-related flexible services

Data indicated that not much money was spent to provide flexible services. That could be simply because many flexible services come at a relatively low cost.

Lever 6 – Innovation through the Transformation Center:

Several innovations have been adopted and shared in the areas of medical, dental and behavioral health. CCOs are making solid progress in eight areas of transformation including oral and behavioral health integration, primary care homes, APMs, health information and community empowerment.

Lori Coyner, 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) populations. (AFDC is now known as Temporary Assistance to Needy Families or TANF). One year later, Phase II added persons who are aged, blind, and disabled, and it added children in state custody or foster care.

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

The OHP 2 demonstration began November 1, 2002. It 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 when SCHIP eligibility was expanded and the Healthy Kids program was created.

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 SCHIP services.
- **Flexibility in use of federal funds:** The state can use Medicaid dollars for flexible services (such as 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 previously had been supported entirely by state funds. These are called designated state health programs (DSHPs). DSHP spending is limited to \$704 million FFP over the demonstration period July 5, 2012 through June 30, 2017. It is 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 CCO model of care, Oregon agreed to 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, the growth in per capita spending, known as per capita medical trend, 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 temporarily offers incentive payments to support hospitals' quality improvement efforts.

B. State contacts

Demonstration and Quarterly Reports

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II. Title

Oregon Health Plan Section 1115 Annual Report
Demonstration Year (DY): 13 (July 1, 2014 – June 30, 2015)

III. Overview

A. Accomplishments

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

Key highlights from this year:

Statewide CCO learning collaborative for the Quality and Health Outcomes Committee

The statewide CCO learning collaborative includes CCO medical, behavioral and oral health directors and quality improvement coordinators. The collaborative focuses on CCO incentive measures and other relevant topics. The Transformation Center facilitated 10 sessions this year, with topics selected with input from participants. While the first year of the collaborative focused on operational and measure specifications of the incentive measures, this second year concentrated on emerging best practices from around the state and peer learning. Sessions this year covered five of the 17 incentive measures: year-end data, health equity, alternative payment methods, opiates and pain management, and leading change. Presenters included CCOs, clinicians, county health departments, dental care organizations, community-based leaders and national experts. An average of 72 participants attended each session. Participants consistently reported that the most valuable aspects of the learning collaborative were small group discussions and sharing information about implementation, strategies, successes and challenges. A majority of respondents rated each session as very valuable or valuable in supporting their work.

More information is available at transformationcenter.org/cco.

Community advisory council learning collaborative

The CCO community advisory council (CAC) learning collaborative provides CAC members and leaders with networking space and support in leadership and organizational development. This year the Transformation Center held the following CAC meetings and events:

- 21 meetings with CAC leadership, including monthly conference calls for 1) CAC chairs and co-chairs (who are CAC members); and 2) CAC coordinators (who are CCO staff). Topics included CAC structure, challenges and successes, community health improvement plan implementation, member engagement, affordable housing, and early learning.
- Two webinars for all CAC members: motivational interviewing and logic model development.
- An “Introduction to CACs” recorded presentation for CACs to use as needed (including an overview of health system transformation, CCOs, and roles and responsibilities of CACs).
- Roundtable discussions and networking meetings at the Coordinated Care Model Summit.
- A two-day statewide CAC Summit brought together 186 participants and included a motivational interviewing pre-conference workshop, a “race for health equity” exercise, community health improvement plan roundtable discussions and networking meetings. More than 90 percent of respondents said the summit was valuable in supporting their work. Travel assistance (provided through a foundation grant) and ADA accommodations have been essential for CAC members to participate at in-person learning collaborative events.

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Innovator agents have been integral in planning and delivering CAC support.

More information about the CAC learning collaborative is at transformationcenter.org/cac.

Quality Improvement Community of Practice

The Quality Improvement Community of Practice includes the CCO Transformation Fund project portfolio managers and builds on the work of last year's Improvement Science in Action Learning Collaborative. This year the Transformation Center hosted a three-month training, "Leading Quality Improvement: Essentials for Managers," through the Institute of Healthcare Improvement. Each of the 16 CCOs participated in at least one of the nine sessions. This in-depth virtual program gave participants skills to focus their staff's efforts, better manage their portfolio of projects, and improve processes to more effectively achieve their organization's strategic goals. The group will go deeper in the next six months with a customized coaching program tailored specifically to the needs in Oregon.

Council of Clinical Innovators

The Council of Clinical Innovators is a statewide multidisciplinary network of innovation leaders, consultants and mentors who are actively working to implement health care transformation projects in their local communities. This year the council launched a Clinical Innovation Fellows program to build the capacity of health care transformation leadership in Oregon and support the success of CCOs. The pilot cohort of 13 fellows included professionals in physical, behavioral and oral health, public health, and social work and represented 10 of the 16 CCO areas. Through developing innovation projects and participating in a year-long learning experience, the fellows developed and refined skills in leadership, quality improvement and methods for spreading innovation across the delivery system. The pilot cohort graduated in June 2015, and every fellow rated the program as valuable or very valuable in their growth as a leader and in supporting their work. The most valuable aspects of the program were networking, project implementation and management skills, and mentoring. One of the successes of this unique program was to begin building a network of next-generation change leaders across Oregon. The council has recruited applicants and selected 15 fellows for the second cohort.

More information about the Council of Clinical Innovators is available at transformationcenter.org/ccli.

Health equity learning collaborative

Upon request from CCOs, the Transformation Center and the Office of Equity and Inclusion convened a health equity learning collaborative for CCO staff leaders. The collaborative's goal was to provide a supportive environment to increase CCO capacity to address health disparities. The collaborative held four sessions focusing on Transformation Plan elements 6 (Addressing Members' Cultural, Health Literacy and Linguistic Needs), 7 (Provider Network and Staff Ability to Meet Culturally Diverse Community Needs) and 8 (Quality Improvement Plan – Eliminating Racial, Ethnic and Language Disparities). Three CCOs participated on the planning committee and each hosted one session.

More information about the health equity learning collaborative is available at: transformationcenter.org/equity.

Flexible services learning collaborative

Flexible services are health-related services not covered by the Medicaid State Plan and provided in lieu of traditional benefits. These services are intended to improve care delivery, improve member health and lower costs. In February 2015, in preparation for developing a learning collaborative on flexible services, the Transformation Center asked the Center for Healthcare Strategies to do an environmental scan of national best practices. In interviews held by the Transformation Center in May and June 2015, CCO indicated an

interest in a flexible services learning collaborative. A learning collaborative was scheduled to launch in October 2015 with the goal of sharing promising practices related to CCOs' use of flexible services.

Coordinated Care Model Summit

The Transformation Center convened a two-day summit December 3 and 4, 2014, titled "Oregon's Coordinated Care Model Summit: Inspiring Health System Innovation." The goal of this gathering was to highlight and share what the CCOs are learning and promote the spread of the coordinated care model across the state. Almost 1,200 people including CCO staff, community advisory council members, providers, community stakeholders, health leaders, health system and plan representatives, consumers, lawmakers, policymakers and funders came together to share concrete, innovative strategies for what health system transformation looks like on the ground.

Highlights included opening remarks by former Governor Kitzhaber; an inspiring plenary by Donald M. Berwick, MD, former CMS administrator; CCO stories of successfully implementing aspects of the coordinated care model; upstream strategies to promote health; a poster session; and 16 breakout sessions highlighting emerging best practices in Oregon. Summit materials are available at:

www.oregon.gov/oha/Transformation-Center/Pages/CCM-Summit-2014.aspx

People who evaluated the summit said its most valuable components were the plenary sessions and networking opportunities. Approximately 90 percent of respondents said they planned to implement at least one innovative practice they learned about at the summit.

This year, the Transformation Center began planning its third coordinated care model summit for November 2015.

Innovation Café

At the request of CCOs, the Transformation Center expanded the focus of the complex care collaborative to convene the Oregon Health System Innovation Café, a two-day statewide meeting about innovative projects addressing complex care, behavioral health integration, traditional health workers, and health information technology and telehealth. The four topic areas were chosen based on the high number of CCO projects in these areas. The meeting included 43 projects presented during rotating small-group table discussions, as well as keynote speakers and affinity group meetings. The meeting brought together 203 participants from across the state including representatives from all 16 CCOs, county health departments, hospitals, clinics, health plans, nonprofits, community organizations and the Oregon Health Authority.

Meeting materials from the Innovation Café are available at: transformationcenter.org/complexcare.

Transformation Center CCO Technical Assistance (TA) Bank

As a result of requests from CCOs and their CACs, in October 2014 the Transformation Center began offering CCOs and their CACs the opportunity to receive technical assistance in key areas to help foster health system transformation. In addition to support and technical assistance provided by other parts of OHA, each CCO was designated 35 hours of free consultation from outside consultants on contract with the Transformation Center. The designated 35 hours include 10 hours of consultation to support CACs and other community-based work and will be accessible through September 2015. Starting in October 2015, there will be a new allocation of hours for CCOs to use until September 2016. Innovator agents participate closely in the process of CCOs requesting and receiving technical assistance.

As of June 2015, the Transformation Center had received 19 TA Bank requests from CCOs, for a total of 262 TA hours. Sixty percent of these requests focused on CAC development, including the community health assessment and community health improvement plan. Other requests focused on health equity,

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quality improvement and measurement, program evaluation and alternative payment methods (see chart below). TA Bank evaluation results for four of 10 completed TA projects show that all CCOs rated the TA as very valuable (75 percent) or valuable (25 percent), and all CCOs rated the TA as very effective (75 percent) or effective (25 percent).

To continue to provide technical assistance through September 2016, the Transformation Center has released a request for applications (RFA) for consultants to contract as technical assistance providers. The Transformation Center continues to communicate with the Office of Equity and Inclusion, Office of Health Information Technology, Public Health Division, Office of Health Policy and Research, and Child Well-being Team to ensure coordination of OHA technical assistance for the topics listed below.

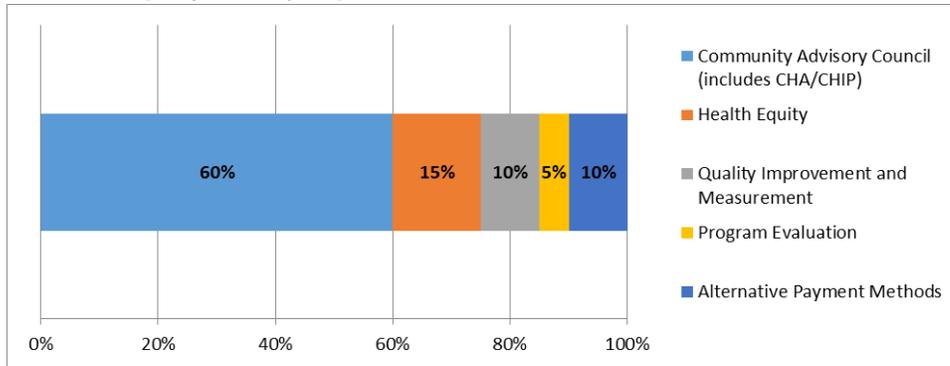
TA Bank technical assistance topics:

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

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

TA Bank projects through June 2015:

CCO	Topic	Hours Requested
1. Willamette Valley Community Health	Health equity	4
2. InterCommunity Health Network	Measurement	11
3. FamilyCare	CAC development, CHIP implementation	16
4. PacificSource Central Oregon	Measurement	25
5. Eastern Oregon CCO	CAC member engagement	5
6. AllCare	CAC member engagement	32
7. PrimaryHealth Josephine County	CAC member engagement	11
8. PrimaryHealth Josephine County, Jackson Care Connect, AllCare	Health literacy	10.5
9. Jackson Care Connect	CAC development, CHIP implementation	8.5
10. Trillium Community Health Plan	Health program evaluation	7
11. Western Oregon Advanced Health	CHIP development	15
12. Intercommunity Health Network	Alternative payment method training	9.5
13. Columbia Pacific CCO	CHIP implementation	19
14. Cascade Health Alliance	CAC member engagement	10.5
15. Health Share	Health equity	25
16. Willamette Valley Community Health	CAC member engagement	16
17. Trillium	Community Health Assessment	7
18. Eastern Oregon CCO	CHIP implementation	30
19. Willamette Valley Community Health	Alternative payment methods	11
Total Hours:		262

TA Bank projects by topic:

More information about the Technical Assistance Bank is available at transformationcenter.org/tabank.

Project ECHO

Project ECHO is an evidence-based telementoring program that uses videoconferencing to connect primary care providers with specialty providers. In September 2014, Health Share of Oregon and Oregon Health & Science University launched Project ECHO in the Portland Metro region with Transformation Fund grant dollars from the Oregon Legislature. This pilot focuses on psychiatric medication management, and about 15 primary care providers participate weekly. Sessions include lectures and case reviews with a psychiatrist, nurse practitioner and pharmacist. The goal is to increase the capacity of primary care providers to treat patients with psychiatric disorders, including those related to sleep and substance abuse.

During this reporting year, discussions began with the Oregon Office of Rural Health for potential to spread ECHO throughout the state. Providence Center for Outcomes, Research and Education completed Phase I of an environmental scan. In early 2015, Oregon began participating in the Center for Health Care Strategies Project ECHO Medicaid Collaborative.

Alternative payment method technical assistance

OHA has engaged the Center for Evidence-based Policy to provide CCOs advanced technical assistance to identify and implement alternative payment methods (APMs). To apply, CCOs completed an APM readiness assessment in June 2015 and will need to submit an online application in August 2015.

Based on this process, up to three CCOs will be selected to work with the Center for Evidence-based Policy to advance their use of APMs. Assistance may include:

- Identifying opportunities to use APMs
- Selecting appropriate APMs
- Engaging stakeholders in APM design and implementation
- Obtaining and using data to model APMs
- Selecting outcome, quality and performance metrics to measure APM success

The center will work with each selected CCO to determine what combination of assistance will be most beneficial in moving APMs forward in their organization.

CCOs not selected through this process may request APM technical assistance through the Technical Assistance Bank.

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
7/1/2014	Completed full dental integration into CCOs	Strengthens transformation and integration	Provides positive access and coordination of benefits	16	955,711 individuals have dental benefits through a CCO as of 6/30/2015.
10/1/2014	New non-emergent medical transportation (NEMT) provider for AllCare Health Plan	Supports NEMT CCO integration	Better coordination of care	1	50,500 AllCare members
4/30/2015	CareOregon Fully Capitated Health Plan (FCHP) closes	FCHP members moved to CCO	Better coordination of care	1	2,595 CareOregon FCHP members

C. Quantitative and case study findings

Innovator agents – Summary of promising practices statewide

Innovator agent learning experiences

Summary of activities	Innovator agents have received a broad range of training about health care transformation. The emphasis over the past year has been on trauma informed care, the ACEs study, health equity and social determinants of health. Behavioral and dental health integration have been on the forefront over this period. Innovator agents have been involved in training around how to best implement these initiatives and have participated in providing training around these areas. Other areas of training have included telehealth, alternative payment methods and opioid abuse. In addition to conferences and summits, Innovator agents regularly have subject matter experts at their weekly phone conferences and monthly in-person meetings to keep them updated on cutting-edge practices.
Promising practices identified	The knowledge and training the innovator agents have received has helped them further health care transformation within the CCOs they serve. Often this learning occurs in partnership with CCOs, which spurs further creativity.
Participating CCOs	16
Participating IAs	9

Learning collaborative activities

Summary of activities	See list of learning collaborative activities.
Promising practices identified	The learning collaboratives have provided guidance and impetus for CCOs to learn from each other about the latest practices. Participation in learning collaboratives has grown over the past year with regular participation by CCOs and innovator agents. The learning collaboratives have promoted health transformation by addressing metrics and issues such as colorectal screenings, developmental screenings, mental health and physical health screenings for children in foster care. Innovator agents provide support to the CCOs as they implement the things they have learned into their practice.
Participating CCOs	16
Participating IAs	9

Assisting and supporting CCOs with transformation plans

Summary of activities	Innovator agents provide training and expertise to CCOs as they continue to implement their transformation plans. Each CCO is in a different stage of development, and because the innovator agents cover more than one CCO, they often are able to provide different strategies that may have not been previously considered.
Promising practices identified	CCOs are embracing the concept of transformation and viewing the plans as blueprints to better health care for the members they serve. The result has been increased behavioral and dental health integration, promotion of alternative payment methods, focus on health equity, and refined use of electronic health records. Innovator agents have provided ongoing support and consultation for CCOs as they update and implement their transformation plans.
Participating CCOs	16
Participating IAs	9

Assist CCOs with target areas of local focus for improvement

Summary of activities	Technical assistance was available through the Transformation Center for CCOs. Innovator agents helped CCOs identify areas where they could best use the hours they were allotted and worked collaboratively with the CCOs and the Transformation Center to choose providers and arrange training.
Promising practices identified	CCOs received technical assistance in the areas of member engagement, CAC support, alternative payment methods and health equity. Innovator agents also have assisted CCOs with community engagement with their local DHS offices, their long term support services innovator agents, behavioral health agencies and housing authorities.
Participating CCOs	16
Participating IAs	9

Communications with OHA

Summary of activities	Innovator agents have monthly in-person meetings with the Transformation Center, Public Health Division, Health Analytics, Office of Health Equity and other OHA divisions. OHA leadership regularly meets with the innovator agents during these meetings. Innovator agents also have weekly phone meetings that include outside speakers to inform them about the most current health practices.
Promising practices identified	Frequent communication with OHA and the Transformation Center has enhanced the ability of the innovator agents to identify and act on specific strategies to improve state communications to CCOs.
Participating CCOs	16
Participating IAs	9

Communications among innovator agents

Summary of activities	Innovator agents meet monthly and have twice-weekly huddles. They also communicate frequently through email.
Promising practices identified	Through frequent communication, innovator agents are able to quickly identify issues and trends across the state and strategize to appropriately address them.
Participating CCOs	16
Participating IAs	9

Community advisory council activities

Summary of activities	All innovator agents regularly attend CAC meetings and provide support and guidance. They have assisted with the development and implementation of the community health improvement plans and updates. The innovator agents have assisted CACs in obtaining technical support through the Transformation Center and connecting them with training, community support and activities.
Promising practices identified	The CACs have shown significant growth in the past year. They continue to better understand and develop their role as an important advisory council to the CCOs.

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Participating CCOs	16
Participating IAs	9

Rapid-cycle stakeholder feedback (to identify and solve barriers; assist with adapting innovations; simplify and/or improve rate of adoption; and increase stakeholder engagement)

Summary of activities	Innovator agents are the feet on the ground for OHA and have developed strong relationships and trust with CCO executive staff, OHA leadership and stakeholders. These relationships and the expertise they have gained through transformation has enabled them to provide feedback to the CCOs and OHA about where barriers lie. Because the innovator agents provide support for more than one CCO, they are able to cross-pollinate good ideas and support and promote sharing.
Promising practices identified	As the key point of contact, innovator agents represent the needs of the community and the CCO to OHA. In addition, the communities they serve look to them as leadership representatives of the state. That relationship enables innovator agents to present information in a way that can remove barriers and improve health transformation and collaboration between the state and local communities.
Participating CCOs	16
Participating IAs	9

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

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

Information sharing with public

Summary of activities	Innovator agents provide community outreach in a variety of formats that include: serving on community boards; participating in community planning; providing training for volunteer groups, medical providers, behavioral health providers and other stakeholders at conferences and summits; and actively participating in the early learning hubs.
Promising practices identified	Innovator agents' presence and participation within the communities they serve promotes and makes the public more aware of health transformation.
Participating CCOs	16
Participating IAs	9

Innovator agents – Measures of effectiveness

Measure 1: Surveys rating IA performance

Data published for current quarter? Type?	Plans for qualitative interviews with stakeholders are forthcoming.
Web link to Innovator Agent quality data	-

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

Data published for current quarter? Type?	Innovator agents submit quarterly reports that support transformation within their CCOs, in partnership with OHA, and other activities focused in the community.
Web link to Innovator Agent quality data	

Measure 3: Innovations adopted

Data published for current quarter? Type?	Several innovations have been adopted and shared in the areas of medical, dental and behavioral health throughout all of the CCOs. CCOs and providers presented
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	their innovations at the Coordinated Care Model Summit in December 2014, the Innovation Café in June 2015 and monthly learning collaboratives.
Web link to Innovator Agent quality data	Projects presented at the Innovation Café are available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx

Measure 4: Progress in adopting innovations¹

Data published for current quarter? Type?	-
Web link to Innovator Agent quality data	Projects presented at the Innovation Café are available at: http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx

Measure 5: Progress in making improvement based on innovations¹

Data published for current quarter? Type?	Based on progress and milestone reports, CCOs are making solid progress in eight areas of transformation including oral and behavioral health integration, primary care homes, alternative payment methods, health information and community empowerment.
Web link to innovator agent quality data	Oregon’s Health System Transformation 2014 Final Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf

Measure 6: CCO transformation plan implementation

Data published for current quarter? Type?	Transformation plans are on track as evidenced by the milestone reports. The Transformation Center offered technical assistance to CCOs that requested it to help promote transformation activities. Innovator agents assisted CCOs in requesting, accessing and implementing the assistance they received.
Web link to innovator agent quality data	Transformation plan reports are available online: http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Transformation-Plans.aspx

Measure 7: Learning collaborative effectiveness

Data published for current quarter? Type?	<p>An increasing number of stakeholders participate in the Transformation Center’s learning collaboratives. For example, stakeholder participation in the Statewide CCO Learning Collaborative has an average of 72 attendees at the 10 sessions held from July 2014 through June 2015 (compared to an average of 66 participants from July 2013 through June 2014).</p> <p>Participant evaluations for the same time period indicate a large increase in the percent of participants who found sessions valuable or very valuable (94 percent from July 2014 through June 2015 compared to 70 percent from July 2013 through June 2014) and smaller increase in the percent who planned to take action based on the learning collaborative (51 percent from July 2014 through June 2015 compared to 41 percent from July 2013 through June 2014).</p>
Web link to innovator agent quality data	-

Measure 8: Performance on Metrics and Scoring Committee metrics

Data published for current quarter? Type?	All innovator agents assist their CCOs in internal planning to align work with improvements on performance metrics. Their consultation and guidance includes contract review and in some cases, clinical recommendations related to behavioral health integration.
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¹ This item will be reported in a qualitative, narrative fashion based on quality, access and cost data and other progress reports submitted by CCOs and reviewed for statewide impact.

Web link to innovator agent quality data	Oregon's Health System Transformation 2014 Final Report is available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf .
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Other evaluation results from Transformation Center learning collaborative can be found in [Section VII](#).

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

None reported.

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

Forum	Comments and issues raised
<p>Oregon Health Policy Board</p>	<p>For more detail, please refer to the board's 2014 and 2015 meeting archives.</p> <ul style="list-style-type: none"> ■ Torrey Powers, ADT Health, July 1, 2014: Commented on her support of the committee's direction to move forward with recommendation of 12-month continuous eligibility in Medicaid. She suggested that Oregon reach out to other states and then together approach CMS with a request to not reduce the FMAP for the ACA Medicaid expansion population. ■ Jody Smith, GlaxoSmithKline, March 3, 2015: SB 440 is a sleeper bill that could have a huge impact. This bill puts the Metrics and Scoring Committee under the Policy Board and could have an impact in moving them from pay for procedures to pay for performance. GlaxoSmithKline is working with a number of states that are coming up with a statewide set of measures to measure health care across the state. The most recent effort is with Washington state where a bill was passed similar to that of SB 440. The success of that effort had three points that Jody highlighted: <ul style="list-style-type: none"> – Diverse group of stakeholders – Very public process – The committee struggled most with the difference between what an outcome measure and a process measure are. ■ Linda Dugan, Health Insurance Agent in Astoria, April 7, 2015: Wanted the Board to be aware that the Federal Exchange is not updating life changes in a timely manner and this could cause issues for those who are incorrectly receiving OHP benefits.
<p>Future of Public Health Services Task Force</p>	<p>For more detail, please refer to the Task Force website.</p> <p>July 23, 2014, public comment:</p> <ul style="list-style-type: none"> ■ Patricia Neal, Public Health Advisory Committee, Lincoln County: Currently all our services are local and should stay that way. Mental health isn't mentioned in the Task Force models but it is part of our department because we are trying to integrate behavioral health with primary care. If regionalization occurs, knowing that all counties are not organized the same, how will individual county needs be met? ■ Lesli Leone Uebel, Benton County Mental Health Planning Committee: Foundational or core components; the draft framework represents a base minimum and doesn't incorporate the unique role of public health in population health and we do not see a role for innovation or integration of the context of community health for health care systems and community resources. This is a critical time for health care transformation and healthcare cannot transform in a vacuum. The draft frame is not innovative. Without additional funding, public health will lose ground and recommends meaningful, sustainable funding across the state; incorporate innovation in the draft framework. A bare minimum of

Forum	Comments and issues raised
	<p>funding across the state will not spark innovation or support innovation but rather it could risk lowering the services across the state to the lowest common denominator.</p> <ul style="list-style-type: none"> ■ Morgan Cowling, Executive Director Coalition of Local Health Officials (CLHO): CHLO held a recent webinar on the task force work and there were a number of large themes that emerged for recommendations: <ul style="list-style-type: none"> – Participants overwhelming support shared services in local public health. Participants were very concerned about imposed consolidation of public health; would it be based on transformation? – There is a belief that regional or shared services should be locally driven based on community needs, transportation corridors, political relationships and take into consideration local systems and challenges. There is widespread disregard for consolidating 34 health departments into 8 health departments. – Substantial solutions to implement a conceptual framework like consolidation of health departments should use local funds for public health. – During the webinar with CHLO, participants tried to answer the question “How do we try to implement this?” Participants agreed that an assessment needs to take place to answer “Where are we right now?” ■ Oregon Nurses Association (ONA): ONA submitted a document for the record. They commented that traditional health workers are the only public health workers specifically mentioned in the framework; they would like to see that all public health professionals be added as a foundational capability. <p>August 20, 2014, public comments:</p> <ul style="list-style-type: none"> ■ Josie Henderson, executive director of the Oregon Public Health Association: Josie read from a prepared statement which was submitted for the record; thanked the task force for their groundbreaking work, and urged the task force to recommend adequate and sustainable funding as part of Oregon’s public system future in their report. ■ Morgan Cowling, executive director, Coalition of Local Health Officials (CLHO): CHLO has not had an opportunity to discuss the straw draft proposal being discussed today, but a webinar is scheduled with Gary Oxman enabling CLHO to comment on the proposed changes at the next Task Force meeting. There are a few general comments I can make now: The proposal does not address the overall timeline for reform; there is language around the first wave of implementation but would like to see a plan for how many waves, important to detail the timeline so the whole state will be operating under the same framework. Work is being done with CCOs around health system transformation across the state; how does the connection to health system transformation happen? We all need to be moving along the same direction in regard to health system transformation. <p>September 10, 2014, public comments. Also see public comments on the task force’s implementation proposal.</p> <ul style="list-style-type: none"> ■ Lila Wickham, president-elect, Oregon Public Health Association (OPHA): OPHA is looking forward to legislation that addresses the changing medical system. OPHA believes we need to educate people on how to use medical/ dental/ behavioral health/ medication while educating doctors on how to deal with patients in a different way and hopes there will be flexibility with the way public health is provided. OPHA hopes the Legislature becomes fully aware of the

Forum	Comments and issues raised
	<p>various ways that public health provides services.</p> <ul style="list-style-type: none"> ■ Muriel DeLaVergne-Brown, chair of Conference of Local Health Officials (CLHO): The conceptual framework presented in this model will require additional resources. CLHO is ready to work with public health to improve the health of Oregonians. The implementation pathways are needed as we look toward the future and it is important that we all work together. Written public comment was provided and included in task force member packets. ■ Stacey Michaelson, Association of Oregon Counties: She would like the changes compiled in a final document to share with commissioners and community partners; does not see a timeline or language that said the Legislature would agree to foundational capabilities or the time an agency would come up with the process and believes that is needed. If this turns into a regional process, what does funding look like? The unfunded mandate causes some concern. She would like to see those areas addressed in the final report.
<p>Metrics and Scoring Committee</p>	<p>For more detail, please refer to the committee website.</p> <ul style="list-style-type: none"> ■ Central City Concern, July 18, 2014, public testimony: OHA and CCOs must begin to measure housing status and food security, and develop metrics that improve access to affordable, safe and sometimes supported housing and food security. ■ Helen Bellanca, MD, MPH, August 22, 2014, public testimony: Proposes moving the following metric from the core demonstration set to the incentive set: “Effective contraception use among women at risk of unintended pregnancy.” ■ Lynn Knox, Oregon Food Bank, August 22, 2014, public testimony: Explained importance of food insecurity screening and resources for patients experiencing food insecurity. Oregon Food Bank is committed to working with the CCOs to implement food insecurity screening, sharing lessons learned, and will provide up-to-date resource information translated into multiple languages for all areas of the state by early in 2015. ■ Cascade AIDS Project, October 17, 2014 public testimony: Asks committee to consider adopting policy that promotes universal HIV testing as a performance measure in Oregon’s CCOs. ■ Providence Health and Services, October 17, 2014, public testimony: Urges committee to use the measure selection criteria it developed at the February 13, 2014, committee meeting; and to develop a long-term strategy that mobilizes the health care community toward long-term cultural change. ■ Oregon Foundation for Reproductive Health, ACLU of Oregon, Planned Parenthood of Oregon, November 20, 2014, public testimony: Urges committee to adopt the benchmark for effective contraceptive use for 2015. ■ American Lung Association of Oregon, March 20, 2014 public testimony: Urges committee to adopt a meaningful metric to measure and improve the delivery of tobacco cessation to individuals who use tobacco products. ■ May 15, 2015, public testimony: Urges committee to adopt patient food insecurity screening and assistance as the first social determinant of health performance measure for Coordinated Care Organizations.

IV. Workforce provider capacity

A. Health professional graduates participating in Medicaid

OHA periodically receives information about medical school, physician assistant, nurse practitioner, and dentistry program graduates from Oregon Health & Science University (OHSU). In accordance with STC 57.b.iii, OHA matches this information with Medicaid provider enrollment data to ascertain what proportion of those graduates go on to serve Medicaid clients. In November 2015 OHA received an updated file of 2014-2015 graduates. Results (for 295 graduates) are shown below:

Proportion of 2014-2015 graduates enrolled as Oregon Medicaid providers

Field	November 2015
Nursing (adv. practice)	36.5%
Physician Assistant	67.6%
Dentistry	13.9%
Medicine*	11.8%

* This number reflects *individual* graduates as enrolled providers. However, because medical school is typically followed by at least three years of continued training in a residency program, with services billed under a supervising physician's Medicaid provider number, this number does not reflect the number of graduates who are doing their residencies in Oregon at *institutions* that are enrolled as Medicaid provider facilities.

B. Statewide workforce development – Traditional health workers

During the 2014-2015 demonstration year, OHA continued efforts to integrate traditional health workers (THWs), including community health workers (CHW), peer wellness and peer support specialists, personal health navigators and doulas. It has become clear that the role of the personal health navigator is difficult to distinguish from the other roles because it is a key role for all of the other THW types, and many individuals choose to become certified in one of the other roles.

In January 2015, 10 of the 16 CCOs reported THW demonstration projects that have resulted in promising outcomes for health system transformation. Since that time, additional CCOs are beginning to plan demonstration projects, recruit and train THWs. Activities undertaken by CCOs include:

- Pregnancy education
- Health literacy training
- Distributing and reviewing “What to do when your child is sick” booklet in preferred language
- Tobacco cessation education and referral
- Established a CHW cadre to refer patients to non-emergent medical transportation, 150 referrals made
- Fielding parent/student surveys on barriers to health services and other supports
- Work with homeless youth to increase connection to clinic for homeless youth, follow-through with appointments and referrals
- Asian THWs housed in culturally-based clinic made welcome calls to new CCO enrollees, established primary care homes, provided chronic disease self-management education

Outcomes of various THW projects include increased follow-through on referrals provided, reduction in emergency department utilization, increased culturally and linguistically appropriate health promotion activities, reduction in high cost medical interventions (C-sections, epidurals), and increased patient satisfaction.

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The table below provides data on THWs certified between July 1, 2014, and June 30, 2015, disaggregated by race or ethnicity and worker type. Upon application for certification, THWs may provide race or ethnicity data from a disaggregated list as required by Oregon’s policy on race, ethnicity, language, and disability (REAL+D) data collection standards (Oregon Revised Statute 413.161). The data below are aggregated, due to small numbers. The THW workforce represents somewhat greater diversity than other health care professions. However, “decline to answer” or blank/missing data represents 14 percent of the total THWs in this reporting period.

Type	African/ African American	American Indian/ Alaska Native	Asian/ Pacific Islander	Latino/ Hispanic	White	Other	Decline to Answer	Unknown	TOTAL
CHW	9	5	4	21	92	2	15	9	157
PSS	17	16	3	9	160	9	17	18	249
PWS	1	0	1	1	12	1	3	1	20
Doula	0	0	0	0	0	0	1	0	1
TOTAL	27	21	8	31	264	12	36	28	427
% of All Races Total	6.3%	4.9%	1.9%	7.3%	61.8%	2.8%	8.4%	6.6%	

Stakeholder engagement

THW stakeholders include CCOs, providers, community-based organizations, state and national research entities, and policy makers. Robust discussions among stakeholders on the THW model have continued. In demonstration year 2014-2015, OHA provided 19 presentations at stakeholder conferences and meetings and participated in 59 meeting with focused discussion on THWs.

THW-related policy

Legislative policy including THWs was introduced to the Oregon Legislature’s 2015 session. The legislative concept and broad community support signaled the recognition of the THW workforce to address inequities in oral disease and improve access to oral health care.

House Bill 2024 requires OHA to adopt rules and procedures for the training and certification of health workers to provide oral disease prevention services and for the reimbursement of oral disease prevention services provided by traditional health workers. A rulemaking committee was convened to define the rules and is due to sunset in June 2016.

V. Utilization data

See [interim evaluation findings](#) for discussion of access to health care services.

VI. Enrollment reporting

A. Ever enrolled report

	Population	Total Number of		
		Clients	Member Months	
Title 19; OHP Plus	PLM Children FPL > 170%	1,846	14,048	
	Pregnant Women FPL > 170%	1,205	8,478	
Title 21; Plus	SCHIP FPL > 170	41,445	286,088	
Optional	Title 19; Plus	PLM Women FPL 133-170%	21,630	134,960

		Population	Total Number of Clients	Member Months
Mandatory	Title 21; Plus	SCHIP FPL < 170%	104,719	763,856
	Title 19; Plus	Other OHP Plus	481,607	3,803,677
	Title 19; Plus	MAGI Adults/Children	880,951	7,552,860
	Title 19; Plus	MAGI Pregnant Women	17,198	115,907
TOTALS			1,550,601	

B. OHP eligibles and managed care enrollment

	OHP Eligibles*	FCHP	CCOA ¹	CCOB ²	DCO	MHO	CCOE	CCOG
July	982,590	3,179	834,692	9,351	60,723	4,460	2,120	47,521
August	998,218	3,140	850,131	1,782	60,362	4,427	1,582	49,335
September	1,008,953	3,091	866,303	2,089	58,744	4,624	1,805	52,865
October	931,298	3,055	881,136	1,623	56,477	4,648	1,604	51,812
November	978,405	2,737	831,019	1,474	53,809	4,480	1,656	50,341
December	999,496	2,733	852,528	1,369	54,782	4,493	1,550	52,087
January	1,028,263	2,710	864,132	1,328	55,836	4,428	1,543	53,547
February	1,044,073	2,695	896,304	1,272	57,317	4,423	1,458	39,552
March	1,060,093	2,647	918,924	1,187	56,137	3,853	1,363	36,760
April	1,081,835	2,595	944,706	1,225	57,521	3,930	1,044	38,309
May	1,079,418	1	942,961	1,150	55,810	3,936	1,005	35,580
June	1,050,178	1	920,099	1,320	53,127	3,956	1,015	35,618
Average	1,020,235	2,382 0.23%	883,578 86.61%	2,098 0.21%	56,720 5.56%	4,305 0.42%	1,479 0.14%	45,277 4.44%

*Total OHP Eligibles include: TANF, GA, PLM-Adults, PLM-Children, CX Families, Adults & Couples, OAA, ABAD, CHIP, FC and SAC.

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

VII. Evaluation activities and interim findings (Demonstration Year July 2014 – June 2015)

A. Evaluation activities and interim findings

In this demonstration year, independent evaluators delivered assessments of implementation and impacts for CCOs and Oregon’s coordinated care model (CCM). These included:

- A final report from evaluators at Portland State University and Providence Center for Outcomes Research and Education (CORE) assessing the early impacts of CCOs as part of the State Health Access Reform Evaluation.
- A final midpoint evaluation of Oregon’s Medicaid demonstration waiver from Mathematica Policy Research.
- A baseline study from CORE assessing the spread of the coordinated care model among CCOs, commercial health plans, hospitals, and provider organizations.

Independent evaluators and OHA staff also delivered evaluation results for specific programs and aspects of the CCM:

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- Analysis of patient-centered primary care home site visits by OHA staff.
- A behavioral health environmental scan assessing the extent of behavioral health integration and successes and barriers to further development.
- Case studies highlighting collaboration between CCOs and local public health authorities.
- Information about CCOs' use of flexible services from interviews with a sample of CCOs.

In addition, evaluators initiated work studies to identify and categorize specific activities each CCO is carrying out to transform the delivery system and determine whether the effects of Medicaid transformation “spill over” to non-CCO patients.

In the tables below, 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 (PCPCHs)

Evaluation activities:	<p>OHA has contracted with independent evaluators to broadly evaluate PCPCH implementation and outcomes. In this demonstration year, the evaluators made progress on their evaluation of the PCPCH program and delivered an analysis of reports from PCPCH site visits.</p> <ul style="list-style-type: none"> ■ Researchers at Portland State University are looking in-depth at 15 to 30 recognized clinics considered to be top-performing or exemplary practices. Researchers will interview key staff at each practice to determine which aspects of the PCPCH model are most important to successful practice transformation. In this demonstration year, practices were recruited for this work and interview protocols were refined. ■ Also in this demonstration year, Providence Center for Outcomes Research and Education (CORE) delivered an analysis of written reports from PCPCH Program site visits to 57 PCPCHs in 2013 and 2014. The report summarizes how well PCPCHs perform on core attributes and identifies best practices among PCPCHs.
Interim findings:	<p>As of June 2015, there were 565 recognized clinics in the state (surpassing Oregon’s goal of 500 clinics by 2015). This represents over 50 percent of the estimated 1,000 primary care clinics in Oregon.</p> <p>PCPCH enrollment is a CCO incentive metric. The statewide baseline (for 2012) for this measure is 51.8 percent.</p> <ul style="list-style-type: none"> ■ The proportion of CCO members enrolled in a PCPCH increased from the 2012 baseline of 51.8 percent to 79.7 percent as of June 2015. ■ It is notable that CCOs sustained this increase despite the significant growth in Medicaid enrollment due to the Affordable Care Act. <p>In its analysis of reports from PCPCH Program site visits, CORE found evidence of progress in the areas of care coordination, continuity of care, and comprehensive whole-person care:</p> <ul style="list-style-type: none"> ■ Nearly all sites had a designated care coordinator. External coordination with referral and specialty care clinics appeared high. ■ Many sites were able to share information in real time with outside providers, and nearly half reported successful two-way communication with outside providers. ■ Half of all sites used a pre-visit plan in which providers and staff would “huddle” to discuss patient needs before scheduled appointments.
Improvement	Oregon’s Patient-Centered Primary Care Institute (PCPCI) provides technical support

activities:	and transformation resources to practices statewide, including learning collaborative opportunities. In this demonstration year, PCPCI conducted 14 in-person sessions for its learning collaboratives. These sessions focused on patient experience of care, improving access, and patient-centered communication. PCPCI also conducted 16 webinars. Topics included referral tracking and care coordination, depression screening and SBIRT for adolescents, building quality improvement systems, and strategies for rural practices.
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Lever 2: Implementing alternative payment methodologies (APMs) to focus on value and pay for improved outcomes

Evaluation activities:	<p>CCO incentive metrics</p> <p>OHA uses CCO incentive metrics to evaluate CCO performance and provide incentives for improvements. In this demonstration year, OHA finalized the 17 CCO incentive metrics for calendar year 2015 and paid out the second quality pool. In addition, the CCO Metrics and Scoring Committee reconvened to review performance to date and begin considering 2016 measurement. The committee made the following revisions to the incentive metric set:</p> <ul style="list-style-type: none"> ■ Added metrics for childhood immunization status and cigarette smoking prevalence as new 2016 measures ■ Removed metrics for early elective delivery and follow-up care for children prescribed ADHD medications ■ Revised metric specifications for screening, brief intervention, and referral to treatment (SBIRT), follow-up after hospitalization for mental illness, and mental and physical health assessments for children in DHS custody. <p>Hospital Transformation Performance Program (HTPP)</p> <p>The Hospital Transformation Performance Program (HTPP) provides incentive payments to DRG hospitals based on 11 incentive metrics. The program covers the period October 2013 – September 2015. Hospitals receive payments based on reporting in Year 1 (October 2013 – September 2014) and performance in Year 2 (October 2014 – September 2015). In this demonstration year, HTPP metrics for Years 1 and 2 were finalized, results were published, and OHA made the Year 1 quality pool payment.</p> <ul style="list-style-type: none"> ■ The Hospital Performance Metrics Advisory Committee met in July 2014 to finalize metrics for Years 1 and 2 for submission to CMS. OHA and CMS reached final agreement on the metrics and payment methodology in August 2014. ■ OHA worked with the Oregon Association of Hospitals and Health Systems to guide and support hospitals with the HTPP. This included launching a program web page, publishing additional supporting documentation, and holding webinars about the program. ■ Hospitals submitted baseline data for Year 1 in Q1 2015. OHA published metric results and paid the Year 1 quality pool in Q2 2015. <p>APMs implemented by CCOs and federally qualified health centers</p> <p>In this demonstration year, OHA made progress on data collection and evaluation pertaining to APMs implemented by CCOs and federally qualified health centers (FQHCs).</p> <ul style="list-style-type: none"> ■ A work group composed of OHA staff and CCO representatives drafted a revised version of the CCO financial report (Exhibit L). The current version of this report is used to calculate percentage of plan payments that are non-fee-for-service. The revised report includes a detailed breakout of non-FFS payments by APM type, including sub-capitation, performance bonus, risk sharing, and risk withhold. CCOs will begin using the new report on January 1, 2016, and will report detailed
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	<p>breakout of non-FFS payments by APM on an annual basis.</p> <ul style="list-style-type: none"> ■ OHA continued internal evaluation of the FQHC APM Pilot in this quarter. The pilot includes three FQHCs that started the pilot in March 2013 (Phase I FQHCs) and an additional five that joined the pilot in late 2014 (Phase II FQHCs). For the evaluation, OHA tracks several metrics on a quarterly basis, including a subset of CCO incentive measures. OHA also is evaluating the value of non-billable innovative patient engagement strategies for each FQHC's attributed population. These include telephone visits, online portal communications, coordinating transitions in care settings, and assisting patients with accessing community resources. In addition to tracking metrics and innovative patient engagement strategies, OHA is building an APM Total Cost of Care dashboard to share with FQHCs.
<p>Interim findings:</p>	<p>Internal analysis of CCO financial reports for Q2 2015 shows that 55.6 percent of all plan payments are non-fee-for-service (FFS). This is an increase of 7.7 percent from the previous quarter, in which 47.9 percent of plan payments were non-FFS. As noted above, OHA continues to work with CCOs on improving APM reporting.</p> <p>For the FQHC APM Pilot, quality metrics indicate that the pilot is associated with improved quality of care for Phase I FQHCs and maintenance of quality of care at a steady level for Phase II FQHCs. Regarding innovative patient engagement strategies, the evaluation indicates that FQHCs have increased the number of services they are providing to their patient populations, and that access for each health center's attributed patient population has been made easier and more convenient.</p>
<p>Improvement activities:</p>	<p>OHA has retained Bailit Health Purchasing to assist CCOs with setting up APMs. Bailit presented at the November 2014 statewide learning collaborative for CCO medical directors and quality improvement coordinators, which focused on the link between payment methodologies and improving quality of care through measurement. Following the collaborative, two CCOs began the process for receiving technical assistance with APMs. In April 2015, a senior consultant from Bailit began working with Intercommunity Health Network (IHN) on a presentation for IHN's leadership to help increase their understanding of APMs and help them assess APM options. In addition, Willamette Valley Community Health submitted a request for technical assistance with identifying opportunities for implementing new APMs, and with improving existing APMs. To provide technical assistance, Bailit will identify existing APMs using staff and stakeholder interviews and document and data review, and will prepare a report documenting its findings and recommendations.</p> <p>OHA contracted with the Center for Evidence-based Policy at OHSU (CEbP) to provide technical assistance to CCOs developing and implementing APMs. The assistance will consist of focused, detailed work with two to three CCOs and more general resources and webinars for the remaining CCOs and other payers and providers. In this demonstration year, CEbP fielded an APM readiness assessment tool to help CCOs evaluate the readiness of providers and other stakeholders to implement APMs. CEbP received 67 responses from 14 CCOs. In addition, CEbP began developing a draft application plan and materials for a request for applications for technical assistance.</p>

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

<p>Evaluation activities:</p>	<p><i>Behavioral health environmental scan</i></p> <p>In partnership with Oregon Health & Science University, the Transformation Center completed an environmental scan of behavioral health integration activities across the state. The goals of the project are to: assess the extent of integration implementation; the strategies and resources used; successes and barriers to further development; and</p>
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	<p>how OHA might best support these efforts. To prepare the scan, OHSU conducted semi-structured qualitative interviews with primary care and behavioral health providers and CCO leaders. To supplement these interviews, Transformation Center staff conducted additional interviews in other CCO service areas and with OHA leaders engaged with integration. The scan was used to develop a technical assistance plan for physical and behavioral health integration, including content areas and delivery strategies.</p> <p>Behavioral Health Home Learning Collaborative (BHHLIC) The Behavioral Health Home Learning Collaborative (BHHLIC) is supported by Oregon’s Adult Medicaid Quality Grant. It assists organizations that are integrating primary care into their behavioral health settings. In this demonstration year, the Oregon Rural Practice-based Research Network at OHSU (ORPRN) began collecting qualitative and quantitative data for its evaluation of the project. In Q2 2015, ORPRN began analyzing two sets of the Behavioral Health Integration Capacity Assessment (BHICA) for each of the participating sites. In addition, ORPRN began conducting interviews and focus groups to learn how team members at each site understand how behavioral health homes fit within the PCPCH model. The collaborative’s activities with sites will conclude in December 2015 and the evaluation will be completed by the end of January 2016.</p>
<p>Interim findings:</p>	<p>Behavioral health environmental scan Findings from the Transformation Center’s environmental scan of behavioral health integration include:</p> <ul style="list-style-type: none"> • There has been extensive integration activity statewide and patients are being positively affected. However, the penetration of integrated care is variable, with smaller and rural practices facing the most challenges. • Greater clarity and guidance is needed on key integration issues, such as sharing behavioral health information, credentialing, coding, billing, practice standards and measures. • Although there is a wealth of information about integration best practices available, many practices are challenged by the breadth and magnitude of change being required. Often, they lack capacity to successfully implement integration strategies. Ongoing access to program consultation and on-site practice coaching are often the most effective. <p>CCO incentive measures Five of the CCO incentive measures relate to physical and behavioral health care integration. Due to measure specification changes in 2015, performance for three of the measures in CY 2011 and CY 2013 cannot be compared to performance in CY 2014 and DY 2014 – 2015. The narrative below compares progress on two of the three updated measures from CY 2014 to DY 2014 – 2015 (one measure was not calculated for DY 2014 – 2015 because it is calculated on an annual basis) and progress on the two measures that were not updated from the 2011 baseline to DY 2014 – 2015. See Appendix E for details.</p> <p>Performance on all measures improved over the time periods considered. Performance on one of the three measures where a benchmark target was available exceeded the target (a benchmark target was unavailable for one measure):</p> <ul style="list-style-type: none"> • SBIRT (screening for unhealthy drug and alcohol use) increased from 6.4 percent in CY 2014 to 8.4 percent in DY 2014 – 2015, but was below the 2015 benchmark target of 12 percent. • Follow-up after hospitalization for mental illness increased from 70.7 percent in CY 2014 to 72.6 percent in DY 2014 – 2015, exceeding the 2015 benchmark target of 70.0 percent. • Mental, physical, and dental assessments within 60 days for children in DHS

	<p>custody increased from 27.9 percent in CY 2014 to 37.1 percent in DY 2014 – 2015, but was below the 2015 benchmark target of 90 percent.</p> <ul style="list-style-type: none"> • Follow-up care for children initially prescribed ADHD medications increased from 52.3 percent (initiation) and 61.0 percent (continuation) in 2011 to 57.7 percent (initiation) and 59.5 percent (continuation) in DY 2014 – 2015.
<p>Improvement activities:</p>	<p><i>Behavioral Health Home Learning Collaborative (BHHLC)</i> Oregon’s Adult Medicaid Quality Grant includes the Behavioral Health Home Learning Collaborative (BHHLC) to support “reverse” integration of primary care into behavioral health settings (described above). In this demonstration year, the BHHLC provided webinars, in-person learning sessions, and ongoing practice coaching to participating practices. In December 2014, CMS approved a 12-month no-cost extension of the grant. Six of the 10 original organizations continued to participate in the second year, and three new organizations joined in March 2015. Based on feedback from the first year, the amount of practice coaching available to participating agencies was doubled and a second vendor was contracted to provide training in care management and cross-training to familiarize behavioral health practitioners with care management guidelines for diabetes and hypertension. As of June 2015, four of the nine organizations participating provided integrated physical health services in the behavioral health facility to a growing panel of patients. Other sites are making progress toward increasing physical health services through co-location or care coordination with partners. The BHHLC will continue practice coaching, learning sessions, and webinars through December 2015.</p> <p>In addition to the BHHLC, the Adult Medicaid Quality Grant supported a performance improvement project (PIP) supporting diabetes monitoring for people with severe, persistent mental illness (SPMI). In this demonstration year, CCOs submitted their quarterly reports related to the diabetes monitoring PIP in July. These were submitted to Acumentra Health, which scored responses to the Standard Eight Improvement Strategies criteria (not on individual CCO study indicators). Once reviewed, the CCOs received their scores for each of the standard eight criteria, as well as a brief summary of the strengths and opportunities for improvement. Initial scores ranged from 30 to 97 with a third of the plans scoring above 80 percent. The CCOs use the feedback provided and resubmit their July reports to increase their scores. The CCOs continue to submit quarterly updates and share findings and best practices at the Oregon Health Plan Quality and Health Outcomes meetings each month.</p> <p><i>OHA reorganization</i> As part of OHA’s reorganization, OHA consolidated Medical Assistance Programs (MAP), the unit responsible for the Oregon Health Plan, with Addictions and Mental Health (AMH) into a new division called Health Systems. The new structure reflects the transformed environment in which CCOs are responsible for integrating physical, oral, and mental health care (see Section 4 below for additional information about the reorganization).</p>

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

<p>Evaluation activities:</p>	<p>Oregon contracts with independent evaluators to assess the effectiveness of the coordinated care model (CCM) as described in Oregon’s Medicaid waiver and implemented by CCOs. The evaluators also assess the spread of the CCM among CCOs, commercial health plans, and health care providers. In this demonstration year, evaluators delivered a report on early impacts of CCOs, a midpoint evaluation of Oregon’s Medicaid waiver, an initial report on CCM spread in Oregon, and a detailed</p>
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analysis of activities CCOs are undertaking to transform the health system. In addition, evaluators delivered a research plan to determine whether the effects of the CCM spill over to non-Medicaid patients. A contractor also delivered case studies highlighting three CCOs' collaboration with their local public health authorities.

Early impact of CCOs

Evaluators at Portland State University and Providence Center for Outcomes Research and Education (CORE) delivered a final report assessing the early impacts of CCOs on health care access, quality, outcomes, and costs. The research was part of the State Health Access Reform Evaluation (SHARE) funded by the Robert Wood Johnson Foundation. The evaluators used survey data to estimate the short-term impact of CCOs on member-reported use of care, quality of care, and health and behaviors. Survey analysis was supplemented with an analysis of claims data to measure the impact of CCOs on utilization patterns and costs.

Midpoint evaluation of Oregon's Medicaid Section 1115 Demonstration

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

Coordinated Care Model spread in Oregon

CORE delivered a baseline study assessing the spread of the coordinated care model among CCOs, commercial health plans, hospitals, and provider organizations. CORE used results from a 2015 survey to measure the extent of each organization's implementation of the coordinated care model in 11 domains, and interviewed a subset of organizations to provide context for survey results. CORE conducted initial surveys and interviews in February – April 2015 and received survey responses from 12 of the 16 CCOs.

CCO document analysis

CORE began work on a project to identify and categorize specific activities each CCO is carrying out to transform the delivery system. The project leverages documents that CCOs submit to OHA under their contracts and Transformation Fund grant agreements, including transformation plans and progress reports, community health improvement plans, and transformation fund grant reports. The research team reviewed documents submitted by each CCO, summarized distinct activities and progress carrying out activities, and categorized activities by transformation area, scope (number of members and geographic area affected), type, and other attributes. An analytic report and coded data set were delivered at the conclusion of the project, following the end of this demonstration year.

Tracking spillover from Medicaid's Coordinated Care Model

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

	<p>Collaboration between CCOs and local public health authorities OHA's Public Health Division contracted with Oregon Consensus to produce case studies highlighting three CCOs' collaboration with their local public health authorities.</p>
<p>Interim findings:</p>	<p>Measures of efficient and effective care collected by OHA From CY 2011 to CY 2014, key measures of efficient and effective care improved (see Appendix B for details):</p> <ul style="list-style-type: none"> • Emergency department visits decreased from 61.0 per 1,000 member months in 2011 to 47.0 per 1,000 member months. • Avoidable hospital admissions per 100,000 member years decreased for diabetes short-term complications (192.2 to 133.6 per 100,000 member years), chronic obstructive pulmonary disease (454.6 to 353.2 per 100,000 member years), congestive heart failure (336.9 to 198.3 per 100,000 member years), and adult asthma (53.4 to 51.5 per 100,000 member years). • Hospital readmissions within 30 days for any cause decreased from 12.3 percent in 2011 to 9.9 percent in DY 2014 – 2015. • Rates of important screenings and preventive health services increased from 2011 to DY 2014 – 2015. These include developmental screening in the first 36 months of life (20.9 percent to 49.5 percent), adolescent well-care visits (27.1 percent to 32.0 percent), immunization for adolescents (49.2 percent to 67.0 percent), childhood immunization status (66.0 percent to 70.1 percent), appropriate testing for children with pharyngitis (73.7 percent to 75.7 percent), and HbA1c testing for people with diabetes (78.5 percent to 81.7 percent). <p>Early impacts of CCOs Evaluators identified positive impacts of CCOs on member-reported access to care, quality of care, and care coordination. There were no impacts identified for membership in a specific CCO on preventive care or ED utilization (preventive care increased and ED utilization decreased regardless of membership in a specific CCO).</p> <ul style="list-style-type: none"> • The survey showed that CCO enrollment was associated with improved member-reported access to medical care compared to Medicaid fee-for-service and no insurance. • The survey showed an association between CCO enrollment and primary care utilization compared to Medicaid fee-for-service and no insurance. Self-reported ED visits decreased for all groups (claims analysis supported this finding). • CCO enrollment was associated with improved member ratings of care quality compared to Medicaid fee-for-service and no insurance. CCOs were also associated with better connections to personal care providers compared to Medicaid fee-for-service. • Pharmacy and costs shifted: CCOs were associated with reduced probability of filling a prescription but increased cost per user and cost per person. • The claims analysis found no changes in overall or total service use and costs. <p>Midpoint evaluation of Oregon's Medicaid Section 1115 Demonstration MPR found that OHA and CCOs made significant progress implementing transformation activities:</p> <ul style="list-style-type: none"> • OHA facilitated transition of the Medicaid delivery system from managed care entities to CCOs, implemented global budgets and CCO incentive payments, and created the Transformation Center, innovator agents, and learning collaboratives to spread innovations. • CCOs contracted with appropriate mental health, addiction services, and alcohol treatment providers to integrate physical health, behavioral health, and addiction

services, expanded PCPCH enrollment, and collaborated with communities to conduct community health assessments.

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

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

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

Coordinated Care Model spread in Oregon

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

CCO Document Analysis

Key findings from CORE's analysis of CCO documents include:

- CCOs focused heavily on physical, mental, and dental integration and workforce development.
- Relative to other areas, CCOs focused less on HIT transformation and APMs. This may be related to high upfront investments needed to support HIT transformation, since APMs often require performance data.
- Common barriers to transformation included provider and workforce capacity, challenges with outreach to the Medicaid population, obtaining demographic and health disparities data, and startup times for collaborating with other organizations.
- Overall, CCOs achieved three quarters of their goals for activities in their transformation plans.

Collaboration between CCOs and local public health authorities

Case studies of collaboration between CCOs and local public health authorities are available at:

<http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Pages/Success-Stories.aspx>. Key findings include:

- Columbia Pacific CCO and Tillamook County Health and Human Services focused on integrating behavioral and physical health.
- Yamhill County CCO and Yamhill County Health and Human Services collaborated on community-based programs for low-income populations.
- Trillium Community Health Plan (CCO) and Lane County Health and Human

<p>Improvement activities:</p>	<p style="text-align: center;">Services are focused on prevention programs.</p> <p><i>Sustainable Relationships for Community Health (SRCH) Program</i> In this demonstration year, OHA’s Public Health Division awarded five grants to local consortia consisting of coordinated care organizations (CCOs), local public health authorities, and chronic disease self-management program providers. Grantees participated in a series of institutes designed to establish improved referral and programmatic relationships to improve health outcomes for pre-diabetes, diabetes, and hypertension. Grantees created multi-year plans and implementation plans around quality improvement for closed-loop referrals and payments/reimbursements for self-management programs, using tools and best practices for provider engagement and data collection. Grantees improved efforts around data collection and measurement concepts; identified relevant performance measures; and identified tools for developing data collection and measurement plans. In future years grantees will establish new processes for sharing data across organizations, establish a shared vision for commitment, and create joint agreements and coordinate key performance indicators to implement the work related to pre-diabetes, diabetes, and hypertension. These efforts are funded by the Centers for Disease Control and Prevention, and align with Oregon’s CCO incentive measures and statewide performance improvement project.</p> <p><i>Health information technology (HIT) initiatives</i> In this demonstration year, OHA’s Office of Health Information Technology (OHIT) staff completed a series of on-site meetings with each CCOs to ensure that state HIT initiatives align with and support CCO needs. OHIT produced a summary document, available here, along with a detailed HIT profile for each CCO. This work is part of a broader ongoing environmental scan on the status of health information technology and exchange across the state.</p> <p>The on-site meetings confirmed that all 16 CCOs made HIT investments to facilitate health care transformation in their communities. Nearly all CCOs are pursuing or implementing health information exchanges and care coordination tools, as well as population management or data analytics tools. CCOs reported early successes in achieving goals such as (1) increased information exchange across providers to support care coordination; (2) making new data available to providers to assist with identifying patients most in need of support or services and to help providers target their care appropriately; and (3) improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data.</p> <p>In addition to their current implementation efforts, CCOs are pursuing additional or improved HIT tools or strategies including (1) connecting providers to HIT/HIE through integration with their EHR workflows; (2) moving from administrative and claims-based case management and analytics to incorporating and extracting clinical data from providers’ EHRs; (3) incorporating behavioral health, long-term care, and social services information; and (4) investing in new tools for patient engagement and telehealth.</p> <p><i>CCO metrics “dashboards”</i> In this demonstration year, OHA began releasing regular quality metric progress reports for CCOs using the automated metric reporting tool (“dashboard”) developed by CORE. The dashboards show data in rolling 12-month windows and can filter key measures by population subgroups such as race and ethnicity, ZIP code, and eligibility. This tool was instrumental in allowing CCOs to efficiently validate OHA’s final 2014 metrics results by allowing users to view overall results and drill down to member-level detail in a single file.</p>
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	<p>The dashboard currently includes all claims-based CCO incentive measures and a limited number of quality and access measures. It will be expanded to include additional measures and functionality.</p> <p>Access-to-care data learning collaborative In this demonstration year, a statewide learning collaborative and quality improvement session for CCO medical directors focused on using the CAHPS access-to-care data to measure outcomes and drive improvement. The session included a discussion on identifying strategies, best practices, tools, and resources for improvement of member access to care.</p> <p>OHA reorganization In this demonstration year, OHA completed an agency-wide reorganization to better deliver results in a transformed health care environment. OHA adopted a new structure that consolidates 18 operational units into seven functional divisions that report to the OHA Director. This includes consolidation of Medical Assistance Programs (MAP), the unit responsible for the Oregon Health Plan, and Addictions and Mental Health (AMH) into the Health Systems division. The new structure reflects the transformed environment in which CCOs are responsible for integrating physical, oral, and mental health care.</p>
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Lever 5: Implementation of health-related flexible services aimed at improving care delivery and enrollee health, and lowering costs

Evaluation activities:	In this demonstration year, OHA analyzed flexible services spending data from CCO financial reports. In addition, OHA’s Transformation Center interviewed CCOs about their use of flexible services including successes, challenges, and information that would be helpful from a flexible services learning collaborative. By the end of the demonstration year, the Transformation Center had collected data from 10 CCOs.
Interim findings:	<p>Analysis of spending data indicated relatively low provision of flexible services, although low spending could also be due to the relatively low cost of many flexible services. Analysis also indicated some confusion about policies and procedures related to flexible services.</p> <p>Among CCOs interviewed about their use of flexible services, the Transformation Center found that flexible services usually address chronic conditions. Successes reported by CCOs included gym memberships and pool passes to support physical activity and wellness, rental assistance to stabilize mental health, early childhood programs to address trauma, incentives to increase adolescent well child visits, and health resilience specialists to identify member needs. CCOs expressed interested in learning about flexible services definitions and design, member communication, relationship of flexible services to rate setting, and examples of flexible services that worked at other CCOs.</p>
Improvement activities:	OHA began planning for a flexible services learning collaborative in fall 2015.

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

Evaluation activities:	<p>Formative evaluation In this demonstration year, OHSU continued its formative evaluation of the Transformation Center. The evaluators observed a range of Transformation Center meetings and events, interviewed Community Advisory Council (CAC) leaders and participants, and assessed the implementation of the Community Advisory Councils’ (CACs) community health improvement plans in order to help guide the center’s support</p>
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	<p>of the CACs. The evaluators analyzed data in real time and routinely debriefed with the Transformation Center to share emerging findings and to refine the direction of the evaluation.</p>
<p>Interim findings/ Improvement activities:</p>	<p>Learning collaborative evaluation</p> <p>In this demonstration year, the Transformation Center continued work on seven external learning collaboratives. From July 2014 through June 2015, all seven learning collaboratives met, including one new learning collaborative (the Innovation Café). A total of 45 formal sessions occurred, attended by an average of 63 people per session.</p> <ul style="list-style-type: none"> • Across all sessions, the roles of attendees were: 21 percent clinical, 20 percent administrative or operational lead, 12 percent quality improvement or quality assurance, less than 1 percent financial, and 46 percent in other roles. • Sessions included 15 teleconferences, eight webinars, and 22 in-person sessions. • There were 37 unique session topics, including health equity, alternative payment methods, opioids and pain management, access to care, and health literacy. <p>Across all sessions, 85 percent of respondents found the session valuable or very valuable to their work and 44 percent of all respondents said they would take action at their organization as a result of attending the learning collaborative session.</p> <p>The evaluation forms asked attendees to identify the most helpful aspects of each learning collaborative. Among the most helpful aspects from learning collaboratives this demonstration year participants identified: group discussion and space for dialogue; hearing specific ideas to affect access to care; hearing about the “nuts and bolts” of behavioral health and primary care integration; and listening to other CCO staff discuss the role of health equity in their work.</p> <p>Technical Assistance Bank</p> <p>In this demonstration year, the Transformation Center launched its Technical Assistance Bank for CCOs. The TA Bank provides a menu of technical assistance topics that CCOs may access for a set number of hours of technical assistance. It enables CCOs to select technical assistance with topics of greatest interest and need. Topics include health equity, metrics and measurement, public health integration, and organizational development for CACs.</p>

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

The state reports quarterly on its progress of reducing the per capita expenditure growth trend. For state fiscal year (SFY) 2015, the state limits the per-member-per-month (PMPM) growth to 3.4 percent—two percentage points below the 5.4 percent trend assumed without health system transformation. Oregon’s quarterly reports demonstrate that the state’s PMPM growth, which included \$150 million in bonus payments for the CMS-approved Hospital Transformation Performance Program, remained within the parameters of the test for SFY 2015. Preliminary estimates for SFY 2016 also indicate the state will remain within the parameters of the test.

IX. 1 percent withhold and incentives

During January 2016, OHA analyzed encounter data received for completeness and accuracy for the subject months of July 2014 through June 2015. All CCOs met the administrative performance (AP) standard for all subject months and no 1 percent withholds occurred.

For incentives discussion, please refer to the [2014 Quality Pool](#).

X. DSHP tracker

For SFY 2015, the overall DSHP limitation was reduced per waiver requirements to \$108 million in expenditure authority. This was due to the ending of the OMIP program expenditure authority, and the reduction in expenditure authority in the Workforce Training and Development program from \$69 million to \$40 million. DSHP draws by quarter were:

State Fiscal Year 2015 Demonstration Year 13	FF Draw/DSHP limitation	New FF Drawn as Result of DSHP
SFY 15 Quarter 1	48,409,521	82,923,960
SFY 15 Quarter 2	39,251,470	69,962,415
SFY 15 Quarter 3	36,600,880	65,237,963
SFY 15 Quarter 4	12,851,817	22,907,273
TOTALS*	\$137,113,688	\$241,031,611

*Draw totals will not match the waiver limitation, because draws in quarter 1 of any SFY include draws applicable to the previous SFY.

XI. Complaints, grievances and hearings – Data and narrative

A. Complaints and grievances

Looking at the trends over the four quarters for all CCOs, the rate per 1,000 members fluctuated from 2.39 per 1,000 members in the 1st quarter to 3.25 in the 4th quarter.

The data show the rates were higher in the last two quarters of the reporting period. The higher rate may be due to an increased focus on complaint reporting. OHA convened a task force during the reporting year to collaborate with the CCOs and their sub-contracted agencies on improving and standardizing complaints and grievances data collection. Areas where the trend and rate is higher are Access to Care and Interaction with Providers or Plans.

The Client Services Unit received an average of 6,895 calls during the reporting period. The highest number of calls relating to the CCOs was for client choice/enrollment; second-highest was for requests for general information.. Client material requests (e.g., for handbooks, ID cards, complaint forms) was the third-highest reason for calls to Client Services.

Interventions

While there has been an increased focus on tracking and reporting complaints, additional work internally with OHA staff and plans is needed to improve reporting and trending analysis in 2016.

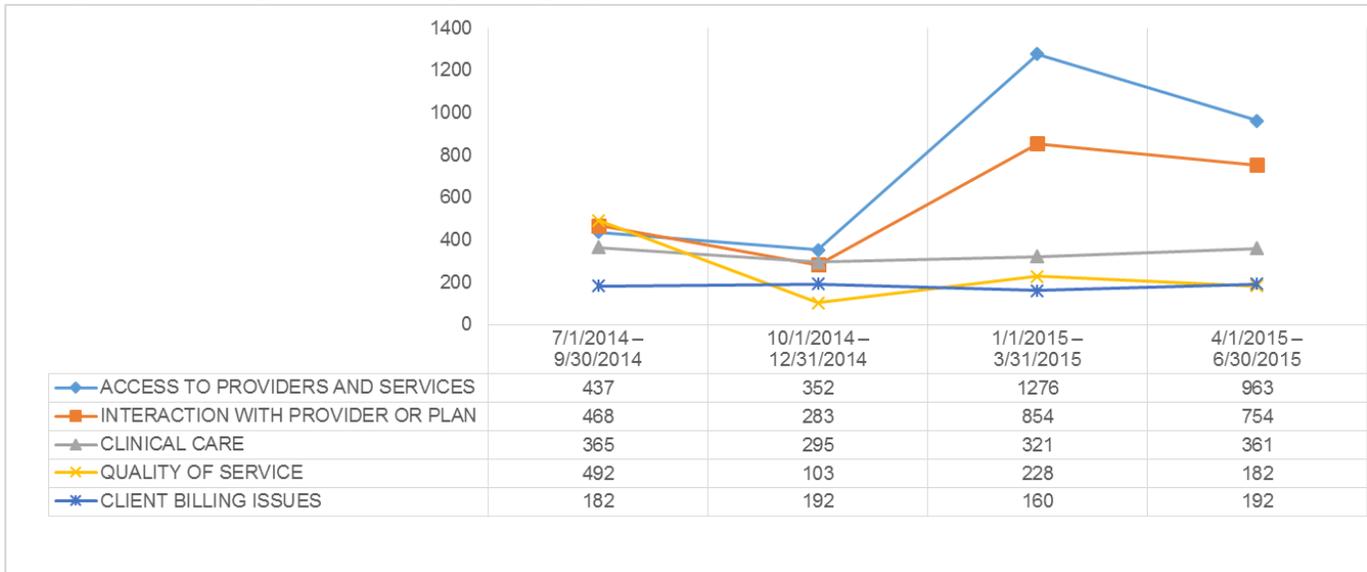
All categories of CCO complaints and grievances per quarter

Complaint or grievance type	7/1/2014 – 9/30/2014	10/1/2014 – 12/31/2014	1/1/2015 – 3/31/2015	4/1/2015 – 6/30/2015	2014-2015 Total
ACCESS TO PROVIDERS AND SERVICES					
a) Provider's office unresponsive, not available, difficult to contact for appointment or information.	123	106	622	419	1270
b) Plan unresponsive, not available or difficult to contact for appointment or information.	33	26	18	30	107
c) Provider's office too far away, not convenient	18	24	36	10	88
d) Unable to schedule appointment in a timely manner.	96	55	91	123	365
e) Provider's office closed to new patients.	34	20	17	24	95
f) Referral or 2nd opinion denied/refused by provider.	17	25	27	29	98
g) Unable to be seen in a timely manner for urgent/ emergent care	25	12	18	20	75
h) Provider not available to give necessary care	42	46	329	242	659
i) Eligibility issues	16	13	80	29	138
j) Client fired by provider	28	21	33	28	110
k) Availability of specialty provider	5	4	5	9	23
n) Dismissed by clinic as a result of past due billing issues	0	0	2	0	2
INTERACTION WITH PROVIDER OR PLAN					
a) Provider rude or inappropriate comments or behavior	179	28	380	291	878
b) Plan rude or inappropriate comments or behavior	10	19	24	21	74
c) Provider explanation/instruction inadequate/incomplete	132	107	289	218	746
d) Plan explanation/instruction inadequate/incomplete	83	44	65	89	281
e) Wait too long in office before receiving care	27	21	54	60	162
f) Member dignity is not respected	14	31	20	35	100
g) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity.	6	6	3	8	23
h) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity	1	3	0	3	7
i) Lack of coordination among providers	16	24	17	29	86
CONSUMER RIGHTS					
a) Provider's office has a physical barrier	0	1	52	14	67
b) Abuse, physical, mental, psychological	2	4	13	8	27
c) Concern over confidentiality	20	22	40	24	106
d) Client not involved with treatment plan. Member choices not reflected in treatment plan. Member disagrees with treatment plan.	99	68	60	63	290
e) No choice of clinician	13	10	16	24	63
f) Fraud and abuse	11	1	9	13	34

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Complaint or grievance type	7/1/2014 – 9/30/2014	10/1/2014 – 12/31/2014	1/1/2015 – 3/31/2015	4/1/2015 – 6/30/2015	2014-2015 Total
g) Provider bias barrier (age, race, religion, sexual orientation, mental/physical health status)	7	7	8	10	32
h) Plan bias barrier (age, race, religion, sexual orientation, mental/physical health status)	1	2	0	0	3
i) Differential treatment for Medicaid clients	14	12	11	17	54
j) Lack of adequate or understandable NOA	1	2	0	3	6
k) Not informed of consumer rights	1	1	33	23	58
l) Complaint and appeal process not explained	0	0	1	41	42
m) Denied member access to medical records	1	3	5	3	12
CLINICAL CARE					
a) Adverse outcome, complications, misdiagnosis or concern related to provider care.	131	104	138	153	526
b) Testing/assessment insufficient, inadequate or omitted	44	40	30	40	154
c) Medical record documentation issue	17	18	15	17	67
d) Concern about prescriber or medication or medication management issues	162	123	112	114	511
e) Unsanitary environment or equipment	7	5	16	16	44
f) Lack of appropriate individualized setting in treatment	4	5	10	21	40
QUALITY OF SERVICE					
a) Provider office unsafe/uncomfortable	21	18	88	86	213
b) Delay, quality of materials and supplies (DME) or dental	37	41	60	63	201
c) Lack of access to ENCC for intensive care coordination or case management services	2	3	2	15	22
d) Benefits not covered	432	41	78	18	569
CLIENT BILLING ISSUES					
a) Co-pays	3	7	5	5	20
b) Premiums	0	0	6	13	19
c) Billing OHP clients without a signed Agreement to Pay	179	185	149	174	687
Total complaints received	2,114	1,358	3,087	2,695	9,254
Total CCO enrollment	883,584	907,542	953,902	827,617	-
Rate per 1,000 members	2.39	1.50	3.24	3.26	-

Complaints and grievances by category, SFY 2015



B. Appeals and hearings

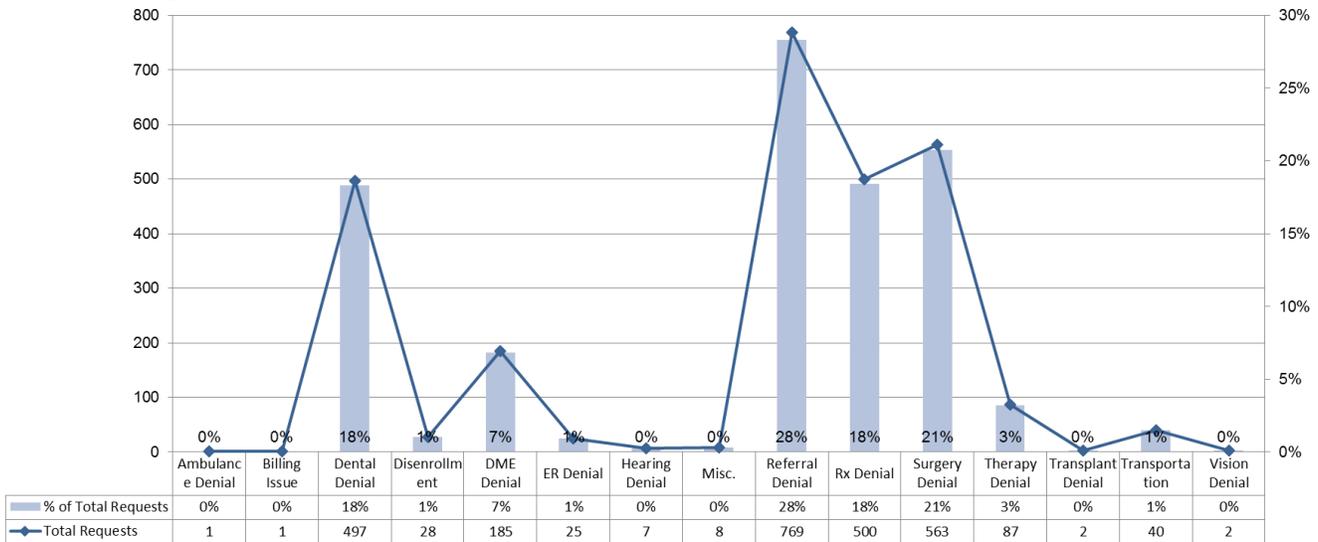
Hearing requests received, SFY 2015

Plan	Total Received	Plan Enrollment *	Per 1000 Members
CCO			
AllCare Health Plan	129	55,644	2.3183
Cascade Health Alliance	127	18,224	6.9688
Columbia Pacific CCO	60	52,568	1.1414
Eastern Oregon CCO	324	53,658	6.0382
FamilyCare	385	138,955	2.7707
Health Share Of Oregon	516	260,272	1.9825
Intercommunity Health Network	206	62,693	3.2859
Jackson Care Connect	52	32,806	1.5851
Kaiser Permanente	19	2,392	7.9431
PacificSource Community Solutions	347	123,611	2.8072
PacificSource Community Solutions - Gorge		13,613	0.0000
PrimaryHealth of Josephine County	32	13,581	2.3562
Trillium Community Health Plan	247	84,481	2.9237
Umpqua Health Alliance	174	30,372	5.7290
Western Oregon Advanced Health	89	23,586	3.7734
Willamette Valley Community Health	472	109,472	4.3116
Yamhill Community Care Organization	31	26,060	1.1896
DCO			
Access Dental Plan		3,585	0.0000
Advantage Dental	19	209,726	0.0906
Capitol Dental Care	2	70,559	0.0283
Care Oregon Dental		8,695	0.0000
Family Dental Care	2	3,616	0.5531
Managed Dental Care Of Oregon	1	3,775	0.2649
ODS Community Health	21	36,830	0.5702

Plan	Total Received	Plan Enrollment *	Per 1000 Members
FFS	163	603,733	0.2700
Total	3,418	2,042,507	1.6734

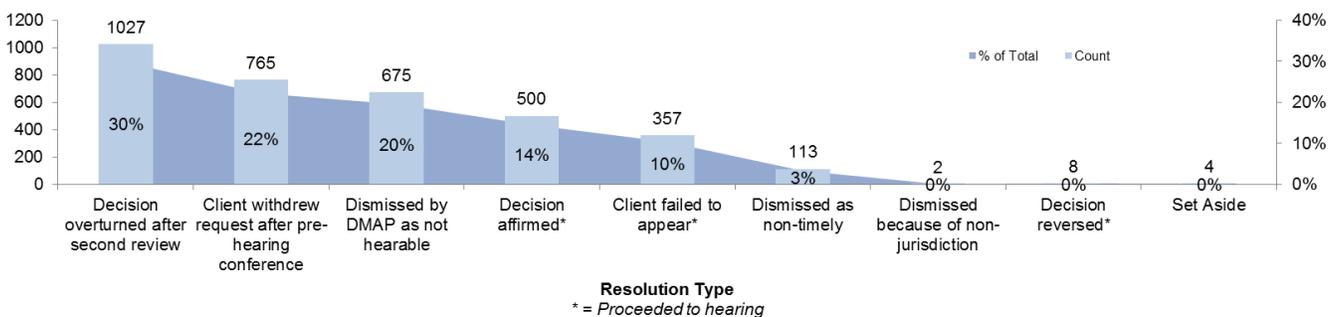
Data Source: New_HearingLog.mdb & DSSURS
 Data Extraction Date: 01/07/2016
 * Plan Enrollment based on Annual Member Months for CY 2014

Main hearing request reasons, SFY 2015



Data Source: New_HearingLog.mdb & DSSURS
 Data Extraction Date: 01/07/2016

Hearing request resolutions, SFY 2015



Data Source: New_HearingLog.mdb & DSSURS
 Data Extraction Date: 01/07/2016

XII. Metrics progress

Throughout the demonstration year, OHA continued to improve its standardized reporting to coordinated care organizations, hospitals, and the public, as well as ongoing measure development. During this third year of the transformation demonstration, OHA distributed the second quality pool payments to CCOs and

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the first quality pool payments to hospitals. This report provides an overview of the measurement activities occurring during the year.

CCO and hospital data are provided in the measures matrixes in Appendix A.

A. CCO measure development and reporting

OHA produced regular reports throughout the demonstration year. It also reported final calendar year 2014 data at the state and CCO level. OHA worked with stakeholders to develop and refine measure specifications, such as the inclusion of adolescents ages 12-17 in the screening, brief intervention, and referral to treatment (SBIRT) for alcohol or substance abuse measure. OHA maintains updated measure specifications and guidance documents [online](#).

Clinical quality measures

During this period, all 16 CCOs successfully submitted their Year Two Technology Plans and EHR-based data submissions for the three clinical quality measures (diabetes, hypertension, and depression screening). Year Two data was used to calculate statewide and CCO-level rates, which were published in the 2014 final report (see below).

Progress reporting

OHA provided CCOs with regular reports, including the launch of the monthly metrics dashboard in October 2014. The dashboard provides CCOs with an interactive tool to analyze performance on CCO incentive and quality and access test measures. Measure results are reflected for a rolling 12-month period, and member-level detail is included for claims-based measures to facilitate measure validation and quality improvement activities. In addition, results are filterable by gender, race and ethnicity, disability status, severe and persistent mental illness status, and other criteria.

OHA also provided CCOs with a report on CY 2014 performance for their final review and validation before distribution of the CY 2014 quality pool.

Final 2014 Performance Report

OHA published two reports on the CCO incentive, state performance, and core performance measures to the Oregon Health Policy Board and the general public. A mid-year report was published in January 2015 and the final CY 2014 report was published in June 2015. All reports are available online at <http://www.oregon.gov/oha/Metrics/>.

Overall, and for the second year, the coordinated care model continued to show improvements in a number of areas of care, even with the inclusion of the more than 434,000 additional Oregonians who have enrolled in the Oregon Health Plan since January 1, 2014. New rules took effect January 1, 2014, opening the Oregon Health Plan to more low-income adults as allowed under the Affordable Care Act. Today, approximately 1.1 million Oregonians are enrolled in OHP. Specific areas of improvement include:

- Emergency department visit rates for people served by CCOs have decreased 22 percent from 2011 baseline data. While some of the improvements may be due to national trends, CCOs have implemented a number of best practices for reducing emergency department utilization rates, such as the use of emergency department navigators.
- Decreased hospital admissions for short-term complications from diabetes. The rate of adult members with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 26.9 percent since 2011 baseline.

- Decreased rate of hospital admissions for chronic obstructive pulmonary disease. The rate of adult members (ages 40 and older) who had a hospital stay for COPD dropped by 60 percent since 2011 baseline.
- Patient-centered primary care home (PCPCH) enrollment continues to increase, indicating continued momentum even with the new members added since January 1, 2014. PCPCH enrollment has increased by 56 percent since 2011.
- Strong improvement to the screening, brief intervention, and referral to treatment (SBIRT) measure, which looks at the percentage of adult members who had appropriate screening for alcohol or other substance use.

Other measures in the CY 2014 report that highlighted room for improvement include cervical cancer and chlamydia screening for women. The changes in these screening rates may be due to changes in national guidelines reported in 2012, which recommended women wait three to five years between Pap tests, and not have their first Pap test until age 21.

2014 quality pool

OHA made the second annual quality pool payments to CCOs in June 2015. This year, OHA held back 3 percent of the monthly payments to CCOs, which were put in the common quality pool and distributed to CCOs that met the benchmark or improvement target on at least 12 of the 17 incentive measures (including Electronic Health Record adoption) and that had 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, which was distributed to CCOs that met the benchmark or improvement target on a subset of four measures: depression screening and follow-up plan, diabetes HbA1c poor control, alcohol and substance use screening (SBIRT), and PCPCH enrollment.

In summary: 13 of the 16 CCOs earned 100 percent of their quality pool, two CCOs earned 80 percent, and one CCO earned 60 percent.

Table: 2014 Quality Pool Distribution by CCO

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	11.7	80%	83%	\$6,170,421
Cascade Health Alliance	11.7	80%	84%	\$1,423,801
Columbia Pacific	13.9	100%	104%	\$4,247,607
Eastern Oregon	12.6	100%	103%	\$6,847,819
FamilyCare	13.8	100%	105%	\$17,157,018
Health Share	16.8	100%	105%	\$34,592,657
Intercommunity Health Network	9.9	60%	62%	\$5,310,493
Jackson Care Connect	13.8	100%	103%	\$4,704,838
PacificSource – Central	12.9	100%	104%	\$8,177,907
PacificSource – Gorge	13.0	100%	105%	\$1,872,161
PrimaryHealth	16.0	100%	105%	\$1,601,588
Trillium	13.6	100%	103%	\$12,658,814
Umpqua Health Alliance	12.9	100%	104%	\$4,491,875
Western Oregon Advanced Health	12.8	100%	103%	\$3,449,486
Willamette Valley Community Health	14.9	100%	104%	\$12,802,864
Yamhill CCO	12.7	100%	105%	\$2,981,967
Total 2014 Quality Pool				\$128,000,000

B. Hospital measure development and reporting

This demonstration year covered the first year of the Hospital Transformation Performance Program (HTPP). Year one (baseline) data were finalized and published, and hospitals received their first payments from the quality pool.

Baseline performance report

All participating hospitals successfully submitted baseline data (September 2013 – October 2014) for over 90 percent of the measures for which they were eligible. Results were compiled and published in the [Hospital Transformation Performance Program Baseline Year Report](#), published in April 2015.

The report showed:

Hospitals are doing well in the area of increased medication safety.

- Adverse drug events due to opioids: all hospitals achieved the benchmark.
- Excessive anticoagulation with Warfarin: 27 of 28 hospitals achieved the benchmark.
- Hypoglycemia in inpatients receiving insulin: 25 of 28 hospitals achieved the benchmark.

Follow-up after hospitalization for mental illness, a hospital-CCO coordination focused measure: 15 of 28 hospitals achieved the benchmark.

Initial quality pool

OHA made the first quality pool payments to hospitals in April 2015. In this first year, a total of \$150 million in funds were awarded based on successful submission of baseline data adhering to OHA guidelines and measure specifications for 11 measures.

A two-phase distribution method determined amounts awarded. In the first phase, all participating hospitals were eligible for a \$500,000 “floor” payment if they achieved at least 75 percent of the measures for which they were eligible. “Achieved” was defined as successfully submitting baseline data in Year One). All hospitals achieved this floor, resulting in \$14 million in payments.

In the second phase, the remaining \$136 million was distributed on a measure-by-measure basis. Hospitals successfully reported most or all of the data required for payment.

Table: Year 1 HTPP quality pool distribution by measure (phase 2)

Measure	Measure weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
CAUTI in all tracked units	9.38%	\$12,750,000	28
CLABSI in all tracked units	9.38%	\$12,750,000	28
Adverse drug events due to opioids	6.25%	\$8,500,000	28
Excessive anticoagulation with Warfarin	6.25%	\$8,500,000	28
Hypoglycemia in inpatients receiving insulin	6.25%	\$8,500,000	28
HCAHPS: staff always explained medicines	9.38%	\$12,750,000	27
HCAHPS: Staff gave patient discharge information	9.38%	\$12,750,000	28
Hospital-wide all-cause readmissions	18.75%	\$25,500,000	28
Follow-up after hospitalization for mental illness	6.25%	\$8,500,000	28
SBIRT: screening for alcohol and other substance misuse in the emergency department	6.25%	\$8,500,000	17
EDIE: hospitals share emergency department visit information with primary care providers and other hospitals to reduce unnecessary ED visits.	12.5%	\$17,000,000	26

Measure	Measure weight	Total amount available for measure	Number of hospitals qualifying for baseline payment
TOTAL	100%	\$136,000,000	

C. Committees and workgroups

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

CCO Metrics & Scoring Committee

This legislatively appointed committee met seven times during the demonstration year to select measures and benchmarks and refine overall methodology for the CCO incentive program. All meeting materials are [available online](#).

CCO Metrics Technical Advisory Workgroup

This workgroup met monthly during the demonstration year to address details related to the incentive measures and overall analytic activities. More than 50 individuals representing the 16 CCOs participated. Meeting materials are [available online](#).

Hospital Performance Metrics Advisory Committee

This legislatively appointed committee met four times during the demonstration year to develop measures and domains, establish benchmarks, and refine specifications and methodology for the hospital incentive program. All meeting materials are [available online](#).

D. 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. Q Corp has been independently producing the 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 multiple measurement periods. Validation is an ongoing process for both the DY and the CY measurement periods, to reflect annual updates to specifications. OHA and Q Corp have worked to reconcile differences found in the data to ensure the quality and accuracy of the quality and access test.

Results from the first quality and access test (July 2013 – June 2014) were reported to CMS in February 2015 and are [available online](#). Results from the second quality and access test are presented in Appendix C.

XIII. Appendices

A. Hospital Transformation Performance Program (HTPP) data

[Attached separately](#). This report includes the final baseline data for the period covering October 2013 – September 2014, as well as preliminary progress report data from the first nine months of the performance year (October 2014 – June 2015).

B. Oregon measures matrix

[Attached separately.](#)

C. DY 13 quality and access test

Under STC 52 and 54 of Oregon's 1115 demonstration waiver, OHA must conduct a quality and access test in each program year that the state achieves its cost control goal to determine whether the state's health system transformation efforts have caused a decline in the quality of care and access to care experienced by state Medicaid beneficiaries.

The test has two parts: part 1 is a relatively simple comparison of program period quality and access to historical baseline levels of quality and access; part 2 is a more complex counterfactual comparison that will be undertaken only if the state fails part 1 in a given program year.

For the first two years, part 1 of the test is passed if a composite score for the quality and access metrics remains constant or improves as compared to the historical baseline. In subsequent years, the composite score must improve. DY 13 is the second year Oregon's quality and access test applies.

Part 1 of the test consists of a single aggregate indicator constructed using the 33 agreed-upon quality and access measures (although individual measures can be excluded from the composite with good reason).

The test result is generated based on the difference between aggregate performance in the demonstration year and the baseline period (calendar year 2011). Full methodology is documented in Oregon's Accountability Plan, online at <http://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf>

DY 13 test results

OHA presents three sets of DY 13 test results for CMS consideration, depending on the level of independence in the measure production underlying the composite score and the number of measures included.

Regardless of which option is selected, Oregon demonstrates aggregated improvement over the 2011 baseline on the quality and access measures.

DY 13 Test #	Description	# of Measures Included (of 39 ²)	DY 13 Test Score
1	<p>DY 13 Test #1 was conducted entirely by Q Corp; all measures included in the composite were independently calculated and validated.</p> <p>Note: Several claims-based measures are still undergoing validation for the DY period, although results for prior measurement periods had been validated and included in previous reporting.</p> <p>Q Corp can only independently calculate claims-based measures, resulting in less than half of the measures being included in the composite.</p>	13	14.3%
2	<p>DY 13 Test #2 was conducted jointly by Q Corp and OHA.</p> <p>Thirteen claims-based measures were independently calculated and validated by Q Corp; non-claims based measures were calculated by OHA. Remaining claims-based measures that are still undergoing validation are not included in Test #2.</p>	28	58.4%
3	<p>DY 13 Test #3 was conducted entirely by OHA; all measures included in the composite were produced by OHA.</p> <p>Slight differences in the code and data used between OHA and Q Corp result in different results for the individual claims-based measures, although the overall trend in improvement is similar.</p> <p>All other data reported in the measures matrix below was produced by OHA.</p>	35	118.7%

See [composite tables](#) (attached separately) for the specific results, included measures, and rationale for exclusions under each result.

² Note measures with multiple rates are treated as separate measures in the composite scoring, resulting in more than the 33 quality and access test measures. For example, the measure Ambulatory Care: Outpatient and Emergency Department Utilization is treated as two measures for the purposes of the composite.